A “Chronic Complainer’s” Guide to the Hystericizing of Fibromyalgia

by

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Author’s Declaration

I hereby declare that I am the sole author of this thesis. This is a true copy of the thesis, including any required final revisions, as accepted by my examiners.

I understand that my thesis may be made electronically available to the public.

Abstract

In the early 2000s, a study set out to test the popular belief that fibromyalgia is "factitiously driven by misinformed media reports and an overly liberal disability compensation system" (White & Thompson 2003). Although the authors disproved this hypothesis, their findings nonetheless provoked a series of editorials that reinscribed these suspicions and were published alongside the original study in the *Journal of Rheumatology*. Working within feminist disability studies and using discourse analysis as a method, I examine how these editorials engage in what Anna Mollow (2014) identifies as the routine hystericization of conditions with medically unexplained symptoms. I argue that these texts mobilize an all-too common narrative of "secondary gain" whereby patients, particularly women, are cast as "chronic complainers" and suspected of feigning or exaggerating illness for some interpersonal or economic advantage. I position these representations within a longer genealogical continuum of poorly understood conditions historically framed as psychosomatic to demonstrate how these editorials recycle and repackage gendered characterizations of nineteenth century nervous disorders and apply them to their (mis)representation of fibromyalgia. By framing fibromyalgia in this way, the authors perpetuate harmful narratives that I argue contribute to the oppression of those of us with misunderstood and invisibilized illnesses.

Drawing on principles of disability justice, I extend this analysis by situating these suspicions toward feminized and unverifiable illness within a broader moral economy that ties human worth to value-laden notions of citizenship, productivity, and independence. In this schema, those perceived as "unproductive" members of society with no "legitimate" claim to illness are positioned as unworthy burdens on the healthcare system and undeserving of social supports. I argue that these pejorative framings reproduce eugenic logics that construct dependency as a social and economic threat, obscuring the fundamentally interdependent nature of human life and legitimizing the restriction of care and support to those deemed undeserving. Ultimately, this dissertation traces how skepticism toward fibromyalgia is embedded in broader historical narratives and cultural ideologies that continue to shape access to care, structuring whose pain is believed, whose suffering is recognized as worthy of care, and which lives are valued and sustained.

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Introduction

In 2004, *House M.D.* premiered and would become one of the most popular medical dramas on television, celebrated for its hyper-rational diagnostician who solves baffling medical mysteries by cutting through the lies of patients. In the very first episode, a fatigued clinic patient tells Dr. House he thinks he might have chronic fatigue syndrome: when the patient says he's tired a lot, House responds, "That's kind of the definition of getting older" and when the patient lists more symptoms after House's pointed skepticism—headaches, mild fever, insomnia, trouble concentrating—House responds, "Apparently not while searching this stuff on the internet." The patient then suggests he might perhaps have fibromyalgia, asking "Is there anything for that?" House agrees with mocking enthusiasm, leaves the room to order "thirty-six Vicodin and change for a dollar," pockets the Vicodin and replaces the now empty pill bottle with the candy he purchased from the vending machine. By episode's end, the patient returns seeking a refill.

The humour in this scene depends on the audience's familiarity with a shared cultural code: that chronic fatigue syndrome (CFS) and fibromyalgia (FM) are not "real" diseases but instead catch-all labels for vague, psychosomatic complaints that belong to the realm of hypochondria or malingering. In this cultural script, patients who invoke these diagnoses—gleaned through amateur internet searches or other media sources—are imagined to be highly suggestible or deceitful. The joke lands because of the audience's shared recognition of the dominant cultural narrative in which patients with CFS or fibromyalgia are imagined as "chronic complainers" who latch onto fashionable, fictitious labels to explain ordinary life difficulties. The patient's easy shift from CFS to fibromyalgia signals that these diagnoses are interchangeable and chosen according to trend: the once popular CFS of the 1990s has been supplanted by the newer "fashionable" diagnosis of the 2000s, fibromyalgia. Whichever

condition the patient attaches themselves to in the episode is irrelevant as both CFS and fibromyalgia are culturally legible shorthand for vague conditions rooted in internet self-diagnosis and motivated by illness beliefs rather than biomedical legitimacy. What does matter is the viewer's ability to track which condition currently circulates as the popular explanation for diffuse everyday pains, and to infer that the patient is motivated by their own belief rather than biology.

The candy placebo is the hinge on which the entire joke turns where the audience is invited to interpret the candy not only as a humorous deception but as a revelation that the patient's "real" illness is his belief. His ready acceptance of fake medication—and his later return for a refill—confirms the suspicion that his suffering is psychological, self-inflicted, or performative. Part of what makes this joke so compelling is that the viewer is invited not only to laugh at the patient, but also to identify with House. The scene produces a subtle sense of moral and intellectual superiority: by recognizing the "type" of patient who invokes chronic fatigue syndrome or fibromyalgia, the viewer gets to feel as savvy, perceptive, and unfooled as the doctor-savant himself. The audience sees what House sees—the supposed gullibility, the self-diagnosis, the fashionable "internet illness"—and, in doing so, is positioned as clever enough to be in on the joke with House. This alignment flatters the viewer's own potential frustrations with people they may have heard use these terms—i.e. "everyone nowadays says they have fibromyalgia"—granting them a vicarious sense of superiority over the patient who "falls for" the fake medication.

In this way, the scene does not simply portray skepticism toward fibromyalgia and CFS but normalizes and rewards the viewer for their skepticism and ability to track the shifts in popular illness discourse the episode is implicitly referencing. The exchange generates viewer

satisfaction precisely because it taps into a cultural trend encouraging scrutiny and skepticism of those who claim illnesses that lack medical legitimacy. Undergirding this entire exchange is House's mantra, introduced and referenced repeatedly in this episode, that treating patients is intolerable because "everybody lies"—this is also the title of the episode. This dictum establishes a worldview in which patient accounts are suspect by default and objective disease is the only legitimate form of truth—and it is a worldview in which the audience is recruited to participate.

While *House* is a fictional medical drama, this episode crystallizes widely circulating narratives about contested illnesses that emerged in the 1980s around chronic fatigue syndrome and were later taken up and entrenched in relation to fibromyalgia through the 1990s and early 2000s. The episode both participates in and amplifies pre-existing beliefs about invisible illness that helps to illustrate the cultural terrain underpinning medical and mainstream discourse on fibromyalgia which this dissertation examines. The cultural logic that emerges in this opening scene provides a point of entry into the medical texts that anchor this dissertation as a whole. I will outline these texts below after I situate them further within the cultural context which prompted their emergence.

1. Cultural Context

Throughout the late 1980s and into the 1990s, chronic fatigue syndrome circulated in mainstream media as a feminized, ambiguously biomedical condition popularly dubbed and disparaged as "yuppie flu"—a label associated with anxious, middle-class and upwardly mobile women whose exhaustion was interpreted less as physiological impairment than as a symptom of stress, emotional fragility, or inability to cope with the pressures of modern life ("'Yuppie flu' is all in the mind, say doctors," *Sunday Times* 1988). Lacking a definitive biomarker and defined largely by subjective symptoms, CFS was repeatedly mocked as a "fashionable" or

"psychosomatic" disorder, a successor to hysteria updated for the modern era. Like hysteria, this framing cast patients as unreliable narrators of their own suffering and encouraged the public to interpret CFS claims through a lens of suspicion, as though the illness functioned more as a problem in coping mechanisms, illness identity, avoidance strategy, lifestyle, or a means to seek attention than as legitimate physiopathology. In this environment, popular media absorbed and amplified the idea that illnesses like CFS were vague, trendy, psychologically-driven, and culturally-contagious, priming audiences to view contested illness as evidence of flawed beliefs rather than biological dysfunction (*Sunday Times* 1988; *Newsweek* 1990; *St. Petersburg Times* 1990).

Fibromyalgia inherited many of these same cultural stereotypes. As CFS was portrayed as a waning fad by the 2000s, fibromyalgia emerged in popular and medical discourse as the newer, more "fashionable" label for chronic, unexplained symptoms (Shorter 1993; Collin et al. 2017). While both conditions were treated dubiously, by the early 2000s fibromyalgia became increasingly entangled with questions of compensation, workplace avoidance, and fraudulent pain claims (Le Page 2005). This is partly due to an increase in long-term disability and worker's compensation claims associated with fibromyalgia. This increase in claims due to fibromyalgia disablement prompted insurers, employers, and courts to treat the diagnosis as inherently suspicious, which was exacerbated by the view that chronic pain is unverifiable, subjective, exaggerated, and easily feigned—putting the diagnosis at high-risk for fraudulent claims (Gervais et al. 2001). An article on "Chronic Pain Compensation in Canada" specifically lists fibromyalgia as one of the chronic pain conditions frequently viewed as "psychogenic, exaggerated, and/or malingered," which has posed difficult policy questions for compensation boards (Noonan & Wagner 2005).

Medical discourse frequently reinforces this view with some literature continuing to characterize fibromyalgia patients as exaggerating or deceitful and possibly incentivized to simulate disease for secondary gain (Ribatti et al. 2025; Schweiger et al. 2017; Fitzcharles et al. 2014; Greve et al. 2009). When fibromyalgia features in popular media it is frequently used as a punchline,[1] contributing to the narrative that it is associated with laziness, faking, overreacting, chronic complaining, or an excuse to avoid work. These characterizations of fibromyalgia have bound the condition to broader cultural anxieties about dependency, un/productivity, and the moral valuation of work. They have also fed a cultural narrative of malingering that has led many to question "is this person *really* in pain or are they merely avoiding work?"

In fact, the suspicion that fibromyalgia represents an attempt to "avoid work" becomes central to how the condition is understood, emerging alongside—and gaining force from—neoliberal labour anxieties surrounding productivity and dependency. Neoliberal restructuring from the 1980s onward involved declining workplace protections and intensified surveillance of workers' bodies, particularly around chronic pain or stress claims. Duncan's (2003) analysis of workers' compensation and chronic pain demonstrates how medico-legal systems treat subjective pain as a governance problem, requiring heightened scrutiny and often casting claimants with "ambiguous" conditions as suspect and potentially motivated by "malingering and unwillingness to work" (458). Grover & Soldatic (2013) similarly trace how disabled people are compelled to

[1] In addition to the *House* pilot episode, the following article published in *The Mighty* includes a list of TV shows that have referenced fibromyalgia. The article notes references to fibromyalgia are rare, but that some depictions associate it with hypochondria or pejoratively frame the condition. A character in the TV show "Haters Back Off," for instance, says she has fibromyalgia to avoid duties at work and gain sympathy. The article also demonstrates the number of instances that fibromyalgia is mentioned together with CFS. However, some media depictions directly engage with the problematic framing of fibromyalgia. The Golden Girls, for instance, is one of the first memorable TV moments that confronts the narrative that "it's all in your head." https://themighty.com/topic/fibromyalgia/fibromyalgia-tv-show. In addition, there is a Reddit thread devoted to "Fibro jokes in TV Shows" that offers more examples of its use as a punchline and how this depiction affects those living with fibromyalgia https://www.reddit.com/r/Fibromyalgia/comments/9q5qw8/fibro_jokes_in_tv_shows

prove their deservingness within increasingly punitive welfare-to-work reforms, where dependency and malingering are central anxieties.

This is the backdrop in which fibromyalgia—frequently litigated in disability and long-term benefit claims and routinely denied for lack of "objective" evidence—became a paradigmatic contested diagnosis entangled with fears of disability fraud and work avoidance. Set against neoliberal values of individual responsibility, resilience, productivity, and self-sufficiency, fibromyalgia was framed as a syndrome linked to work avoidance and moral failing. Just as CFS has been cast as psychological weakness, stress-related, fashionable, and media-driven, these stereotypes were applied to fibromyalgia with heightened suspicion, making patients especially susceptible to accusations of manipulation or "secondary gain" through benefit-seeking or avoidance of work.

2. Testing the Hypothesis of Secondary Gain: White and Thompson's Study

The association of fibromyalgia with feigning illness for secondary gain was so ubiquitous in the 2000s that it prompted a 2003 study to investigate this hypothesis. Pre-dating the premiere of *House* by three years, White and Thompson published "Fibromyalgia syndrome in an Amish community: a controlled study to determine disease and symptom prevalence." This study was prompted by the popular cultural belief that FM arises as an "illness behavior" fostered by sensational media coverage or by permissive disability-compensation systems. The Amish community in Aylmer, ON was chosen specifically for the study because its residents neither use electronic media nor consult publications produced outside their own community; they abstain entirely from public or private insurance or disability programs; their cultural emphasis on self-reliance—or as the study put it, their "very strong work ethic and sense of independence" (1836)—further discourages pursuing any form of financial assistance. The

primary purpose of this study was therefore to test whether fibromyalgia would be non-existent in a community without exposure to mass media, without access to disability or insurance compensation, with strong cultural norms discouraging seeking external help or claims of disability, and with values of independence and hard-work—values that are commonly framed as lacking in fibromyalgia patients. Thus, if FM was a "media, litigation, or compensation-driven ailment, it should be uncommon, if present at all, in the Amish" (1836).

Despite the absence of these purported social incentives, the study's authors surprisingly found FM to be not only present but notably more prevalent than in the adjacent community of urban London, ON and southeast London's rural community, at 7.3% versus 3.8% and 1.2%, respectively (1838). Their findings indicated that access to litigation or disability compensation does not meaningfully increase the prevalence of fibromyalgia. They further note their findings correspond with other data that has found fibromyalgia is often more common in countries where disability benefits and compensation systems are expected to be more limited—such as Pakistan, Poland, and South Africa—than in nations with comparatively more generous compensation structures like Sweden, Denmark, and Finland (1838). The results of this study, therefore, challenged the common assumption that diagnoses of fibromyalgia are largely driven by media sensationalism and the availability of compensation, which underlies arguments suggesting individuals feign illness for secondary gain.

3. Editorial Reactions

In response to these findings, White and Thompson's study provoked a strong reaction from (largely) members of the editorial board of the journal in which it was published: *The Journal of Rheumatology*. Published in the same issue alongside the study, these responses comprise three editorials (Hadler, Ehrlich, Wolfe) and one editor's commentary (Gordon):

- George Ehrlich, “Pain is Real; Fibromyalgia Isn’t”;
- Duncan Gordon, “Fibromyalgia: Real or Imagined?”;
- Nortin Hadler, “‘Fibromyalgia’ and The Medicalization of Misery”;
- Frederick Wolfe, “Stop Using the American College of Rheumatology Criteria in the Clinic”

Taken together, these articles reiterate a familiar set of claims about fibromyalgia in direct contradiction to the evidence presented in the study to which they respond. They regurgitate the same cultural stereotypes about fibromyalgia that I outlined above: very broadly, that fibromyalgia is an illness belief popularized in the media and that patients choose to exaggerate their pain and suffering for the supposed illness gains they receive in the form of personal and financial awards.

These 2003 editorials comprise the initial archive that I will be analyzing throughout this dissertation. In addition to these editorials, I consider both earlier and more recent publications by these authors, which together demonstrate a concerted effort to shape and control the narrative representation of fibromyalgia over several decades. These articles—whose titles alone signal their stance on fibromyalgia—include:

Table 1. Additional Publications on Fibromyalgia

	Author	Year	Type	Publication	Title
1.	**George Ehrlich**	2003	Letter to the Editor	Arthritis & Rheumatology	Fibromyalgia Is Not a Diagnosis: Comment on the Editorial by Crofford and Clauw
2.	**George Ehrlich**	2003	Editorial	Clinical Rheumatology	Fibromyalgia; A Virtual Disease
3.	**Duncan Gordon**	1997	Comment	The Journal of Rheumatology	Fibromyalgia: Out of Control
4.	**Duncan Gordon**	2003	Discussion paper	The Ontario Workplace Safety and Insurance Appeals Tribunal (WSIAT)	Fibromyalgia Syndrome

5.	**Nortin Hadler**	1996	Editorial	Journal of Occupational and Environmental Medicine	The Disabled, the Disallowed, the Disaffected and the Disavowed
6.	**Nortin Hadler**	1996	Editorial	Spine	If You Have to Prove You Are Ill, You Can't Get Well. The Object Lesson of Fibromyalgia
7.	**Nortin Hadler**	1997	Editorial	The Journal of Rheumatology	Fibromyalgia: La Maladie est Morte. Vive le Malade!
8.	**Nortin Hadler & George Ehrlich**	2003	Editorial	Journal of Occupational and Environmental Medicine	Fibromyalgia and the Conundrum of Disability Determination
9.	**Nortin Hadler & Susan Greenhalgh**	2005	Editorial	Spine	Labeling Woefulness: The Social Construction of Fibromyalgia
10.	**Nortin Hadler**	2013	Editorial	The Journal of Rheumatology	Workers' Compensation, Fibromyalgia, and Kafka
11.	**Frederick Wolfe and Joshua Potter**	1996	Article	Rheumatic Disease Clinics of North America	Fibromyalgia and Work Disability: Is Fibromyalgia a Disabling Disorder?
12.	**Frederick Wolfe**	1997	Editorial	The Journal of Rheumatology	The Fibromyalgia Problem
13.	**Frederick Wolfe**	2000	Editorial	The Journal of Rheumatology	For Example Is Not Evidence: Fibromyalgia and the Law
14.	**Frederick Wolfe**	2000	Editorial (response to articles published in same issue: "Fibromyalgia: can one distinguish it from simulation" and "Fibromyalgia: can one distinguish it	The Journal of Rheumatology	Sayin' 'Stand and Deliver, For You are a Bold Deceiver': Faking Fibromyalgia

			from malingering"		
15.	**Frederick Wolfe**	2009	Review	The Journal of Rheumatology	Fibromyalgia Wars
16.	**Frederick Wolfe & Brian Walitt**	2013	Opinion	Rheumatology	Culture, Science and The Changing Nature of Fibromyalgia
17.	**Frederick Wolfe & Johannes Rasker**	2021	Article	Cureus	The Evolution of Fibromyalgia, Its Concepts, and Criteria

Collectively, the batch of 2003 editorials and the additional articles authored by Ehrlich, Gordon, Hadler, Ehrlich, and Wolfe listed in this chart are the primary documents under analysis in this dissertation.

I will examine this archive for what Anna Mollow (2014) has observed is the routine hystericization of conditions with medically unexplainable symptoms (186). Even though hysteria is no longer a valid diagnosis, symptoms which cannot be captured through biomedical technologies are often treated as if they are imaginary, exaggerated, or un/consciously feigned. Individuals with chronic illnesses without visible pathology are moreover framed through narratives of malingering in which they are suspected of faking their symptoms for undeserved entitlements or other rewards (Mollow 186). My analysis of these articles therefore considers how pain and fatigue conditions such as fibromyalgia—but also other invisible and diagnostically-unverifiable illnesses more broadly—are positioned within a genealogical continuum of poorly understood symptoms historically framed as psychosomatic. I argue that the gendered cultural logic of hysteria has been mobilized to discredit the testimonies of women with invisible illnesses, dismiss their symptoms as arising from exaggeration or weakness, and cast doubt on their own understanding of their lived bodily experiences in favour of disciplining their unruly bodyminds. In short, to be ill with fibromyalgia in this cultural climate is to be

disbelieved, cast as a malingerer, receive inappropriate or no medical care, and treated as a burden to society. Although the archive centers on fibromyalgia, I analyze how skepticism toward fibromyalgia and similarly invisible conditions is woven into broader cultural narratives that have historically devalued particular bodyminds and faulted them for diverging from able-bodied norms.

Beginning with the texts under analysis, I trace the genealogy of the ideological frameworks that structure skepticism toward fibromyalgia, situating them within a longer history of medical and cultural discourse on nineteenth century hysterical-nervous disorders and moralized views of productivity and dependency. Tracing these historical antecedents reveals how contemporary representations of fibromyalgia are shaped by enduring cultural anxieties about bodily legitimacy, work, the specter of disability fakery, and beliefs about the proper functioning of bodies under capitalism. Within a capitalist society shaped by long-standing associations between disability and the capacity for work—and further intensified under neoliberal governance—human worth is increasingly measured through values of productivity and independence, exemplified by the waged worker, against which those with pain and fatigue conditions are cast as deficient, non-compliant, or as evading the civic and moral obligations of work. Ultimately, the representation of fibromyalgia in these authors' medical discourse illuminates that these prevailing attitudes toward disabled women in pain—including those that frame them as unproductive, dependent, or morally suspect—are entangled in complex histories of gendered, classed, ableist, and racist views of the body. These views have consequently shaped whose experiences of suffering are considered legitimate and who is determined to be worthy of care.

Fibromyalgia is a disorder with no known cause, primarily characterized by widespread pain and fatigue,[2] and absent a definitive biomarker. It is mainly diagnosed in women (Abbi & Natelson 2013). I have been diagnosed with fibromyalgia for over 15 years and lived with these and other poorly understood symptoms for far longer. This dissertation is inspired by my experience of living with invisible illnesses—chronic conditions that are not readily visible and are routinely treated with suspicion. This positionality informs my analysis,[3] shapes how the argument unfolds, and underscores the epistemic stakes of fibromyalgia's representation: in particular, how medical credibility shapes whose pain is believed, whose knowledge counts, and whose suffering is recognized as legitimate.[4] Disability studies scholars note that a disability studies approach encourages those of us living with contested or chronic conditions to intervene in problematic medical discourses and to more actively shape how such conditions are represented (Vidali 2013). Following this approach—and the principle of "nothing about us without us"—this project participates in reshaping conversations about fibromyalgia and other contested or poorly understood conditions that have historically excluded the perspectives and knowledge of those who live with such conditions.

[2] I would describe this type of pain as a deep burning or aching in the muscles and joints, along with fatigue that can be debilitating. Other symptoms are many, some of which include heightened sensory sensitivity, varied cognitive difficulties, digestive issues, and headaches or migraines ("Fibromyalgia": NHS 2022; Cleveland Clinic 2022). These are more or less the most commonly referenced symptoms within the community, but fibromyalgia symptoms are varied and can often enfold other disorders, such as irritable bowel syndrome (IBS). While I have provided references for these commonly listed fibromyalgia symptoms, these descriptions are also widely documented within patient communities and reflect shared lived experience. I therefore draw on experiential knowledge in describing the condition, recognizing how such accounts are often afforded less epistemic weight than clinical criteria, even where clinical definitions rely on patient-reported symptoms.

[3] Throughout the dissertation, I move between more distanced and more situated forms of address. In particular, I at times adopt first-person plurals (us/we) to re-signal for the reader my own positionality within the community under discussion and to align with disability studies' emphasis on lived experience as a form of knowledge.

[4] While my positionality informs this work, I remain attuned to the uneven distribution of epistemic and material harms, especially for women whose experiences of invisible illness are compounded by racialization, economic precarity, or limited access to care. This analysis is grounded in equity-oriented feminist disability studies commitments that foreground these differential stakes.

Part of that reshaping is reflected in how I chose to write this dissertation. Academic writing conventions often prioritize clarity and linearity. At the same time, I am mindful that expectations of constant clarity and linearity are not neutral, but are themselves tied to normative assumptions about cognition, coherence, and what counts as legitimate academic knowledge production.[5] One aim of the project is to remain attentive to how those expectations can marginalize forms of thinking and writing shaped by chronic illness. The arguments in this dissertation therefore build and accumulate, returning to concepts from different angles as additional historical context and analytical layers are introduced. In this sense, the dissertation proceeds somewhat archaeologically: earlier sections excavate historical and cultural foundations upon which later analyses build, even as those foundations are interpreted through the project's evolving analytical frameworks. Each stage of the argument lays groundwork for the next, establishing context before moving toward broader analyses of the discourses, institutions, and forms of epistemic authority that shape how contested illnesses are understood. This recursive movement reflects how discourse itself operates: meanings circulate, reappear, and accumulate across different historical moments and institutional contexts rather than unfolding in a strictly linear fashion—an approach that is consistent with discourse-analytic methods that trace how ideas are reiterated, reframed, and sedimented across texts and sites (Fairclough 1993). While I aim to provide sufficient orientation for the reader (through headings organized into sub-levels, explicit framing of sections, sign-posting across chapters, and strategic return to key concepts), I do not reduce this complexity to a uniformly streamlined structure, as doing so would risk reproducing the very epistemic norms this project seeks to interrogate. Scholarship on contested

[5] For a discussion of clarity in writing as a "taken-for-granted virtue," and how demands for clarity may be "implicated within a wider capitalist system that privileges time, productivity, linearity, and outputs," please see Thorneycroft (2025), who notes that what counts as "clear" language aligns with—and serves—the communicative demands of the neoliberal capitalist project: "Troubling the Quest for Clarity" (DOI: 10.16993/sjdr.1215).

illnesses has long been shaped by interpretive frameworks that position individuals' accounts as unreliable or secondary to expert authority. By writing from the standpoint of lived experience while simultaneously engaging historical and discourse analysis, this project treats experiential knowledge not as anecdotal supplementation but as an epistemic perspective capable of illuminating how such frameworks operate.

4. The *Rheumatology* Authors: Who Are They and Why Do They Matter?

Below are brief biographies describing who these *Journal of Rheumatology* authors are and why their narrative of fibromyalgia matters.

Duncan Gordon

Duncan Gordon was a well-known figure in rheumatology and the longtime editor of *The Journal of Rheumatology* (1979–2012). He was Professor of Medicine at the University of Toronto from 1976, and his clinical and research work focused on rheumatology, in which he published extensively. Gordon also served as an assessor for Ontario's Workplace Safety and Insurance Appeals Tribunal (WSIAT) beginning in 1988. As a recognized expert, he was recommended by the Tribunal's medical counsellors to author a 2003 discussion paper on "Fibromyalgia Syndrome," intended to provide a balanced overview of current medical knowledge. Such papers, written for lay readers, offer general summaries of medical topics frequently encountered in appeals and are often relied upon by Tribunal panels when making decisions. As a result, the information they contain can carry considerable influence in the adjudication process.

Gordon's discussion paper references (without citation) the opinions of Nortin Hadler, including his unsubstantiated claim that FM "promot[es] dependency, and somatization by persons disaffected with their work," as well as George Ehrlich's view (though Ehrlich is not

named) that FM "represents a functional disorder of a broken urban society" (4). These perspectives are presented as medical knowledge, despite the fact that both originated in editorials responding to White and Thompson's study, which contradicted their assertions. Moreover, the paper frames these editorials as legitimate counterpoints to White and Thompson's peer-reviewed findings, implying equivalence of evidentiary weight—an important issue for a Tribunal presumed to have limited familiarity with fibromyalgia and relying on this report's "balanced overview." The discussion paper was reviewed again in 2013 and deemed to still provide "a balanced overview of medical knowledge" (n.p.). However, a 2014 article assessing medico-legal challenges in fibromyalgia adjudication noted that the report "falls short in up-to-date information," that its recommended readings were heavily skewed toward discussion-type articles, and that the 2013 review did not correct these shortcomings (Fitzcharles et al.).

Frederick Wolfe

Frederick Wolfe has been one of the most influential figures in shaping how fibromyalgia is defined and represented—both within the medical community and in broader public understanding. He has served on many editorial boards, joining the editorial board of the *Journal of Rheumatology* in 1991. He has published hundreds of articles, dozens of which focus on fibromyalgia alongside many additional papers where fibromyalgia appears as one of several pain or rheumatic conditions under study. He was lead author in the development of the 1990 American College of Rheumatology (ACR) classification criteria for fibromyalgia, which established the first widely adopted diagnostic framework for fibromyalgia, defining it through widespread pain and tender-point examination. This framework effectively determined the terms through which fibromyalgia would be recognized in medicine. The 1990 criteria became the

dominant reference point for decades, and because they emphasized tender-point examination, Wolfe's framework helped define fibromyalgia as a rheumatologic entity grounded in measurable bodily findings, reflecting an epistemic stance that structured whose symptoms counted as legitimately ill. He later led the development of the 2010 ACR preliminary diagnostic criteria, which replaced the tender-point exam with the Widespread Pain Index (WPI) and Symptom Severity (SS) scale. This reconceptualization shifted the field away from localized physical findings toward a multidimensional symptom profile—pain, fatigue, cognitive difficulties, and sleep disturbance—to acknowledge the condition's systemic and heterogeneous nature. Both the 1990 and 2010 criteria are the most cited articles on fibromyalgia globally[6] (Atci). Of the top 50 cited articles on fibromyalgia, Wolfe is listed 5 times, more than any other author.

Wolfe established and directed the National Data Bank for Rheumatic Diseases (NDB) which produced highly cited longitudinal studies that became the backbone of clinical guidelines and public commentary. Because these datasets were among the largest available, Wolfe's interpretations of symptom stability, chronicity, and prevalence carried exceptional influence, subtly guiding which aspects of fibromyalgia were emphasized: functional impairment, severity scores, or psychosomatic dimensions. His later papers (2018) describe fibromyalgia as a "social construction of organized distress" where he argues FM is shaped by sociocultural forces and patient advocacy. This representation of fibromyalgia has influenced public and professional narratives by advancing its framing as a psychosocial construct expressed through bodily symptoms rather than understood as pathophysiological.[7] In this way, Wolfe's scholarly

[6] As of 2019, the 1990 criteria publication was cited 9304 times.

[7] In forwarding this view, Wolfe fails to consider decades of research on neurophysiology: from early fMRI evidence of central sensitization (Gracely et al. 2002; Cook et al. 2004) to neurochemical abnormalities (Russell et al. 1994; Harris et al. 2008) and recent PET evidence of glial activation (Loggia et al. 2015; Albrecht et al. 2019).

authority through his heavily-cited publications and leadership in criteria development granted him significant discursive power. His publications did not merely describe fibromyalgia; rather, they contributed to constructing the very language and logic through which the condition continues to be evaluated, validated, and contested. His scholarly output and citation impact of this work—especially his authorship of the 1990 and 2010 ACR criteria—has granted him substantial rhetorical authority that significantly shaped how fibromyalgia has been medically defined and discussed for more than three decades and contributed to how the condition is conceptualized by clinicians and understood by the broader public.

Nortin Hadler

Nortin Hadler has been publishing on fibromyalgia within the broader discourse of overmedicalization since at least the mid-1980s and continued to do so until approximately 2013, with invited public lectures and keynotes extending into the late 2010s. His biography on the University of North Carolina Institute of Medicine website cites over 200 papers and 12 books focused on "the illness of work Incapacity" [sic] and "the challenges of applying disability and compensation insurance schemes to predicaments such as back pain…in the workplace." A prominent critic of the fibromyalgia diagnosis, Hadler's publications frequently argue that it represents a sociocultural construct—a "global illness narrative," as his UNC School of Medicine biography describes it—rather than a discrete medical entity (University of North Carolina School of Medicine). His sustained work in these areas contributed to his appointment to the National Academy of Social Insurance in 2000. His editorial service further reflects his standing within the medical establishment: he served on the editorial boards of *Annals of Internal Medicine* (1991–94), *Journal of Occupational and Environmental Medicine* (1989–), *Arthritis and Rheumatism* (1980–87), *Spine* (1993–2005), and as Editor of *The Pain Clinic Journal*

(1985–2014). Although not on the editorial board of *The Journal of Rheumatology*, he was repeatedly invited to contribute opinion pieces.

Some of Hadler's editorials and opinion pieces analyzed in this dissertation appear on his CV under the category "Original Articles Published Following Peer Review." These articles are not identified as editorials, even though he maintains a separate section for editorials on his CV. While editorials undergo internal editorial-board review, this process differs from the rigorous process of external peer review. Of note, several of these pieces were published in journals for which he served on the editorial board.[8] This classification presents editorial commentary in a format typically reserved for peer-reviewed scholarship and contributes to the perception of these positions as authoritative. His skepticism toward fibromyalgia is thus afforded the credibility of peer review, creating the impression that his long-standing, untested opinions constitute objective medical fact. This distinction is relevant because some of these editorials later appear as supporting citations in Hadler's own publications, and his opinion pieces have been referenced in policy contexts, such as Duncan Gordon's discussion paper for the Workplace Safety and

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[8] While it is possible that some editorials may, in certain cases, be submitted for external peer review, I have not found documentation confirming that this occurred for the editorials in question. What can be established, however, is a consistent pattern within Hadler's CV: within the articles analyzed in my corpus (see the chart "Additional Publications on Fibromyalgia"), every editorial published in journals on whose editorial boards Hadler served was listed in his CV under "Original Articles Published Following Peer Review." These include the following editorials published in *Spine*: "If You Have to Prove You Are Ill, You Can't Get Well. The Object Lesson of Fibromyalgia" (1996) and "Labeling Woefulness: The Social Construction of Fibromyalgia" (2005); and in *The Journal of Occupational and Environmental Medicine*: "The Disabled, the Disallowed, the Disaffected and the Disavowed" (1996) and "Fibromyalgia and the Conundrum of Disability Determination" (2003). All of these were published during the years Hadler served on the respective editorial boards (as documented in his CV), and the journals themselves clearly identified these pieces as editorials.

By contrast, Hadler's editorials published in journals where he did *not* serve on the editorial board were categorized under "Book Chapters, Review Articles, Editorials, and Other Invited Articles." This patterned discrepancy—editorials treated as peer-reviewed originals only in journals where he held editorial roles—raises questions about conflict of interest and about the extent to which the authority of these publications may have been amplified. His CV documents these discrepancies: https://www.med.unc.edu/medicine/rheumatology-allergy-immunology/people/nortin-m-hadler/.

Insurance Appeals Tribunal (WSIAT). These citations indicate the degree to which Hadler is recognized as a rhetorical authority on fibromyalgia—even without empirical verification, his opinions have been accepted as true and credible—which has shaped institutional understandings of fibromyalgia and its legitimacy as a compensable illness.

In addition to his numerous editorials on fibromyalgia and related topics, Hadler's perspective appears in several of his books, including *The Last Well Person: How to Stay Well Despite the Health-care System* (2004), *Worried Sick: A Prescription for Health in an Overtreated America* (2008), and *Stabbed in the Back: Confronting Back Pain in an Overtreated Society* (2009). As their subtitles suggest, these books argue that medical interventions are often hazardous, everyday life is overmedicalized, and treatment can turn healthy people into patients. The "worried well," he argues, are vulnerable to a profit-driven medical industry. While *The Last Well Person* provides a broad critique, *Worried Sick* examines specific medical interventions. One chapter, "It's In Your Mind," is largely devoted to the argument that fibromyalgia represents the medicalization of "having a 'bad day'" (135). The chapter begins with the line "…to be well is…to have the wherewithal to cope…" (135)—a refrain that recurs across Hadler's editorials on fibromyalgia. He then rebrands fibromyalgia as "the Syndrome of Being Out-of-Sorts" (SOOS), a term he uses throughout the chapter. A preliminary review suggests that much of the language and anecdotes in this chapter echo, often nearly verbatim, those found in his editorials. The central argument of this book is to do nothing. In his risk-benefit analysis, Hadler feels the most ethical and wisest form of care is often to withhold it.

Stabbed in the Back extends these arguments but focuses specifically on chronic back pain. The book reframes chronic back pain as a social, economic, and cultural phenomenon rather than a biomedical condition, arguing that imaging technologies, surgical procedures, and

compensation systems perpetuate disability and dependence. This book is also more interested in arguing that workplace injury claims, workers' compensation, and litigation drive the medicalization of back pain. Fibromyalgia features prominently in chapter 3, "The Pall of Persistence," alongside discussion of nineteenth-century railway spine, which Hadler presents as a historical precursor to fibromyalgia. As in *Worried Sick,* he reiterates many of the same arguments and phrases found in his *Rheumatology* editorials, particularly in sections on "Illness Behaviors" and "The Sick Role."

Together, these two books clarify Hadler's stance on fibromyalgia, revealing that his perspective has remained unchanged over several decades. He introduces no new evidence, nuance, or reconsideration of emerging research in this time; rather, he reproduces the same claims in virtually identical language. This repetition is significant not only for its lack of intellectual evolution but also for how it reinforces the stability of his skepticism as a fixed and authoritative position within medical discourse. Over time, the repetition of the same arguments functions rhetorically as a form of proof. The consistency of his claims lends them the appearance of credibility, allowing his convictions to operate as evidence.

George Ehrlich

George Ehrlich served on editorial boards including *The Journal of Rheumatology* and *JAMA* and was recognized as a Master of the American College of Rheumatology. These positions afforded him considerable institutional legitimacy, enabling his views on fibromyalgia to circulate with the appearance of authority despite being grounded in assertion rather than empirical evidence. Ehrlich's influence on fibromyalgia discourse is disproportionately tied to a cluster of highly visible publications from 2003. That year, he authored the editorials "Fibromyalgia, a Virtual Disease" and "Pain Is Real; Fibromyalgia Isn't," both of which argue

that while chronic pain exists, naming it "fibromyalgia" transforms ordinary discomfort into a medicalized syndrome sustained by patient advocacy, sympathetic clinicians, and social or legal incentives in urban Western contexts where disability compensation is available. He argues that fibromyalgia is a socially-manufactured illness that has been turned into a compensable disease and that the diagnosis should be abandoned altogether. He reiterates these points in his 2003 "Fibromyalgia Is Not a Diagnosis: Comment on the Editorial by Crofford and Clauw" in *Arthritis & Rheumatism* and again in his *JAMA* reply to "Organic vs Cultural Explanations of Chronic Fatigue Syndrome and Fibromyalgia," where he refers to fibromyalgia and CFS as "sociopathies"—pseudo-illnesses shaped by urban social environments that encourage imitative behavior and are motivated by compensation.

These 2003 editorials have been widely cited in subsequent clinical guidelines and review articles, both by authors who share Ehrlich's skepticism and by those who treat his claims as representative of dismissive medical attitudes toward fibromyalgia. For example, the 2012 Canadian national guidelines on fibromyalgia explicitly reference "Fibromyalgia, a Virtual Disease" when discussing debates over the syndrome's legitimacy. A 2021 overview of fibromyalgia's evolution by Wolfe and Rasker cites "Pain Is Real; Fibromyalgia Isn't" as a touchstone in the controversy surrounding the condition. The latter has functioned as a provocative soundbite that has become shorthand for questioning fibromyalgia's legitimacy. Although Ehrlich published only a handful of fibromyalgia-specific pieces—and these were polemical, opinion-driven, and lacking supporting evidence—they appeared in highly visible journals and were frequently cited in later discussions (including by prominent figures such as Wolfe) as though they represented authoritative positions within the field.

Hadler and Ehrlich additionally co-authored a 2003 paper published two months after their individually-authored editorials in the *Journal of Rheumatology* that further amplified and gave legitimacy to Ehrlich's position. Whereas Ehrlich was not a major voice in fibromyalgia research, by 2003 Hadler was already a well-established critic of fibromyalgia and was frequently cited in discussions of workers' compensation and back pain. Their collaboration aligned Ehrlich's views with Hadler's more longstanding critique, which essentially allowed Ehrlich to piggyback on Hadler's prominence thus giving his views more legitimacy and a broader reach.

a) Their Rhetorical Authority

It is significant that the editorials *The Journal of Rheumatology* chose to publish in response to White and Thompson's study articulated a unified skepticism toward fibromyalgia. Because published editorials typically reflect the priorities and perspectives of a journal's editorial board,[9] these selections indicate that the journal itself played an active role in elevating skeptical commentaries. As editor of the *Journal,* Gordon prefaces these editorials with the statement that the journal chose to "highlight 3 *different* editorial views of fibromyalgia (FM) based on the results of a study in an Amish community in rural Southwestern Ontario" (1666; emphasis added). It would have been more accurate to state the *Journal* chose 3 *similar* editorial views of FM for they all advance a largely psychosocial understanding of fibromyalgia and argue to abandon the diagnosis altogether. By selecting and foregrounding these skeptical commentaries—many of which group fibromyalgia with CFS as socially constructed or dubious

[9] Although journals often include formal disclaimers noting that editorials represent the author's views, in practice editorials function as the de facto stance of the journal: they are curated, invited, or written by members of the editorial board, and thus reflect the perspectives the journal chooses to elevate. For this reason, editorials in *The Journal of Rheumatology* can be understood as signaling the journal's stance toward fibromyalgia at the time.

conditions—the journal effectively used its institutional authority to platform these opinions and contribute to a narrative of doubt surrounding the diagnosis. This narrative was reinforced during a critical moment in FM discourse—at a time when FM was gaining greater awareness and studies like White and Thompson's were challenging contestations of legitimacy—which has continued to influence perceptions of fibromyalgia.

Although my analysis centers on what might seem a small archive of texts from a single journal issue, the reach of these publications extends far beyond these pages. The scale and scope of their impact have been profound: circulating through medical education and training, they have shaped how generations of medical students in Canada and the US learn to evaluate fibromyalgia, with downstream effects as those students carry these evaluative frameworks into clinical practice and reproduce them in their own assessments of patients. These texts have informed decades of policy and tribunal decisions concerning workplace injury and disability claims, affecting thousands of lives, as evidenced by their continued citation in Gordon's WSIAT report (Gordon 2003), which continues to be used to guide adjudication.[10] They have contributed to publication norms through which fibromyalgia is repeatedly scrutinized and contested. They have also seeped into clinical guidelines, with material consequences for who is likely to receive care and whose is denied. In this way, this journal's issue does not represent an isolated site of discourse, but a focal point through which medical skepticism toward fibromyalgia has been disseminated, normalized, and amplified, which translates into material consequences for patients' lives.

[10] Gordon's report is still available as the sole medical discussion paper on fibromyalgia on the WSIAT website. As the discussion paper notes, it is "frequently considered in Tribunal appeals" and, although not required, adjudicators may consider and rely on it in their assessments. The report was still being referenced in adjudication decisions as of 2021: see Workplace Safety and Insurance Appeals Tribunal (WSIAT), *Decision No. 953/21*, August 24, 2021, https://www.wsiat.ca/

The influence of Wolfe, Hadler, Ehrlich, and Gordon on the medical representation of fibromyalgia is both longstanding and substantial. In sum, these authors have shaped the interpretive boundaries within which fibromyalgia has been understood for more than three decades. Each advances a framework that positions fibromyalgia primarily as a psychosocial or culturally-mediated phenomenon rather than a legitimate condition—an interpretive stance that has been circulated through high-visibility journals such as *The Journal of Rheumatology*, which Gordon himself edited. Through the authority of their publications and institutional roles, they helped naturalize skepticism, reinforce diagnostic doubt, and embed the assumption that fibromyalgia is a problem of psychology, culture, or patient behavior. The authors' rhetorical influence on the representation of fibromyalgia and other medically unexplained symptoms can be understood as a key site in which longstanding ableist norms are reproduced within medical discourse.

5. Conceptualizing Ableism

To define how I understand ableism, I draw on T.L. Lewis' 2022 definition:

> A system of assigning value to people's [sic] bodies and minds based on societally constructed ideas of normalcy, productivity, desirability, intelligence, excellence, and fitness. These constructed ideas are deeply rooted in eugenics, anti-Blackness, misogyny, colonialism, imperialism, and capitalism. This systemic oppression leads to people and society determining people's value based on their culture, age, language, appearance, religion, birth or living place, "health/wellness", and/or their ability to satisfactorily re/produce, "excel" and "behave." You do not have to be disabled to experience ableism.

Lewis' understanding of ableism reveals how the *Rheumatology* authors reinforce ableist norms in their representation of fibromyalgia: I will examine how they uphold narrow norms of

biomedical visibility by devaluing illnesses that lack visible pathology; how they explicitly mobilize productivity norms by framing FM patients as drains on resources; how they use "wellness" as a way to gatekeep care by suggesting patients are "well" because symptoms cannot be confirmed through laboratory testing even while these same patients are simultaneously positioned as behaviourally unwell, i.e. morally deviant. In these frameworks, I will show how the authors participate in a systemic process of devaluing bodies and minds that do not conform to these constructed expectations. Together, these norms form the basis of the critical orientation that guides my analysis.

While Lewis provides the broad definition of ableism, Jay Dolmage offers a valuable framework for understanding how ableism operates within institutions. Although Dolmage develops his argument in the context of higher education, his broader point is that ableism operates as a rhetorical system that is not accidental but intentional. As he writes, "[ableism] requires agents. It requires actions and intentional inaction" (46). This conception emphasizes that ableism is sustained not only by active participation in producing harmful narratives but also by inactions, such as withholding recognition, accommodation, and care. Dolmage's notion of institutional ableism is readily applicable to medical institutions where decisions about diagnosis, treatment, legitimacy—who is worthy of care and whose suffering is recognized—are shaped as much by what physicians refuse to do as by what they actively claim. Understanding ableism as both action and inaction provides a valuable lens through which to examine the rhetorical power exercised by these *Rheumatology* authors.

Wolfe, Hadler, Ehrlich, and Gordon serve as key agents within this rhetorical system. They enact ableism through both actions and inactions that confer credibility on some bodies and deny legitimacy to others. They write, select, and disseminate accounts of fibromyalgia that cast

it as psychosocial, culturally-generated, exaggerated, or feigned. At the same time, their framing calls for inaction: by insisting that fibromyalgia is a social construct, repeatedly stressing psychosocial causation, and advocating for abandoning the label, they implicitly and explicitly encourage clinicians to withhold diagnostic recognition, medical legitimacy, and forms of care or investigation that might otherwise be pursued. The call to abandon the diagnosis functions rhetorically as a directive not to intervene. Their authority sustains a system in which fibromyalgia patients are marginalized through the active production of dismissive narratives and through the sanctioned inaction that follows from those narratives. Thus, these authors do not simply express skepticism: they participate in the active maintenance of ableist norms. Identifying these dynamics at the outset enables the chapters that follow to examine in detail how the Rheumatology authors' rhetoric perpetuates a pejorative representation of fibromyalgia and invisible illness in general and the material consequences of this representation on contested bodies.

6. Feminist Disability Studies

This initial critical framing aligns closely with Feminist Disability Studies (FDS). A newer field of inquiry coined by Rosemarie Garland-Thomson in the early 2000s, FDS integrates the previously siloed fields of feminist theory and disability studies, a merger that transforms our understanding of the workings of power and privilege upon bodies that have been marked as "other" against an imaginary norm. It is a complex conceptual framework that is particularly attentive to intersectional analyses and which critically interrogates ableism as a foundational cultural logic that underpins and mutually-reinforces all systems of oppression.

In the introduction to *Feminist Disability Studies* (2015), Kim Q. Hall emphasizes that FDS is not merely the sum of feminist theory plus disability studies but a transformative analytic

that fundamentally reimagines both fields. Their intersection produces a critical framework capable of interrogating the nexus of social, political, and epistemic forces that naturalize bodily norms and authorize oppression (1–2). Hall's conceptualization aligns with Rosemarie Garland-Thomson's landmark essay that introduced the concept where she insists that integrating disability into feminist theory is not about adding another "identity"; instead, it seeks to transform our understanding to reveal how the ability/disability system structures all other categories of oppression—including race, sexuality, ethnicity, gender, and other systems of power—that have produced hierarchies of worth and defined who is considered valuable. She states FDS exposes how "Western thought has long conflated femaleness and disability" as "defective departures from a valued standard" (6). For example, women have been historically defined as deviations from a standardized male norm—seen in Aristotle's descriptions of women as mutilations, abnormalities, and excesses—which casts women as either "lesser" or "monstrous" versions of men. These are the same formulations of deviancy that have been used to stigmatize people with disabilities.

It is, however, important to understand that disability is being used as a "category of analysis" to show how bodies are marked as "other" and deemed inferior (19). This allows an extension of feminist critique that "[r]ecogniz[es] how the concept of disability has been used to cast the form and functioning of female bodies as nonnormative" (19). Language that characterizes deviance "police variation and reference a hidden norm from which the bodies of people with disabilities and women are imagined to depart" (20). Garland-Thomson refers to the disabled figure as a synecdoche to emphasize how disability functions as a container for anything deemed undesirable, excessive, unruly, lacking, abnormal, deviant—all things culture marks as non-normative. Using disability as a conceptual lens emphasizes how ableism functions as a

broad system of power and that by integrating disability we can "clarif[y] how this aggregate of systems operates together, yet distinctly, to support an imaginary norm and structure the relations that grant power, privilege, and status to that norm" (4). This reimagining of disability has been crucial to understanding the role of the disabled figure in the matrix of power relations.

Analyzing the *Rheumatology* authors' discourse through an FDS framework reveals how their diagnostic skepticism, dismissal of patient testimony, and pathologization of women with medically unexplained symptoms are not isolated clinical judgments but expressions of these broader cultural logics. FDS is uniquely situated to expose how their framing of fibromyalgia relies on representational and epistemic structures that cast women's pain as unreliable, excessive, psychosomatic, or morally suspect—tropes deeply rooted in the historical conflation of femininity and disability that Garland-Thomson identifies. FDS shows that hierarchies of worth are produced through normative expectations of bodies, which in turn illuminates why the authors demand visible pathology to confer legitimacy and construe contested illnesses as a violation of biomedical and gendered norms.

Through an FDS lens I am able to analyze the rheumatologists' recurrent pathologizing characterizations of fibromyalgia patients as disciplinary interventions designed to regulate bodily ambiguity and reinscribe an imaginary norm of the rational, self-contained, symptom-free subject—an ideal historically aligned with masculine, able-bodied privilege. In this way, FDS provides a critical apparatus capable of revealing how the authors' rhetoric operates within and reinforces intertwined systems of sexism and ableism: it shows how women with fibromyalgia are rendered unreliable subjects lacking credibility and how their suffering is reframed within gendered stereotypes that blame their symptoms on personal or moral failings or psychological (in)stability. FDS therefore not only contextualizes their discourse within a longer history of

pathologizing women's bodyminds but also exposes how medical authority participates in producing disability and gender as sites of deviance, thereby authorizing the systematic invalidation of these patients' experiences. Thus, an FDS analysis situates these medical texts within broader systems of representation and power that render certain bodies unintelligible, untrustworthy, or unworthy of care, thereby illuminating the cultural and epistemic violence enacted through seemingly objective clinical discourse.

7. Situating this Study within FDS Scholarship on Invisibilized Illness

My analysis is aligned with feminist disability scholars who have made significant contributions to discussions of the embodied realities of what are often termed *invisible illnesses* and the hystericization of contested illnesses within medical and cultural discourse. I prefer the term *invisibilized* over *invisible* because this distinction emphasizes that these are not neutral terms and this process is not passive; people, bodies, and symptoms are actively rendered invisible. In "Hysterical Again: The Gastrointestinal Woman in Medical Discourse" (2013), Amy Vidali analyzes how women with gastrointestinal disorders—whether in nineteenth-century texts or contemporary studies of IBS—are persistently represented as psychologically defective, unreliable, or personally culpable for their symptoms. Vidali argues that despite advances in medical knowledge, a recognizable figure she calls "the gastrointestinal woman" continues to structure medical discourse from the 1880s to the present. This figure is cast as anxious, emotionally unstable, and responsible for her illness through negligence, indolence, or flawed character. Her symptoms are framed not as legitimate pain or distress but as expressions of internal psychic pathology, prompting physicians to blame, dismiss, or discipline rather than treat. Vidali's readings reveal that the underlying logics of these representations have changed

little in more than a century, even as diagnostic labels have shifted from hysteria and "nervous derangements" to worry, anxiety, hypochondriasis, or personality traits (40).

This continuity in the psychologization of functional disorders reflects what Vidali identifies as the persistence of hysteria under new diagnostic labels—anxiety, hypochondriasis, catastrophizing, maladaptive coping, emotional dysregulation—showing how medical discourse repeatedly reframes chronic pain as psychological instability rather than legitimate somatic experience. As she notes, the gastrointestinal woman "takes up too much of her doctors' time" and becomes a type whose symptoms must be interpreted through presumed psychological defect (34). Vidali further shows that psychologization performs a rhetorical function: it displaces scientific uncertainty onto patients, allowing clinicians to maintain epistemic authority by converting biomedical ambiguity into patient pathology. Even when contemporary data undermine psychological explanations, authors continue to assert that worry, anxiety, or personality must be causative.

Vidali argues that medical discourse assigns an identity-type to these women that constructs them as unreliable patients. The patient becomes a recognizable problem figure whose symptoms demand disciplinary correction rather than care. This construction is reinforced through several discursive strategies: drawing on Beizer, Vidali notes that the nineteenth-century practitioner would repress women's speech so it could be expressed only as "inarticulate body language," later interpreted by a male narrator (9; qtd. in Vidali 46), while contemporary researchers rely on standardized diagnostic tools and invasive testing that substitute quantification for listening. In both periods, these practices produce the same outcome: women's experiences are overwritten by medical authority, their testimony pre-emptively discredited, and

they are deemed "responsible for [their] own care (or overburdening others), and excluded from the medical conversations about what is best for [them]" (54).

This is the same dynamic I will identify in the *Rheumatology* literature on fibromyalgia. Just as Vidali compares contemporary representations of IBS with nineteenth century framings of gastrointestinal disorders, I too will compare the rheumatologists' portrayal of fibromyalgia to historical representations of nineteenth century hysterical-nervous disorders marked by pain and fatigue. Through this analysis, I will show how the authors participate in longstanding cultural scripts of feminine unreliability and weakness by pathologizing women's pain through narratives of deviance, weak will, and psychological excess. The persistence of these narratives demonstrates that contemporary dismissals of functional disorders are grounded not in new scientific insight but in entrenched cultural anxieties about women's bodies and minds. Vidali emphasizes that medical narratives do not merely describe illness but actively construct stigmatized identities, reinforce ableist norms, and restrict who is granted epistemic authority. Her insights illuminate the historical depth of the *Rheumatology* authors' rhetoric on fibromyalgia. These authors inherit—and uncritically perpetuate—an ideological legacy that frames conditions like fibromyalgia as expressions of feminine excess, defective character, or psychological instability rather than as legitimate health conditions. Such portrayals help construct an identity category that justifies disbelief and legitimizes withholding care.

Similar to Vidali, in "Criphystemologies: What Disability Theory Needs to Know about Hysteria," Anna Mollow (2014) documents the ongoing cultural currency of hysteria in medical discourses and perceptions of people with "undocumented disabilities," which she argues plays a central role in their oppression (185). However, Mollow contends that mainstream disability studies, shaped by the social model and its critique of the medical model, has downplayed the

connection between disability and suffering. She notes this has had consequences for our understanding of the lived realities of undocumented disabilities. There is good reason for this, as disability has historically been stereotyped as tragic and pitiable. To fully understand Mollow's critique it is helpful to provide a brief overview of two primary models of disability: the medical model and the social model.

The (bio)medical model "frames atypical bodies and minds as deviant, pathological, and defective" (5). Within this model, disability is pathologized and individualized: emphasis is placed on diagnosis and treatment to restore the person to a pre-illness state. When disability is figured "as an individual defect lodged in the person," explains Tobin Siebers (2008), the onus falls on the individual to overcome their "problem" in order to "achieve full capacity as a human being" (4). This conceptualization equates the normal human condition with being "healthy" and free from defects, while framing disability as inherently unhealthy and undesirable. Importantly, this framing does not "recogniz[e] illness and disability as part of what makes us human" (Kafer 2013, 4).

Disability studies emerged in response to this medical framing and therefore rejects the (bio)medical understanding of disability as pathology. Rather than conceive of disability as a deficit to be fixed, cured, or eradicated, the field foregrounds the perspectives and experiences of disabled people. Disability studies redirects the gaze from disability as a medical problem requiring intervention to disability as a socially constructed and hierarchized category. It recognizes disability as political and shifts attention away from locating disability in individual bodies toward understanding disability as a product of social environments and relations (Kafer 6).

While the medical model locates disability within the individual body, the social model conceptualizes disability as arising from social, environmental, and physical barriers. It distinguishes between disability and impairment, encouraging recognition that the "problem" does not reside in the person but in the external structures that oppress those with impairments. People are not disabled by their impairments; society disables them. This reframing enabled collective movements focused on eliminating barriers, expanding access, and combating discrimination—directly countering the individualized medical model that sought to eliminate disability. Since its articulation, the social model has been taken up extensively by disability scholars.

However, the wholesale rejection of the medical model also led to insufficient acknowledgement of the disabling experiences of chronic illness and the lived realities of pain and suffering. Susan Wendell (2001), for example, speaks to this tension in "Unhealthy Disabled: Treating Chronic Illnesses as Disabilities." She writes that because the medical model treated disability as an inherent illness requiring cure, many disabled people have been reluctant to admit vulnerability or need for care. Historically, disclosing such needs put people at risk of forcible institutionalization due to requiring "services to perform tasks of daily living," resulting in loss of autonomy, opportunity, community, and safety (17). Thus, disability activists and scholars shifted emphasis away from medicalization and toward addressing structural ableism. Moreover, because illness is associated with passivity, dependence, and suffering, there is fear that acknowledging these realities will collapse disability back into stereotypes of weakness or tragedy—precisely what the social model resists. There is additional concern that such acknowledgement may divert attention from necessary structural change. Wendell's discussion helps explain why chronic illness has been marginalized within disability studies and activism.

Yet this strategic distancing has also left those who experience distressing bodily symptoms with few avenues to articulate those realities.

Therefore, feminist disability scholars have offered an important intervention that critiques the rigid divide between medical and social models and the tendency to distance disability from embodiment. They began asking questions such as: to what extent does rejecting the medical model overlook disabled people who desire cure (Kafer 2013, 6; Hall 2015, 3)? For those living with chronic pain or ongoing discomfort, how can the social model address suffering that persists even in barrier-free environments? Where does a rejection of medicalization leave those who seek diagnosis or treatment to manage symptoms (Wendell 18; Mollow 187; Vidali 37; Price 276; Kafer 3–4)? FDS offers crucial nuance, clarifying that no single model fits all and returning analytic attention to the body and embodiment.

Addressing similar concerns, Mollow argues in "Criphystemologies" that dissociating disability from illness has inadvertently erased recognition of invisibilized illness experiences. This erasure can reproduce the oppression of individuals whose symptoms are dismissed as "hysterical," forcing them to fight continually for acknowledgement of real, disabling suffering. As Wendell notes, many who identify as "unhealthy disabled"—those with long-term, unstable, and fluctuating impairments—do not fit conventional images of disability and must constantly remind others of their needs and limitations. In short, we pass as "normal" and able, which leads to our experiences being minimized, denied, or ignored, and to expectations that we, as Mollow writes, "push through" (186). These are some of the unintended consequences of strategically denying suffering, which has left chronic illness undertheorized and underacknowledged.

To address this gap in the lived experience of chronic illness as disability, Mollow proposes criphystemologies: epistemologies that affirm and legitimize the embodied experiences

of people with undocumented disabilities. Undocumented disabilities[11] are conditions deemed "invisible" or "unapparent to the casual observer," medically unverifiable, or insufficiently measurable by biomedicine—such as environmental illness, repetitive strain injury, chronic back pain, IBS, depression, fibromyalgia, PTSD, CFS, and borderline personality disorder (185–86). Mollow argues that "people with undocumented disabilities are routinely hystericized—that is, we are treated as if our impairments were 'hysterical' symptoms rather than legitimate diseases—by the mainstream Western medical profession and the culture at large" (186). This hystericization is reinforced by the historical denial of suffering, which treats lack of visual proof as illegitimate grounds for illness—a stigmatized view that was inadvertently compounded by disability studies' strategic disavowal of suffering in relation to disability. This disavowal unintentionally bolstered existing cultural scripts that view invisible illness with suspicion, making recognition of disabled suffering even more difficult and leaving those with undocumented disabilities vulnerable to dismissal.

Through a close reading of Freud's case history of Dora, Mollow demonstrates that the diagnostic logic of hysteria constructs disabled subjects as inherently untrustworthy narrators of bodily distress. Freud's interpretive methods—dismissing Dora's testimony, construing disagreement as denial, and framing symptoms as unconscious expressions of sexual conflict—exemplify a hermeneutic regime in which the patient's account is never taken at face value (188–90). Freud's mechanism of invalidating patient narratives has direct consequences in contemporary treatment of women with undocumented disabilities: patients reporting multiple

[11]Mollow's preference for using the term "undocumented disabilities" engages with the issue of distinguishing between "documented" and "undocumented" as well as "visible" and "invisible." Mollow is clear that this term is not intended to suggest a static binary, that in fact many illnesses are both undocumented in some contexts and heavily documented in others (i.e. through heightened surveillance). Moreover, some illnesses might be documented but remain invisible or later become visible (such as might occur in the case of, for instance, lupus—which Mollow also references).

and unverifiable symptoms such as fatigue or pain routinely have their symptoms attributed to stress or labeled as psychosomatic, and they are seen as manipulative, fabricating, motivated by secondary gain, insufficiently committed to wellness, or adopting fashionable illnesses. These are many of the same invalidating frameworks Vidali identifies. Like both Vidali and Mollow, I conduct a close historical analysis of nineteenth-century disorders framed as nervous in character or incentivized by supposed gains, examining their medical and cultural representations to demonstrate the genealogical continuity through which the same tropes identified by Vidali and Mollow reappear in the *Rheumatology* authors' characterization of fibromyalgia.

Mollow's analysis positions hysteria not as an obsolete diagnosis but as a continuing cultural logic shaping contemporary skepticism toward fibromyalgia and other contested conditions. She observes that "[t]he theory of hysteria is a symptomatic effect of this denial" of "sickness, suffering, and pain" that an indiscriminate rejection of the medical model participates in (196). Mollow calls out a "troubling point of convergence between the axioms of Freud's theory of hysteria and those of disability theory's most influential arguments" (200): both rely on disavowals that "disability is *not* suffering, *not* misfortune, *not* tragedy" (200; emphasis original). Such disavowals do not undo past violence but repeat it in "secondary form," contributing to disability oppression by obscuring suffering and pain and excluding criphystemological ways of knowing (200). Therefore, acknowledging suffering does not require accepting the tragedy model; refusing the realities of suffering merely reproduces the ableist logic Freud employs that renders undocumented disabilities unintelligible. This is crucial for my analysis: when the *Rheumatology* authors deny or pathologize patients' accounts of pain, they participate in the very logic Mollow identifies that makes undocumented disability incomprehensible and thereby authorizes the hystericization of women's pain and the systemic

invalidation of their experiences. Thus, it is important to be critical of indiscriminate rejections of the medical model and to consider, as Mollow suggests, the possibility of "*claim*[ing] medicalization as part of a reclaiming of disability" (196).

In "The Bodymind Problem and the Possibilities of Pain," Margaret Price adds that disability studies must also attend to the material, relational realities of pain—including forms of mental and bodily suffering that cannot be wholly explained by structural oppression alone. She asks, "how…do we confront the point that impairment is sometimes bad, especially impairment that involves pain"; does confronting this "force us to return to a split between impairment and disability?" and, most pointedly, "what shall we do with pain?" (274). Positioning her work alongside a decade-long disability studies turn toward desire, Price argues that this celebratory orientation—while positive and politically generative—too often sidelines pain, suffering, and the negative or unbearable dimensions of impairment. She resists the field's tendency to avoid evaluative claims about "badness," insisting that some kinds of pain must be acknowledged as real, serious, and sometimes intolerable—not reducible to oppression alone (275). Her reading of Crow (1996), Kafer (2013), and Patsavas (2014) highlights how compulsory able-mindedness and the valorization of disability desire can inadvertently silence those whose experiences include suicidal ideation, self-injury, or chronic, unrelenting pain: "the sort of pain that impels one to self-injure or to consider or attempt suicide" (276). Instead, Price advocates for a cripistemology of pain that accounts for both structural violence and the deeply situated, relational negotiations through which pain is understood, responded to, and held. She argues that "when people experience pain, their experiences should be treated *as real*. And in some cases, as *really bad*" (276).

Price illustrates the reality of bad, painful, "exceptional experiences of disability" that are "painful in and of themselves" through a hypothetical scenario in which two people—Person A and Person B—occupy the same room (277). Person A is experiencing severe mental pain and attempts to alleviate it by striking their head with a lamp, while Person B witnesses this and seeks simultaneously to help and to prevent further injury. Price notes that two realities co-exist in this room: Person A's belief that the action will relieve unbearable mental pain, and Person B's belief that the action constitutes physical harm. Neither reality is wrong; both are real and meaningful. This example demonstrates that pain is not merely an individual, internal event but is shaped by the spaces we inhabit, our environments, our sociopolitical locations, and our relationships with others. It underscores the "inseparability of bodily/individual and social/environmental elements" (273). Crucially, the scenario also forces a value judgment—someone must decide what should happen—which exposes how relational, contextual, and affective judgments of harm structure whose realities are treated as coherent or legitimate. This insight becomes especially salient for analyses of contested conditions where medical actors similarly adjudicate between competing realities of pain.

Price suggests a way forward for approaching such situations by urging us to "consider the pain of the situation in terms of a feminist DS ethics of care" (278). Such an ethics "means moving together and being limited together" (279). This type of care is grounded in collective, interdependent practices that treat painful experiences as meaningful rather than aberrant. It does not require that we understand another person's pain, only that we "respect each person's pain as real and important" (279). This is how "care emerge[s] between subjects considered to be equally valuable" (279). To be considered equally valuable, Price explains, is to have one's experience treated as meaningful—to have one's pain witnessed and responded to with the

intention of alleviating suffering (276). Much of Price's insight distills to the importance of being believed, not judged or shamed, and treated with kindness. Her scenario is focused on mental disability and unfolds between two people who know and care for each other, yet the relational principles she identifies raise compelling questions beyond this specific context. What happens if we extend Price's model to a very different environment—the clinical encounter—which is shaped not by familiarity but by power asymmetries?

The clinic amplifies the dynamics Price identifies between divergent realities and interpretations of pain, power, and the demand for interpretive judgment. Yet, unlike in Price's example, the clinician's reality is grounded in normative frameworks shaped by biomedical training, diagnostic conventions, and culturally sedimented assumptions about measuring credibility. These norms authorize the physician's interpretation of pain while simultaneously disqualifying their patients. Applying Price's framework highlights how biomedical authority routinely eclipses the patient's lived experience and forecloses the possibility of care as Price describes it. Price's suggestion for an ethics of care would instead require clinicians to treat patient's pain as meaningful even in the absence of diagnostic confirmation, to witness rather than judge, and to approach the encounter with a commitment to alleviating suffering rather than determining credibility. In this frame, care does not depend on confirming biomedical legibility; it emerges from recognizing the patient as an equally valuable subject whose suffering warrants response. Price thus offers a way forward for resisting epistemic invalidation that characterizes the dismissal of fibromyalgia pain and reframes the clinical encounter as a site where care could be grounded in recognition. Price's framework therefore provides a critical lens through which to read the rheumatologists' portrayals of fibromyalgia. It illuminates how their interpretive

judgments reinforce norms that invalidate their patient's symptoms but also how this encounter could be reimagined to provide the recognition and care their patients seek.

While Price shows how we might reimagine care for painful conditions as relational and interdependent, in more recent scholarship Hsu (2023) shows how care has been systematically withheld for those with contested illnesses, specifically ME (myalgic encephalomyelitis) also sometimes called CFS ("Framing the Activists"). Hsu argues that scientific and mainstream discourse about ME (and now long COVID) repeatedly repackages longstanding racist, sexist, and ableist assumptions into new rhetorical frames that delegitimize patient testimony and constrain scientific progress. Using frame analysis and James Cherney's concept of ableist warrants, Hsu demonstrates how narratives about hysteria, malingering, and militant patient activism quietly persist beneath shifting framings about ME, which continue to shape public understanding of the condition and justify neglect in healthcare and future research.

Hsu draws from Stephen Toulmin's model of argumentation and Cherney's ableist warrants to demonstrate how framings about ME shift over time but that these new framings still contain the same argumentative logic underneath. Hsu's adaption of Toulmin's argumentation model uses the concepts of claim, data, warrant, and backing:

> CLAIM: The author's central assertion that they want the audience to accept.
>
> DATA (evidence): facts, observations, examples offered to support the claim.
>
> WARRANT: underlying assumption that connects the data to the claim, i.e. *what are you basing this claim on?* Warrants are what make the claim make sense.
>
> BACKING: Additional evidence or reasoning that supports the warrant by justifying why the underlying assumption should be accepted.

The formula for how these work together looks something like this:

- Data → *because* Warrant → *therefore* Claim
  (with Backing shoring up Warrant)

Warrants, which I will expand on below in my methods section, are rarely stated outright. Instead, they "[rely] on audience's implicit values to provide the underlying logic" (Hsu 4). Cherney and Hsu emphasize warrants are in part so powerful because they appear neutral and common sensical, even though they often rely on ableist, sexist, and racialized assumptions. When they are involved in "perpetuat[ing] social discrimination," leaving the warrant unspoken renders the argument even more powerful (4). Hsu uses this argumentative method to "track how gendered and racialized warrants conspire with ableism to discredit patient testimonies" of ME patients, which they note extends to "contexts well beyond this disease" (4). In doing so, Hsu is able to trace the "underling argumentative logic" that persists in pejorative framings of ME, and other contested illnesses, to uncover how arguments gain currency and are sustained over time (4). Hsu notes that ME in particular is revealing for how "values endure and transform to suit shifting social contexts" and that "[e]ach reframing enables old prejudices to drift into new narratives" (9). This reframing means that the underlying ableist and sexist logic that labelled women with hysteria can continue to have currency in newer diagnoses of poorly understood and contested illnesses.

In addition to this rhetorical framework, Hsu's article makes several important points for my analysis of the *Rheumatology* authors' rhetoric. First is Hsu's observation of the rise in use of the biopsychosocial (BPS) model.[12] They note that in the 1980s and 1990s BPS functioned as a way for psychiatrists to reframe ME without explicitly invoking the discredited label of hysteria, even as it reproduced many of the underlying assumptions about hysteria. Although the term "biopsychosocial" appears to acknowledge biological, psychological, and social factors, Hsu notes that in practice BPS practitioners emphasized psychological or social explanations,

[12] Fibromyalgia has also been framed within a biopsychosocial model in rheumatological literature; see, for example, Wolfe and Rasker (2021).

suggesting that ME stemmed from distorted "illness beliefs" rather than biomedical dysfunction. This framework allowed BPS clinicians to insist they were not accusing patients of intentional deceit while simultaneously implying that symptoms were sustained by misguided thoughts amenable to correction through cognitive behavioral therapy (CBT) or graded exercise therapy (GET); thereby, "establish[ing] grounds for further accusations of fakery" (9). When patients failed to improve—or worsened, as many did[13]—this logic made them vulnerable to accusations of feigning illness. By promoting the idea that individuals should be able to think or exercise their way out of illness, BPS research reinforced the notion that those who remained sick were responsible for their own continued suffering.

Hsu notes that the logic of BPS medicine proved politically useful during the Reagan and Thatcher eras when governments sought to restrict disability benefits by so-called undeserving claimants by invoking theories of "learned helplessness" and the "sick role" to suggest they were avoiding work (10). The BPS framing of ME as a behavioral escape from cultural expectations of work aligned perfectly with these austerity-driven agendas, positioning ME patients as prime examples of alleged welfare misuse. As Hsu states, this narrative helped fuel exaggerated fears of disability fraud, legitimizing and normalizing suspicion toward disability claimants and enabling the routine questioning of any claim deemed insufficiently verifiable.

Moreover, Hsu observes, "when researchers carry these assumptions into their work" they end up embedding those biases in publications, creating a "citational chain" that authors can draw on to support "future discriminatory claims" (4). Research also shows that clinicians often rely on prevailing cultural narratives when making diagnostic judgments; therefore, the stories circulated in academic and public discourse—especially about marginalized groups already

[13] Post-exertional malaise (PEM) is a predominant symptom of CFS/ME, which makes prescribed exercise especially dangerous as it puts them at great risk of worsening their condition.

experiencing what Hsu refers to as "narrative scarcity"—provide the frameworks through which patient behavior and credibility are likely to be evaluated and patient care is determined (10). Previously Hsu noted that researchers could avoid outright calling women "egocentric or manipulative" by citing prior studies which already "made those claims and rely on the established correlation between" for instance, "hysteria and dysfunctional personalities" (7). This means that newer researchers can reference earlier studies that framed women with unexplained symptoms as emotionally unstable or deceitful without explicitly labeling them as such, thereby extending the citational chain that reinforces gendered suspicion.

This will be an important observation of the *Rheumatologists* citational practices which I will argue have likewise created a circular citational chain to legitimate their claims. Over time, the continual repetition of these associations naturalizes the link between contested illnesses and supposed personality flaws, allowing misogynistic assumptions to solidify as "common sense" and to serve as the unspoken backing for warrants making sexist claims. Even when data are provided that challenges these claims and their underlying logic, they are more easily discounted because of the power of the naturalizing function that gives particular warrants such traction over time.

Finally, Hsu emphasizes that the stories we tell about illness do not merely shape opinion—they actively injure the people they target. Hsu demonstrates how racist, sexist, and ableist assumptions coalesce to delegitimize ME patients and, in doing so, create material bodily consequences. The narrative representation of "hysterical women," impoverished people of color, or supposed disability "frauds" encourage clinicians to read physiological pain as delusion or deception, and uses the stigma attached to psychiatric diagnoses to brand already vulnerable patients as "crazy" or morally suspect (15). When individuals speak out about harmful treatments

or unrelieved symptoms, their objections are recast as proof of their irrationality, which discourages scientific inquiry and dissuades further research into the illness. The resulting vacuum of knowledge becomes a rationale for continued neglect, producing a self-reinforcing cycle in which dismissive narratives directly contribute to worsening health. As Hsu notes, ME is only one case in which harmful discourses **"**materialize as physical damage" (15). Hsu thus underscores the ethical responsibility of rhetoric disciplines that have the capacity "to intervene in the many bad faith arguments depriving people of care" (15).

8. Methodology

To guide my analysis of these texts, I primarily use discourse analysis alongside an adapted set of rhetorical methods, which I outline below. I find that discourse analysis and rhetoric pair well with a feminist DS theoretical framework for all are engaged with unveiling the workings of power in language and upon the body and investigating dominant narratives for how they enforce hierarchies of worth. Hsu's use of Cherney's *Ableist Rhetoric* coupled with Toulmin's argumentation method has been especially informative for my initial investigation into how fibromyalgia patients have been captured within hystericizing and malingering rhetoric. Although I do not employ the systematic process of identifying Data, Warrants, Backing, and Claim that Hsu does, I instead use an adapted version of this argumentation model to focus on claims. A brief clarification of warrants is nevertheless useful here, as the concept helps illuminate how interpretive logics intersect with the ideological assumptions that underlie the rheumatologists' rhetoric.

Cherney describes warrants as an "interpretive framework [formed] from pre-existing opinions, values, and views" which are then "[applied] to determine what that thing means" (19). Warrants are the ways by which everyone comes to comprehend a given text (and I am using

'text' broadly to indicate any 'thing' that can be interpreted). Warrants "[form] the logic that connects things and concepts," operating "in the space between the message sent and the message received" (18). Warrants are essentially then each individuals' implicit values and biases that have been constructed through their life experiences and through the governing or dominant discourses that structure particular worldviews. People come to rely on warrants when encountering a new or perplexing situation and the generalizability of warrants provide a basis from which to interpret something according to a "comfortably familiar" lens (20). This describes a tendency to filter new information through existing schemas in which unfamiliar or ambiguous data is interpreted in ways that reaffirm pre-existing beliefs, values, or expectations—much in the same way confirmation bias functions.

As Cherney points out, challenges to conventional or naturalized so-called "common sense" understandings are particularly difficult to dismantle when they are entrenched and constantly "reified," as Cherney puts it, by encounters with unfamiliar contexts or when "meaning seems unstable." Samuels similarly speaks to this point in *Fantasies of Identification*, arguing that "once embedded in the cultural realm," fantasies or mythologies "stubbornly persist" even when they are "disproved, undermined, or contradicted" (3). Cherney also notes that their generalizability enables warrants to apply to a wide variety of situations beyond the immediate one. In this sense they take on a dominant narrative status: one that is well-established and the accepted go-to from which to interpret a situation. Thus, the stabilizing function of warrants that are widely applicable to new situations is in part why it is so difficult to change ideological proclivities even with new information. I would add part of the power of warrants seems to reside in their use as a type of mental heuristic: a generalizable shortcut to apply to

complex situations. Heuristics are a necessary part of processing that lighten cognitive load but because of this are likely to perpetuate implicit biases that can cause harm.

Using different terminology and a three-dimensional model, Fairclough has also argued for this interpretive schema between the self encountering a 'text' and the meanings that are implicitly and explicitly attached to this text to make the text comprehensible to that person. Each person perceives a text through an individualistic lens that has been constructed through an interplay of their own experiences and the culture in which they live. Cherney's notion of warrants can be productively understood through Fairclough's three-dimensional model of discourse, which emphasizes the interrelation of (1) the text itself (or discursive event), (2) the discursive practices that shape its production and interpretation, and (3) the broader social context and ideological structures (including the "implicit and explicit rules, norms or mores governing discourse and society") in which it circulates (Johnson and McLean 380). Warrants operate across these three dimensions. At the textual level, warrants shape the specific choices an author makes in framing, defining, and valuing particular concepts. At the level of discursive practice, warrants inform how a text is taken up, interpreted, re-circulated, and affirmed or contested by audiences. And at the level of social practice, warrants reveal and reinforce the broader ideological formations that naturalize certain assumptions as "common sense." In this way, warrants can be seen as the connective tissue between the personal interpretive lens of the individual reader or author and the dominant cultural narratives that give that lens coherence and make such interpretations feel stable and familiar.

Fairclough's emphasis on the dialectical relationship between discourse and ideology also helps clarify why warrants can be so resistant to disruption. Cherney describes warrants as interpretive shortcuts that provide familiarity when meaning appears unstable. Fairclough would

describe this as the operation of ideology in everyday life, where dominant values and assumptions become naturalized through repetition across institutions, professions, and public discourse. Thus, warrants are not merely private or idiosyncratic habits of thought but are shaped by what Fairclough calls orders of discourse: the historically sedimented ways of speaking and knowing that circulate in institutions, professions, and public culture, i.e. the governing of how and what can be said given a specific context. The *Rheumatology* authors draw on warrants that are not simply reflecting the individual authors' beliefs but connect to a longer genealogy of medical authority, productivity ethics, and suspicion of unverifiable illness. Their rhetoric derives its persuasive force precisely because it resonates with broader social practices and dominant cultural logics that valorize independence and the moral obligation to maintain productivity in a neoliberal capitalist landscape.

Relatedly, this analysis is also informed by a Foucauldian understanding of discourse, in which discourse does not simply reflect reality but actively produces what is culturally intelligible as knowledge, legitimacy, and truth (*Power/Knowledge*). Foucault emphasizes that discourses shape the conditions under which certain statements can be taken as evidence, who is authorized to speak, and what forms of experience count as real. Medical discourses, in particular, organize the field of what can be known about bodies, symptoms, and credibility. Medical discourses emerge through longer histories of power that privilege objectivity, measurement, and self-regulation while discounting subjective pain and emotional expression. This Foucauldian framing clarifies why the claims made by the *Rheumatology* authors might appear reasonable, common sensical, and carry currency within their professional context. These claims are made possible by pre-existing discursive formations that value independence, productivity, and visible injury as markers of legitimate illness. Discourses that pathologize

dependency and doubt unverifiable symptoms are therefore not accidental. They are the product of institutional histories and power relations that have shaped the boundaries of what counts as illness, what requires proof, and whose testimony can be trusted. This also helps situate the *Rheumatology* authors' rhetoric as not merely drawing on a historically-embedded cultural narrative of invisible illness but actively taking part in producing and perpetuating this narrative in their publications.

Cherney identifies three foundational warrants that organize ableist culture: 1) *deviance is evil,* 2) *normal is natural,* and 3) *body is able.* The first frames bodily deviance as a sign of sin, corruption, or possession; the second naturalizes the constructed norm and casts departures from it as violations; the third equates presumed ability with competence and treats disabled bodies as inherently lacking. As I will reveal in my analysis, all three warrants are operationalized in the *Rheumatology* authors' rhetoric on fibromyalgia in the following ways: the warrant that *deviance is evil* appears in their portrayal of fibromyalgia as a dangerous epidemic, patients as problems to be contained rather than cared for, and "illness behaviours" as moral failures. Their fear that FM might "infect" others with an "illness identity" reflects a classic possession narrative. Though they never call patients evil, they repeatedly imply instability, irrationality, and social risk.

Normal is natural will emerge in their reliance on a medically constructed "normal body" as the baseline of legitimacy: anything outside it becomes suspicious or pathological. Patients' coping, productivity, and emotional stability are judged against this presumed natural standard, and their pain is framed as excessive or disproportionate because it fails to match biomedical expectations of visible, measurable pain. Their prescriptions for cognitive-behavioural correction and personality change further reveal an effort to restore patients to this imagined norm. Finally, *body is able* operates through the presumption of capacity and suspicion of inability. Ability is

the default, and fibromyalgia patients are treated as able until they supply visible proof of impairment. Invisible illness is thus reframed as psychological weakness, poor will, regulatory dysfunction, or secondary gain rather than evidence of disability. The authors assume bodies should push through discomfort; failure to do so is interpreted not as impairment but exaggeration, poor coping, or moral deficiency.

These warrants do not operate separately but overlap and reinforce one another. Reporting pain without visible pathology becomes suspicious precisely because it violates the assumption that pain worth measuring must be objectively verifiable. In the absence of such proof, the body is presumed able and judged against normative standards of capacity. When patients cannot meet those expectations, they are cast as unreliable narrators of their own bodies, their symptoms reframed as perceptual distortions or character flaws rather than legitimate illness. I have conducted this preliminary analysis to show how interlocking ableist logic underlies the *Rheumatology* authors' claims about fibromyalgia, lending their arguments persuasive force because they draw on deeply sedimented cultural warrants.

If I were to place this argumentation within Toulmin's model, it would resemble this:

CLAIM: Fibromyalgia is primarily a psychosomatic condition.

DATA: Many women patients are reporting symptoms without measurable pathology.

WARRANT: If symptoms are not objectively measurable, they are not biomedical.

BACKING: Medicine relies on biomedical markers to validate disease.

This model demonstrates how evidence is seemingly used to advance claims about fibromyalgia's lack of legitimacy, but that ableist warrants undergird these claims: in this illustrative example, the warrant is that real disease must be visible, measurable, or objectively verifiable. But other warrants are in play simultaneously that might not be as obvious, such as: women exaggerate pain, women are more likely to have distorted perceptions of pain, women

seek medical attention for normal states of discomfort, psychosomatic symptoms reflect maladaptive behaviour or problems with coping. These are just some of the readily identifiable warrants that will underpin the broad claim that fibromyalgia is psychosomatic. Therefore, while Cherney's formulation of ableist warrants provides a valuable foundation of the cultural logic underpinning some of the rheumatologists' claims, the rheumatologists also use much more narrow and specific warrants. These warrants have been derived from my analysis and I have listed them in thematic groups below. I am fore-fronting them in the introduction, and methods section specifically, because they help explain how I am (and am not) using warrants throughout.

A. Independence/Dependence
    - Disabled people are dependent burdens on society.
    - Relying on assistance signals moral failing rather than structural need.
    - Disabled claimants must be scrutinized to prevent deception.
    - Too many compensation claims signal abuse of the system.
    - Too much recognition of disability creates dependency.
    - Asking for help signals weakness, exaggeration, or lack of effort.
    - A good citizen is an independent, self-sufficient individual.
    - The ideal body is one that is self-regulating and self-managing.

B. Biomedical Authority
    - Medical/scientific authority is the ultimate arbiter of bodily truth.
    - Patients are unreliable narrators of their own bodies.
    - Subjective symptoms are less legitimate than objective signs.
    - Illness without biomedical markers is psychological, not physical.
    - Medicine is objective; patients are emotional.
    - Legitimate illness must be visible, measurable, or quantifiable.
    - Suffering that cannot be medically explained is a problem of the patient, not the model.
    - Patients should trust physicians' interpretations over their own experiences.

C. Gendered Stereotypes
    - Women with unexplained symptoms are exaggerating or hysterical.
    - Women exaggerate symptoms for attention or social rewards.
    - Emotional expression signals exaggeration or heightened awareness, not legitimate illness.
    - Pain in women is more likely to reflect emotional instability.
    - Women's reporting of pain is less credible than men's reporting of pain.
    - Women are inherently weaker and therefore more susceptible to illness narratives.

D. Moral Character
    - Disabled people are lazy.
    - Legitimate pain follows predictable biomedical patterns.
    - Deviations from expected patterns reflect emotional or behavioral dysfunction.
    - Chronic pain without trauma or inflammation is illegitimate.
    - Moral character influences authenticity of suffering.
    - Work is a marker of health; inability to work signals personal failure.

E. Social and Economic Threat
    - A preponderance of diagnostically unverifiable illnesses is a sign of a social problem.
    - Medically unexplained symptoms are inherently suspect.
    - Too many people identifying as ill indicates cultural weakness.
    - Illness identity spreads socially and threatens collective resources.
    - Claims of disability are threats to social order.
    - Chronic illness is a threat to economic stability.

F. Paternalism
    - Disabled people are objects of pity and charity.
    - Physicians know what is best for patients, even against their wishes.
    - Withholding diagnosis protects patients from the harms of iatrogenicity.
    - Restricting access to care or validation is benevolent when patients are misguided.
    - Patients' desires for recognition or treatment are misguided expressions of emotional need.

G. Productivity
    - A valuable person is a productive person.
    - Disability is legitimate only when it prevents productivity.
    - Non-productive individuals are morally deficient.
    - The purpose of medical care is to restore productivity and independence.

As you can see, there are numerous warrants—or we might call them mythologies—at work. This list is not intended to be exhaustive—there are surely more I have missed—but it is a starting point for the interpretive logic underlying the *Rheumatology* authors rhetoric. I have included this list in the introduction to illustrate the methodological difficulty I encountered of applying these warrants practically: the *Rheumatology* authors' claims were often not using, and did not map neatly onto, a single warrant. Instead I found their claims mobilized multiple, mutually-reinforcing warrants at once—as I endeavoured to demonstrate in my preceding

example above. Attempting to identify isolated warrants behind each claim began to feel reductive and I felt risked oversimplification. The interpretive logic behind the authors' claims is far messier and complex than the systematic process of applying Toulmin's argumentation method would allow me to convey. Warrants did not offer additional clarity and did not accurately capture the complexity of the ideological beliefs backing the authors' statements on fibromyalgia. Further, the systematic process of applying warrants reduced this complexity in a way that I see as akin to my critique of standardized assessments in chapter five that I argue attempt to box in and simplify messy realities into a uniform model that appears objective but ultimately fails to capture nuance.

Therefore, even though I have provided this list here for reference, in my analysis I found it much more productive to examine the author's central *claims* and thoroughly trace how these *claims* are legitimized through recognizable ideological logics that have been historically reproduced within medical discourse, social policy, and cultural discourse. The warrants I identified above are still operational in the mutually-overlapping way I describe, but I do not focus on identifying them outright and, in some cases, I might describe them using different language. Depending on the claims presented, one or more of them are always underwriting the authors' claims in the manner I have already identified in this section. However, by focusing on their claims instead, and later strategies, I was able to develop what I feel is a more nuanced and expansive analysis of how these texts reproduce (gendered, classed, and ableist) reasoning through clusters of overlapping assumptions that are historically-contingent, and collectively authorize the invalidation of fibromyalgia and the patients who experience it. My first four chapters are therefore organized by the authors' collective claims before I turn to addressing these claims as *strategies* in my latter chapters.

Neither do I attempt to undertake a detailed micro-level CDA following Fairclough's three-dimensional model. Rather, I have drawn on Fairclough (and Foucault) briefly in this introduction to clarify how the individual interpretive habits of the *Rheumatology* authors are shaped by broader ideological, cultural, and institutional discourses. My primary analytical focus remains on identifying the authors' claims and strategies and illuminating the underlying logic and assumptions that animate those claims, rather than mapping each instance of textual, discursive, and social practice in a systematic way. In this way, I follow the lead of Margaret Price in *Mad At School* in that my use of discourse analysis is not microlinguistic. Price explicitly notes that while she is informed by Fairclough she does not apply CDA in the highly detailed linguistic mode associated with Fairclough, but rather draws on what Ellen Barton describes as a broader, inductive approach that identifies "rich features" that meaningfully link a text to its context (Price 23).

Barton's approach to discourse analysis "involves looking at texts, inductively identifying their rich features and salient patterns, and then using these features and patterns as examples in an argument in support of some generalization(s) or claim(s) about the meaning relations between features, text and, and their contexts" (qtd. in Price 23). This framework is particularly useful in examining repeated turns of phrase, metaphors, and characterizations in the *Rheumatology* articles. For example, the recurring descriptors and characterizations of patients as predisposed to chronic complaining, hyperbole, somatizing, or insufficiently self-managing function as discursive signals that reveal how the authors are positioning fibromyalgia patients relative to dominant narratives of productivity, legitimacy, and medical authority.

Following Price and Barton, my analysis proceeds by tracing these recurring and meaningful "rich features" to identify and organize the claims the *Rheumatology* authors advance

and the interpretive logics that underlie those claims. These patterns then form the basis for examining, in later chapters, how these claims operate strategically to invalidate patient testimony, justify withholding care, and reproduce broader cultural anxieties surrounding dependency, malingering, and the policing of boundaries to access medical and welfare systems.

To demonstrate how this analytic process works, for example, the *Rheumatology* authors routinely describe fibromyalgia patients as "chronic complainers" or "somatizers," and this repeated linguistic choice or characterization functions as a rich feature in Barton's sense. Price uses the example of *wheelchair-bound* versus *wheelchair user* to illuminate how descriptors do more than merely categorize; they subtly define what kind of subject the individual (or patient) is presumed to be. "Complainers" suggests a person whose verbal expressions of pain are excessive, unwarranted, or motivated by secondary gain, while "somatizers" frames patients as individuals who convert psychological distress into physical symptoms rather than reflect the experience of genuine bodily illness. The choice of these terms encourages the reader to interpret patient testimony through the lens of suspicion, emotional instability, or character weakness. The language cues the reader to connect the text to long-standing cultural narratives that equate legitimacy with visible injury, that devalue subjective accounts of pain, and that portray individuals with medically unexplained symptoms as morally suspect, psychologically weak, or insufficiently disciplined in their self-regulation. In this way, the recurrence of "complainer" and "somatizer" is not incidental. It is a patterned feature that reveals how the text draws upon and reinforces broader ideological and ableist assumptions about illness, credibility, and individual responsibility for one's health. I paid close attention to these patterned features that recur across texts and my analysis of them led to the formation of thematic claims. Identifying these features is therefore central to tracing how the *Rheumatology* authors construct their claims and how

those claims are embedded within cultural narratives that privilege objective measures of illness and/or disability, productivity, and independence.

Following Price's broader application of CDA, I first identify recurring linguistic features and argumentative patterns embedded in the authors' claims about fibromyalgia and its sufferers (Chps. 1-4), and I then analyze how these claims function strategically in Chp. 5-6. This methodological approach provides the groundwork for the dissertation's central project which is to show how these claims participate in long-standing cultural narratives that shape whose pain is believed, whose suffering is recognized, and whose needs are deemed legitimate. My focus, therefore, is on unpacking the ideological logics and cultural mythologies that authorize medical invalidation and sustain the narrative frameworks through which it is reproduced.

9. Chapter Overview

The chapters that follow trace how these discursive strategies frame fibromyalgia and related conditions and examine how they shape whose suffering is recognized and whose access to care is restricted, culminating in a discussion of the justice implications of restricting care for those living with invisibilized illnesses. The first four chapters of this dissertation focus on the *Rheumatology* authors' claims about fibromyalgia. In the opening chapter, I demonstrate how they collectively construct fibromyalgia patients as satisfying the first criterion of malingering: to falsely or grossly exaggerate their symptoms. First, I establish the conceptual terrain by clarifying the DSM criteria for malingering and trace the historical and cultural roots of disability suspicion. From this foundation, I turn to a close reading of the *Rheumatology* editorials themselves. I organize the authors' portrayals into a series of recurring claims that together sustain a rhetoric of suspicion: 1) The FM patient is almost always a woman; 2) Pain is a lifestyle; 3) Medicalization increases disability; 4) FM is controversial; 5) FM is psychological.

Chapter two then contextualizes these claims within the social and discursive environment of the 1990s. I consider how fibromyalgia is represented as the “new hysteria” within a cultural climate that looks suspiciously on women in pain. This section further explores these *Rheumatology* articles alongside prominent and popular texts published in the same era that refer to conditions such as fibromyalgia (FM) and chronic fatigue syndrome (CFS) as hysterical syndromes.

Chapter three builds on the previous to illustrate how these same authors suggest that fibromyalgia patients satisfy the second and most essential criterion of malingering: exaggerating or faking illness to escape work or to obtain external incentives, entitlements, or other rewards. These entitlements are often referred to as secondary gains. I argue that the authors imply fibromyalgia is motivated by secondary gain by situating it on a historical continuum with nineteenth-century nervous disorders such as railway spine and neurasthenia—conditions which were cast as either signs of nervous weakness in women or as convenient excuses for avoiding work or securing compensation. By tracing how these earlier diagnoses were used to distinguish the "legitimately sick" from the supposedly undeserving, I will show how the *Rheumatology* authors recycle and repackage the same ideological assumptions in their representation of fibromyalgia.

Chapter four extends this analysis to examine how pain and fatigue conditions were historically entangled with cultural and economic ideologies that cast them as threats to the moral value of work, ideals of progressive civilization, and fears of parasitic dependency. Together, these first chapters trace the origins and evolution of ideological frameworks in medical and cultural discourse—spanning nineteenth-century nervous disorders, moralized views of work and dependency, and late twentieth-century discourses of new hysteria—that underpin contemporary skepticism toward fibromyalgia.

Chapters five and six re-examine the authors claims as strategies designed to police suspected malingering. Following Garland-Thomson's observation that medical validation displaces patient testimony, I show how the *Rheumatology* authors deny patient narratives and medically invalidate fibromyalgia symptoms in order to claim epistemic authority over the body. This chapter examines standardized tests used in fibromyalgia diagnostic criteria—including the tender point test and pain scales—which ostensibly render pain visible and measurable but which I argue in turn function to override patient testimony and invalidate illness claims.

Chapter six examines how the authors frame the withholding of medical legitimacy as a necessary safeguard against malingering. By casting fibromyalgia patients as dependent burdens, malingerers, and epidemic threats to social order, the authors justify withdrawing medical resources altogether. I analyze how this invalidation is rationalized through a rhetoric of benevolence in which the authors claim that restricting care protects patients, the public, and disability systems from harm. Ultimately, I argue that this framing rests on the myth of independence, which pathologizes the need for care and obscures the reality of universal interdependence.

Chapter 1:
Malingering

1. Introduction

In this chapter, I focus specifically on the ways in which the *Rheumatology* authors and their works under analysis frame fibromyalgia patients as malingerers. Specifically, I examine how these authors frame their patients as satisfying the first criterion of malingering: to falsely or grossly exaggerate their symptoms. I argue that their representation of fibromyalgia patients establishes a framework of suspicion that undermines patients' credibility and contributes to the ongoing hystericization of fibromyalgia within medical discourse.

In the first part, I define some key terms from the Diagnostic and Statistical Manual of Mental Disorders (DSM) that exemplify how fibromyalgia continues to be represented as a hystericized condition. I then turn to Ellen Samuels' exploration of the concept of the "disability con" which reflects the idea that some individual's fake disability for personal gain (*Fantasies*). Samuels states that suspicions of disability fakery emerged in the nineteenth century as a response to social welfare initiatives and subjected disabled people to the demand of constantly proving their authenticity. The disability con will be considered for how it has informed societal attitudes toward disability and shaped how invisible illnesses in particular are regarded with suspicion and policed through methods of diagnostic surveillance. From here, I briefly discuss how fibromyalgia has been associated with suspicions of malingering—an enduring narrative that is in part documented and spread through publications in prominent medical journals. Taken together, these sections situate the diagnostic and cultural logics that make it possible to read fibromyalgia patients as malingerers, providing the foundation for the analysis that follows.

In the last section, I narrow in on the portrayal of fibromyalgia in the corpus of *Rheumatology* editorials that I have organized into a series of claims. Their claims have been derived from "inductively identifying" in their texts the meaningful "rich features and salient patterns"—repeated turns of phrase, metaphors, and characterizations (Barton 23). I argue that the patterns underlying these claims collectively create sustained suspicion of fibromyalgia patients as malingerers. The articles under analysis in this part are listed in the introduction chapter and appendix. These publications span over two decades, and I contend that they reveal a concerted effort by these authors to control the narrative of fibromyalgia representation in medical contexts.

2. Defining Malingering and Related Disorders in the DSM

Before I begin analyzing these *Rheumatology* articles, it is necessary that I define some terms and their related disorders. To do this, I will be taking a tour through various editions of the DSM with an emphasis on its continually shifting classification of supposed disorders that focus on individuals with medically unexplained symptoms and their encapsulation as unconsciously or consciously faking their symptoms. This diagnostic history is important because, as I will show, the *Rheumatology* authors draw on these categories—often implicitly and sometimes explicitly—when characterizing fibromyalgia. In particular, while these authors do not name hysteria or malingering outright, they frequently draw on the language of somatic and somatizing disorders and describe features consistent with factitious disorder and malingering. The disorders I focus on in this section share similar symptomology and are mainly distinguished from each other by the individual's perceived motivation and whether or not their intent is conscious or unconscious. The chart below illustrates how these distinctions rely

primarily on subjective determinations of *intent* and *motivation* and will serve as a reference point as I compare these disorders.

Table 2. Disorders Listed in the DSM

Disorder	Intent	Symptoms	Motivation
Factitious Disorder (DSM-V)	***Conscious*** (intentional production of symptoms)	Fake or self-induced symptoms, but without external rewards	Desire to assume the "sick role" (internal incentives such as interpersonal or medical attention)
Malingering[14]	***Conscious*** (intentional deception)	Exaggerated or fabricated symptoms	External incentives (e.g., financial gain, avoiding responsibility)
Somatization Disorder (DSM-III)	***Unconscious***	Multiple, recurring, medically unexplainable physical symptoms across different areas of body	Psychological distress manifests as persistent physical symptoms
Hysteria (Conversion Disorder) (DSM-III)	***Unconscious***	Neurological or physical symptoms with no medical cause	Psychological distress converted into physical symptoms
Neurasthenic Neurosis (DSM-II)	***Unconscious***	Chronic fatigue, weakness, headaches, difficulty concentrating	Emotional exhaustion due to stress; a depletion of nervous energy
Somatic Symptom and Related Disorders (DSM-V)	***Unconscious***	Distressing physical symptoms (may or may not be medically explained), plus excessive thoughts, feelings, or behaviors about symptoms	Psychological distress and health-related anxiety, leading to excessive symptom focus

[14] Malingering is first explicitly codified in the DSM-III. While the concept predates the DSM, this marks its formal inclusion in psychiatric classification—not as a mental disorder, but as a condition warranting clinical attention. Even though malingering is not considered a disorder, I have included it in this chart under Factitious Disorder because, particularly in the DSM-5, it is presented in parallel with factitious disorder as a form of intentional symptom production differentiated primarily by motivation—external incentives in malingering versus internally oriented incentives in factitious disorder.

The first term I will begin with is the title of this chapter: malingering. I will subsequently address related disorders and classifications including factitious disorder, somatic symptom disorders, somatoform disorders, conversion disorder, and somatization disorder—all of which to some extent can be considered as offshoots of the historical diagnosis of hysteria. Malingering is a term that originated in the late eighteenth century and was, at this time, applied to soldiers and sailors. At the core of its meaning is that one feigns sickness to evade or shirk their duty (typically, of work). Thus, the OED defines the verb malingering as "[t]o pretend or exaggerate illness in order to escape duty or work; to feign or produce physical or psychological symptoms to obtain financial compensation or other reward" (3rd edition). In the 5th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) published in 2013, the essential feature of malingering is said to be "the intentional production of false or grossly exaggerated physical or psychological symptoms" that are motivated by external incentives such as avoiding work duties, obtaining financial compensation, or obtaining drugs (such as pain killers) (727).

The DSM-V distinguishes between malingering and what it refers to as "factitious disorder"[15] by stating that "the motivation for the symptom production in malingering is an external incentive, whereas in factitious disorder external incentives are absent" (727). Moreover, "evidence of feigning" would indicate a diagnosis of factitious disorder (as opposed to suspicions of malingering) if the intent is to "assume the sick role" rather than "obtain an incentive such as money" (321). Factitious disorder, thus, can be motivated by internal incentives, such as care and sympathy from others or a sense of victimhood. Important to both malingering and factitious disorder is the individual's *intentional* production of symptoms in

[15] The DSM-V replaced the previous Munchausen Syndrome with Factitious Disorder. In the DSM-III Factitious Disorders occupied their own category. The DSM-III specifies that "[i]n the past, some of the disorders classified [under Factitious Disorders] would have been subsumed within the category of Hysteria" (286).

order to deceive (727). This differentiates these two conditions from conversion disorder (the diagnostic label that replaced a form of hysteria) as conversion disorder symptoms are said to not be intentionally produced (DSM-III). Confusingly, though, while deception is the defining feature of factitious disorder, this deception can be unconscious to the individual (Onofrj et al. 4073). Given these definitions and descriptions, emphasis is put on the fact that so-called malingerers intend to deceive specifically to receive undeserved *external* entitlements for personal gain. These disorders clearly significantly overlap and are delineated from each other based on clinician's perceptions of patients' motivations for feigning illness and the degree of perceived awareness of this behaviour.

The DSM-V warns that malingering should be strongly suspected if *any* combination of four pieces of criteria[16] is observed. Notably, even just two—1) a discrepancy between an individual's reported symptoms and objective evidence and observations and 2) being a non-compliant patient: not cooperating during diagnostic evaluation and not following a physician's prescribed treatment—are sufficient to trigger suspicion (727). It would seem these criteria encourage a suspicion of malingering even in the absence of the DSM-V's initial descriptions of motivation and reward. Any patient whose symptoms cannot be independently verified and who disagree with the physician's treatment plan are suspected of having an underlying motivation to feign illness for rewards. The DSM's warning further encourages a physician's surveillance of these patients. Thus, those of us with medically unexplained symptoms (MUS) or diagnostically unverifiable illness whose main symptoms are pain and fatigue—symptoms which are near impossible to determine objectively—are at greater risk of being labelled a malingerer. If, for

[16] The four DSM-5 criteria for suspecting malingering are: (1) medicolegal context, (2) marked discrepancy between reported symptoms and objective findings, (3) lack of cooperation during evaluation or noncompliance with treatment, and (4) the presence of antisocial personality disorder (727).

instance, one was to go to the doctor to request pain killers for chronic pain symptoms while testing did not objectively reveal this pain, then attempts to seek relief would potentially be construed as drug-seeking behaviour and evidence of feigning symptoms—fulfilling the hallmark features of motivation and reward that define malingering.

There are many problems with the DSM's approach as a means to code, classify, and pathologize human variability. The purpose of this chapter is not to criticize the DSM for its significant limitations and assumptions about individualized mental illness through its deficit-based medical framework.[17] What I do want to focus on is how the DMS's description of malingering and its slippery categorizations of related disorders mentioned above reveal a preoccupation with categorizing people as 'real' or legitimately disabled because of the access this label presumably provides to those deemed *worthy* of various societal and financial supports. In fact, citing a 2018 book titled *Dying to be Ill: True Stories of Medical Deception*, Onofrj et al. state that some perceive the "creation of social welfare and the access to financial compensations or unnecessary care" as a "catalyst" for the diagnostic category of factitious disorder and the related malingering, the former of which did not appear as a definite disorder until the publication of the DSM-3 in 1980 (under the label Munchausen syndrome) (4073). To be informally labelled as a malingerer, then, is to be coded as someone who is fraudulently faking symptoms for personal gain and entitlements to which one is perceived as *unworthy* or *undeserving*. Both of these disorders—factitious disorder and malingering—function as a means to deny supports.

[17] For a discussion of the DSM's limitations see Malott, K.M., Barraclough, S. & Yee, T. Towards Decolonizing Diagnosis: a Critical Review and Suggested Alternatives. *Int J Adv Counselling* 45, 1–17 (2023). https://doi.org/10.1007/s10447-022-09501-0.

Importantly, while factitious disorder is considered a diagnostic category in the DSM-V, malingering is not—it is more of a behavioural condition that is described as a potential focus of clinical attention. As such, malingering is not considered evidence of any disorder but as a deliberate deception. The only discernable difference between these two conditions—malingering and factitious disorder—is that one is motivated by receiving an external reward. The only seeming difference between these two disorders and conversion disorder is the intent is deemed to be conscious in the former or unconscious in the latter. But as I demonstrated above with the DSM-V's four pieces of criteria warning of malingering, the DSM contains many caveats that often contradict its own definitions which are meant to distinguish between conditions. For example, although malingering is defined by intentional symptom production for external gain, the criteria used to suspect it do not require evidence of either, effectively loosening the boundary between these categories in practice. This same tension between definition and application appears in the DSM-V's discussion of conversion disorder where it states that "[t]he diagnosis of conversion disorder does not require the judgment that the symptoms are *not* intentionally produced (i.e., not feigned), because assessment of conscious intention is unreliable" (321). This strongly suggests that there is much more maneuverability in diagnosis of these conditions and overlapping symptoms than their distinctive classifications imply. Therefore, even though malingering is not considered a mental disorder in the DSM, we can think of these three conditions as residing along a continuum, or occupying different points on a spectrum, and that those invoking these terms or descriptors of them might not be so concrete on how they differ as well. As I will demonstrate, the *Rheumatology* authors evoke these descriptors broadly, focusing on whichever aspect they wish to draw upon to prove their argument. Therefore, they may refer to fibromyalgia as a somatization disorder in one

description then describe the features of factitious disorder or malingering in another. This diagnostic instability provides the conceptual flexibility that enables fibromyalgia to be framed through overlapping logics of suspicion, which I show are taken up in the *Rheumatology* literature.

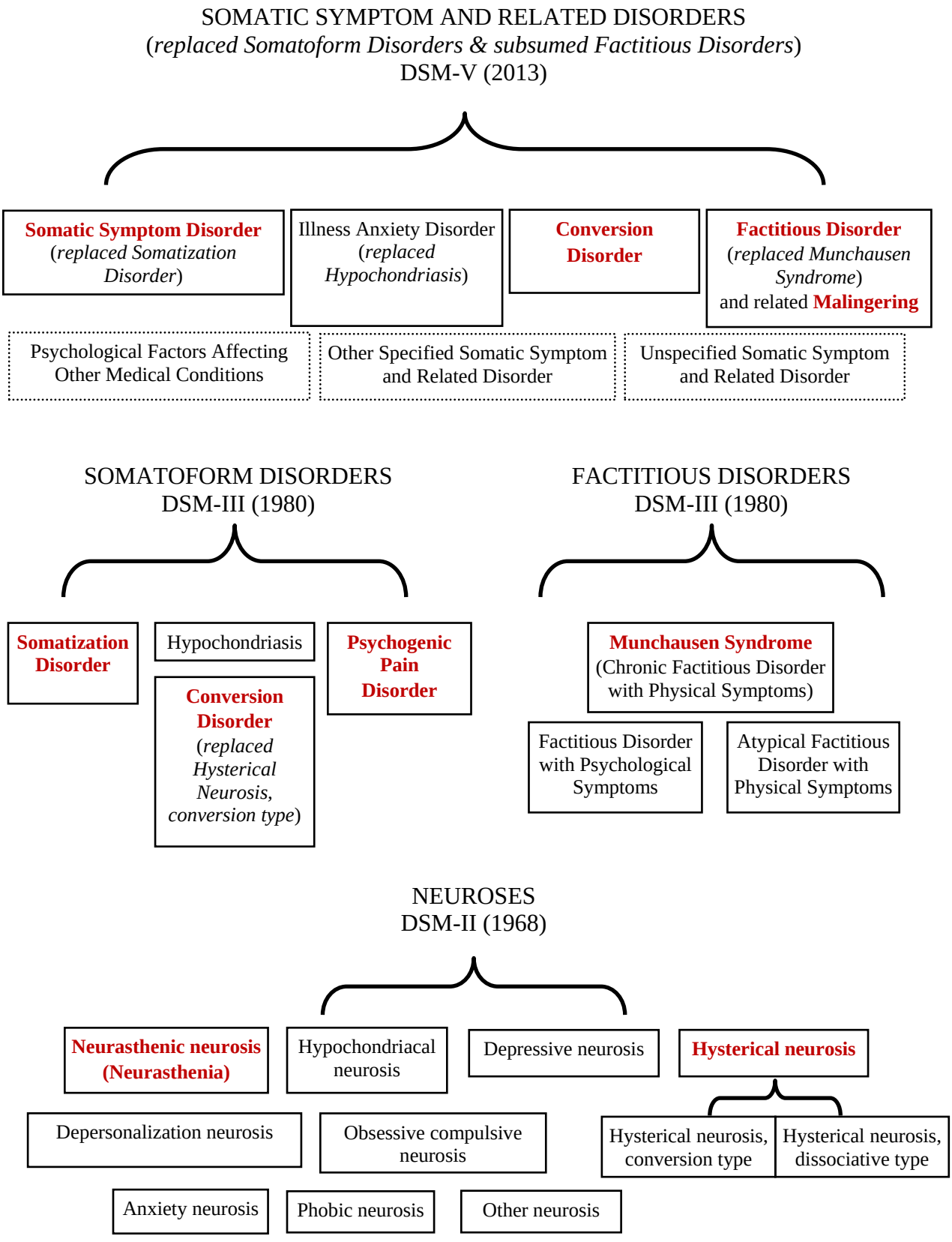
In the DSM-V, factitious disorder is considered to be one of the conditions under the diagnostic class Somatic Symptom and Related Disorders. This category was introduced in 2013 in the DSM-V and subsumed many previously distinct disorders. Prior to Somatic Symptom and Related Disorders[18] these conditions were classified as Somatoform Disorders (Onofrj et al.). Somatoform disorders entered the DSM-III at the same time hysteria was removed and was placed under its umbrella under various disorders. In the DSM-III, somatoform disorders included conversation disorder already mentioned above as well as hypochondriasis, psychogenic pain disorder, and somatization disorder. The DSM-IV explicitly states that somatization disorder is formerly known as hysteria or Briquet's syndrome (named after the nineteenth century French physician who published his *Treatise on Hysteria* in 1859). Taken together, this diagnostic reorganization does not eliminate hysteria so much as redistribute its symptoms across multiple categories, each capturing different aspects of what was once a single, more diffuse diagnosis. One can see how features of hysteria were essentially parsed apart and placed within different diagnostic categories under the somatoform disorders.

According to the DSM, somatoform's replacement with somatic symptom disorders[19] in the DSM-V was intended to eliminate confusion about the overlap across somatoform diagnoses.

[18] Pain and fatigue are considered defining symptoms of somatic symptom disorder.
[19] The DSM-V makes a point of stating conditions that fall within this categorization are most useful to primary care physicians and non-psychiatric clinicians because they are most commonly encountered in primary care or other medical settings. This is relevant when diagnosing this specific classification of disorders is understood to occur in settings where individuals are seeking medical care that might dismiss physical symptoms as a somatic syndrome in the absence of observable diagnostic evidence.

However, this shift also introduces a barrier to cleanly tracing the history of hysterical diagnoses, obscuring their continuity and enabling these newer categories to be applied with considerable flexibility in practice. To recap these diagnostic changes for clarity, there is a documented trajectory of the diagnosis of hysteria being replaced under “somatoform disorders” and “fictitious disorders” in 1980, umbrella terms that are again replaced in 2013 under the current “somatic symptom and related disorders” label. I include a visual representation below of some of these changes from the DSM-II through to the DSM-V to help identify these shifting categorizations through time. The terms bolded in red are those that have either been mentioned in this chapter or will become relevant in the following chapters.

Figure 1. DSM Classifications



Due to the continual reclassification of disorders in the DSM and the entanglement of various conditions that are absorbed under different labels in newer editions, the re-defining of hysteria and related disorders throughout the years is slightly obscured. But given this trajectory, messy as it is, the categorization of these conditions should be considered within the larger historical continuum of diagnosing hysterical disorders. None of the articles under analysis in this chapter outright mention hysteria or malingering, but they do frequently reference somatic, somatizing and somatization. They also describe features of factitious disorder and malingering. At the time of the *Rheumatology* articles' publication, somatization disorder was placed within the somatoform disorders (as discussed above). In the DSM-V, it specifies that the new classification of somatic symptom disorders covers those who would have in the past been considered for a diagnosis of somatization disorder (310). In part, what the reclassification of somatoform disorders into somatic symptom disorders in the DSM-V has achieved is to enfold factitious disorder within this new diagnostic class, which was previously separated into its own class by the distinction that physical symptoms are *intentional* in factitious disorder and malingering.

The constant teasing apart of specific disorders and then enfolding them under different classifications has blurred the boundaries between them. As a result, these categories become available to clinicians not as discrete diagnoses but as overlapping explanatory frameworks that can be selectively invoked depending on the interpretive needs of the case. Moreover, the distinction between all of these disorders is ultimately of little consequence as the DSM-V has already admitted that judging a patient for conscious or unconscious intention is undependable. What cuts across all of these disorders is the assessment that a patient's physical symptoms cannot be medically explained and the determination that the patient displays abnormal and

excessive thoughts, feelings, and behaviours in response to their symptoms (DSM-V 309). It is only after accepting this basis that determinations of whether a patient is faking—consciously or unconsciously and for what motivation—enters the discussion. These distinctions are more clearly shown in Table 2 "Disorders Listed in the DSM" above. In this table, I chose to include the broader DSM-V category that is somatic symptom and related disorders in which factitious disorder is placed (most easily shown in Figure 1). This is because it shows the contradiction between so-called 'conscious' vs 'unconscious' intent. Somatic symptom and related disorders are designated as unconscious, yet nestled within this broader category factitious disorder is deemed conscious—both of these designations of apparent intent are depicted in Table 2.

The DSM-V stresses that the new category of somatic symptom and related disorders is intended to remove the focus from a lack of medical explanation for physical symptoms because the previous somatoform disorder classification implied physical symptoms were "not real" (309). The new classification instead emphasizes the patient's own feelings about their physical symptoms as abnormal and excessive. Thus, while symptoms such as pain are now acknowledged as real to the patient, they are also considered to be caused by the patient's mental state or as personality related. This focus on not blaming the individual and acknowledging their pain as real but still determining that their symptoms are physical manifestations of psychological states will be important when I begin to analyze my corpus. The DSM-V further states that somatic symptom disorders on the whole "embod[y] persistent problems related to illness perception and identity" and that in most cases "individuals present with somatic symptoms and medical disease conviction" (310). So, pain is real but it's still kind of your fault.

The DSM-V was published after the *Rheumatology* publications that I am most focused on in this chapter's analysis; however, the explanation of the reclassification of somatic symptom

disorders plainly states that the DSM is responsive to how diagnoses of supposed disorders are applied in the clinic. Moreover, in an article published in 2013—the same year as the DSM-V—Wolfe and Walitt outright state that "[o]utside the rheumatology community, fibromyalgia was seen primarily as one of a series of somatic symptom disorders" ("Culture, Science, Fibromyalgia" 753). The *Rheumatology* authors articulate this same description of somatic symptom disorders that emphasizes pain or physical symptoms are not the patient's fault, but that that their physical symptoms are a product of their illness beliefs, that being ill becomes their entire identity, and rather than recognize psychological factors the individual stubbornly clings to the notion that they are medically unwell. They sometimes refer to this as "disability conviction" (Hadler and Ehrlich 2003 "Conundrum of Disability Determination", 1031).

The *Rheumatology* authors however do not just stop here. They also imply their patients have a motivation to adopt the "sick role" whether it is for the attention they might receive interpersonally or medically (thereby satisfying the criteria for factitious disorder) or in the form of external gains such as disability compensation (i.e. as malingerers). In many ways, the authors' descriptions of their patients across these supposed disorders are as slippery as the diagnostic classifications that attempt to delineate these various disorders. The *Rheumatology* articles' narratives of their fibromyalgia patients are reflective of a viewpoint that perceives certain patients and their symptoms with suspicion, a suspicion that has been codified in key medical texts such as the DSM—a dynamic I return to the in the analyses that follow. In this chapter and the next, I focus more specifically on the ways in which the authors and works under analysis construct their patients' as satisfying the first criterion of malingering: feigning or excessively exaggerating physical symptoms. In chapter 3, I will expand on this to address the second and most essential criterion of malingering: faking illness for external incentives.

3. On the "Disability Con"

Before turning to an analysis of the *Rheumatology* articles, it is necessary to situate their suspicion of malingering within a broader historical context that has long cast disabled people as potentially deceptive. Ellen Samuels' (2014) concept of the "disability con," developed in *Fantasies of Identification*, traces the longstanding cultural narrative that disabled people fabricate illness for personal gain. In *Fantasies,* Samuels identifies an emerging anxiety surrounding bodies and identities and the fear of their potential for deception. Samuels' discussion of the disability con provides crucial context for the articles under analysis in this chapter and the persistent suspicion of malingering they reflect. Using Samuel's analysis of the emergence of the disability con in the nineteenth century helps situate these articles within a historical context that has regarded invisible disability as subject to scrutiny. It places the claims within these articles—that I argue collectively demonstrate a framing of their patients as malingerers—along a rhetorical continuum that has led to increased questioning and surveillance of disabled bodyminds—of which the DSM is taking part—to determine whether someone is 'truly' disabled or whether they are faking for undeserved rewards.

In "Part 1: Fantasies of Fakery," Samuels identifies the concept of a disability con that emerged in the mid to late nineteenth century, then re-emerged approximately one hundred years later in the twentieth century and she argues is still in operation today. Samuels connects this emergence of the disability con to newly available social supports. The notion of fake disabled bodies, Samuels argues, was "a response to new extensions of social benefits to disabled people and others…" (19-20). Discussing what she terms the crisis of identification, Samuels describes the "growing social anxieties" in the mid-nineteenth-century U.S. which were "driven by rapid changes in personal and geographic mobility, urbanization, and the breakdown of class- and

appearance-based systems of knowledge" (50). It is at this time that the figure of the "con man" emerged as a symbol of these intersecting anxieties.

First appearing in an 1849 news article as the "confidence man," Samuels notes the con man describes "a wily swindler whose success derives from his manipulation of others' perceptions" (50). Samuels emphasizes the importance of disability for the figuration of the con man, describing it as a symbol through which "deep fears about the deceptive potential of disabled bodies" are affixed and arguing that the disability con is a "central and recurring element" of its cultural portrayal (50). She argues that the disability trope and that of the con man have become so entwined in contemporary cultural imagination that they are now inseparable. By this logic, "if con men almost always pretend to be disabled, maybe disabled people are especially prone to con games" (52).

Prior to this conflation of disability and con, disabled figures were regarded in three common ways: as divine, with charity, or with suspicion (58). By the approach of the twentieth century, however, mythic interpretations had been left behind and the contradictory view of disabled people as either worthy of charitable compassion or regarded with suspicion and resentment were "highly regularized to clearly distinguish the 'real' disabled, for whom one must show charity, from the 'fake' disabled, against whom one can freely vent all one's resentment for their nonproductivity, compounded by righteous anger over their deception" (58). This process endeavoured to demarcate the "genuine 'cripples'" from "the malingerers," or "those deemed *unable* to work" from "those deemed *unwilling* to work" (Garland-Thomson 49; emphasis added).

In her discussion of "the confidence man" through an analysis of American novelist Herman Melville's novel of the same name, Samuels suggests that "many centuries of symbolic

association of physical disabilities with evil portent, moral failing, and sexual transgression" also "amplified…the fear that social support would encourage fraud" (Samuels 58). Samuels explains that the association of 'real' disability with 'evil' as a basis for suspecting disability fakery seems illogical but emphasizes the importance for understanding how attempts to define distinct boundaries between disabilities that are 'real' or 'fake' are contingent on the fluidity of "disability itself" (58). In an explanatory note to these comments, Samuels cites Deborah Stone's research on the history of this dynamic: disability, Stone states, is more problematic than "other traditional categories of social dependency," because, for one, "no single condition of 'disability' is universally recognized" (222). Moreover, "because physical and mental incapacity are conditions that can be feigned for secondary gain…the concept of disability has always been based on the perceived need to detect deception" (222). Therefore, "the very category of disability was developed to incorporate a mechanism for distinguishing the genuine from the artificial" (24, 32; qtd. in Samuels 14).

What Stone's comments highlight is a contradictory tension between what one is experiencing—one's interiority—versus what is visibly detectable on the outside—a surface that is able to be read by others (59). The fear is that this surface does not reveal "its inner truth"[20] (Kawash 132; qtd. in Samuels 18). For the disability con, this tension between who someone is (or claims to be) versus who they appear to be is at the heart of discussions surrounding supposed illness fakery. As Samuels argues, this anxiety surrounding disability imposture is not confined to the nineteenth century but re-emerges in later historical moments—particularly alongside expansions of social welfare—where questions of legitimacy and deservingness

[20] This dynamic reflects a broader pattern within medical discourse wherein subjective experience is subordinated to externally observable signs. I return to this dynamic in greater detail in chapter 5 where I further discuss the epistemology of visibility.

become newly intensified. In this way, the ubiquity of this trope in contemporary society speaks to a social climate in which "one is often assumed to be faking a disability unless and until it has been proved by either medical certification or obvious physical signs" (52). This is the social backdrop and attitudinal thrust of these articles. The articles individually and collectively reflect the fear that "unworthy" individuals were claiming disability in order to receive undeserved monetary or other forms of compensation. These deep-rooted suspicions of malingering led to the increased questioning and surveillance of disabled bodyminds for their conformity to the disability category.

4. Associating Fibromyalgia with Malingering

This section begins my analysis by demonstrating that suspicion of malingering operates as a recurring framework within both the broader medical literature on fibromyalgia and the *Rheumatology* articles that form my corpus. It is difficult to find any medical literature on fibromyalgia that does not raise the question of malingering. Chronic pain and fatigue-related illnesses, such as fibromyalgia and chronic fatigue syndrome, are especially prone to suspicions of malingering. Published alongside an article authored by Frederick Wolfe in 2000 in the *Journal of Rheumatology* are two more that explicitly ask "Fibromyalgia: can one distinguish it from malingering?" (Smythe) and "Fibromyalgia: can one distinguish it from simulation?" (Khostanteen et al.). In 2007, an article on "Malingering in the medical setting" claims that fibromyalgia (FM), followed by chronic fatigue syndrome (CFS), "are feigned most frequently" and especially so when there is a financial incentive (McDermott and Feldman). These authors even go so far as to say that malingering should be suspected in every case where "there are tangible incentives" and Western medical technologies cannot determine an organic cause. Numerous articles since continue this trend of attempting to distinguish between "real" patients

and “detect[ing] possible malingering in fibromyalgia” (Belenguer-Prieto et al. 2013; Torres et al. 2010).

In a 2000 editorial, “For example is not evidence: Fibromyalgia and the law”, Wolfe responds to a report by Mailis et al. describing a case of a family of 6 who were diagnosed with FM following a motor vehicle accident with legal proceedings around this case being drawn out for 9 years. Wolfe uses this case report as a springboard to refer to a “recent case” in which a woman was involved in a motor vehicle accident and immediately reported pain, which fit the American College of Rheumatology (ACR) criteria of the time. During her legal proceedings, six rheumatologists confirmed her diagnosis of FM. Yet, surveillance tapes “showed a normal, healthy individual with no abnormalities whatsoever” (1116). Based on these tapes, the rheumatologists reverted their diagnosis and determined this was a case of malingering. Wolfe says, “Everyone got it wrong” (1116). Ignoring for the moment how unlikely it is that pain is visible on the body, that chronic pain is not static, or what it even means to be declared “healthy” through visual observation alone, Wolfe uses this case to suggest that it is too easy for individuals to fake fibromyalgia and satisfy the ACR criteria. He claims that a physician’s greatest bias is their “trust and empathy” toward their patient (1116). This trust and empathy are portrayed as something patients will take advantage of to receive undeserved compensation, effectively hoodwinking their physician. The ACR criteria then is posited as opening the door to disability compensation.

In this editorial, Wolfe also references data from Lithuania, which he says has no compensation system and accordingly no increased reportage of long-term symptoms following motor vehicle accidents. This comparison shows how fixated discussions of fibromyalgia are on questions of malingering and the idea that fibromyalgia as a diagnosis is enabling malingerers to

receive unfair compensation. Wolfe's reference to Lithuania's lack of compensation system recalls one of the bases of White and Thompson's 2003 study to which the *Rheumatology* authors are responding to: to test the hypothesis that fibromyalgia is a compensation-driven ailment. This framing is not uncontested. In a letter to the editor in response to Wolfe's editorial, another physician states "[s]uspicion and/or blame placed on innocent patients whose behavior may not be easily understood is misdirected" and "[t]o approach such individuals as if they were malingerers…makes us agents of the government and of the insurance companies" (Romano 674). Romano's comments suggest that the physician's greatest bias may not be their trust and empathy, as Wolfe claims, but the suspicion with which some patients are regarded for experiencing pain that is misunderstood.

Accusing patients with unverifiable pain of malingering continues to this day and is especially evident in cases where the individual seeks financial compensation. Twenty-four years after Wolfe's article was published, a June 2024 article on how to screen for suspected malingering argues that malingering accounts for a significant financial burden to the healthcare system; therefore, identifying malingerers is crucial to reducing healthcare costs (Sawar et al.). In this article, Sawar et al. identify a black, female patient who presented with generalized pain following a motor vehicle accident. They imply that the patient's symptomology was "discordant" with the lack of objectively observable verification and therefore diagnose the patient with malingering (n.p.). This reflects one of the DSM-V criteria for suspecting malingering discussed above, which encourages clinicians to treat discrepancies between reported symptoms and objective findings as grounds for suspicion (727). Diagnosing this patient with malingering enabled the physician to limit care and minimize follow-up appointments which they state contributes to limiting healthcare expenditures. At no point do the

authors consider the racial and gender bias cited by several studies that have found black women's pain is much more likely to be dismissed and undertreated (Hoffman et al. 2016; Zhang et al. 2021). It is worth noting that fibromyalgia is a common diagnosis given to individuals with generalized pain following motor vehicle trauma (McLean et al. 2005). This is what prompted Wolfe's editorial commentary above. And yet, these clinicians are wholly focused on setting a precedent on how to catch someone in the act of feigning illness to reduce healthcare costs by denying treatment.

Having established that malingering functions as a pervasive framework within the medical literature on fibromyalgia, I now narrow my focus to a sustained analysis of articles by Wolfe, Hadler, Ehrlich, and Gordon. In the corpus of *Rheumatology* articles under analysis, accusations of malingering are likewise tied to an interest in reducing healthcare spending. Perceived incentives motivate these physicians to scrutinize their patients, looking for signs of faking illness, and capturing their patients within narratives that paint their disclosures of pain as evidence of fraudulent claims of disability. When mentioning his review of cases of individuals diagnosed with fibromyalgia following a traumatic injury, Wolfe (1997) references their "long histories of medical complaints and FM symptoms" as proof that these individuals are conning the system (1248). He declares that he has "seen 3 cases of clear cut fraud" where "patients alleging disability were, in fact, entirely well and feigning illness"—patients who were caught out through increased surveillance (1248).

In what follows, I document the various ways that Wolfe, Hadler, Ehrlich, and Gordon place their patients within narratives of malingering. I do this by examining the claims they make, explicitly or implicitly, that imply their patients are exaggerating their symptoms for the purpose of receiving personal gain or external rewards. While none of the authors specifically

reference malingering, they describe it by voicing their suspicions that patients are exaggerating their symptoms in the interest of playing the sick role and receiving some incentive, whether it is motivated by attention-seeking, financial compensation, or avoiding the duty of work. The ways in which the authors represent their patients as malingerers is by downplaying, dismissing, or normalizing their patient's symptoms through these claims.

The rest of the chapter is organized around five recurring claims that collectively structure the authors' representation of fibromyalgia patients as malingerers. I analyze each of these claims in turn: 1) The fibromyalgia patient is almost always a woman; 2) Pain is a lifestyle; 3) Medicalization increases disability; 4) Fibromyalgia is controversial; and 5) Fibromyalgia is "psychologically-motivated at all costs" (Vidali 50). On the surface and individually, these claims may not sketch a perfect picture of a so-called malingerer. Taken together, however, they describe many of the features that define malingering and related somatic disorders. While the chapter addresses these claims individually, they function cumulatively rather than independently, together producing a broader pattern of suspicion across the *Rheumatology* texts. On the whole, these authors' claims function to create sustained suspicion of diagnostically unverifiable physical symptoms that has historically impacted the type and quality of care women with invisibilized illnesses have received.

5. CLAIM: The FM Patient is Almost Always a Woman

Somatic symptom disorders carry the leftover debris of hysteria and as a result have long been heavily gendered and more often diagnosed in women. While malingering has been traditionally more diagnosed in men (likely because of its historical association with sailors and soldiers and gender bias in expectations of work), factitious disorder has been diagnosed in

women more because of the association that women are more frequent healthcare users.[21] Fibromyalgia follows a similar fate: it is diagnosed in women approximately 4 times more often than men and in some estimates up to 9 times more (Statistics Can 2006). This diagnostic disparity emerges, in part, from longstanding gendered assumptions within medicine that make women's symptoms more likely to be interpreted as excessive attention to bodily sensations, emotional vulnerability, or psychological distress, particularly when those symptoms lack clear biomedical explanation (Hoffmann and Tarzian, 2001, 13-14; Vidali 2013). Scholars have shown that such assumptions shape the diagnosis and interpretation of contested illnesses, contributing to the feminization and psychologization of conditions such as fibromyalgia (Wendell 1996). In this way, contemporary characterizations of fibromyalgia reproduce enduring gendered tropes associated with hysteria, in which women's pain is framed as excessive, emotionally driven, and motivated by a tendency to complain and desire for attention. In this section, I address the *Rheumatologists'* claim that most individuals who "embrace" the diagnosis of fibromyalgia are women. To do this, I will focus on analyzing Ehrlich's 2003 article "Pain is Real—Fibromyalgia Isn't", followed by Hadler's 2003 article "'Fibromyalgia' and the Medicalization of Misery" for their explicit or implicit portrayal of the fibromyalgia patient as a woman.

Of the four *Rheumatology* authors whose rhetoric I analyze, Ehrlich in particular is intent to characterize the 'FM patient' as a woman. He is the only one of the *Rheumatology* authors who consistently and exclusively uses the pronouns she/her. He states that "all manner of

[21] While it is true that women have been documented to be more frequent healthcare users, this is often because of gynecological care and due to women's longer life expectancies compared to men which leads to more age-related conditions and on-going care. This statistic also might obfuscate that when women's symptoms are not taken seriously, as has been well documented, they might require more frequent visits to various healthcare practitioners to have their symptoms treated. This might on the surface make it seem that women are more frequent healthcare users but some of these incidents might be for the same untreated condition. These experiences have been documented in Maya Dusenbery's 2017 book *Doing Harm: The Truth About How Bad Medicine and Lazy Science Leave Women Dismissed, Misdiagnosed, and Sick*.

associated symptoms or nonsymptoms become prominent when the individual focuses on *her*self and *her* discomfort (and it is mostly women who fall into this category)" (Ehrlich 1666; emphasis added). In addition to clearly labelling the FM patient as a woman, these comments paint the FM patient as overly concerned and preoccupied with their symptoms or "nonsymptoms" as Ehrlich says—which is an implicit suggestion that these symptoms are not in fact real but manufactured either by deliberate deception or by focusing too closely on one's body. For Ehrlich, it is not just that these patients are overly focused on their discomfort, but that they openly talk about it. He refers to these women as "chronic complainers" (1666)—a common stereotype levelled at women who are perceived as voicing trivial complaints. Reporting of subjective symptoms then becomes the complaint of an unreliable narrator who is only intent on seeking attention for her woes—one of the first criteria for identifying a malingerer. So-called excessive thoughts about symptoms fits accordingly with the predominant feature of somatic symptom disorders as described by the DSM-V.

Hadler suggests something similar to Ehrlich. While he does not specifically refer to FM patients as comprising a particular gender, Hadler does describe characteristics that have been feminized and especially when characterizing female hysteria. For example, Hadler states "I suspect that few suffering with persistent chronic pain are suffering in silence. I suspect that their narrative of distress is very dependent on the listener" (Hadler 1668). Such a characterization harkens back to descriptions of the female hysteric who was accused of excessive talking about themselves and their illness, which was in turn pathologized as a symptom of their disease.[22] Hadler goes on to say "[w]e have no data as to how these people select a confidant. They

[22] Nineteenth century physician Silas Weir Mitchell, infamous for the rest cure, believed that excessive talking about and over-attention to one's symptoms reinforced illness beliefs. This is in part why a key aspect of his rest cure focused on isolation thereby limiting communication (Mitchell 1884; Showalter 1985).

probably choose many and often" and "[i]f they are seduced by the construction, 'scientific medicine,' they will choose a physician" (1668). Hadler's phrasing relies on deeply gendered assumptions about appropriate expressions of pain. The implication that "these people" do not "suffer in silence" invokes a culturally masculine ideal of stoic endurance, implicitly casting fibromyalgia patients as deficient in the self-control and restraint associated with credible suffering.

Like Ehrlich, Hadler portrays the FM patient as prone to talking excessively to anyone and everyone who might constitute a "sympathetic listener" (1668). This listener takes the form of a physician if the individual is "seduced by the construction" of "scientific medicine" (1668). His suggestion that patients are "seduced" by scientific medicine further feminizes them, invoking a gendered script in which women are positioned as emotionally impressionable and vulnerable to persuasion rather than capable of rational judgment. Framing their engagement with medical care as a form of seduction casts their pursuit of a diagnosis not as a reasoned response to suffering but as evidence of emotional susceptibility. Moreover, merely expressing one's symptoms and seeking the attention of a physician is reframed as a symptom in itself: "excessive talking" becomes an illness behaviour that reveals one's attachment to the sick role and one's personal gain in receiving attention for it. This illness behaviour fits within the second claim I will be addressing: excessive talking about one's symptoms of pain is a lifestyle choice.

6. CLAIM: Pain is a Lifestyle

Another one of the ways these articles demonstrate their suspicions of malingering is by portraying the pain their patients describe as a lifestyle choice. Within this claim, I analyze Hadler's 2003 article "'Fibromyalgia' and the Medicalization of Misery"; Gordon's 2003 article "Fibromyalgia—Real or Imagined?"; Wolfe's 1997 article "The Fibromyalgia Problem";

Ehrlich's 2003 "Pain is Real: Fibromyalgia Isn't," and Hadler and Greenhalgh's 2005 "Labeling Woefulness." In this section, I further argue that the authors' framing of pain as a personal lifestyle choice contributes to a normalizing of pain that fails to recognize pain may be experienced to an unusual degree. This framing functions to downplay the patient's symptoms in order to dismiss them as a product of one's abnormal or excessive thoughts about their health**.**

One recurring way this suspicion is produced is through Hadler's editorial, in particular, which states that those with fibromyalgia "choose to be patients." This line—"These people are choosing to be patients"—is repeated four times throughout the short editorial and is often placed at the end of a paragraph as the key take-away. This repetition exemplifies a "rich feature" in that it "offers a cue to the reader" of how the author is situating their patients as actively choosing to be in pain (Barton 23). As a rich feature, the author's linguistic choice may seem subtle but it "appear[s] often enough" and contributes "in a significant manner to the way that [the] text makes meaning" (24). This repeated phrase does the heavy lifting to imply that individuals play the part of an ill individual: that they adopt certain behaviours in order to perform the sick role and adopt this role as a lifestyle (i.e. the primary motivation in factitious disorder). In this way, the claim positions patients as responsible for their own suffering. In fact, Ehrlich's article "Pain is Real; Fibromyalgia Isn't," more explicitly states that "chronic pain becomes involved in a lifestyle mix" (1666).

Referencing Hadler's views, Gordon states "ineffective 'circular treatment acts'" that [patients] subsequently receive [upon diagnosis] only reinforce illness behaviours" (1665). Illness behaviours are of much concern to the authors as they perceive these behaviours as evidence of the patient's attempts to assume an ill lifestyle, to which Wolfe says treatments only contribute. Wolfe (1997) cites a "myriad [of] treatments" that "have sprung up and are

recommended by experts and experts' organizations" that he, like Gordon, prefaces with having "little evidence" of "any substantial longterm benefit":

> Tricyclic antidepressants and antidepressant and non-antidepressant doses, selective serotonin re-uptake inhibitors, other antidepressants, tranquilizers, muscle relaxants, anti-epileptics, nonsteroidal anti-inflammatory drugs, guiafenesis, fluconazole, physical therapy, stretching, trigger point injections, tender point injections, massage, water therapy, craniosacral release, and aroma therapy. (1248)

This catalogue, in addition to his comments that they are endorsed by experts' organizations, I argue is intended to suggest an excessiveness that is supported by an industry intent on enabling a sick lifestyle. Not only are these treatments depicted as excessive, they are also presented as having "little scientific rationale and research support" (1248). Wolfe is implying that these interventions only exist to promote and sustain this lifestyle: "it seems clear that many FM treatment initiatives promote medicalization and prolong illness" (1248). It is unclear how these treatments would "prolong illness," as he offers no concrete examples, but there is the implicit suggestion that treatments (as a result of diagnosis) enable, justify, and legitimate illness that presumably would not exist if there was not an environment manufactured to support it.

Put more bluntly, Hadler states "the treatment act is plying the patient with intimations as to the pathophysiology of their nociception. That is how the person suffering persistent widespread pain learns to be a patient with 'fibromyalgia' (FM)" (Hadler 1669). In other words, treatment acts that take patient's pain seriously teach the patient to take that pain seriously, too. This framing draws on the concept of learned illness behaviour, which interprets illness identity as something produced through social and clinical reinforcement, thereby, positioning diagnosis itself as a mechanism that generates rather than recognizes illness. This is why Hadler (1996)

insists “anyone who has to prove he or she is ill will be rendered more ill in the proving” (249). Rather than see treatment interventions as alleviating symptoms, even if not offering a ‘cure,’ they perceive treatments as supporting a patient’s illness beliefs and thereby perpetuating a lifestyle of the ill. The diagnosis itself is blamed for “foster[ing] a life of somatising” that contributes to the “magnification of symptoms” (Hadler 1997, 1251). There is that pesky word “somatizing” that outright states physical symptoms are manifestations of psychological distress and connects fibromyalgia to hysteria.

Ehrlich, too, blames the diagnosis for fostering this lifestyle when he states that “giving a name to the pains has spawned the very symptom amplification and imitative behaviour the rheumatologic profession should be combating” (1666). Hadler and Ehrlich talk about symptoms as if they exist in isolation and that grouping them together under a label is what makes these symptoms disabling, which they are clear they want to avoid. Grouping these symptoms under the heading of fibromyalgia in their view is what enables individuals to mimic a lifestyle that they see as “counterproductive to coping” as “coping requires avoiding the magnification of symptoms” (Hadler 1251).

Hadler even goes so far as to say that upon diagnosis, “[t]he patient is forever changed. Their narrative is laced with the clinical heuristics they have learned, which they can recite with objectivity that approaches dispassionate” (Hadler 1669). The patient so framed is described as performing a role (the sick role), having memorized the clinical shorthand that will supposedly lead them to a specific diagnosis. They also appear to be judged for not displaying Hadler’s opinion of the appropriate affect: “objectivity that approaches dispassionate.” In the same publication, Hadler has also condemned the patient’s narrative of “distress,” making it unclear how an individual is supposed to convey their symptoms in a way that would not inevitably

frame their narration as a performance (1668). As Dusenbery (2017) has observed in *Doing Harm*, this puts women in a double-bind: if they if they are too unemotional, they must not be experiencing the pain they report, but if showing distress, they must be exaggerating their symptoms or performing an act (n.p.). For Hadler, this is a performance that forever changes the patient, as if once they "choose" to play the role of the ill they will adhere to this performance for their lifetime.

In a 2005 article authored by Hadler and Greenhalgh, they name the process of adopting this lifestyle "Becoming a Fibromyalgic":

> However welcome the label may be, it tends to have powerful and often unrecognized effects on those so labeled. The most fundamental is on one's identity, one's sense of self. From being a whole person with many life options, the fibromyalgic is often transformed into a long-term patient whose life is dominated by, and limited by, disease. Becoming a fibromyalgic requires the rewriting of one's illness narrative. This new narrative of distress is always laced with idioms that are learned and used to mark the experience. ("Labeling Woefulness" 3)

Described as more than just a lifestyle, diagnosis has such power that it eclipses one's entire identity to transform a previously "whole person" into a fragment of one's self. Hadler and Greenhalgh's comments reflect a long-standing dehumanization of disabled people wherein they have been perceived as "less than," as incomplete or inferior to non-disabled people and that their lives are less valuable and therefore not worth living. In this case, "when she or he chooses to be a patient with chronic widespread pain," they undergo a metamorphosis from a "whole person" into a "long-term patient whose life is dominated by, and limited by, disease"[23] (1670).

[23] In his 2008 book *Worried Sick*, Hadler becomes far more forthright in expressing this dehumanization: in his discussion of fibromyalgia in a chapter titled "It's In My Mind," he says "[b]oth skill and responsibility are required

Their words parrot what the DSM-V refer to as "severe somatic symptom disorder" which is when "health concerns" begin to dominate one's life and "[become] a feature of his or her identity" and "can lead to invalidism" (311). Moreover, it is because of medicalization, Hadler and Greenhalgh argue, that these individuals are enabled to rehearse and repeat "idioms" that aid them in fulfilling their new chosen identity. These individuals are not relaying their symptoms only to access medical care; rather, they "want" to be sick—or so the authors heavily imply. This characterization is very close to the DSM's description of factitious disorder, previously known as Munchausen's, where the individual is said to want to play the sick role for the increased attention and sympathy it allegedly brings.

Wolfe (2009) claims that labeling contributes to the adoption of this lifestyle. It is as a result of labeling, Wolfe says, that an individual learns to "[become] a patient": quoting Huibers and Wessely, Wolfe states "labeling leads the patient to 'believe she has a serious disease, leading to symptom focusing that becomes self-validating and self-reinforcing and that renders worse outcomes, a self-fulfilling prophecy'" (676). Notice how this quotation deliberately uses the pronoun "she": it is she who is portrayed as overly focused on her symptoms, and it is the diagnostic label that grants permission to attend to so-called illness behaviours. If one was not ill

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if the doctor is to avoid unnecessarily keeping patients as patients, rather than facilitating their return to personhood" (149). In this quotation, Hadler suggests that patients are somehow removed from being whole people and that a "return to personhood" means to cease being disabled. He makes similar remarks in this same book in his discussion of prostate cancer where he states urinary incontinence (a possible risk of prostatectomy surgery) which might necessitate wearing "diapers" is a "catastrophe" that results in a reduced quality of life that is worse than the potential fate of death (99). Although he is not talking about fibromyalgia or unexplained illness, his comments perhaps reveal an underlying fear of disability and the body's vulnerability where being confronted with the possibility of living with a disabled body is, for him, a life less worth living. In referring to urinary incontinence as a "catastrophe for most"—a moral judgement—he also implies that the realities of living with disability equates with tragedy and diminished personhood. To be clear, I do not mean to suggest urinary incontinence or other drastic changes in bodily function would not be distressing and require adaptation physically and mentally but Hadler seems to frame this possibility of bodily difference as an intolerable (even horrific) outcome, so much so that he says he will not undergo any preventative screening for prostate cancer because the potential trade-offs (risk of becoming disabled) are too great (101). Hadler's views on prostate cancer provide important context for they mirror his ableist attitude toward fibromyalgia and chronic pain where he sees patients as representing failures of personhood and embodying the spectre of potential dependency.

before, the "self-fulfilling prophecy" of a diagnosis convinces them that they are now. It is the label that leads to "the development of an illness identity" and enables the individual to become a victim (676). For Wolfe and his colleague Hadler whom he references, "[d]iagnosis leads to transgression into the sick role" (676). He advocates that the "dangers of labeling" are so severe that the diagnostic labels such as CFS should be abandoned altogether (676). In their view, whatever symptoms or "complaints" (Wolfe 676) an individual has cannot be significant enough to warrant treatment. It is better that they minimize and dismiss these symptoms as mere complaints than acknowledge them through a diagnostic label that medicalizes their symptoms and risks the "dangers" of allowing someone to assume this sick role.

7. CLAIM: Medicalization Increases Disability

Medicalization is one of the key topics with which the authors of these editorials engage. Their claim that medicalization increases disability is tied to and builds on the previous idea that fibromyalgia and its related symptom of pain is a lifestyle choice. This claim extends that logic by reframing illness as produced through medical intervention rather than bodily experience. Within this claim, I will be primarily engaging with Wolfe's 2009 article "Fibromyalgia Wars." I will also touch on the commonality in his rhetoric regarding medicalization with Ehrlich's 2003 article and Hadler and Greenhalgh's 2005 article, both of which I in part analyzed in the section above. In addition, in Wolfe's 2009 article he includes a quotation from a 2002 article by Moynihan et al. titled "Selling Sickness: The Pharmaceutical Industry and Disease Mongering." Wolfe uses this article to bolster his argument that the medicalization of FM unnecessarily creates patients. As such, I will pay some attention to Moynihan et al.'s article for its similar argument that ordinary life is being medicalized and profited from. I argue that all of these

articles under analysis in this section downplay patient's physical symptoms, which contributes to the broader narrative that portrays them as malingerers.

The authors of these articles vehemently oppose what one refers to as the "medicalization of misery" and the diagnostic label of fibromyalgia, for in their minds it creates ill patients out of thin air who are otherwise suffering from the normal everyday pains we all experience (Ehrlich 1666). In a more recent publication, Wolfe (2009) quotes an article titled "Selling Sickness" to argue that medicalization of fibromyalgia "...reset[s] the borders of acceptable behavior, bodies, and states of being, and represents a selling of sickness that widens the boundaries of illness and grows the markets for those who sell and deliver treatments" (qtd. in Wolfe 674). As Moynihan et al. state, "[a] lot of money can be made from healthy people who believe they are sick" or in convincing them that they are (886). The reference to disease mongering in the subtitle of Moynihan et al.'s article refers to the phenomenon of medicalizing "ordinary life" (886). It can include "turning ordinary ailments into medical problems, seeing mild symptoms as serious, [and] treating personal problems as medical" (886). Note the similarity to Ehrlich's claim that FM is merely a medicalization of common everyday pains (1666).

This perception of individuals as exaggerating common symptoms is coded into the DSM as a pathology. The defining feature of somatic symptom disorders is "excess" or "abnormal" thoughts about symptoms that interfere with daily life—effectively treating such thoughts as an unhealthy fixation on what are often reduced to mere everyday aches and pains. In addition, people with these conditions are also described as frequent seekers of medical care, who insist their symptoms have a medical cause, and that they want to assume the sick role. If one is in constant pain or experiencing other physical symptoms that are interfering with daily life, it seems like a typical response would be to seek the help of a physician to figure out what is going

on. And yet, when these symptoms have been predetermined to be somatic and the physician's diagnostic tools definitive, the response is to deem the individual's mind and behaviour as deviant and the source of their ills. Any subsequent complaints for what are believed to be typical pains are then chalked up to increasing evidence of their obsession, further cementing the individual's placement within modernized hysteria classifications.

Thus, this type of normalizing of pain and other symptoms is one of the ways that these authors dismiss patient's symptoms as merely the complaints of a chronic complainer. While pain might still be acknowledged as real—as Gordon explicitly points out in his 2003 article's title "Pain is Real"—one of the arguments is that the more a person focuses on their pain—is "too" vigilant—the more intense their pain becomes. In other words, extreme focus on everyday aches and pains makes the pain seem bigger than it is, allowing it to dominate one's life. Within this logic, minimizing a patient's reporting of pain should minimize their pain as well, over time. It is like a "reset" of their excessive thoughts and preoccupation with pain. On the other hand, if a physician grants their patient sympathy for their pain or—gasp—validates it with a diagnosis of FM, then the physician has contributed to the problem of increasing disability, unnecessarily in their view.

To return to the quote above in which medicalization "represents a selling of sickness," fibromyalgia is described as a diagnosis that is packaged and sold to consumers who want to live the lifestyle of the sick role and by companies who want to profit off them. Wolfe is suggesting that pharmaceutical companies are exploiting the vulnerability of these patients who want to believe they are sick and enabling them to legitimize their conviction that they are truly sick. This quote also emphasizes one of the concerns with diagnosis is it redefines "acceptable behaviour, bodies, and states of being" (674). In his own words, Wolfe elaborates on this fear

that medicalization "expands the diagnostic boundaries and results in new patients being diagnosed with FM" which—using the same metaphor of change as Hadler and Greenhalgh at the end of the last section—he states "transform[s] persons not receiving medical care or considering themselves sick (non-patients) into patients" (674). This then leads to "expanding new treatments to those not receiving them, defining psychological distress and deviance as illness, and defining (multiple) unexplained symptoms as disease" (674). Wolfe's comments are interesting for they argue against pathologizing and medicalizing so-called psychological "deviance" from some norm, and yet these comments reveal a belief that fibromyalgia is caused by "psychological distress and deviance"—even though many of these authors have stated that they do not know the causative factors (and which Wolfe also admits when he mentions in the same sentence that these symptoms are unexplained).

Medicalization therefore is posited by all of these authors as harmful to the individual. Wolfe takes this a step further when stating "[w]e take the position that *society* is harmed in important ways" as he provides the following list of reasons for "[t]he price of medicalization" (Wolfe 674; emphasis added):

- Treating the wrong illness
- Expanding the base of fibromyalgia patients
- Expanding unnecessary, marginally effective treatment
- Increasing medical costs and treatments
- Increasing disability
- Corrupting scientific research
- Corrupting the dissemination of scientific information
- Changing psychosomatic illness into compensable disease
- Confusing correlation with causation

While treating the wrong illness is certainly a valid reason to have misgivings about the diagnosis of FM, the authors heavily imply that the "real" illness is in fact psychological in origin. Even the list above reveals this bias as Wolfe cites "changing psychosomatic illness into

compensable disease," suggesting that fibromyalgia's diagnostic recognition enables access to disability benefits that would otherwise be unwarranted. By including compensability among the "costs" of medicalization, Wolfe implicitly frames compensation as a reward granted through diagnostic expansion, rather than as a necessary support for individuals whose illness limits their ability to work and sustain themselves.

Listing "increasing medical costs" as a reason to not diagnosis FM reveals that one of the key concerns is the cost of these patients to the healthcare system, as if by simply not diagnosing FM money can be saved. I suppose this is true if diagnosis is the only means to treatment. This was certainly the case for the 2024 situation I referenced in the opening section of this chapter on "Associating Fibromyalgia with Malingering" where malingering was overtly used as a diagnosis to limit healthcare expenditures and thereby mitigate costs to the system. Treatments that are "marginally effective" are stated to be "unnecessary." This conclusion ignores how patients might feel about treatments that could provide some alleviation of symptoms. It is also not clear what "effective" could mean, whether that is referring to a "cure" or whether it is ineffective at treating some symptoms such as pain that have already been declared by Wolfe and others to be aspects of normal, everyday life.

The concern with "expanding the base of fibromyalgia patients" can be discussed together with the concern of "increasing disability." Throughout these articles, the authors have acted as if the diagnostic label of FM is responsible for creating patients with these symptoms and that their symptoms do not seem to matter (or exist) until they are categorized under FM or given medical authorization. Regardless of whether symptoms are collected under the umbrella of a particular label, individuals are still living with these symptoms—eliding this fact does nothing to eliminate the pool of people in need of healthcare. However, it does reduce healthcare

spending by denying treatment altogether. It also disperses these individuals with common symptoms to make it easier to argue for the psychologization of their symptoms. Wolfe effectively says as much when he states that "the problem is not so much FM, but psychosocial issues, inappropriate pain behavior, and sometimes somatization" in his 1997 article "The Fibromyalgia Problem" (1249).

A diagnostic label, according to Wolfe, contributes to "the opposite of what [they] should wish to accomplish"—"prolong[ing] medicalization and dependency" where instead they see their mission as to "halt the trend to label patients with FM as disabled, and…the societal trend toward encouragement of the disability concept" (1249). He echoes this sentiment in his 2009 article when he states that the FM diagnosis comes "at the cost of creating and expanding illness" (676). Again, the label is blamed for "creating" illness, but more to the point, these comments demonstrate the view that disability is bad. Disability, in their view, leads to "dependency," which they wish to eradicate. Disability is a threat to their agenda: discouraging the "disability concept" in their minds, and therefore ceasing medicalization, is essential to decreasing claims for compensation. In "Selling Sickness," the authors relatedly argue that inappropriate medicalization diverts resources "away from treating or preventing more serious disease" (Moynihan et al. 886). Giving legitimacy to FM, then, is a waste of time and resources and ultimately detracts from funding going toward the more serious and deserving diseases.[24] The view that treating certain populations constitutes a waste of resources that would be better invested elsewhere has been a recurring feature of political and economic discourse since at least

[24] In *Doing Harm*, Dusenbery notes the discrepancy in funding for chronic pain, which affects 100 million Americans, is a leading cause of long-term disability and "costs the nation $560 billion to $635 billion in health care costs and lost productivity each year." Even though chronic pain affects more people than heart disease, cancer, and diabetes combined, the NIH has only devoted 1 percent of its annual budget to studying chronic pain, which is a mere 5 percent of what goes to studying diabetes, heart disease, and cancer" (n.p.).

Thomas Malthus's late eighteenth-century argument that providing relief to the poor would encourage dependency and squander resources better allocated to the productive and deserving members of society.[25]

As touched on above, Wolfe has other reasons for renouncing FM that amount to a conspiracy between different stakeholders who benefit financially or otherwise from medicalizing FM. Part of Wolfe's argument stems from his disapproval that pharmaceutical companies are participating in "direct-to-consumer advertising" of drugs approved to treat FM. Wolfe describes this marketing as a type of ruse where industry is motivated to sell drugs and they do this by "convincing physicians and payors that FM is a real disease" which "increase[es] diagnosis by expanding the definition of FM" and allows these companies to "[recruit] patients" with medically unexplained physical symptoms (MUPS or MUS) into the diagnostic label and treatment of FM (674). Described above as "disease mongering," Moynihan et al. state that "[a] lot of money can be made from healthy people who believe they are sick" or in convincing them that they are (886).

Wolfe is correct that the pharmaceutical industry has been essential to legitimizing fibromyalgia as a "real" disorder. The FDA's approval of the first drug to treat fibromyalgia in 2007, and two other drugs in 2008 and 2009,[26] has helped in validating it as a real disease. This approval prompted *The New York Times* 2008 publication of "Drug Approved. Is Disease Real?"

[25] I am referring here to Thomas Malthus's 1798 *An Essay on the Principle of Population*, in which he argued that providing relief to the poor would worsen their condition by encouraging population growth that would inevitably outstrip available resources. Such support, in his view, diverted resources away from the industrious and productive members of society. Although Malthus was writing specifically about poverty rather than disability, his argument established a broader logic in which certain populations were framed as undeserving consumers of limited social resources—a logic that would later inform eugenic thought and modern constructions of disability as a deviation from norms of productivity and social worth (Davis 1995). I will discuss this eugenic logic more explicitly in chapters 4 and 6.

[26] Pregabalin (Lyrica) was approved in 2007; duloxetine (Cymbalta) in 2008; milnacipran (Savella) in 2009.

which references Lyrica's TV ad campaign. Also referenced in *The Times* article are Wolfe, Hadler, and Ehrlich who seem to dominate discussions of fibromyalgia from a physician-perspective. Hadler reiterates that the diagnosis of fibromyalgia encourages "people to think of themselves as sick and catalogue their pain" and that the more "these people" who "live under a cloud" are "around the medical establishment, the sicker they get" (A22). His comments align with the DSM-V's description of somatic symptom disorders. Ehrlich says that most people "manage to get through life with some vicissitudes, but we adapt" and "people with fibromyalgia do not adapt" (A22). Ehrlich's comments also repeat the idea discussed above that all people experience health challenges and changes but those with fibromyalgia want attention for what everyone else learns to live with without complaining. Wolfe states that he considers fibromyalgia to be a response to "stress, depression, economic and social anxiety" and that the disease does not exist (A22).

While the focus of *The New York Times* article is on pharmaceutical companies profiting from fibromyalgia as a disease state and contesting its validity as real, it does quote a doctor who specializes in treating fibromyalgia who says that "the disorder is undertreated and that its sufferers have been stigmatized as chronic complainers" (A22). This observation is hard to refute. Fibromyalgia is undertreated and underfunded (NIH Report 2009). Wolfe's 2009 "Fibromyalgia Wars" seems to have been inspired by the approval of these drugs and the legitimacy it gives fibromyalgia as a diagnosis that he, and Ehrlich and Hadler are against. Notwithstanding whether these drugs are actually effective, conditions that are perceived as legitimate or "real" typically receive more research funding. In turn, more research might contribute to legitimizing a contested disease.[27] Wolfe, Ehrlich, and Hadler are adamant that

[27] Migraine has similarly been historically maligned as a woman's problem, personality-related, and demonstrative of an inability to cope with life's stressors. It is only as a result of FDA approval of drugs, such as Imitrex

fibromyalgia is a construct but when research on it has been chronically underfunded it is difficult to determine on what basis they are forming this opinion.

The continued marginalization of fibromyalgia reflects the enduring influence of an older generation of physicians whose training was shaped by now-outdated assumptions about invisible illnesses. Evidence of this generational divide is visible beyond fibromyalgia itself. In a recent article published in *The Guardian* in 2024 concerning CFS/ME, one doctor notes that a broad problem within the NHS is these doctors "were taught that people with ME have got a functional rather than physical illness" because their generation learned it "is not a biological illness." Even though "[w]e now know that is wrong" directly as a result of further research "demonstrating that this clearly is a biological illness with biological underpinnings," the generation that was taught it is not physical "are the ones currently setting medicine policy and that's a significant problem." Wolfe, Hadler, Ehrlich, and Gordon similarly represent the old guard who have been dominating conversations on fibromyalgia, some of them for decades. Their advocacy for less funding and less research into fibromyalgia as a disease is misplaced and may reflect the diagnostic paradigms in which their medical training was grounded.

Recent research (2021) on fibromyalgia at King's College London, made possible by funding from various agencies, has identified antibodies in individuals with fibromyalgia that cause an increase in the activity of pain-sensing nerves throughout the body (Goebel et al.). The results of this study show that fibromyalgia might be a disease of the immune system. This research challenges previous views that fibromyalgia originates in the brain. The study also

(sumatriptan), and more research funding that it is now known to be a neurological disorder. This in turn has resulted in more funding for research into more effective medications in recent years. For example, the preventative medication Emgality (a humanized monoclonal antibody) has been available since 2018. It decreases the frequency of migraines, lessens their severity, and lessens dependency on pain medications which can have undesirable side effects from long-term use.

found that clearing these antibodies from the system resulted in recovery. Recognizing fibromyalgia as an autoimmune disorder that may be treatable by removing these antibodies from the blood and offering a hitherto absent diagnostic test through blood work is a profound finding that would have not been possible without further research and the funding to conduct that research. Research findings such as these are not just important for potential treatments and proving symptom legitimacy for patients, but are critical for assessing one's health risks. For instance, people with autoimmune diseases are at greater risk of contracting covid-19, are at higher risk for more severe covid-19 and poor health outcomes (Mikuls et al. 2021). Moreover, when biological validity is required for, say, accommodations to work from home during a pandemic (not that biology should be the determining factor in accommodations), these kinds of research findings become imperative to reduce unnecessary healthcare risks, not to mention costs. While the purpose of this chapter is not to argue for the causes of fibromyalgia, it is hard to refute that more research is beneficial.

Nevertheless, in 2009 Wolfe posits more funding for fibromyalgia research is bad. He implicates academic physicians and researchers in a scheme of legitimizing fibromyalgia. According to Wolfe, "when an illness is accepted through political pressure and in the *zeitgeist*, funding becomes available at the NIH" (675). Wolfe may be referencing the fact that it was only as a result of years of patient advocacy that funding eventually became available for fibromyalgia in 1996 for a mere 1 million dollars ("Advocacy" Fibromyalgia Network). At the time Wolfe published this article in 2009, NIH funding for fibromyalgia received 11 million dollars of its total 30 billion dollar annual budget, or about .00036 percent (NIH Report 2009). For a disorder that as of 2015 was estimated to affect 2-5% of women, 10 million of the US population, and with an economic burden of 18 billion per year, fibromyalgia is one of the most

poorly funded at the NIH. This is true of many disorders that predominantly affect women, are of unexplained etiology, do not cause foreseeable death, and feature prominent symptoms of pain and fatigue. For instance, in the same year chronic fatigue syndrome (CFS) funding was only receiving half that of fibromyalgia, at 5 million (NIH Report 2009).

Because university researchers depend on grants, Wolfe says, this available funding creates an ideal situation in which "[t]here is always something to study" (675). He questions these researchers' expertise because, he states, they "have a vested interest in the current paradigms" and all their research produces is reinforcement of the "'fibromyalgia is a disease' research concept that was formed by political pressure" (675). A glance at the projects that were funded by the NIH in 2009 actually reveals that many of them focused on lifestyle modification, patients' weight, patient perceptions of pain, behavioural treatment, exercise, illness beliefs, motivational interviewing, and mood regulation—certainly not "reinforcing [the] 'fibromyalgia is a disease' research concept'" (NIH Report 2009). Nevertheless, Wolfe writes that along with this investment in the disease concept, Industry hires academics to publish articles on FM. Thus, in the listing above he concludes that scientific research and its dissemination is corrupt as it is subject to "political pressure and industry funding" and in his view distorts information to the public (675). In this way, suspicion extends beyond individual patients to encompass the broader medical and institutional networks associated with fibromyalgia. In a way, Wolfe is also arguing that there is a whole apparatus in place that contributes to sustaining a lifestyle of the sick, that the "pharmaceutical-academic complex," along with attorneys and patient support groups, all have a stake in continuing FM. Taken together, this framing casts medicalization itself as the source of disability, reinforcing suspicion that the condition is produced rather than experienced.

8. CLAIM: FM is Controversial

In this section, I examine how Wolfe, Hadler, and Gordon frame fibromyalgia as an inherently controversial and contested illness. While fibromyalgia has historically been subject to diagnostic uncertainty, these authors do not merely describe that controversy—they actively sustain and amplify it, even in the face of accumulating research supporting its legitimacy. By emphasizing fibromyalgia's contested status, they position skepticism as the rational and responsible stance, thereby justifying resistance to further research, clinical recognition, and resource allocation. Alongside continued analysis of Wolfe's 2009 article "Fibromyalgia Wars," I analyze Hadler and Greenhalgh's 2005 "Labeling Woefulness" and Gordon's 2003 report for Ontario's Workplace Safety and Insurance Appeals Tribunal—all of which portray fibromyalgia's legitimacy as unsettled despite growing medical recognition. I will further discuss their claims alongside disability scholar Anna Mollow's analysis in "Criphystemologies," which examines how conditions historically regarded with suspicion, undertreated, and framed as controversial continue to be contested even as they undergo processes of medicalization. This section concludes with Wolfe's most recent comments on fibromyalgia in a 2021 article published shortly after research emerged suggesting autoimmune mechanisms (referenced above), illustrating the persistence of controversy narratives even as biological evidence accumulates.

One of the key reasons Wolfe provides for his characterization of fibromyalgia research as corrupt is that major medical organizations and informational sources do not foreground skepticism or explicitly frame fibromyalgia as controversial, which he interprets as evidence of institutional bias rather than growing scientific consensus. In his view, treating fibromyalgia as a legitimate ailment without stressing its controversial status is biased and misleading the public

by suggesting it is widespread and serious. In "The Fibromyalgia Wars"—a title that explicitly draws attention to its controversial nature—Wolfe refers to fibromyalgia as "a bitterly controversial condition" and describes "the wars" as consisting of a debate over the "legitimacy of the diagnosis" (671). Hadler and Gordon also seek to emphasis fibromyalgia's controversial status. In 2005, they elevate fibromyalgia's status to "one of the most impenetrable and controversial labels in medicine today" (1). In a 2003 report prepared for Ontario's Workplace Safety and Insurance Appeals Tribunal, Gordon includes a section labelled "Controversy" (3). Under this section, he reiterates there has been a question of whether FM merely represents "a functional disorder of a broken urban society that has been embraced by a medicolegal industry of lawyers seeking compensation benefits for their clients with FM" (3).

Gordon's comments firmly suggest that fibromyalgia is motivated by the external incentive of financial compensation, the essential criteria for malingering. The fact that this speculation is included in a report to a tribunal that makes decisions about who does or does not receive compensation seems rather manipulative. Although Gordon does include the findings from White and Thompson's study that challenge the view that FM is a compensation-driven ailment, he also references Hadler's opinion that FM "promot[es] dependency and somatization by persons disaffected with their work," which is surely bound to influence the adjudicators decisions regarding an individual's right to claim compensation (qtd. in Gordon 3). Gordon has previously commented on the FM controversy in 1997, citing "the controversial role of psychogenic factors" (1247). In "Selling Sickness," Moynihan et al. argue that the public "has a right to know about the controversy surrounding disease definitions" of the "relatively benign natural course of many conditions" (891). The latter of these comments again attempts to argue the point that aches and pains are not unusual to everyday life. In all, the focus on fibromyalgia

as a controversial label seeks to de-medicalize these symptoms that the authors perceive as aspects of ordinary life. Giving credence to this condition, they argue, only supports the network of involved individuals who profit off the diagnosis while leaving the "victims" (patients) largely without help (Moynihan et al. 886).

I do want to be clear that medicalization is not always desired and has a fraught history as the medical model has been used to pathologize disabled people and other subjugated bodies. But as Anna Mollow writes in "Criphystemologies," "[f]or disabled people who suffer from our impairments but are discounted as 'hysterical,' *more* medicalization of our conditions, not less, is sometimes desired" (196). Mollow follows this comment with a note that "[f]or many disabled people lack of access to medical care, and lack of recognition that we are genuinely ill, are more salient aspects of our oppression than excessive medicalization" (196). Therefore, the authors' insistence that medicalization is harmful partly because it provides "short-term legitimacy and social benefit to patients" (Wolfe 2009, 676)—the very things that Mollow identifies those with medically unexplainable symptoms vitally need—only contributes to further oppression. At the very least, the authors' insistence on emphasizing that fibromyalgia continues to be controversial works to undermine any legitimacy the diagnosis has gained over the years. For these authors, it is important that any mention of fibromyalgia is always associated with questions of its legitimacy and that the debate over its psychosomatic or psychogenic etiology is sustained.

More recently, in 2021 Wolfe and Rasker published an article on the evolution of fibromyalgia and its classifications. The second sentence of the abstract mentions its controversial nature regarding psychological issues (1). But what I find most interesting about this article is, first, its neglect to mention the previous 2021 study finding a link between fibromyalgia and autoimmune disorder and, second, its comments in the conclusion that restate

fibromyalgia is biopsychosocial. Wolfe acknowledges that fibromyalgia "pain and distress" is "real" before emphasizing the importance of the accumulation of evidence of psychosocial symptoms and psychologic features (16). This brief acknowledgment functions less as a validation of patient experience than as a rhetorical concession that is immediately qualified by a return to a framework that locates the significance of that suffering in psychosocial rather than biological terms.

Near the end of this conclusion the authors again reference the controversy over its etiology and state that some factions believe "fibromyalgia should be best considered a primary pain disorder fueled by central sensitization or a more broadly based somatic syndrome or bodily distress disorder" (18). Ignoring the previous 2021 study, the authors repeat that FM is psychological symptoms manifesting physically (i.e. somatic) and they reference BDD or what is better known as bodily distress syndrome (BDS). Per Fink, a Danish doctor, is an expert on BDS who attributes conditions like fibromyalgia and CFS to patient perceptions of illness that are "treatable" if patients "learn to be less worried about [their] symptoms, and learn strategies to cope with stress and strain" (5). Their treatment protocol makes clear that sufferers' "health beliefs or illness perceptions" are blamed for "worsen[ing] their symptoms and contribut[ing] to the maintenance of [their] disability" (Rehfeld, Schröder and Fink 5). Thus, while the symptoms are real, illness beliefs are yet again the culprit. Finally, Wolfe and Rasker's very last sentence of the article claims that the pain "found in fibromyalgia might be a universal condition of mankind at differing levels of severity" (18). Wolfe et al.'s statement is quite similar to Ehrlich's which I have previously referenced, that "everybody has pain sometimes" and that those with fibromyalgia are merely unable to cope like everybody else does with a common symptom. This contributes to the minimization of symptoms by suggesting pain is just a fact of life.

Wolfe and Rasker's publication is quoted in an article published in January 2024 questioning the validity of the view that fibromyalgia is an autoimmune disorder (Clauw et al.). Clauw et al. uses previous publications by rheumatologists who are trained to treat autoimmune disorders and their insistence in decades past that fibromyalgia is not an autoimmune disease as evidence that it is not. Therefore, articles such as the ones under analysis in this chapter, which continually state fibromyalgia must be somatic because it does not follow the same pattern as their prior experience with rheumatoid disorders, is granted more credence than the findings from the 2021 study. Clauw et al.'s method of argumentation is similar to how Wolfe, Hadler, Ehrlich, and Gordon responded to White and Thompson's study with denial of their findings in favour of peddling the same narrative that they have been for years. Even when research identifies other possible causes of fibromyalgia, its predominant representation in the late 1990s and early 2000s as a functional somatic syndrome continues to prevail. It is this continual privileging of established interpretive frameworks over emerging evidence that sustains fibromyalgia's status as a "controversial" condition; thereby, legitimizing ongoing suspicion toward patients whose symptoms cannot be easily verified.

9. CLAIM: FM is "psychologically-motivated at all costs"

Continuing with an analysis of Wolfe's 2009 article, I will consider that the reasoning behind denying the medicalization of fibromyalgia rests on the assumption that it is a disorder caused by psychological factors and is a somatic condition. This claim relocates the source of illness to the mind, allowing bodily symptoms to be treated as suspect while directing attention toward psychological intervention. As Amy Vidali has stated about perceptions of irritable bowl syndrome (IBS) in her article "Hysterical Again," Wolfe and the other authors imply FM is "psychologically-motivated at all costs" (Vidali 50). This is why medicalization in their view

only causes more harm. They believe that treatment should not focus on physical symptoms that are manifestations of psychological factors (i.e. are somatic symptoms). Physical symptoms are thus reframed as expressions of underlying psychological disturbance rather than evidence of disease. In this section, I will also emphasize Wolfe's citational practice in which he cites various figures who have a long history of claiming conditions similar to fibromyalgia with unexplained etiology are psychosomatic or psychogenic.

Before I delve into this particular claim in Wolfe's article, I want to pause here and acknowledge that Wolfe's concerns about the role of the pharmaceutical industry are not without warrant. There is a concern that fibromyalgia is a misappropriate diagnosis, effectively "treating the wrong illness" (Wolfe 674), and that the label itself does create a supply of patients that the wellness industry can then prey on by marketing drugs to them with the goal of making a profit. Practicing treatment on these patients can then be used as evidence of the disorder and reinforce its status as a disease. However, once you consider Wolfe's and the other authors' reasoning for denying FM as a diagnostic label, it becomes clear that one of their major purposes for doing so resides in their belief that FM is psychological in origin, representing psychological distress or deviance, and therefore treatment is argued to be nonsensical and useless.

Wolfe makes this assumption explicit in 1997 when he states "[f]rom the beginning, the debate about FM has been whether the syndrome was primarily a psychologic or psychiatric disorder. The debate still rages" (1248). He claims that there is "mounting evidence that many patients have major affective, somatization and personality disorders" and that "persons with primary psychological disorders embrace the diagnosis of FM…" (1248). Wolfe additionally asserts "others have presented evidence" that FM is a mood disorder (1248). Claiming that a

majority of physicians share a skepticism of fibromyalgia, he cites Sir Simon Wessely[28] and Matthew Hotopf who refer to FM as "that grey area between medicine and psychiatry that is also occupied by chronic fatigue syndrome (CFS), irritable bowel syndrome, and many others" (qtd. in Wolfe 671). In addition, Wolfe references Edward Shorter's 1992 *From Paralysis to Fatigue* in which he argues that FM and CFS should be placed on a "continuum of psychosomatic illnesses," with discussions of its trajectory from hysteria featuring prominently (qtd. in Wolfe 672). From his 1997 article to 2009, Wolfe has consistently tried to suggest that fibromyalgia is a somatization or personality disorder and that persons with these supposed disorders will cling to a fibromyalgia diagnosis that they feel may lend more legitimacy to their symptoms.

Other supposed evidence Wolfe cites that fibromyalgia is a mental disorder includes the leagues of physicians who believe those with medically unexplained syndromes (MUS) have either psychiatric illnesses (64%) or personality problems (84%) (671). This statistic is particularly interesting because it not only includes Hotopf again as an author (which suggests a circularity of citational practice), but Wolfe mentions the survey was of 400 general practitioners in the UK and leaves out the information that only 262 GPs actually completed and returned the questionnaire. Neglecting to convey that 35% (138) of GP's either did not respond or complete the survey gives the appearance that the percentage of practitioners who believe MUS are psychiatric or personality-related as much higher than it presumably is. It also obscures the

[28] Simon Wessely is a British psychiatrist and is one of the most well-known and influential researchers of myalgic encephalomyelitis/chronic fatigue syndrome (ME/CFS). He is responsible for helping to develop the CBM (chronic behavioural model) which focuses on altering a patient's behaviour and perception of their illness and therefore opposes the idea that CFS is an illness of physical origin. In this way, Wessely's research is very similar to Per Fink's research on BDS. Wessely was involved in the controversial and discredited PACE trial which assessed methods such as CBT (cognitive behavioural therapy) and GET (graded exercise therapy) for individuals with CFS and which has been heavily criticized for methodological faults. The authors of this study redefined their definition of improvement partway through which led to false attributions of improvement that significantly and unethically altered the results of the study. More information can be found about Simon Wessely's career and influence on CFS research at https://me-pedia.org/wiki/Simon_Wessely.

potential sample bias as those with an interest might be more likely to respond. Regardless, a physician's attitude or disbelief about patients with MUS can hardly be used as evidence that MUS (an umbrella term that contains diagnoses such as fibromyalgia and CFS) is psychosomatic or psychogenic.

For example, in a 2022 Survey of US Doctors (which consisted of participants who were predominantly white, male physicians) it was found that "physician's bias and general reluctance to care for people with disabilities play a role in perpetuating the health care disparities they experience" (Lagu et al. 1387). Specifically of their attitudes toward people with disabilities, some expressed that "a lot of people are wanting some form of accommodation and a lot are illegitimate" (1390). Other participants suggested caring for people with disabilities was burdensome, that "they can create a big thing out of nothing" and that disabled people "are an entitled population" (1391). Physician's attitudes towards those with MUS must be looked at in this context and understood as part of a larger issue where patients with disabilities are looked upon as burdens to overwhelmed doctors who might themselves be lacking support to provide appropriate healthcare and therefore try on different strategies to discharge them from their practice (Lagu et al.). Psychologizing FM could very well be one of the ways physician's deal with patients they perceive as having problems outside their scope of knowledge and who they might feel are taking up valuable resources.

Aside from physician attitudes towards MUS, other citations Wolfe uses to convince the reader that the majority believe FM is psychosomatic include citing himself, Hadler, and Wessely again. These citations are strung together by Wolfe to lend the impression that skepticism of fibromyalgia is widespread, but when looked at more closely they constitute a small group of individuals who have long argued for the psychological origins of medically

unverifiable syndromes, some of whom have built their careers on linking these disorders to hysteria. This citational pattern reinforces the appearance of consensus while sustaining a narrow interpretive framework that privileges psychological explanations. Wolfe, however, does have hope that "future understanding" of FM will come in time and patients can look forward to improvements, "but first," he says, "we must take control of our own beliefs about FM as a disease…and about the role of psychological factors" (1249). Thus, the understanding he is referring to is the acceptance that FM is psychological in origin and not a disease. Improvements are therefore framed as dependent on addressing the patient's psychology. Wolfe moreover claims that by attending to the so-called psychological factors, they will be able to "tease out those subsets of patients with normal psychological status from those with major psychological abnormalities" (1249). Wolfe is suggesting that only by measuring a patient's psychological status against a sanist norm will the truth finally be revealed that fibromyalgia is a disorder primarily caused by psychological disturbance. In this formulation, the legitimacy of the illness is made contingent on psychological evaluation, further displacing attention from bodily symptoms and reinforcing their interpretive dismissal.

10. Conclusion

So far, I have analyzed the *Rheumatology* authors' claims that 1) the fibromyalgia patient is almost always a woman 2) the symptom of pain that defines fibromyalgia is a lifestyle choice 3) medicalization increases disability 4) fibromyalgia is controversial, and 5) fibromyalgia is "psychologically-motivated-at-all-costs" and is therefore a (psycho)somatic condition. Taken together, these claims are supported by an entrenched belief—or we might call it a mythology—that legitimate illness is objectively verifiable and medically unverifiable illness is therefore regarded as inherently suspect and best explained as a psychological, moral, or motivational

problem rather than biomedically legitimate.[29] As discussed at the outset of this chapter, this logic is reflected and institutionalized in the DSM's criteria for malingering, which encourage clinicians to treat discrepancies between reported symptoms and objective findings as grounds for suspicion. This skepticism is furthermore intensified when the claimant is a woman, which draws on a long history in which women's bodily testimony is treated as especially unreliable. Collectively, these claims produce a broader interpretive framework in which medically unverifiable illness is consistently recast as psychological, exaggerated, or fraudulent—a framework that enables fibromyalgia to be understood as a contemporary iteration of hysteria.

Building on this framework, the next chapter will consider the claims these authors have made within the larger discourse on medically unverifiable illnesses at the time of their writing. I will be analyzing prominent texts from academics and social theorists who are not physicians but who have made significant claims about the legitimacy of illnesses such as chronic fatigue syndrome (CFS) and fibromyalgia and who have collectively argued that they are merely the newest, modern iterations of hysteria or the "new hysteria." This claim rests on an assumption that medically unverifiable illnesses marked by pain and fatigue are best comprehended through the inherited diagnostic logic of hysteria, which has historically rendered such symptoms psychological, feminized, and morally suspect. Hysteria thus operates as a historical template through which new, unverifiable and diagnostically ambiguous conditions are interpreted and understood. As I analyze these texts, I align their arguments with the *Rheumatology* authors'

[29] This belief could instead be restated as intersecting warrants. For example, the following warrants which I identified in the introduction are at play: illness without biomedical markers is psychological, not physical; legitimate illness must be visible, measurable, or quantifiable; subjective symptoms are less legitimate than objective signs, to name a few. Moreover, these biomedical warrants intersect with gender-specific warrants, such as women with unexplained symptoms are exaggerating; pain in women is more likely to reflect emotional instability; women's reporting of pain is less credible than men's reporting of pain. These are only some of the warrants underlying the authors claims. Importantly, there is no single warrant and to identify one would be simplistic. Rather, a network of multiple, mutually reinforcing and overlapping warrants together work to sustain the logic behind the claims.

rhetoric to highlight the prevalence of a mainstream narrative within which fibromyalgia and related conditions are subsumed. This master narrative casts those with invisibilized illnesses as fraudsters using their story of illness for personal or material gain.

Chapter 2:
Fibromyalgia is the "New Hysteria"

1. The Social and Discursive Climate of the 1990s

The portrayal of FM patients in the *Rheumatology* articles is reflective of a common and dominant narrative that was taking hold in the 1990s concerning fibromyalgia and similarly-related illnesses. This chapter seeks to contextualize the *Rheumatology* texts within a social environment that looks suspiciously on women in pain by situating their articles alongside popular cultural texts published in the same era. For reasons that at first seem unclear—but may be in part related to the removal of hysteria from the DSM-III in 1980 in conjunction with second wave feminist views of hysteria—many medically complex and poorly understood disorders came to be colloquially branded as the "new hysteria" by some prominent scholars: notably, Elaine Showalter, Edward Porter, and Simon Wessely.

This chapter will examine this claim as drawing on a longstanding interpretive logic in which pain and fatigue conditions that resist biomedical verification are understood as analogous to earlier hysterical diagnoses. Rather than generating new clinical understanding of these conditions, this interpretive logic reactivates a familiar explanatory framework to make sense of diagnostic uncertainty. As Cherney notes, warrants gain persuasive force through their application to unfamiliar contexts. In this case, the historical category of hysteria is mobilized to stabilize meaning where it appears uncertain or unstable. The generalizability of this warrant allows it to be readily applied to new conditions, enabling it to circulate as a dominant and "stubbornly persistent" narrative within cultural discourse on medically unverifiable illness (Samuels 40). A prominent and influential figure who promotes this rebranding of fatigue and pain conditions as the new hysteria is feminist scholar and literary critic Elaine Showalter.

Six years prior to the publication of the initial 2003 editorials under analysis,[30] Showalter published *Hystories: Hysterical Epidemics and Modern Culture*. Her earlier works, including her widely influential 1985 publication addressing the gendered diagnosis of hysteria titled *The Female Malady: Women, Madness, and English Culture, 1830-1980,* are highly influential in feminist literary and Victorian studies and further established her as a leading scholar of gender and a historian of nineteenth-century hysteria. With *Hystories* (1997), Showalter extended this scholarly work into more public-facing debates about invisible illness, adopting a more prominent public intellectual role that reflected a broader late-twentieth-century moment in which academic expertise increasingly intersected with media and public discourse. In doing so, she contributed to the circulation of hysteria discourse beyond academic contexts into broader medical and cultural discussions.[31] In this work, Showalter applies her historical framework of hysteria to six contemporary conditions and experiences—alien abduction, Chronic Fatigue Syndrome, satanic ritual abuse, recovered memory, Gulf War syndrome, and Multiple Personality Syndrome—which she collectively interprets as evidence of modern hysterical epidemics. Showalter's argument is that these supposed "epidemic contagions" are modern-day hysterias that, unlike traditional viruses, are instead spread through cultural narratives.

To understand the discursive environment in which the *Rheumatology* articles under analysis were produced, I examine the section of Showalter's *Hystories* that addresses chronic fatigue syndrome (CFS). For the purposes of this chapter, I focus on Showalter's commentary on CFS to demonstrate how it discursively constructs the condition in ways that parallel the

[30] Notably, earlier publications by Gordon, Hadler, and Wolfe on the so-called fibromyalgia problem coincided with the publication date of *Hystories*. All published in *The Journal of Rheumatology,* these articles include: Hadler, "Fibromyalgia: La Maladie est Morte. Vive le Malade!"; Gordon, "Fibromyalgia—out of control?"; Wolfe, "The Fibromyalgia Problem." A list of these and additional articles by these authors is available in Table 1.
[31] Showalter served as President of the Modern Language Association in 1998 and was elected a Fellow of the Royal Society of Literature in 2011.

Rheumatology authors' representations of fibromyalgia. Showalter's *Hystories* is frequently cited by the *Rheumatology* authors analyzed here as an authoritative support for their own claims despite her lack of medical expertise. In addition to being used as an authoritative source, her work itself participates in the mainstreaming of interpretive frameworks that position invisible illnesses as products of social and psychological forces rather than biomedically legitimate disease. Both emerging from and contributing to cultural narratives that frame unverifiable illnesses as culturally-mediated and medically illegitimate, *Hystories* forms part of a broader intertextual network through which hystericizing discourses surrounding invisible illnesses were produced, circulated, and legitimized across academic, medical, and public domains, and subsequently re-inscribed within the rheumatologists' texts.

For example, in his editorial "Pain is Real; Fibromyalgia Isn't," Ehrlich cites Showalter's *Hystories* as "sensible antagonism to FM" and as evidence to bolster his argument that fibromyalgia is not real. Wolfe's 2009 article "Fibromyalgia Wars" explicitly draws on Showalter's *Hystories* to argue that fibromyalgia's contested status reflects shifting cultural interpretations rather than stable biomedical criteria. He suggests that judgments about whether FM is considered a "real" disease depend on its social construction, prevailing psychosocial explanations, and the interests of particular individuals and institutions that benefit from its recognition. In this account, disease legitimacy is determined by societal acceptance of which conditions warrant validation, which he describes as a process that changes over time as diagnostic meanings migrate and reattach to new symptom constellations (672). In this way, Wolfe draws on Showalter's account of hysterical epidemics as culturally-mediated phenomena—spread through cultural narrative and media discourse—and applies this theory directly to fibromyalgia.

In this same 2009 article, Wolfe also cites Edward Shorter and Simon Wessely—the latter multiple times—each of whom are cited by Gordon and Ehrlich, respectively. In fact, Wolfe's claim above echoes Shorter's in that both argue diseases are considered legitimate or not depending on whether the presentation of symptoms adhere to the pressure of cultural expectations or norms. Shorter and Wessely are contemporaries of Showalter. Showalter even credits Shorter as a source of inspiration for *Hystories*, including heavily citing his work in her book. Wessely is likewise heavily featured in *Hystories*, his works cited a significant 31 times. This matters because Showalter is utilizing their arguments on CFS as hysteria to inform her own conclusions. Their collective works are part of the same intertexual conversation, each of them adding to and perpetuating a particular narrative representation of CFS. As such, I not only analyze Showalter's *Hystories* extensively below but also Shorter's work, namely *From Paralysis to Fatigue* (1993), and Wessely's works, in particular his 1990 article "Old Wine in New Bottles." Alongside my analysis of primarily Showalter's work, but also Shorter and Wessely's, I will be making comparisons to the *Rheumatology* authors' claims. In doing so, I highlight how their respective representations of CFS and FM converge to produce and reinforce a broader cultural narrative in which these conditions are understood as psychogenic, culturally-produced, and therefore open to suspicion.

2. CFS & Fibromyalgia

Chronic fatigue syndrome shares similar symptomology with fibromyalgia. Even Ehrlich notes their association and conflates the two, stating that "chronic fatigue syndrome" is "closely related" and a "related term" to fibromyalgia ("Pain is Real" 1666; "Fibromyalgia is not a Diagnosis" 276). In a 2003 report on "Fibromyalgia Syndrome" prepared for Ontario's Workplace Safety and Insurance Appeals Tribunal, Gordon writes that "FM also overlaps with

the related clinical entities of chronic fatigue syndrome, sleep disorders and psychological problems" and "[a]bout one-third of patients with FM meet criteria for diagnosis of chronic fatigue syndrome" (3). Many others have referred to these two illnesses as two sides of the same coin: with fibromyalgia more predominantly presenting with pain and CFS with fatigue (Abbi and Natelson 3). There are notable and important differences between them, but both FM and CFS share a remarkably similar symptomology (Abbi & Natelson 2012), as do many other comorbid conditions that, too, fall under the umbrella of invisible or invisibilized illness (Rodgers 2019).

In the 1990s and the turn of the century, there was much overlap in discussions of CFS and FM in medical and academic literature and in some instances these conditions were erroneously and problematically conflated (Abbi & Natelson 2012; Meeus & Nijs 2007). In short, they were often considered to be two branches of the same disorder, sometimes with fibromyalgia being subsumed within the label CFS (Shorter *From Paralysis to Fatigue*). This is still true today. A quick Google search will yield plenty of discussion regarding their shared symptomology. An interesting note is that, as of 2026, FM is still classified as a syndrome, which is to say that research has not been able to identify an etiological cause to classify it as a "disease" but does recognize a collection of shared symptoms. As I have already discussed previously in the section "FM is Controversial," the authors of the editorials use its classification as a syndrome to emphasize its continual "controversy" as a diagnosis (Gordon 1997, 1247). Its supposed status as controversial is also the basis for their argument that fibromyalgia is an "iatrogenic" syndrome; that is, "it has to be named by a doctor to exist" (Ehrlich 1667).

CFS, on the other hand, is more often recognized as a disease[32]—its modern term is Systemic Exertion Intolerance Disease (SEID), but chronic fatigue syndrome is still in popular usage even though it is now technically a misnomer. CFS is also often hyphenated with the term ME (myalgic encephalomyelitis). Given their rhetorical conflation it is beneficial for the purposes of this chapter to discuss both FM and CFS/ME somewhat in tandem as they are certainly perceived and discussed this way by many who do not have either of these conditions but who have contributed to the public discourse on each. I am also not qualified to parse these two conditions and many in the CFS/ME community speak of them as one condition. Moreover, despite its classification as a disease, the *Rheumatology* authors lump CFS in with fibromyalgia as unverifiable syndromes (Ehrlich 1667). Because my intention in this chapter is not to argue for the causes of CFS or FM, but rather to examine how invisibilized illnesses are rhetorically framed by certain members of the medical community and public figures, Showalter's discussion of CFS provides highly relevant context for the FM articles. In this discussion, I contend that both CFS and FM are framed within similar terms, under the same stigmatizing rhetoric.

3. A Language of the Body: The Madwoman Speaks

Showalter fundamentally views CFS as a language of the body. What I mean by this is the symptoms of CFS are reframed as an expression, a subversive embodiment of resistance to oppression. This has also been a common argument for the supposed cause of hysteria: when

[32] Even though CFS has more validation as a disease as opposed to a syndrome, that is not to say that many physicians or the public at large do not regard it with a similar suspicion to fibromyalgia and question its legitimacy as a physical illness. I would even suggest that since the Covid-19 pandemic and the realities of what has been termed long covid or post-covid have become more known, there has been an increase in attempts to question the validity of CFS as its symptoms overlap extensively with long covid. See Hsu (2023) for a documentation of this overlap in "Framing the Activists." I can only speculate but the prevalence of long covid amongst the population and the resulting consequences of more individuals needing to claim disability compensation might account for the motive to dismiss CFS and long covid as psychogenic to try to mitigate the number of individuals who have access to compensation.

one's voice is denied, the body has offered another means to express its resistance to societal pressures. Showalter accordingly claims that CFS is a "protolanguage rather than a disease" (13). To grasp Showalter's argument, it is necessary to understand her views on hysteria: described as "a cultural symptom of anxiety and stress," Showalter states "hysteria…[is] a body language of women's rebellion against patriarchal oppression," which she views as "a desperate, and ultimately self-destructive, form of protest" (*Hystories* 10). Because this is Showalter's underlying assumption about hysteria, she assumes that CFS is likewise a self-destructive bodily rebellion that, she is careful to say, is not any individual's fault, but rather an unconscious impulse that could be treated through psychoanalysis—if patients were willing to acknowledge this root cause (117).

Showalter's viewpoints on this issue are strikingly similar to Freud's account of hysteria, which posited a root psychological cause—repressed trauma (typically sexual)—and suggested that patients could be cured if a physician uncovered this trauma through psychoanalysis. In fact, Showalter implies that Freud's methods can alleviate the suffering of CFS: "Unfortunately, though some critics claim that psychoanalysis is passé, Freud's message never got through to millions of people, who still distrust and fear the unconscious and its power over us. As a result, they suffer needlessly" (9). While Showalter contends she does not blame the individual, she does blame modern media and even "contemporary feminist theorists and therapists [who] have inadvertently helped to spread new hysterical disorders" through their belief that hysteria "epitomize[d] universal female oppression" (10).

What distinguishes Showalter's critique from that of other feminist theorists is her rejection of arguments of hysteria's political valorization. While she subscribes to the idea that hysteria is a language of the body, she fundamentally does not believe that it serves any kind of

emancipatory potential, as other feminist writers have argued, and which Showalter implies has falsely legitimized the idea that these are meaningful forms of expression and thereby contributed to their spread. What Showalter does believe is that this language of the body is an unconscious expression that is maladaptive. Showalter reframes hysteria—and by extension CFS—as a psychological response to cultural stress that should be addressed through psychoanalytic and therapeutic intervention. In this way, she does not simply dismiss invisible illness, but participates in its psychologization through a framework that presents itself as sympathetic to patients' suffering while relocating the source of illness within the psyche rather than in underlying biological processes. Accordingly, she advocates psychological intervention rather than biomedical recognition.

4. A Lifestyle Choice

As discussed in the previous chapter, one of major claims that the *Rheumatology* articles make about fibromyalgia is that it is a lifestyle choice. In making this claim, they are contributing to the image of the fibromyalgia patient as a malingerer who chooses to be sick for personal gains. Just as the *Rheumatology* articles frame FM as a lifestyle, so too does Showalter: she accuses "CFS organizations [for] sponsor[ing] social activities that made chronic fatigue almost a way of life—outings, coffee hours, self-help groups" (125). Rather than see these activities as social *supports* for those with CFS, they are reconfigured by Showalter as social *activities* that signify adherence to a sick lifestyle. They are framed as akin to a new trend that people are trying on, and as evidence of self-indulgence. Wessley makes a similar claim. He quotes Oppenheim who wrote in 1908 of the "great harm" caused by patients gathering in a common place—"spreading the mental infection by constant conversation and comparison of their complaints"—to argue that these "patients would now be considered 'somatizers'" (1990,

42). Thus framed, support groups provide the means to fuel the "disease" of convincing one another that you are all truly sick.

Wolfe (2009) makes a similar assertion to Showalter when he argues that "[t]he success of the FM movement owes much to ubiquitous and well organized patient support groups" (675). These support groups, with their "public relations departments" are credited with "exceptional success in lobbying and influencing legislation" (675). The "real successes" of such lobbying, Wolfe states, "have come by inducing Congress to require the NIH to support FM research and to publicly buy into the FM disease concept" (675). On the one hand, these authors agree that "more research is required to identify the many factors that seem to cause and perpetuate this vexing medical problem"; on the other, though, they seem to be against research specifically focused on understanding fibromyalgia as they instead argue for more attention to psychological factors (Gordon 1665). Wolfe's comments echo Ehrlich's who states "support and advocacy groups aggravate the problem" (1666). In his view, advocacy contributes to the legitimation of the FM diagnosis and "in sophisticated societies" allows for the "tort lawyers and their experts for hire [to] spring into action" (1666). His point is that "we have turned a common symptom into a remunerative industry" (1666).

In painting these support groups and activities as partly responsible for spreading the "epidemic" of CFS, Showalter herself engages in pathologizing the individuals who engage in these activities. Individuals with CFS are not alone in being accused of perpetuating the "CFS lifestyle"; as Showalter claims, "[r]esearch into the causes of CFS is a way of life for many people as well" (125). Referencing the lack of "convincing evidence" after "hundreds of costly studies," Showalter suggests that research into CFS is never-ending when "the possibilities seem endless because every new virus or chemical must be investigated in its turn" (125). Not only do

these comments frame CFS research as a futile cost to the system, but they also frame it as part of an industry that fuels the spread of this disease. Put another way, many stakeholders—patients, medical practitioners and researchers, and government funding agencies—are variously invested in CFS being a real disorder because it purportedly sustains their individual and collective lifestyles. These comments echo Wolfe's argument about the "pharmaceutical-academic complex" as discussed in the claim that "Medicalization Increases Disability" above.

In positioning chronic fatigue as a lifestyle choice, Showalter begins her chapter devoted to CFS with two anecdotes that invite the reader's comparative analysis: the first features a "young English woman rendered almost helpless by chronic fatigue syndrome" who was "miraculously cured by a faith healer" in 1993 (115). Prior to this healing ritual, "Jo" was physically unable to do many routine daily activities, such as brush her teeth, or walk, or work. Now, Jo can bicycle three miles to work every day. The last sentence in this story includes a quote from Jo herself who relays that she used to be "insecure" and "was always anxious," but following her healing she now "feel[s] whole for the first time in [her] life" (115).

Showalter follows this ostensibly inspiring story of overcoming illness[33] with another: the reader is transported to Dundee, Scotland where a woman "and her three children have become virtually housebound" with CFS.[34] Here, "there was no faith healer…to help" (115).

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[33] This is commonly referred to in critical disability studies as inspiration porn. Stella Young gives a ted talk in 2014 explaining the concept: https://www.ted.com/talks/stella_young_i_m_not_your_inspiration_thank_you_very_much?subtitle=en

[34] A very recent 2025 study by DecodeME—which is the largest ever genetic study on ME/CFS and the first to center the voices of people with lived experience—found those with CFS have significant genetic differences in comparison to the general population, which increase one's chances of developing ME/CFS. While Showalter is trying to imply this mother and three children being "virtually housebound" reflects a lifestyle choice, the genetic component identified by the study may help explain why CFS can affect several family members. The study has not yet been peer-reviewed but its preprint was made available on Aug. 6 2025 at this link: https://www.research.ed.ac.uk/en/publications/initial-findings-from-the-decodeme-genome-wide-association-study-. A summary of the study's findings is available here: https://www.decodeme.org.uk/initial-dna-results/?utm_medium=social&utm_campaign=genetic%20results. Of note, the study supports previous research that identified a genetic signal in the nervous system that has been repeatedly associated with chronic pain.

Immediately the reader is given the impression of utter passivity where this family is depicted as resigned to their fate. Not many details are provided about this situation, making the details that are given even starker. Of these, Showalter notes that the husband and eldest son (who "was away at college" and seemingly spared from this affliction) are "unaffected" (116). Both believe it is not psychological and included is a quote from the husband stating he "trusts [his spouse] completely" (116). Using this information, Showalter comments that "[p]sychological conflicts…would be a betrayal of trust, a breach in the marital contract; debilitating illness must be accepted" (116). In this re-framing, the husband seems to only believe in the reality of his spouse's illness because to not would suggest disloyalty. From here, the journalist who interviewed this family is quoted stating the children and their mother "appear curiously unconcerned about their future—or lack of it. They talk about being ill, but they do not talk about getting well" (116).

Claiming that those who are ill are not interesting in getting well is a common accusation levelled at those with unverifiable illnesses who speak publicly about their chronic symptoms. The assumption is that because you talk about your symptoms, you must be preoccupied with them and seeking attention, instead of focusing on getting better. This is one of the defining features of the DSM-V's somatic syndrome disorders. There is clearly an element of toxic positivity expected wherein stating anything "negative" is considered harmful. Hadler echoes a similar sentiment in a 2006 article titled "If you have to prove you are ill, you can't get well"—a mantra he has repeated in previous publications, including a full decade earlier (Hadler 1996 "The Disabled, the Disallowed, the Disaffected and the Disavowed," 249). In Hadler's 2003 "'Fibromyalgia' and the Medicalization of Misery" he suggests patients have a "narrative [that] is laced with the clinical heuristics they have learned, which they can recite with objectivity that

approaches dispassionate" (1669). His perception that the patient is dispassionate shares a commonality with Showalter's claim that the mother and her children express apparent detachment and indifference about their future. Both Showalter and Hadler curiously depict these individuals as excessively emotional in some respects—as overly anxious, preoccupied with their condition—and in others as detached automata who are simply following the steps they have learned to recite.

Feminist theorist Susan Wendell, who has lived with chronic fatigue syndrome since 1985, published *The Rejected Body* one year prior to Showalter's *Hystories*. In it she writes how "it is not uncommon for people to weep with happiness and relief upon receiving, after a long period of uncertainty, a definite diagnosis of a severely debilitating or even life-threatening illness" (129). This is not because people want to be unwell, but because "[t]he diagnosis, however grim, restores them to society" (130). For anyone who has experienced receiving "little or no support," dismissals that their illness "[cannot] be too serious," or statements that if doctors cannot find the problem that it is "all in your head," a diagnosis might feel "euphoric"—as seventy-five percent of interviewees declared feeling after being diagnosed with ME (Wendell 130). In a culture of medical-scientific hegemony, a diagnosis is often necessary to be believed by even family and friends and is certainly necessary to receive other forms of support (Wendell 129).

Nevertheless, in ignoring or refusing to acknowledge these realities, Showalter cherry picks[35] these few influential anecdotal quotations—particularly the journalist's remark that the

[35] In a review of *Hystories* following its publication, Mary Schweitzer who also lives with CFS and is former professor of History and Women's Studies at Villanova University, noted the amount of cherry-picked data that informed this book, which Schweitzer states deliberately ignored or misrepresented a large body of peer-reviewed medical research in favour of portraying CFS within Showalter's own framing. https://networks.h-net.org/node/24029/pages/31360/epidemics-and-modern-media-parts-i-and-ii.

Dundee family "talk about being ill, but they do not talk about getting well" (116). These quotations reinforce a familiar refrain: these people do not want to get better. Note the similarity to Hadler's "these people are choosing to be patients" (1668). To state that "these people" do not talk about getting well implies that they are only ill because they choose to be. They want to be patients; they want to play the sick role. Furthermore, in punctuating her own thoughts on the matter, Showalter states this "family's story cries out for Ibsen" (116). Referring to the famous Norwegian playwright, Showalter suggests that CFS is a dramatic performance that should be dissected on Ibsen's stage in a similar-fashion to his own nineteenth century plays.[36] Showalter's characterization of CFS as a performance mimics depictions of the hysteric woman who was likewise described as a performer by 19th century British physician Brudenell Carter (Scull *Hysteria*, 68). Showalter moreover contends that this is a performance that when popularized, as hysteria was in the late nineteenth century, has helped CFS "become the 'malaise of the Eighties'" (116).

5. The Power of Illness Beliefs

Showalter leverages these tokenized examples to demonstrate what she claims underpins diagnoses such as CFS: the power of belief. Whereas the first example depicts a woman being cured of her illness via her belief in the power of this faith healer (and by extension, religion), the second demonstrates a similar faith that one is truly sick. CFS is posited as a type of "religion" in this household, as "a way of life" (125). It is never stated outright, but in both of these cases there is an implicit inference that these women are delusional. Gordon implies the same when he claims that individuals convert their inability to cope with everyday stressors into physical

[36] In particular, Henrik Ibsen's plays *Hedda Gabler* and *A Doll's House* explored the domestic pressures placed on women and the symptomatic responses that at that time would have been construed as indicative of female hysteria: i.e. nervousness, irritability, and abandonment of children, to name a few.

symptoms in order to "avoid dealing with reality" (2003). More explicitly, Showalter's first example implies that a willingness to believe illness can be cured will override the "illness beliefs" (as medical professionals commonly refer to it) that the individual is currently stuck on.

Showalter is not alone in framing invisible illnesses in this way. In an editorial published the same year as *Hystories*, Hadler questions fibromyalgia's status as a syndrome: he states that without the "validity of the quantification of tender points…FM devolves to a belief system held by a cadre of clinicians and communicated to any patient sufficiently wretched to be receptive" ("La Maladie est Morte" 1250). In his book on psychosomatic illness, *From Paralysis to Fatigue* (1993), Showalter's contemporary Edward Shorter wrote of "belief" and the changeability of symptoms in CFS. Referring to a "subculture of invalidism," Shorter states that one of its characteristics is "pathoplasticity" which means "the willingness to change symptoms and attributions as new fads appear. Chronic fatigue sufferers are quite willing to believe that they also have other illnesses that are stylish at the moment" (n.p.). In a chapter section titled "Patients Reject the Psychological Paradigm," Shorter refers to his own experiences as an observer in an inpatient clinic for psychosomatic disorders to argue that a quarter of patients with fibrositis (the original term for fibromyalgia) "had a fixed belief in [the] given diagnosis" (n.p.). He follows this claim by citing a 1980s study that "concluded…a substantial proportion of psychiatrically-ill patients believe their illness to be physical in origin." Belief has been codified in the DSM under the various disorders mentioned in the beginning of chapter 1 with the most recent version of the DSM referring to "medical conviction" as an underlying characteristic of somatic symptom disorders (310).

Shorter himself demonstrates a strong belief that fibromyalgia and CFS (along with other conditions distinguished by pain and fatigue, which he refers to as "diseases of fashion") are

simply different diagnostic labels given to the same syndrome. He explains "it was only…national diagnostic traditions that made them sound like different diseases" (372). From here Shorter makes the explicit link between fibromyalgia and hysteria: eight female patients Charles Despine described in 1838 as exhibiting "local pain or *points hystériques*" Shorter connects to neurologist William Gowers' proposed term in 1904 "*fibrositis* for these diffuse aches and pains" (372). Thus, in Shorter's view, fibromyalgia was the newly socially accepted term to describe Despine's "hysterical points." It is important to note that Shorter, like Showalter, is also not a trained physician. And yet each of their publications are cited by Ehrlich, Hadler, Gordon, and Wolfe as proof that fibromyalgia is a contested illness and therefore merits continual questioning.

Shorter, like Showalter and the authors of the *Rheumatology* articles, psychologizes the physical symptoms of fibromyalgia and CFS. Citing a slew of examples where researchers believe fibrositis to be a "form of depression" that is "presenting primarily as pain," Shorter makes the case that fibromyalgia and CFS are just the newest and most popular diagnostic labels in a long line of hysterical syndromes (374). These illnesses, Shorter and Showalter further argue, are sustained through the individual's belief that they are unwell. Even when one's limitations resulting from their physical pain and fatigue are taken seriously by doctors who recommend rest or exemption from forced physical education in schools, Showalter accuses these doctors of "creat[ing] invalidism in children, a Munchhausen-by-proxy syndrome"[37] (132). While the harm of overexertion[38] for those with CFS is more well-known today, Showalter refers

[37] As explained in chp. 1, Munchausen-by-proxy syndrome was removed in the DSM-V and replaced with "Factitious disorder imposed on another."

[38] This is recognized today as post-exertional malaise (PEM) to refer to the worsening of symptoms following even minor physical or mental exertion. PEM is considered the defining symptom of CFS/ME.

to these cautions as "scare literature" that has prompted more diagnoses of ME as "anxious parents" run to their doctors (132).

Similar to the examples with which Showalter opens her chapter, the idea that illness is created by acknowledging the reality of an individual's suffering mirrors the arguments in the *Rheumatology* articles where, Hadler claims, fibromyalgia does not exist until it is diagnosed. This diagnosis, in turn, he argues, leads to "instruction in illness behaviours" (1670). In his section on "The Epidemic of Chronic Fatigue," Shorter, too, refers to fibromyalgia as a "template" to suggest that patients learn to mimic the symptoms that they present to their doctor to lend them the legitimacy of a 'real' disease: "various diagnoses…were appropriated by individuals with psychosomatic illness who wished to confer the imputed organicity of the diagnosis on their own condition. These organic diagnoses represented templates on which patients suffering from a wide variety of nonspecific symptoms could model their complaints as they brought them to the doctor" (367). Hysteria, Showalter writes, was also "a mimetic disorder; it mimics culturally permissible expressions of distress" (15). All of these authors are suggesting that individuals learn culturally acceptable ways to present their symptoms to doctors to lend them an air of legitimacy, but that these are merely performative and further demonstrate the deception to which patients will resort to prove they are unwell in order to receive rewards.

6. Social Feedback Loops

Shorter suggests that this type of behaviour is not only immoral but exacerbated by a breakdown in social and familial values that define postmodern life. He connects this breakdown to one's supposed fixation with ascribing "internal states" to disease. He claims that "a substantial body of evidence shows" that this "willingness" to credit any of life's discomforts to disease is associated with "the splintering of social relationships that has marked postmodern

life" (384). One of the consequences of this breakdown, he states, is that "[p]eople who are socially isolated tend to have higher rates of somatization in general than those who are not" (383). He then explains that the "mechanism" responsible for this is the removal of social "feedback loops" which intensifies one's propensity to self-diagnose. Shorter contends that the value of a feedback loop is that when one is overly worried that they have acquired a real illness, someone else is there to disabuse them of this notion. He offers the following analogy: "The advantage of living closely with others is that one can test one's ideas. I'm feeling poorly today. Do I have chronic fatigue syndrome? No, it's because you slept poorly last night. This is the kind of feedback that occurs routinely in living together with others" (384). Thus, being in close proximity to others acts as a type of buffer against "people's vulnerability to fixed ideas about illness" and supposed tendency to somatize, which Shorter says has increased in the postmodern period (381). He refers to this feedback as "collective wisdom" that benefits all.

In Ehrlich's editorial "Pain is Real: Fibromyalgia Isn't," he voices a similar sentiment to Shorter's contention of the value of feedback loops. After Ehrlich refers to fibromyalgics who dare talk about their symptoms as "chronic complainers," he states that "[i]n rural areas…[they] aren't well tolerated. In cities, one can round a corner and become anonymous" (1666). His comments suggest that if one is from a small town, there exists a type of surveillance network—or to use Shorter's term "feedback loop"— that expects some degree of conformity to the norm or status quo.

Ehrlich reiterates these thoughts in another 2003 editorial "A Virtual Disease." He states that "predominantly women" suffer from chronic "aches and pains" that these women "probably represent many who have difficulty coping and who ruminate about the discomforts they feel until these take over much of their consciousness" (10). He then references the nineteenth

century concept of "Gemeinschaft"—or community—which he says "provid[es] norms of behavior," and unlike "Gesellschaft"—or society—fosters support for these "fragile personalities" (10). Moreover, a community structure found in rural communities—as opposed to urban environments where "symptoms are collated as fibromyalgia"—has "little community tolerance of chronic complaining" (10). These fragile women then get away with complaining about their aches and pains in the city where a rural atmosphere would put a stop to such behaviour.

Ehrlich is also suggesting that the anonymity of the city allows individuals too much freedom to, perhaps, don this sick mask. To live the sick lifestyle. To play the 'disability con' Samuels refers to and which I discussed in chapter 1. It is another way of stating that anyone on the street can decide to present a façade of illness with no social checks on their behaviour and absent of supposedly good-intentioned neighbourly advice to buck up because "everybody has pain sometimes" (Ehrlich 1666). An inability to persevere despite pain, like everyone else, is thus framed as a moral failing that can be corrected with social discipline.

Ehrlich's comments echo the profound anxiety surrounding bodily identity that Ellen Samuels identifies in *Fantasies of Identification*, where she traces how nineteenth-century social and economic transformations produced widespread fears of bodily imposture and disability fraud. The transition to modern capitalism, along with rapid expansion and urbanization resulting in exponential social, class, and geographic mobility, produced a deep cultural anxiety of identity imposture: the idea that anyone could don a mask in order to masquerade as someone they are not and ultimately swindle some unsuspecting individuals. The anonymity of the city in modern capitalism ostensibly removed feedback loops that keep individuals, their idiosyncrasies, and their tendency to somatize in check. Ehrlich's distinction between rural areas as being less

tolerant than urban areas evokes the generalization that rural areas are more conservative or traditional in values than a city which tends to have a more diverse population and arguably more progressive values.

This distinction is interesting to consider alongside Shorter's argument for feedback loops where he goes on to suggest that male companions in the form of husbands, for instance, act as a type of check on their spouse's behaviour. He refers to women who are single, divorced, or widows as "frequent attenders" of healthcare who are "found high in neuroticism and to have histories of poor health" (383). Conjuring the image of undisciplined women running amok in the city that is akin to late nineteenth century fears of the 'New Woman',[39] Shorter implies that the breakdown in family values that marks postmodern life might also be referring to a move away from the traditional values of a patriarchal family structure. The male head in this household would then have the authority to cure his wife of her "neuroticism" through his helpful feedback.

7. Media-Driven Ailments

For Shorter, "[t]he unmarried, divorced, and widowed" are especially vulnerable to somatization and the suggestion of illness (384). One place that these suggestions of illness are said to originate is in another predominant feature of postmodern life: the media. Shorter believes that women who live alone, who have "few 'significant others' with whom they may discuss interpretations of their own internal states" are "easy prey" for conditions like FM and CFS which he opines are "chic mediaspawned diseases" (384). Shorter states that "it was

[39] The New Woman represented fears of the time that women were subverting traditional gender roles by choosing to prioritize education over marriage, economic independence, and sexual autonomy which were perceived as a threat to a social order that privileged male authority and traditional family structures and gender norms (Ledger 1995, 1997; Liggins 2006).

diffusion by the media that has given these disease labels such enormous popularity" (374). Fibromyalgia, CFS, and related MUS conditions have long been talked about as fashionable illnesses. Published in the same year as Showalter's *Hystories*, one article titled "Somatization and Fashionable Diagnoses: Illness as a Way of Life" outright names fibromyalgia and CFS as somatization disorders, stating that "[i]n past decades the persons who seemed to seek a life-style of illness were known by a variety of terms, such as hysterics or invalids" (Ford 7). According to this physician, "the facilitation of mass communications" has enabled these patients to adopt the current fashionable label that gives "persistent somatizers" a "culturally sanctioned idiom of psychosocial distress" (8). He concludes, "[h]ysteria has not gone away, it just has a new style" (14).

Showalter follows Shorter's lead and claims that CFS is a disease of fashion, just as hysteria came to be viewed in the nineteenth century. Also, like Shorter, Showalter claims that CFS is a media-popularized condition. Her conviction in this viewpoint is so strong that in 2018, over twenty years after publishing *Hystories,* Showalter tweets:

> Thinking it is time for me to update HYSTORIES: Hysterical Epidemics and Modern Culture (1997), my book on hysterical syndromes and conspiracy theories spread through the media. Social media came after I wrote it; epidemic contagion infinitely worse now. (Showalter (@ecshowalter), 2018)

Her tweet makes it clear that she continues to attribute (medically) unexplained contemporary syndromes to media-driven cultural contagion, positioning social media as intensifying the same processes she described in *Hystories.* By explicitly invoking *Hystories,* a text that frames conditions such as CFS as forms of "hysterical epidemic" sustained through media contagion, the tweet extends her existing framework into the digital era. Whether referring specifically to

medical syndromes or more broadly to forms of socially transmitted belief, her characterization of social media as intensifying epidemic contagion reiterates her longstanding analogy between illness identities and conspiracy theories. Social media, which is often discussed by disabled individuals as alleviating isolation and essential to community formation, is framed by Showalter as aggravating patient illness beliefs and intensifying what she describes as epidemic contagion. Rather than being seen as a means for individuals lacking appropriate care from their physicians to learn community-led strategies for living with their illness, social media is positioned as worsening the spread and mutual reinforcement of illness narratives, creating self-reinforcing feedback loops that sustain illness identities in a manner akin to conspiracy theories. This characterization reinforces her broader claim that conditions such as CFS are "fashionable illnesses," whose emergence and proliferation follow the same dynamics of social transmission that sustain conspiracy theories.

Labelling certain conditions as "fashionable illnesses" is decidedly gendered language that suggests it is mostly suggestible women (because they are weak) who fall victim to the media's coercion. For Showalter, the media is effectively to blame for convincing individuals experiencing "symptoms we've all endured" that they have a disease (*Hystories* 127). She suggests that the "media sensation" of CFS is publicised in outlets like women's magazines, women celebrity role models, and TV shows that target women audiences such as *The Golden Girls* (124). She does not acknowledge the lack of agency she is giving to women whom she portrays as mindlessly consuming the media fed to them.

Shorter's commentary on fashionable media illnesses is the same. Referencing a study that demonstrates the overlapping symptoms of many related conditions, Shorter states that "the diseases of fashion are interwoven with one another" and that ninety percent in this study were

found to be “suffering from at least one other media-popularized condition,” such as “fibrositis” while some “reported eight or more diseases of fashion” (380). His comments fail to recognize that co-morbidities are common with invisible illnesses as one condition can exacerbate another condition, such as with autoimmune conditions that put individuals at higher risk of developing additional conditions. Instead, Shorter chooses to frame this occurrence as patients adopting whichever diagnostic label is popular at the time. He says of those in this study, most were on disability and “none expected to return to his or her former job” prior to explicitly stating that “88 percent were women” (380). These women patients, he concludes, “are suggestible and at high risk for acquiring diagnoses that are popularized by the media” (380).

This narrative that fibromyalgia, CFS, and related disorders with overlapping symptoms are fashionable illnesses popularized by the media was one of the hypotheses prompting White and Thompson’s study. This study, introduced and briefly discussed in the introduction, merits closer examination here because it played a direct role in provoking the *Rheumatology* editorials that continued to characterize fibromyalgia as a culturally fashionable and media-driven illness despite empirical evidence to the contrary. Crucially, the media-driven hypothesis was closely tied to the assumption that fibromyalgia emerged from media-saturated urban environments rather than socially cohesive rural communities, making the study’s rural Amish population an especially revealing test case.

White and Thompson deliberately selected a rural Amish community for their study, noting that “Amish communities culturally are very distinct and purposely isolated from the rest of North American society” (1835). As they explain, Amish communities follow traditional values and a patriarchal family structure, preferring to live a modest life; they do not use electricity, consume any non-Amish media, and they rarely enter non-Amish public spaces. This

makes the Amish community ideal when attempting to determine the media and society's role in influencing the Amish community's behaviour and thoughts and the diagnosis of fibromyalgia. The first objective of their study was to estimate the prevalence of FM in this small rural Amish community. The secondary objective was to compare this prevalence of FM and its symptoms to non-Amish rural and non-Amish urban controls. Contrary to expectations derived from the media-driven hypothesis, the authors found that FM was more prevalent in the Amish community than in their control groups.

Because Amish communities are largely insulated from mainstream media, they would be unlikely to exhibit patterns consistent with the hypothesis that fibromyalgia spreads through media influence, as Ehrlich, Showalter, and Shorter have suggested. The study's findings therefore directly refuted this claim. In addition, Shorter and Ehrlich's contention that rural environments and traditional social structures temper the inclination toward fibromyalgia is also undermined. The Amish community exemplifies precisely the kinds of traditional, patriarchal family structures and close-knit social organization that Shorter proposed would mitigate such conditions, yet fibromyalgia remained prevalent. While Shorter and Showalter advanced these claims prior to the publication of White and Thompson's findings, the authors of the *Rheumatology* editorials were directly responding to that research. Even after empirical evidence had challenged the notion that fibromyalgia was a media-driven ailment reflective of a "broken urban society" (Gordon "WSIAT" 3), these editorials continued to reproduce these tired and disproven ideas.

8. A Problem of Gender

As was the case with hysteria, Showalter has notably, and problematically, narrowed in on examples of chronic fatigue that affect women. In particular, white women. Her section on

"CFS: The Patients" describes this woman as the quintessential career woman of the 1990s, aka the superwoman who tries to "have it all." They lead "frantic lives with multiple responsibilities: jobs, childrearing, volunteer work, exercise, and social activity" (127). Her focus on women is perhaps unsurprising given that CFS is known to be diagnosed in women at a much higher rate. However, Showalter's reasons for choosing women affected by CFS is to make explicit the connection between the hysteria of old and the "new hysteria" that is CFS. Her description of the busy women with frantic lives afflicted by CFS calls forth the nineteenth century hysteric patient who was presumed to be too stimulated by life and given Weir Mitchell's infamous rest cure. Showalter does rightfully recognize that "[h]ysteria is inevitably a feminist issue, because for centuries doctors regarded it as a female reproductive disease" (9). She goes on to emphasize that "even in the 1990s, women patients outnumber men in virtually every category of unexplained illness and recovered memory," and specifically, "80 percent of those with chronic fatigue syndrome are women" (9). Yet despite acknowledging both hysteria's long-standing association with gender and the disproportionate prevalence of CFS among women, her analysis does not consider how sexism or misogyny within medical institutions might contribute to this discrepancy.

In attempting to link CFS to hysteria through gender, Showalter relies on many of the same stereotypes that depicted "hysterical women." For instance, she explains away the reaction from those whose symptoms have been psychologized as being unwilling to acknowledge this factor because they "live in a culture that looks down on psychogenic illness" (117). Hadler makes a similar comment that "[m]ost Westerners are offended by the suggestion that their symptoms are in their mind" (1668). This type of framing makes it impossible to argue against because you either accept the supposition that your physical symptoms are psychological or you

deny it because you cannot accept it. In other words, the premise is both false and misleading. Freud used the same method of argumentation in his case study of *Dora* where he states that if a patient does not believe his theory of why they are unwell it is either because they cannot accept it or because it is unconscious and therefore out of their grasp of understanding (44). Either way, the patient is wrong and the doctor is right.

In a similar vein to the *Rheumatology* editorials, Showalter insists that the sources of these symptoms are "psychological, circumstantial, or emotional" (117). She even comments that the acronym ME "ironically emphasizes the patient's self-absorption" (124). This comment is not dissimilar to Ehrlich's remarks that the fibromyalgia patient is guilty of being excessively focused on "herself and her discomfort" (1666). It is also similar to past depictions of hysteria. Just as the *Rheumatology* articles do, Showalter is painting a picture of women with CFS as dramatic, emotional, and at times deceptive (unconsciously so)—all stereotypes that have been levelled against women who do not adhere to normative societal expectations (Ussher 1991). These are the same stereotypes that are embedded in the DSM-V's classification of somatic symptom disorders. In this case, because an individual's symptoms cannot be independently verified and are therefore incomprehensible to those who have not experienced this level of fatigue or pain, the patient is judged as being overly dramatic about everyday pains or intending to deceive. Thus, these experiences are regarded as highly suspect, by both Showalter and the authors of the *Rheumatology* articles.

9. Ableist Feminism

Showalter expects that "defining…chronic fatigue" as "contemporary hysterias and analyzing them on a continuum with alien abduction stories and conspiracy theories will infuriate thousands of people…" (8). She even acknowledges that hysteria has "insulting

connotations" and that "[it is] a term that particularly enrages some feminists because for centuries it has been used to ridicule and trivialize women's medical and political complaints" (8). It is a wonder, then, that Showalter would likewise use the term hysteria to trivialize women's experiences of CFS by psychologizing their symptoms, attributing them as a "response to emotional conflict" (17). Linking CFS to hysteria in this way raises a fundamental question: how is Showalter's diagnosis of hysteria any different than the previous century's diagnosis that sought to discipline and deny the experiences of those who were captured within its oppressive framework?

It is helpful to clarify the framework Showalter draws on and how it informs her analysis of CFS and related disorders. Showalter's analysis is grounded in a social constructionist framework that operates through a psychogenic model of symptom formation. For Showalter, cultural narratives function as pathogenic forces capable of producing symptoms in psychologically susceptible individuals. Her description of CFS as an "epidemic" reflects a model of cultural transmission in which illness narratives circulating in media provide scripts that vulnerable subjects may internalize and embody.

Showalter's analysis emerges from feminist theory of the late twentieth century in which hysteria was widely reinterpreted as a meaningful "language of the body"—an approach that sought to challenge the historical dismissal of women's suffering by reframing symptoms as embodied expressions of distress. While this reinterpretation aimed to restore legitimacy to women's experiences, it often retained the premise that symptoms were psychogenic in origin, even as it contested their moral and political meaning. Although Showalter adopts this insight that hysteria is culturally-mediated, she diverges from feminist efforts to reclaim hysteria as a *meaningful* expression of embodied distress. While she does believe hysteria is "an affliction of

the mind… expressed through a disturbance of the body," she outright rejects the idea that this language of the body is subversive (14). She instead argues that symptoms are unconsciously produced through psychological susceptibility to cultural narratives, thereby reinforcing an interpretive framework that ultimately locates pathology in the individual subject. Clarifying this distinction reveals the extent to which Showalter's analysis remains continuous with the psychogenic framework historically used to explain hysteria. Showalter reproduces the same logic by treating CFS as a culturally-generated expression of psychological distress in which illness identities produced by cultural narratives are unconsciously internalized and enacted by "unhappy, vulnerable" individuals (17). In this way, Showalter extends the interpretive tradition of hysteria into contemporary diagnostic contexts, preserving its individualized explanatory structure even while invoking social and cultural causation.

Situated within a social constructionist framework, Showalter's analysis reflects broader tensions within feminist theory in the 1990s, particularly its failure to fully account for the material realities of chronic illness and disability.[40] Notably, *Hystories* was published just one year after Susan Wendell's *The Rejected Body* (1996), which argued that feminist and philosophical theories of the body were "skewed toward healthy, non-disabled experience" and therefore incomplete insofar as they neglected to account for the lived realities of chronic illness and bodily suffering (5). Wendell identifies that in challenging the pathologization of women's bodies, feminist theory often implicitly assumed a stable, capable subject, marginalizing those whose embodiment is shaped by illness, pain, and functional limitation (63-64). As Ellen Samuels notes, "feminist theories that attempt to de-pathologize the normative female body"

[40] Similarly, the social model of disability has been challenged for its difficulty accounting for chronic illness and invisible conditions, particularly where suffering may persist even in the absence of social barriers (Kafer 2013); see Introduction for a fuller discussion of FDS critiques.

have done so “at the expense of the physically deviant or ill body” (Samuels, “Critical Divides” 60). Arising from a feminist desire to create distance from ascribed feminine weakness, feminist theory has often rejected associations between women and perceived bodily “abnormality,” reinforcing a distinction between normative and deviant embodiment.

As Lamp and Cleigh further demonstrate, this distancing has deeper historical roots: early feminists rejected the classification of women as “defective,” not by challenging the ableist hierarchy that produced such categories, but by insisting that women did not belong to them, thereby preserving disability as a negative category against which feminist subjectivity could be defined (176). Feminist efforts to assert women’s rationality and political fitness thus frequently relied upon disavowing bodily vulnerability, reinforcing distinctions between capable, autonomous subjects and those marked by illness or impairment (Lamp and Cleigh 186). It is precisely this exclusion of bodily vulnerability from feminist theoretical frameworks that Susan Wendell’s work seeks to address.

Showalter’s unwillingness to consider invisible chronic illness as anything other than a psychological or emotional response to cultural anxieties exemplifies the limitations Wendell identifies. By treating symptoms as psychogenic expressions of cultural anxiety, Showalter forecloses the possibility that they may reflect physiological processes whose mechanisms remain misunderstood. Her analysis reflects what Wendell describes as an excessive focus on the “cultural construction of ‘the body’” at the expense of bodily experience itself: such approaches “confuse the lived reality of bodies with cultural discourse about and representations of bodies,” and “deny or ignore bodily experience in favour of fascination with bodily representations” (Wendell 1996, 44). While social constructionist and postmodern theories have been essential in exposing how illness and disability are shaped by discourse and institutional power, disability

scholars caution that an exclusive emphasis on cultural meaning risks obscuring the lived realities of pain, fatigue, and functional limitation. Such approaches may inadvertently reproduce the epistemic dismissal they seek to critique by reducing bodily realities to sites of cultural inscription (Wendell 1996, 2001; Samuels 2011).

10. Conclusion

I have examined Showalter's argument that CFS should be understood as hysteria at length because it illuminates the broader discursive environment in which the *Rheumatology* articles on fibromyalgia were produced. These *Rheumatology* articles do not exist in a vacuum; rather, they are in active conversation with other prominent texts of the period that draw on a shared rhetorical history of invisible illness and disability. My analysis intends to highlight the dynamic intertextuality between the authors medical discourse, cultural criticism, and broader social processes in order to emphasize how these texts do not merely reflect but actively shape dominant understandings of contested illness. These texts are reflective of and participate in a long-standing rhetoric concerning invisible illnesses and demonstrate a concerted effort by some to link these illnesses to hysteria. Across these writings, fibromyalgia and related conditions are interpreted through familiar cultural narratives that treat medically unverifiable pain and fatigue as reiterations of hysteria. This is a framework that carries with it longstanding assumptions about gender, psychology, and morality. However, unlike the *Rheumatology* authors who are speaking from a position of medical authority, it is notable that figures such as Showalter and Shorter are not clinicians. Shorter is a medical historian and Showalter is an English professor and cultural critic. Yet, they both participate in the same interpretive logic by diagnosing the lived experiences of CFS as hysteria despite a lack of medical authority or presumed experiential knowledge of the conditions they theorize.

Nevertheless, I do agree that there is a meaningful connection between hysteria and contemporary perceptions of CFS and FM, but it is not the one for which Showalter is arguing. Showalter's conclusion that these conditions are simply modern iterations of the same illness is, I suggest, hasty and reductive, and risks doing harm to disabled women and others whose experiences are dismissed by this equivalence. The association between hysteria and invisible illnesses speaks less to diagnostic continuity and more to enduring cultural attitudes toward bodily experiences that resist biomedical verification. On the one hand, these cultural logics are reinforced by social and institutional structures that privilege an epistemology of visibility when determining what counts as "real." On the other, invisibly ill individuals are judged against ableist norms that assign value according to productivity, self-sufficiency, and independence—that is, one's perceived capacity to contribute to capital.[41] The next chapter builds on this analysis by examining how fibromyalgia patients are cast as malingerers within a cultural framework that treats unproductivity as moral failure and how the category of disability is regarded as opening the door to entitlements to the so-called undeserving.

[41] These dynamics reflect two identifiable intersecting argumentative warrants: first, that legitimate illness must be visible and measurable; and second, that human worth is tied to productivity. This productivity-based warrant closely aligns with Cherney's ableist warrants *body is able* and *normal is natural* as ability, endurance, and productivity are presumed to be default states.

Chapter 3:
Entitlements

1. The Myth of Faking Disability for Financial Compensation

In chapters 1 and 2, I focused on how medical professionals and society at large cast fibromyalgia (FM) patients as satisfying the first criterion of malingering: to falsely or grossly exaggerate their symptoms. However, as much as these *Rheumatology* authors are focused on downplaying and psychologizing the symptoms of FM, they are equally preoccupied with the idea that individuals are receiving unearned and unfair rights and privileges. This chapter will build on the previous two to demonstrate how this same collection of articles suggests that fibromyalgia patients satisfy the second and most essential criterion of malingering: exaggerating or faking illness to escape work or to obtain external incentives, entitlements, or other rewards. These entitlements are often referred to as secondary gains.

In this chapter, I argue that the *Rheumatology* authors' discussion of fibromyalgia reflects a rhetoric that Anna Mollow (2014) and other feminist disability scholars identify as dominating discussions of impairments that are not easily quantifiable or measurable. Mollow's analysis of the hystericization of invisibilized illnesses identifies that those of us with these impairments "are suspected…of fabricating our disabilities to obtain undeserved 'entitlements'" (186). These "entitlements" were first conceptualized by the father of psychoanalysis, Sigmund Freud, as "secondary gains." As I discussed in chapter 1, Ellen Samuels states that suspicions of disability fakery emerged in the nineteenth century partly as a response to welfare initiatives. This notion that individuals were feigning disability for gains was reflected in the concept of the "disability con." Prompted by the persistence of this narrative, the basis of White and Thompson's study was to test the hypothesis that fibromyalgia is a media-driven ailment and motivated by "an

overly liberal disability compensation system" (1835). Although the study disproved these claims, the *Rheumatology* editorials in response continued to disseminate the narrative that fibromyalgia patients are motivated by interpersonal or economic advantage.

This chapter will, therefore, more closely examine the belief that fibromyalgia patients are feigning or exaggerating disability for secondary gains. In doing so, I attend not only to the authors' explicit arguments but also to the "rich features" of their texts—particularly the recurring analogy of fibromyalgia to historical disorders. One of the ways the authors imply that fibromyalgia is motivated by secondary gain, I argue, is by situating it on the historical continuum of past hysterical nervous disorders of the nineteenth century: the central claim at issue in this chapter is that fibromyalgia is simply the rebranding of two nineteenth-century nervous disorders, railway spine and neurasthenia. It is through this explicit historical claim that the broader, implicit narrative of secondary gain is supported and made to seem plausible.

Much of this chapter will be devoted to exploring how neurasthenia and railway spine were similarly framed in their time and place as representative of 1) a nervous weakness particular to modern women with compromised coping mechanisms and 2) an excuse to avoid work and a convenient means to obtain financial rewards. An examination of these historical disorders alongside fibromyalgia highlights a cultural fixation with distinguishing between the "legitimately sick," who are deemed worthy of social support, and the "unworthy," who are imagined as feigning illness to avoid work (neurasthenia) or to obtain compensation (railway spine). Furthermore, in tracing the historical rhetoric of neurasthenia and railway spine, I aim to reveal how the *Rheumatology* authors are recycling and repackaging old ideologies that surrounded characterizations of these disorders and applying them to their representation of fibromyalgia. Because these earlier diagnoses were themselves culturally associated with

exaggeration, malingering, and compensation-seeking, invoking them transfers those same suspicions onto contemporary fibromyalgia patients. By claiming fibromyalgia is the latest in a long lineage of nineteenth century disorders associated with secondary gain, the authors perpetuate a harmful narrative that I argue contributes to the oppression of those of us with misunderstood and invisibilized illnesses.

2. Secondary Gains

Secondary gains can be thought of as "incentives" to play the sick role. These supposed incentives are often conceived of as interpersonal advantages and social rewards, such as increased attention, sympathy and compassion, freedom from work or other responsibilities, financial compensation, and so on. It is assumed that even in the case of unquestionable illness or disability, individuals still receive some secondary benefit in the form of any of the social rewards mentioned above. In the case where illness is questioned, however, secondary gains are construed as much more devious. I will briefly consider Mollow's analysis of Freud's treatment of "hysterical" patient Dora for its discussion of how Freud's theory of secondary gain considers illnesses as "useful things" and a "powerful weapon" that is wielded in order to "secure social rewards" (Mollow 189; Freud 37, 41). It is helpful to revisit Freud's conceptualization of secondary gains arising from medically unexplained syndromes as the *Rheumatology* authors are essentially reiterating his theories in their representation of fibromyalgia. Freud theorized that Dora (Ida Bauer) was motivated to be ill as a manipulation to "detach her father from" his relationship with a married woman (Frau K): "There could be no doubt…that she had an aim in view which she hoped to gain by her illness," and Freud was "quite convinced that she would recover at once if only her father were to tell her that he had sacrificed Frau K. for the sake of her health" (41). Thus, in Freud's assessment, Dora's illness is nothing more than a desperate child

seeking attention from her parent. Attention-seeking is one of the claims levelled against many individuals with medically-unexplained symptoms and is framed as an illness behaviour that the *Rheumatology* authors likewise allege of their fibromyalgia patients.

In terms of Dora, Freud "hoped [the father] would not let himself be persuaded to do this, for then…she would certainly not fail on every future occasion to make use once more of her liability to ill-health" (41). If Dora's father "gives in" and separates from Frau K., Freud posits this will provide a type of training in manipulation for Dora where she will continue to use her illness to get what she wants. This would be considered a learned illness behaviour—the idea that patients' expression of symptoms is learned, adopted, and used to secure desired outcomes—a concept the *Rheumatology* authors also develop in their editorials and which I discuss in Chapter 1.[42] Freud's next comments reveal this very trajectory of thought. He suggests that in the same way Dora uses her illness in an attempt to gain her father's affection, "[w]hen such a child has grown up to be a woman… [illness] will procure her the care she longs for; it will force her husband to make pecuniary sacrifices for her and to show her consideration…and it will compel him to treat her with solicitude if she recovers, for otherwise a relapse will threaten" (43). Freud's focus does not appear to be on the reality of illness at all, but rather the idea that illness leads to gains and it is these gains that are the underlying motivator for Dora and those with similar conditions. Moreover, being ill becomes a learned illness behaviour that is reinforced through the supposed interpersonal rewards that are achieved as a result.

On hysterical disorders, Freud also states "[i]t is true that the paralysed and bedridden woman would spring to her feet if a fire were to break out in her room, and that the spoiled wife

[42] Specifically, I discuss illness behaviours in Chapter 1, section 5 ("The FM Patient is Almost Always a Woman") and section 6 ("Pain is a Lifestyle"), where I examine how symptoms are framed as behaviours and interpreted as evidence of attachment to the sick role.

would forget all her sufferings if her child were to fall dangerously ill…" (44). Freud argues that if "deprived of [their] most powerful motive" for being ill, the patient will be "temporarily or perhaps even permanently freed from his illness" (45). To justify his patient's protestations of this theory of secondary gain, Freud purports these motivations are "unconscious" to the individual who is said to be unaware of their "intention to be ill" (44). Framing perceived motivation in this way is convenient, for it silences the individual experiencing the symptoms while also suggesting it is not their fault since their motivations are unconscious. This is fitting for how hysteria was considered an unconscious conversion of psychological distress into physical symptoms, as opposed to the later factitious disorder and malingering which are only differentiated based on their supposed conscious intent (as shown in Table 1 in Chapter 1). These examples and Freud's reasoning, moreover, bear a striking resemblance to Showalter's CFS anecdotes discussed in chapter 1 in that they likewise intended to convey an individual's unconscious illness beliefs. In the same way that Showalter describes "Jo" as miraculously cured of her CFS after visiting a faith-healer, Freud maintains that with identification of the original psychological motivator, the patient's illness disappears altogether—or at least until the next bout of psychological needs.

In addition to the gain of social rewards, Freud moreover asserts that "the symptoms of the disease are nothing else than *the patient's sexual activity*" (114; emphasis original) to which Mollow notes Freud is suggesting "that hysteria entails an erotic enjoyment of illness in and of itself" (189). As Mollow explicates, many (if not most) of Dora's symptoms and behaviours are explained away as unconscious sexual or reproductive urges. Any of Dora's initial objections and later silences are reconstrued by Freud as "tacit accept[ance]" (Mollow 189; Freud 47). In short, Dora has no voice (and certainly the concept of consent is absent as well). When she does

have a voice it only serves the purpose of being subject to interpretation. Every comment, every mannerism is assessed in turn to fit within Freud's totalizing narrative of hysteria. Mollow stresses that this is a similar quandary that those with invisible illnesses face. Fittingly, Mollow quotes from Jennifer Eisenhauer who utilized the pseudonym Dora when writing of her experiences of bipolar disorder to emphasize "the irony of trying to speak when everything said becomes a 'symptom' of . . . 'abnormality'" (31; qtd. in Mollow 190).

I draw on Anna Mollow's critique of the Freudian concept of secondary gain to clarify the *Rheumatology* authors' opinions on fibromyalgia and its connection to a long history of questioning the motivation of ill patients and suggesting their illness is feigned for entitlements. In Freud's estimation, individuals are so motivated by these gains that they would rather hold onto their illness than be well. I argue that the narrative of illness gains popularized by Freud is reflected in these editorials, which respond to debates over the diagnostic validity of fibromyalgia and whether its symptoms constitute a real illness. As already discussed, these articles, which are authored by male members of the medical community, psychologize[43] the symptoms of fibromyalgia much in the same way that Freud does in his analysis of his patients. They also explicitly link fibromyalgia to past disorders that, too, were subject to suspicion partly as a result of their supposed secondary gain in the form of financial compensation and other rewards.

[43] When questioning how invisible illnesses are framed as psychological in origin, I am not suggesting that illnesses resulting from physical causes are somehow more legitimate than those that are psychological or more deserving of treatment. Neither do I intend to re-stigmatize mental disabilities or reinforce a false dichotomy of the body/mind as many illnesses, including FM and CFS, have psychological components. I only mean to emphasize that the "stigmatizing label 'crazy'" (Mollow 196) is being used to invalidate patient experiences and justify a lack of patient care. In fact, I would say that the authors are relying on the stigma of mental illness in order to deny care altogether.

3. Historical Precursors: Railway Spine and Neurasthenia

"If…fibromyalgia is a relatively new disorder, was there no such illness before 1940? Or were the symptoms of fibromyalgia present earlier, but differently named, perhaps as neurasthenia?" (Wolfe and Walitt 2013)

In the same year that he wrote "Pain is Real; Fibromyalgia Isn't," George Ehrlich wrote a Letter to the Editor published in *Arthritis and Rheumatology* in which he explicitly links fibromyalgia to two disorders of the nineteenth century that came to be associated with hysteria: neurasthenia and railway spine. Therein, Ehrlich refers to fibromyalgia as a "procrustean bed"; meaning, he views fibromyalgia as an arbitrary diagnosis that attempts to force symptoms to fit within its rigid confines much in the same way that past hysterical disorders have been criticized for placing a wide array of symptoms under a specific diagnostic label. This metaphorical bed, Ehrlich goes on to say, "will ultimately have to be destroyed, as forerunners, e.g., railway spine and neurasthenia, were superseded, unfortunately, by something worse, the diagnosis of fibromyalgia" (276). Ehrlich's comments here are brief and might seem of minimal importance, yet they place fibromyalgia on the continuum of hysterical or nervous disorders and in doing so reveal the author's own bias that fibromyalgia is little more than a repackaging of past diagnoses that contained a collection of symptoms now considered to be of psychological origin.

In an additional 2003 editorial titled "Fibromyalgia, a Virtual Disease," Ehrlich again mentions fibromyalgia's association with railway spine and neurasthenia, but makes a far more sweeping statement:

> …under a number of names and concepts, these spurious disorders have always been with us. Undoubtedly, they helped motivate Kramer and Sprenger, the inquisitors, approvingly sent by Pope Innocent VIII to stamp out witchcraft, to pursue and ultimately lead to the stakes tens, perhaps hundreds, of thousands of women in late 15th early 16th

> Century Europe, chiefly in Germany. The same symptoms reappeared in the 19th Century under the name, railway spine, later as neurasthenia, and as fibrositis before the term, fibromyalgia, was coined. (10)

Of note in this quotation is Ehrlich's lumping together of railway spine, neurasthenia, and fibromyalgia with witchcraft. Fundamentally, the persecution of witches was about controlling non-conforming women who were viewed as threats to gender norms of their time. As Ussher (2011) writes in *The Madness of Women*, "the outspoken, difficult woman of the sixteenth century was castigated as a witch, and the same woman in the nineteenth century a hysteric…" (81). Ehrlich is drawing a link between symptomology to argue that the same symptoms have appeared under different labels throughout centuries. But what his comments more importantly reveal is his understanding of fibromyalgia and these other disorders as hysteria, or more simply as nervous disorders—even though he never uses the term. Like hysteria, the troublesome fibromyalgia patient is "difficult to treat," perhaps representing "fakers, self-indulgent, undisciplined, and morally weak" women (Jimenez 157; qtd. in B. Cohen 160). It is not that Ehrlich is arguing witchcraft (or hysteria) were real: he is arguing that fibromyalgia is a label that represents "social problems and maladjustments," which "[m]edicine is ill-prepared to deal with" (10). To Ehrlich, witchcraft, hysteria, railway spine, neurasthenia, and fibromyalgia are mythic labels that are applied to "truly wretched people" who, as Ehrlich suggests elsewhere in this article, may be "encouraged to get worse 'or at least not better'" by treatment—a framing that casts them as unwilling to improve and as harmed by medical legitimation (10). Thus, Ehrlich's invocation of witchcraft does more than imply historical continuity. It also allows him to implicitly contrast past persecution with present-day medical restraint; thereby, positioning

contemporary refusals to diagnose or treat fibromyalgia as a more rational—and ostensibly more humane—response to similarly "troublesome" subjects.

In 2013, a decade after Ehrlich's publications, Wolfe and co-author Brian Walitt more extensively expand on the belief that fibromyalgia is the new face of neurasthenia and railway spine in an article titled "Culture, Science, and the Changing Nature of Fibromyalgia." The entirety of their opinion piece attempts to show the trajectory from neurasthenia to fibromyalgia as diagnostic labels. The article is broken into 5 main sections that mirror many of the claims I have already addressed in chapter 1: for instance, two of the sections focus on "the fibromyalgia controversy" and "psychological factors," but with the addition of a newly devoted section to "fibromyalgia and neurasthenia." This latter section contains the quote in the epigraph above that directly articulates the claim that fibromyalgia is perhaps a rebranding of nineteenth century nervous disorders.

Throughout this section, Wolfe and Walitt focus on the overlap between characterizations of neurasthenia and fibromyalgia. One of these overlaps consists of their claim that "[a] person with neurasthenia today would be likely to satisfy fibromyalgia criteria and be given that diagnosis" (754). And whereas fibromyalgia used to be considered a local pain disorder it has "evolved…to a generalized pain and multiple symptom disorder with remarkable similarities to neurasthenia" (754). These claims are not surprising given that George Beard, writing on neurasthenia, lists over 80 symptoms in his 1881 publication *American Nervousness* (7-8). It would therefore not be difficult to find symptoms that match those of fibromyalgia. One symptom which Wolfe and Walitt narrow in on is what is known as "fibro fog" which they state resembles the "mental fatigue of neurasthenia" (754). Fibro fog is essentially brain fog, referring to the cognitive difficulties associated with fibromyalgia. Like mental fatigue, it is a broad term

that encompasses an array of cognitive challenges and is a common symptom in a wide range of conditions. This similarity and the fact that both fibromyalgia and neurasthenia report a variety of symptoms leads the authors to state that this "very strong resemblance of fibromyalgia to neurasthenia is a key observation" (754). They also address the decline of neurasthenia as a diagnosis and attribute the success of fibromyalgia to "powerful societal forces [that] have been marshalled on behalf of" the label which they reckon "will sustain fibromyalgia, at least in the short term" (755). In this way, like neurasthenia, they consider the diagnosis of fibromyalgia to be a product of its time and place and wholly influenced by a nurturing sociocultural environment that has allowed the diagnosis to survive and even flourish.

From here, the authors claim that hysteria, neurasthenia, and railway spine are now recognized as "almost always psychogenic disorders" as time has "[brought] clarity to confusing illnesses of the past" (754). This clarity ostensibly empowers them to see fibromyalgia as a mere modern variant of past disorders that are now understood to be psychogenic. This allows the authors to imply this is how we should approach fibromyalgia now, too. With this understanding, they lay the groundwork for contesting symptoms as suspicious and as motivated by secondary gain. They justify the "lay and medical suspicion of the symptom complaints of those with fibromyalgia" with the example that not only are there "too many symptoms" but that these symptoms are "too severe and unusual" when these patients also present as "too healthy" in comparison to "patients with other pain disorders" (753). They do not explain what symptoms they find too severe or what is unusual about them, but one can infer that their measurement of health is based on a lack of verifiability of pathology using diagnostic measurement tools. Suspicion of symptoms that cannot be objectively verified is therefore warranted and supports the notion that psychogenic disorders "can attract societal attention and disapprobation,

particularly when they ask for social advantage or disability pensions" (754). The implication is that these symptoms which are too many, too severe, and too unusual are reported as a means to acquire interpersonal or external rewards; thus, fitting the requirements for suspecting malingering. The lesson of neurasthenia and railway spine, it seems, is that they were also a way to gain entitlements. Thanks to the newfound clarity on psychogenic disorders and their association with seeking compensation, physicians can now play an integral role in putting a stop to these abuses of the system by recognizing perplexing conditions as primarily psychogenic and motivated by secondary gain.

4. Linking Fibromyalgia to Past Framings of Nervous Disorders

Given the significance the *Rheumatology* authors place on neurasthenia and railway spine in their discussions of fibromyalgia, and their arguments about their psychogenic nature, I devote much of this chapter to outlining how these conditions emerged in the cultural imagination of the nineteenth century and how they were perceived according to the major texts and figures involved in representing them during their time period. If it is largely taken for granted that fibromyalgia is a new label for past neurasthenic and related disorders, it is imperative to assess how these disorders were framed in their time as diseases of modernity that afflicted particular individuals and granted access to either financial compensation or some other societal reward such as receiving attention or avoiding work. I will argue that much of the commentary on neurasthenia (and railway spine) mirrors current debates on the legitimacy of fibromyalgia as both conditions are cast as dubious. Although I, too, will be examining the overlap between these conditions, unlike the *Rheumatology* articles—which are focused on portraying their patients and society as willing victims of a useless diagnosis—I will instead situate these overlaps in the

larger context of societal fears that individuals are receiving undeserved rewards and essentially absconding from their civic and moral duties.

In what follows, I will begin with a brief history of the emergence of railway spine in the mid-nineteenth century by referencing some key texts and figures involved in its representation: namely, the medical discourses of Sir John Eric Erichsen and later Herbert Page, as well as its literary representation in widely popular sensation novel, Mary Elizabeth Braddon's *Lady Audley's Secret*. I will then address the claim that fibromyalgia resembles the past diagnosis of railway spine, a disorder that came to be perceived as induced by the psychological trauma of a physical event and connected to increased claims for disability compensation. From here, I will connect the diagnosis of railway spine to the later diagnosis of neurasthenia through a discussion of George Beard's 1880 *A Practical Treatise on Nervous Exhaustion*. My discussion of neurasthenia will draw on Anson Rabinbach's account of the evolution of neurasthenia in his 1990 book *The Human Motor* which examines the metaphor of the working body as a machine and documents the emergence of a preoccupation with energy and fatigue and the limitations these placed on ideals of human and societal progress.

a) Railway Spine

In 1850s Britain, railway accidents were increasing in frequency and this correlated with an increase in compensation claims against railway companies (Harrington 11). An increase in claims brought increased attention to passengers who suffered post-accident injuries that were then described as "nervous in character" (Harrington 11). Many of these passengers were found to have sustained superficial injuries, yet subsequently developed worsening symptoms. It was considered a medical anomaly. As a result of these factors—the lack of verifiable chronic injury coupled with what was seen as a dramatic and problematic increase in compensation claims that

were potentially prone to subterfuge—the concept of "railway spine" gained traction in the medical community.

The first full-length study of railway spine was conducted by surgeon Sir John Eric Erichsen (1866) in *On Railway and Other Injuries of the Nervous System*. Erichsen believed the spinal column suffered a physical shock in railway collisions, a type of concussion that caused inflammation of the spinal membranes and led to injury of the nervous system. Erichsen's supposition aligned with Victorian medicine's belief at the time that nervous disorders had an organic cause. While Erichsen believed the origin of railway spine to be physiological, a later edition of his book (1875) acknowledged the fear evoked by the accident could have affected the nervous system even in the absence of a physical injury to the spine (Harrington 12). However, he maintained that railway spine was of physiological origin.

Then, in 1883, surgeon Herbert Page inverted Erichsen's theory, arguing that fear produced the physiological changes in the nervous system, stating that not enough attention had been given to the mind in this disorder (Harrington 13). Unlike Erichsen who rejected this supposition, Page drew an explicit association between railway spine and traumatic hysteria by "strongly suggest[ing] that they were forms of the same phenomenon" (Harrington 13). Page correlates the "profound psychical disturbance…induced by the shock and terror of a railway collision" to the "'hysterical' condition…in which there is loss of control and enfeeblement of the power of the will" (52-53; qtd. in Harrington 13). As Harrington notes, the "connection between the experience of a traumatic event and the manifestation of seemingly 'hysterical' nervous disorders" anticipates the works of Hermann Oppenheim, Jean-Martin Charcot and Sigmund Freud (13).

i. The Cultural Force of the Railway

Railway spine and concerns over the effects of this new technology on the body did not just exist in the pages of medical texts or the lives of those affected by its force. It was a cultural phenomenon that permeated the public imagination and found further exploration within literary representations.[44] In particular, sensation novels of the 1860s contributed to the emerging discourse on nervous shock, reflecting Victorian anxieties about the effects of modernization on nervous overstimulation and broader concerns with moral degeneration and decline. As Katarzyna Badowska observes, "today it is something of a critical commonplace to discuss the sensation novel in terms of the cultural fears and anxieties that it (unconsciously) expresses" (158). Medical accounts of railway accidents, Daniel Martin notes, "gave a public face to the decade's much-publicized anxieties about modernity's effects on the human nervous system" by exposing the physical and psychological toll of industrial life (136). In effect, the material reality of railway accidents substantiated these fears of modern technology's effects on the body. As a result of the physiological effects of railway accidents, "mid-Victorian medical experts contributed to an understanding of modern life as a continual assault upon the body and the senses" (Martin 136).

At the same time, sensation fiction was understood not only as reflecting modern anxieties but also as constitutive of them. As Nicholas Daly (2004) argues, "sensation" was understood as a "keyword of modernity" (45), and the sensation novel actively participates in creating the modernity that it represents (37). Some physicians, such as Edwin Morris and Sir

[44] During the "railway mania" of the 1840s, over 8,000 miles of new track were approved, and by 1900 over nine hundred million passengers were using Britain's rail system annually. Railway travel also reshaped reading practices: from the 1850s onward, "book stalls catering to thousands of daily commuters" stocked "newspapers, magazines, and cheap, popular fiction," which became known as "railway literature" (*Broadview Anthology of British Literature: The Victorian Era*, 2nd ed., LXVI).

John Erichsen, believed sensation novels themselves were contributors to these modern afflictions (Martin 136). These novels did not merely reflect shock and overstimulation, they embodied it: creating, playing on, and inciting mental and emotional agitation in readers' minds that mirrors the destabilizing effects of a rapidly changing world. As Martin further observes, the popularity of sensation novels such as *Lady Audley's Secret* was tied to this capacity to affect readers' bodies by accelerating heart rate and stimulating the nervous system (131). Their circulation through railway bookstalls as cheap "yellow-backs" further embedded them within the rhythms and movements of railway travel (131).

Critics frequently framed sensation fiction as both a symptom and a catalyst of moral and cultural degeneration. As Badowska notes, nineteenth-century reviewers themselves "were united in diagnosing the sensation novel as a symptom of modernity" (157), and Braddon's work in particular was understood as "a sign of the times" (157). One anonymous critic claimed such works were "indications of a wide-spread corruption, of which they are in part both the effect and the cause" (qtd. in Maitzen). Another critic in 1866 in the *Westminster Review* likened the genre to "a virus… spreading in all directions" (qtd. in Fantina). In 1863, Henry Longueville Mansel in the *Quarterly Review* condemned sensation novels as life-draining indulgences, "called into existence to supply the cravings of a diseased appetite" that "foster the disease" and designed to "preach to the nerves instead of the judgment" (qtd. in Allingham). These critiques converged on the idea that sensation fiction catered to base desires, undermined moral judgement, corrupted both individuals and society and thereby contributed to the erosion of social and moral order. These criticisms aligned the genre with the very forces of degeneration and nervous disorder that modernity was feared to provoke. Taken together, these medical, cultural, and literary discourses suggest that anxieties about railway travel and nervous shock

were not confined to clinical contexts but were widely circulated and negotiated across nineteenth-century culture.

As Martin observes in their article on "Railway Fatigue and the Coming-of-Age Narrative in *Lady Audley's Secret*," general social commentary reveals an understanding that "nineteenth-century life was rapidly devolving into a dispersal of shocking events, none perhaps more shocking than the incidental events of mobile bodies in the literature of the 1860s" (136). A popular sensation novel of the day, Mary Elizabeth Braddon's *Lady Audley's Secret* (1862) embodied these very fears. Martin's (2008) reading of the novel "situate[s] Victorian anxieties about railway travel within the context of…the fatigued and nervous modern body" (131). And as Taylor writes, the novel "embodie[s] both the perils of modernity and the fear of degeneration" ("Introduction" xii). Rather than offering a comprehensive literary analysis, I situate *Lady Audley's Secret* as a cultural text that reflects and circulates broader anxieties about mobility, identity, and fraud in the context of modern technological change. While the novel has often been understood as staging femininity as unstable, excessive, and potentially deceptive (Pykett 1992; Gilbert and Gubar 1979), my interest here is in how these concerns intersect with anxieties about female mobility and modernity.

While railway crashes are conspicuously absent in the novel, the text nevertheless engages with the expanded mobility made possible by rail travel and the social consequences that follow from it. Rail travel functions as a condition of possibility for identity transformation, enabling Lady Audley to discard her former identity (as Helen Talboys) and assume a new one (Lucy Graham, later Lady Audley) in a different location that would have otherwise been inaccessible. As Martin argues, *Lady Audley's Secret* frames this "secret mobility" as a threat "not because of the visibility of women's bodies in new public spaces of the railway" but

through their “discreet and hidden circulations” made possible by railway expansion, which enable forms of movement that evade detection and verification (141; 132). The novel repeatedly situates this transformation within a framework of suspicion, as characters attempt to uncover the “mystery” of Lady Audley’s past—most notably through Robert Audley’s sustained investigation into her identity across the latter half of the novel—foregrounding identity as something that can be constructed, concealed, and potentially manipulated for personal gain (Martin 142). In this way, the narrative participates in a broader cultural logic in which increased mobility gives rise to concerns about unverifiable identities and the possibility of deception.

Within this framework, the railway comes to signify not only physical movement but also the conditions under which identity becomes unstable and difficult to verify “in the railway age” (Martin 142). The anxieties associated with railway travel extend beyond its physiological effects to encompass fears about social dislocation and the erosion of stable identity categories. As Byerly observes, travellers “found themselves in a fluid environment that lacked many of the usual markers of social class and identity” (173). Samuels further notes in *Fantasies*, “rapid expansion and urbanization taking place” in the mid-to-late 1800s “produced unprecedented anxieties regarding the knowability of identity” (2). Lady Audley’s mobility is thus positioned within a wider network of concerns about the capacity for individuals to move undetected across spaces, assume new identities, and exploit these conditions for personal advantage (Martin 132). The figure of Lady Audley, moving across social and geographic boundaries, becomes legible within a cultural discourse that “reveals anxieties about the mobilization of women's bodies” and the possibility of fraud (Martin 132).

In this context, the novel’s persistent framing of Lady Audley as an object of suspicion—in particular, through Robert Audley’s efforts to uncover the “mystery” of her identity—mirrors

contemporary medical concerns about how to interpret uncertain or unverifiable conditions. Just as physicians debated whether symptoms following railway accidents were genuine or fabricated (Morris 1868, v), the narrative structure of *Lady Audley's Secret* organizes the reader's understanding through Robert Audley's investigation, which hinges on interpreting inconsistencies and gaps in the evidence surrounding Lady Audley's identity (Vol. I, Chp. XI, "The Mark Upon My Lady's Wrist"). Suspicion thus becomes the dominant interpretive mode through which both bodily symptoms and social identities are read. As Natalie Houston observes in the Broadview "Introduction" to *Lady Audley's Secret*, sensation fiction "reveals everyone to be a potential detective, criminal, or victim—or, even more disturbingly, some combination of these roles" (29). Houston's comments underscore how uncertainty and suspicion structure perception within the genre, making identity itself something to be interpreted, verified, or doubted (29). This interpretive uncertainty is reinforced by the forms of mobility Martin identifies in which rail travel in the novel made identity increasingly difficult to detect and verify (132). More broadly, these examples suggest a recurring nineteenth-century concern, intensified by modern mobility and technological change, in which interpreting signs or symptoms becomes increasingly difficult and distinctions between victimhood and culpability harder to sustain (Samuels 1-2). At stake is the problem of how to determine where responsibility lies—whether the individual is to be understood as a genuine sufferer or as fabricating claims—a problem that, as Harrington (1996) shows, was central to medico-legal debates over railway injuries and their competing explanations in terms of physical injury, psychological shock, and imposture.

These concerns with modern technologies and the possibility of fraud find a parallel in one of "the core medical problems resulting from railway accidents" posed by Morris' *A Practical Treatise on Shock* (1868): "what should surgeons do with those intricate cases in which

there is every reason to believe the symptoms of [shocks to the nervous system] are fabricated?" (Morris v; qtd. in Martin 136). Morris thus frames the clinical problem as one of interpretation: whether to treat symptoms as genuine or fabricated. Here, the interpretive roles Houston identifies reappear in medical form, with the physician as investigator, the patient as either victim or suspected fraudster, and the clinical encounter as a site in which ambiguous evidence must be interpreted. The problem Morris articulates thus reflects the same broader cultural logic in which suspicion structures the interpretation of both bodily symptoms and social identities. As my brief discussion of *Lady Audley's Secret* sought to demonstrate, literature was actively shaping and participating in this broader cultural conversation on the effects of modern technological innovations on the body and the threat they might pose to bodyminds, while also giving voice to concerns about the role new technologies played in creating the conditions possible for fraud—particularly in contexts where claims to injury or identity were increasingly difficult to verify.

ii. "The Rebirth of Railway Spine"

While railway spine as a diagnosis faded over time, its history has been invoked in discussions of fibromyalgia. In a 1996 article, Cohen argues that the "derailment of railway spine" offers a "timely lesson for post-traumatic fibromyalgia syndrome,"[45] cautioning against the tendency, also evident in earlier diagnoses such as neurasthenia and hysteria, to collapse such conditions into psychogenic or tautological constructs. Cohen identifies that the recognition of railway spine as a diagnosis was the first time chronic back pain following minor trauma "became accepted as a cause of compensable disability" (181). The combination of back pain 1)

[45] Sometimes "fibromyalgia" is differentiated as "post-traumatic fibromyalgia syndrome" when symptoms are linked to a traumatic event that is considered a causal trigger, such as a motor vehicle accident or a history of trauma.

qualifying as a disabling condition and 2) being legitimatized as deserving of compensation is in part why it garnered such interest in the medical community. Cohen traces the evolution of railway spine to argue that conceptualizations of musculoskeletal pain syndromes (especially fibromyalgia) that assume primary psychogenesis is an epistemological error that has had profound effects.

Originally, railway spine connoted a physical spinal disorder that in the later part of the nineteenth century became "subsumed by the popular 'Neurosis' construct" where neurosis was "redefined from being an organic disorder of the nervous system to being entirely psychogenic" (181). This error, Cohen says, "enabled some writers to use 'railway spine' to bolster their argument that many other unexplained somatic symptoms must be psychogenic" (193). One of the major issues with this logic, Cohen identifies, is that a psychogenic hypothesis is untestable, and thus cannot be proved or disproved (193). Still, as I discussed above, this psychogenic assumption is the basis of Wolfe and Walitt's argument where they claim that fibromyalgia should be recognized along the continuum of psychogenic disorders like railway spine and neurasthenia.

Cohen examines the claim some physicians make that viewing railway spine as a physical disorder has "obscured the importance of psychosocial factors in the causation of disability" (181). Granting any credence to the possibility that fibromyalgia symptoms are *not* of psychological origin has been framed by the *Rheumatology* authors as enabling a patient's illness beliefs and thereby detracting from addressing their psychosocial factors, i.e. the real root cause of their pain (see "Framing Pain as a Lifestyle" in chp. 1). As Cohen's argument indicates, what has been less considered is that the opposite may be true: "over-estimating the effect of mental influence" and assuming that symptoms "are merely intensified by attention" in the absence of

objectively-verifiable symptoms makes it "easy to minimise suffering, and attribute too much to the mental condition" (195). Cohen suggests that the symptoms themselves become psychologized when the diagnosis is considered questionable or insufficient in explaining symptoms. This is exactly what occurred with railway spine which he notes came to be known as "railway brain"—a reframing intending to discredit physical symptoms and stress a psychogenic hypothesis (181).

According to Cohen, the symptoms encapsulated by fibromyalgia are, similar to railway spine and other disorders classed as traumatic hysteria, at the same risk of being regarded as "psychogenic by default" (197). Cohen's prediction that fibromyalgia will follow the same trajectory as railway spine in this regard seems accurate as Ehrlich, Wolfe and Walitt explicitly make the argument that fibromyalgia should be recognized as a modern iteration of these past disorders now ostensibly considered to be psychogenic. The linking of fibromyalgia to trauma, as occurred with railway spine, Cohen states, "introduces a fallacy which invites pejorative dismissal" and this "threatens to withdraw clinical legitimacy from those who suffer" (197). While Wolfe and Walitt invoke historical comparisons to support a psychogenic framing of fibromyalgia, Cohen similarly turns to the history of railway spine—but as a warning against precisely this move. Without heeding this warning, Cohen argues, the over-attention to "nosological issues" (i.e. how to define and classify disorders) at the expense of symptoms of pain and tenderness will result in history repeating itself and any opportunity to further understand the suffering of chronic pain and tenderness "will have been lost" (197).

The lesson of railway spine for fibromyalgia, then, is that far too much focus has been given to (untestable) hypotheses that claim its psychogenic origin and far too little attention has been paid to the symptoms of pain and tenderness that are reported. Instead, the underlying

assumption that symptoms without a discernable pathology are “purely psychosomatic” and triggered by factors such as “beliefs, emotions, culture, stress, sleep disturbance and personality” should be questioned (196). Moreover, this list of triggers is claimed to be “activated…more readily when compensation or litigation are issues" (196). Whereas the *Rheumatology* editorials consider the supposed psychogenesis of railway spine as the most important factor in current understandings of fibromyalgia symptoms, Cohen’s analysis offers another timely lesson for debates around fibromyalgia: that psychogenic hypotheses came to define railway spine in the wake of increasing compensation claims. Cohen’s discussion raises an essential question: is it that psychologically-disturbed individuals are claiming physical symptoms for secondary gain or is the psychologization of symptoms a socio-institutional response to mitigating these compensation claims?

It is impossible to disentangle proposed theories of causative factors of railway spine from discussions of compensation. Views on railway spine as a nervous disorder became more dominant as railway companies were legislated to pay accident victims compensation. In a 1916 publication on *Diseases of Occupation*, Oliver writes that these people “pretend to be the victims of serious injuries after even mild railway accidents!”; however, he also attributes this in part to the “nervous condition” following the shock (qtd. in Cohen 193). Sometimes referred to as “traumatic neurosis,” many believed that railway spine occurred following accidents when compensation was payable (193). A medical examiner of compensation claimants in England viewed railway spine as “merely a psychical condition” that was inclined toward “introspection and gross exaggeration” that “mulcted” railway companies “in large sums,” which they claim would currently be solved by “[m]odern methods of psycho-therapeutics” (qtd. in Cohen 193). There was no limit on the amount that railway companies could be required to pay in

compensation for damages. This not only led to large payments that greatly concerned the companies, but also held them accountable to the public to put in place preventative safety measures as a result of public pressure from increased damage claims.

Because of the increasing and unchecked costs associated with amounts of compensation and the burden this placed on railway companies, physicians became invested in "[d]istinguishing between those with genuine complaints and those who feigned disease and were claiming compensation following railway accidents" (Cohen 182). The "simulator of disease" was described as prone to over-act, report a detailed list of inconsistent symptoms, and greatly exaggerate their importance (182). This was of course seen as especially the case when compensation was involved. This explanation was supported by those who reportedly witnessed the "rapid recovery of the health of accident victims [following] favourable jury verdicts and payment of damages" (Cohen 184).

However, while physicians employed by railway companies touted this explanation, British neurologist William Gowers disagreed, finding that their "pain tended not to subside, even with the 'sovereign balm' of substantial compensation" (qtd. in Cohen 185). Thus, like many disorders with unexplained symptoms, railway spine was considered controversial and a potentially convenient means to dupe railway companies into providing compensation. Retrospectively, some physicians have claimed that railway spine was "hysterical neurosis, conversion type," in which psychological distress manifests as physical symptoms, "or malingering and simulation for secondary gain" (Cohen 193). This is the same fear that Morris articulated above in 1868: that symptoms of shocks to the nervous system could be fabricated for personal gain. Since fibromyalgia has been rebranded by some as "the rebirth of railway spine"

(Ferrari 2010), the characterization of railway spine as a nervous disorder that some learned to exploit for secondary gain is especially pertinent to current debates regarding fibromyalgia.

b) From Railway Spine to Neurasthenia

The argument that railway spine represents a psychical disturbance—one that exposes a weakness of the will in response to the shock of modern technological innovation—anticipates the second disorder Ehrlich mentions: neurasthenia. While railway spine was associated with trauma and shocks to the body and mind brought on by modern technology, neurasthenia emerged in the same period but persisted well into the twentieth century. It was similarly perceived as a weakness of the nerves when confronted with the pressures of modern life.

Neurasthenia was classified in the DSM-II (1968) as neurasthenic neurosis (as visualized in the chart of DSM Classifications in Figure 1). It was replaced and dispersed into a variety of anxiety and mood disorders in the DSM-III (1980). Like with railway spine, understanding the historical context of neurasthenia's emergence and its applicability to current representations of fibromyalgia is helpful in grasping how the *Rheumatology* authors place fibromyalgia on the historical continuum of hysterical disorders, within which symptoms have been psychologized and which suggest these individuals, typically women, are too mentally weak to withstand the demands of modern life. For Ehrlich, Wolfe and Walitt, who have explicitly drawn a connection between railway spine, neurasthenia and fibromyalgia, the diagnosis of FM merely represents the latest in a long line of hysterical nervous disorder diagnoses in which one's "will" to be healthy has been exhausted. Many of the characterizations of fibromyalgia patients in the *Rheumatology* articles could be mistaken for past depictions of neurasthenic patients in the nineteenth century, as I will proceed to elucidate within a brief history of the cultural phenomenon of neurasthenia.

c) Neurasthenia: A Medical and Cultural Phenomenon

Neurasthenia, or nervous exhaustion, was first popularized in 1869 by American neurologist George Miller Beard. The term, meaning "weak nerves," encompassed "all forms and types of nervous exhaustion coming from the brain and spinal cord" (Rabinbach 153). In fact, railway accidents were recognized as capable of producing shocks to the nervous system severe enough to make a person become neurasthenic.[46] The OED defines neurasthenia as "a disorder characterized by feelings of fatigue and lassitude, with vague physical symptoms such as headache, muscle pain, and subjective sensory disturbances, originally attributed to weakness or exhaustion of the nerves and later considered a form of neurotic disorder" (OED 3rd edition). A quick google search will tell you the term is now outdated but will point to what is commonly believed to be its modern iteration: chronic fatigue syndrome.

Neurasthenia was considered an urban disease. Like railway spine, it was associated with modernity. This association between nervous disorders and modern life draws on "an established tradition of medical writing that associated the rise of nervous conditions with the rise of civilization" (Logan 18). Neurasthenia became the diagnosis that encapsulated the growing number of city dwellers seeking medical care who were "seemingly healthy" aside from "experience[ing] physical pain, emotional distress, and profound exhaustion" (Schuster). Understood as a "culturally oriented diagnosis," neurasthenia explained their symptoms as a depletion of nervous energy brought on by city life (Schuster). Neurasthenia, Schuster writes, "stands as a reminder of the interaction between medicine and culture" that "helps illustrate how health care both influences and is influenced by developments in the rest of society" (n.p.).

[46] Beard believed that neurasthenia was a type of umbrella for many diseases of the nervous system within which hysteria was included, while French neurologist Charcot thought nervous states following railway accidents to be manifestations of hysteria (Cohen "Derailment of Railway Spine").

As Roy Porter writes in the introduction to Peter Logan's *Nerves and Narratives*, "nerves" are the "concepts that linked doctors with the literary world" (xii). Literary writers were steeped in this culture: they were not simply borrowing medical ideas, but inhabiting a shared conceptual terrain structured by nervous physiology. As Logan emphasizes, this is not an argument of "influence but rather that this nervous body was an integral part of the culture in which these writers lived" (22). Even when writers did not engage the body with the technical precision of medical authors, they nevertheless "could not think at all about these things without using the basic grammar of its nervous structure as the means through which the amorphousness of personal experience was organized and explained" (Logan 11).

This nervous grammar circulated widely through elite culture, popular media, and spiritual movements[47] alike. As David Schuster notes in "Neurasthenia and a Modernizing America," "incorporating neurasthenic characters into fiction also became vogue," with authors such as Edith Wharton, Theodore Dreiser, Henry James, Thomas Mann, and André Gide—"many of whom," he claims, "were neurasthenic themselves"—"all exerting a powerful influence over the popular understanding of the illness" (Schuster 2328). Edith Wharton's early short fiction, for example, treats neurasthenia as a socially produced condition linked to urban modernity, technological change, and gendered expectations. Said to suffer from neurasthenia herself, her later stories such as "A Cup of Cold Water," "A Journey," and "The Reckoning" use interior narrative techniques in her sympathetic stories of neurasthenia to humanize and explore the unique neurasthenic consciousness in her female protagonists (Ohler "Intimacy and Neurasthenia in Edith Wharton's Early Stories"). Authors like Wharton thus actively shaped how neurasthenia was understood by the general public. As Schuster states, understandings of

[47] For instance, Schuster observes that adding to this influence was "Christian Science and Emmanuel movements" which "gave the diagnosis a spiritualist edge by claiming to be able to heal the illness through religious faith" (n.p.).

neurasthenia were shaped by a multitude of influences: "[e]ncouraged by medical professionals, modeled by the social elite, contained within the pages of popular fiction, and showcased by religion, the disease became broadly defined by physicians and the general public alike" (Schuster 2328). Literature thus both responded to and actively took part in defining the condition with industrialization and modernity reshaping how writers understood the body, energy, and fatigue.

i. "fibromyalgia, the neurasthenia of the late 20th century"

The emergence of neurasthenia as a cultural phenomenon can be better understood when situated within a shifting paradigm in late eighteenth- and nineteenth-century Europe in which medical, moral, and economic discourses increasingly portrayed productive physical labor as the normative ideal toward which individuals in a capitalist society should strive. To fail to be sufficiently productive in such an environment was not only regarded as a moral sin, but was also considered anti-rational, anti-society, and even anti-human. In *The Human Motor*, Rabinbach explains how by the last decade of the nineteenth century, fatigue experts, laboratory specialists, and the new science of social hygiene intersected in the creation of a new field of expertise that applied empirical research and rational principles to the human body in an attempt to cure social problems and protect the social body from perceived threats.

Prior to 1860, fatigue received very little to no attention in the medical or scientific community, but by the late 1800s "the U.S. Surgeon General's index listed more than one hundred studies of muscle fatigue, as well as numerous studies of 'nervous exhaustion,' 'brain exhaustion,' 'neuresthenia,' and 'spinal exhaustion'" (Rabinbach 20). This range of mental and/or physical fatigue disorders were classified as diseases of the will ("les maladies de l'energie"). These diseases of the will became the subject of an outpouring of scientific, medical,

and popular literature (20). Beard's version of neurasthenia specified that it was 1) characterized by profound mental and physical fatigue 2) most common amongst intellectually demanding professions, and 3) a product of the increasing demands and activities associated with modern civilization. Considered the malady of the day in the 1880s, neurasthenia represented the most acute form of mental fatigue at a time when fatigue was increasingly associated with the demands of modernity (Rabinbach 153). Accordingly, neurasthenia was unquestionably seen as a "disorder of a modern civilization" and in Beard's estimation a "pathology peculiar to the American continent and unique to the American life style" (Rabinbach 153). Indeed, a more recent 2016 article published in *The Atlantic* refers to neurasthenia as "Americanitis: The Disease of Living Too Fast"[48] (Beck).

Neurasthenia shares similar descriptions to fibromyalgia. It was considered an "unstable mimesis of other maladies" with a "protean symptomology" (Rabinbach 159-60). It "frequently resembled both hysteria and melancholia" and Freud notes that "hysteria and neurasthenia were often combined" (Rabinbach 160). Beard also subsumed hysteria and hypochondriasis within neurasthenia, according to British psychiatrist Simon Wessely (1990), who argues ME (myalgia encephalitis) is the modern-day neurasthenia in "Old Wine in New Bottles" (40). Andrew Scull (2009) in *Hysteria: The Disturbing History*, too, states that "[c]hronic fatigue syndrome has an obvious overlap with the neurasthenia of the late nineteenth century" (139). In attempting to draw a link between neurasthenia and ME, Wessely explains how efforts to distinguish between neurasthenia and hysteria portrayed neurasthenic patients as "deeply concerned about their condition and eager to cooperate," while "hysterics were accused of evasiveness" or "even

[48] Popular commentary sometimes satirized neurasthenia as a condition of modern urban life— occasionally dubbed "New York-itis" in late nineteenth-century humor and pamphlet literature—underscoring the extent to which the diagnosis circulated in public discourse (Lutz 1991).

intentional deception" (Wessely 40). In effect, patients were placed in a binary of compliant and submissive neurasthenics versus the non-compliant and uncooperative hysteric. This distinction sounds suspiciously like the one formalized in the most recent DSM-V, which differentiates factitious disorder and malingering from other related disorders through its emphasis on intentional or conscious deception as depicted in Table 1 in chapter 1.

Wessely reckons the idea that the neurasthenic is "more appropriate in their behaviour" stems from a recognition on the physician's part that they occupy the same class status as their patient (40). Neurasthenia was considered common amongst intellectually demanding professions and this commonality aligned physicians with their patients, which perhaps resulted in a more generous interpretation of their patients' behaviour (40). This reveals how attempts to parse hysteria and neurasthenia, both of which shared similar symptomology, relied heavily on a combination of the physician's assessment of one's behaviour and the identity positions that situate one within a neurasthenic or hysteric diagnosis. Distinctions between fibromyalgia and chronic fatigue syndrome have similarly been subject to physician interpretation of symptoms and behaviour. Wessely has suggested elsewhere (1999) that fibromyalgia shares more in common with chronic fatigue syndromes than not and claims "[t]he distinction between fibromyalgia and CFS is largely arbitrary, and both overlap with affective disorder" (cited in Shorter 374). He further implies that attempts to "divide fatigue and myalgia syndromes" by medical specialty is as debatable as it was considered at the time to divide neurasthenia by the organ afflicted (1989; 1990, 37). Therefore, while I will be referencing neurasthenia and fibromyalgia specifically, neurasthenia's association with hysteria, and fibromyalgia's with chronic fatigue syndrome, are not as distinct as their diagnoses suggest and certainly not in the minds of the doctors who do the diagnosing (as Wessely's comments demonstrate). Ehrlich

makes his understanding of the imbrication of these disorders clear when he refers to "the closely related chronic fatigue syndrome" as FM's "cognate" (1666-67).

Like neurasthenia, fibromyalgia has been cast as a condition particular to modernity. In the first sentence of his 1997 article, Frederick Wolfe claims that "Fibromyalgia (FM) is prevalent in all industrialized countries" (1247). Published in response to Crofford and Clauw's "Fibromyalgia: where are we a decade after the American College of Rheumatology classification criteria were developed?", George Ehrlich also pinpoints FM as existing "in some, mainly urban, cultures, mainly in advanced and industrialized nations" (276). Gordon has further reiterated in a report to the Ontario Workplace Safety and Insurance Appeals Tribunal (WSIAT) that the diagnosis of fibromyalgia might be evidence of a "broken urban society" (3). Because fibromyalgia's predominant symptoms of pain and fatigue remain medically unexplained and have been associated with features of modernity, this has led some to claim "fibromyalgia [is] the neurasthenia of the late 20th century" (Quintner and Cohen 1093). Evidently, the narrative that fibromyalgia is a disease of modernity, activated by the pressures of modern life, became a common refrain. In fact, the purpose of White and Thompson's study which prompted the rash of 2003 *Rheumatology* editorials was primarily to test the theory that FM is a disorder of modern society and driven by the media. In their objective, the study explicitly states that the rural Amish community was chosen to compare the prevalence of chronic pain and fatigue to non-Amish rural and urban controls.

ii. "the sensibility trembles at every breath": A Problem of Coping

One of the most significant claims the *Rheumatology* authors make that frames fibromyalgia as a disorder of modernity and links it to the past medical diagnosis of neurasthenia is their insistence that FM represents a problem of coping with the stresses of modern life. As I

outlined above, neurasthenia was fundamentally considered a disease that afflicted individuals who could not cope with the increasing pressures of urbanization and modern society. And as I discussed in chapter 1 in my analysis of Showalter's *Hystories,* she likens conditions such as fibromyalgia (lumped together with CFS) to "epidemics" that not only threaten to spread like a contagion but are also seen as indicative of an inability to cope with modernity. For instance, in a section of her chapter labelled "From American Nervousness to Epidemic Fatigue: How it Began," Showalter places chronic fatigue syndrome along the continuum of neurasthenic disorders, calling CFS a new form of "effort syndrome" (119). Just as neurasthenia was once framed (and as CFS and related disorders are framed by Showalter), fibromyalgia has similarly been represented as an inability to cope with the pressures of modern life.

Nortin Hadler continually makes this suggestion in his 2003 editorial in which he claims that patients with FM "have exhausted their wherewithal to cope" (1669). Much of this short two-page editorial focuses on the issue of coping with Hadler mentioning variations of the term ten times. Hadler explicitly ties fibromyalgia to an inability to deal with what he perceives as "normal" life stressors. He states that those with chronic widespread pain are "bedeviled by life challenges" that make any efforts towards wellness a "Sisyphean" task—or, in other words, requiring great daily effort with a futile outcome. Whereas most people prevail against the "morbid predicaments of life," those "living under this pall" of widespread pain find life challenges so "insufferable" that they pose "unforgettable setbacks" (1668). It is because of their apparent fixation on undesirable life events that their noting of symptoms is described as amplified and carrying more import than Hadler deems these symptoms deserve. He mocks that "variations in bowel habits are very concerning, and diminished vigor seems oppressive. There is no *joie de vivre* [joy of life]" (1668). Aside from minimizing the symptoms of fatigue and pain

these individuals are reporting, Hadler is also suggesting that a positive outlook on life acts as a kind of buffer against life challenges.[49] The reason these other people cannot cope is because of their inherent pessimism that manifests in an abnormal "magnification of [bodily] symptoms" (1997, 1251).

Hadler is effectively setting up a binary between "normal" individuals who can cope with life's stressors versus those perceived as weak due to an "abnormal" preoccupation with themselves and challenging life events. Hadler reckons those in the latter group are unable to "cope with their pain" because they are "overwhelmed by confounders that lurk in the psychosocial context in which their pain is suffered" (2003, 1668). Wolfe and Walitt (2013) have also described fibromyalgia as a "psychocultural disorder" which they define as one "that is shaped primarily by psychological factors and societal influences" (751). Hadler identifies that these main psychological factors are "anxiety or depression" which he states those who reported persistent pain were four times more likely to suffer from in comparison to patients without persistent pain (1668). While there may be a correlation between chronic pain and psychological components, as would presumably be the case with many chronic illnesses, Hadler heavily implies that psychological factors are a causal factor in persistent pain conditions. He does not consider that untreated or undertreated chronic pain could in turn cause depression and anxiety. Hadler, like his colleagues, only consider causation to go in one direction—where psychological factors cause physical symptoms, rather than the inverse. This causal factor is allegedly responsible for weakening a person's resilience to pain, leading to "compromised coping that causes patients to seek care in the first place" and to "[choose] to be patients" (1669).

[49] Similar reasoning appeared in medical discourse on childbirth, where physicians often attributed the severity of labor pain to women's fear or emotional state, suggesting that proper preparation or attitude could mitigate suffering (Wolf 2009).

In keeping with this simplistic binary Hadler has constructed between appropriate and normal responses to pain and modern life stressors versus abnormal preoccupations with the same, he offers the following commentary:

> Regional musculoskeletal pain is an intermittent and remittent predicament of normal life. Feeling "well" demands the sense of invincibility that we can cope with our next musculoskeletal morbidity. Being well symbolizes our triumph that we had the wherewithal to cope with the last episode for as long as it took for that episode to remit, to cope so well that the episode is barely memorable, if at all. Being well does not mean avoiding the challenges of regional musculoskeletal disorders; that is not possible. These challenges are as much a part of life as heartache, heartburn, headache, and the like. (Hadler 2003, 1668)

It is clear in this narration that Hadler is placing all experiences of pain as a normal and unavoidable part of life. While pain certainly is part of life and does serve a useful and vital survival function, Hadler is rather dismissively lumping chronic pain into this equation. I would even suggest Hadler is implying that overwhelming chronic pain only exists insofar as an individual is overly focused on its symptoms and lacks the ability to cope, thus magnifying the symptoms beyond their actual reality. Pain is also situated as something that all individuals must contend with in a battle that we either "triumph" over or face defeat from, based on our own coping mechanisms. In this way, triumphing over pain represents a type of moral achievement which those who fail must lack the wherewithal to obtain. Moreover, since pain is posited as a normal part of life that cannot be avoided, those who are defeated by it are framed as too weakened by their own mental state to cope with this normal part of life. Hadler talks about pain as if it is symbolic for weeding out the mentally fit who "cope so well that the episode is barely

memorable, if at all" and those who are less mentally fortified so as to buckle under the strain of normal human experiences and therefore convince themselves they are unwell. "These patients" are further assumed to be under the impression that "being well" means living a pain-free life, as if the minor intermittent aches and pains Hadler references are representative of the pain those with fibromyalgia are reporting (1668).

Hadler's comments are in line with beliefs on medicalization that were put forth in Ivan Illich's 1976 book *Medical Nemesis*, which Wolfe references in his 2009 publication: Wolfe states that Illich's "attacks on medicalization in society set out some markers that are germane to understanding FM and opposition to it" (673). Illich's core argument is that modern society has impaired quality of life by overmedicalizing normal human experiences. This overmedicalization of life has resulted in undermining an individual's capacity to cope independently which fosters dependency on experts rather than encouraging self-reliance. Illich termed this process iatrogenesis. Illich's book devotes a chapter to pain, which argues that in modern society "[p]eople unlearn the acceptance of suffering as an inevitable part of their conscious coping with reality and learn to interpret every ache as an indicator of their need for padding or pampering" ("The Killing of Pain" n.p.). Hadler's remarks mirror Illich's in that he also frames reporting of persistent pain as a desire to be entirely pain-free which they both see as a hallmark of "cosmopolitan medical civilization" ("The Killing of Pain"). Modern society, they both argue, has lost the perception that pain offers inherent value, which they state was a fundamental part of traditional cultural views of suffering.

It is worth paying a bit more attention to Illich's comments about the role of pain in traditional cultures for how he structures the experience of pain as an expectation that it is something to be endured individually and how he positions resilience as a virtue. Illich believes

that pain should be approached as a challenge, not "managed or produced out of existence" (n.p.). One of the ways individuals are able to cope with this challenge is by "integrating it into a meaningful setting" which is to interpret the value of its necessity to life rather than "annihilate it" (n.p.). Illich emphasizes that pain is an individual's problem, one that is intended to test their fortitude and expression of virtues such as "[p]atience, forbearance, courage, resignation, self-control, [and] perseverance" ("The Killing of Pain"). In traditional cultures, "[p]eople knew that they had to heal on their own, to deal on their own with their migraine, their lameness, or their grief" and individuals learned various routines to "enable pain to be borne with dignity" ("The Killing of Pain").

Illich raises some interesting points that underscore essential underlying beliefs in the *Rheumatology* articles representation of fibromyalgia patients. One point is that pain and suffering should be endured *quietly*. No complaining. Another is that pain should be endured *individually*. The individual, alone, is responsible for finding methods to deal with their own pain. Pain then takes on a meaning far beyond the simple experience of it. When pain is placed within this interpretive schema, the endurance of pain signifies one's moral character which is surmised through an in/ability to cope with stressors. Being able to cope with pain is a virtue; being unable to cope with pain is a failure of the individual in modern society. Seeking care (or attention) for pain, therefore, marks one as neither enduring quietly nor independently. It reveals a failure to rise to the challenges brought on by pain. Modern society (or cosmopolitan medical civilization as Illich refers to it) has contributed to undermining the individual's coping mechanisms for suffering by offering the potential (or temptation) to alleviate pain. By offering a way out of pain, modern society has inadvertently weakened individuals' coping skills, to which particular types of people, mainly women with "fragile personalities" (Ehrlich "A Virtual

Disease" 10) are ascribed as more susceptible. Logan noted the same inclination in the early nineteenth century writings of Thomas Trotter to associate susceptibility to nervous disorders with the "greater delicacy and sensibility" of the female body (Logan 23; Trotter 49). As Logan writes, this weakness was most apparent in "the urban female" where Trotter states, "the sensibility trembles at every breath" (Logan 23; Trotter 36). Ironically, while these authors are arguing that an individual's wherewithal to cope is compromised in a modern society that has lost key values of traditional cultures, modern capitalism under its neoliberal iteration stresses these exact same values of the independent, autonomous self-supporting and resilient individual. This is an essential point to which I will return in the next chapter.

I have already discussed in chapter 1 the *Rheumatology* authors' views on medicalization and their beliefs that medical labeling has created FM by pathologizing normal, everyday experiences. However, key to their arguments against medicalization is their view that it leads to compromised coping and the loss of the ability to deal with life's challenges. Medicalization, and the option for treatment that might arise as a result, are therefore posited as "counterproductive to coping" (Hadler 1997, 1251). Hadler and Greenhalgh (2005) bluntly state that "[w]hen people with persistent widespread pain seek care, it is because they have exhausted their wherewithal to cope and are casting about for attention to their suffering" (3). Hadler is clear that he perceives "symptoms of persistent widespread pain…as likely surrogate complaints to psychosocial confounders to coping" (1669). Thus, pain is not really the issue. It is not that these individuals cannot cope with their pain and other symptoms. Pain is merely a substitute for the real psychological variable that impedes appropriate coping. Medicalization is a problem in this case because "[t]he medical contract demands specific treatment for the cause of the pain" which Hadler says is "groundless" in cases of chronic pain since "typical treatment acts overlook the

compromised coping" that is the original underlying factor in patient's seeking care (1669). Hadler repeats this sentiment several times in his 2003 editorial stating that a compromised "wherewithal to cope" replaces any "pain and biomechanical" weakness in driving people to seek care (1668). The solution in this case is not to offer treatment or a diagnostic label, but to "directly [approach] the challenge to coping" (1668).

The Amish community that was chosen for White and Thompson's study was selected in large part for their value of independence (1836). For this reason, these community members were viewed as unlikely to seek financial assistance from external sources. This value of independence—along with self-reliance and self-sufficiency—is treated by Illich, and echoed in White and Thompson's framing of the Amish community, as characteristic of what is imagined as "traditional" cultures rooted in religious ways of life. Fibromyalgia patients who exhibit this so-called "compromised coping," and may seek care or support from external systems as a result, are situated in opposition to these values. However, what is perceived as their failure to value independence is coded as a psychological shortcoming that makes it unbearable to cope with everyday stressors that distinguish modern life.

In *Gendered Pathologies,* Sondra Archimedes (2012) explains how in the nineteenth century "[s]cientific discourse reproduced bourgeois moral codes, concealing religious and social beliefs behind a face of objectivity" (24). And Rabinbach observes that "[n]owhere is this attempt to replace moral discourse with science more evident than in the discovery of fatigue by European physiologists" (6). The language of coping used in these editorials' pinpoints an inability to cope as a mental pathology: that is, they do not blame the individual, but they do suggest that an individual's coping mechanisms are defective. Conceiving of the body/mind as a type of machine, there is a malfunction in the individual's ability to cope that must be repaired.

The doctor is then poised to intervene by diagnosing the mental affliction causing their physical symptoms which are presumably manifesting as a maladaptation to modern societal pressures, or a weakness of coping. This puts the problem of coping in biomedical terms. However, behind this biomedical explanation of coping lies the unspoken virtues of self-reliance, self-sufficiency, and independence—values Illich attributes as essential to many traditional cultures (n.p.). These also happen to be fundamental principles of capitalist societies. Therefore, an individual's inability to cope indicates a corruption of values, a deviance from the expected ableist norm or standard. In this way, the problem of coping is a modern vice that is allowed to flourish in modern society and must be corrected.

Thus, compromised coping in fibromyalgia patients is considered both a pathology and a moral failing, the latter of which is concealed behind a discourse that emphasizes an individual's weakness in the face of modern pressures but which implies their lack of commitment to ideals of independence, self-sufficiency and self-reliance. Like with neurasthenia, the stresses of urbanization afflict fibromyalgia patients whose constitution is too feeble to withstand the demands of modern life. Gordon essentially says as much in his report to the WSAIT when he reiterates an Alberta judge's 1995 opinion that "individuals with FM cannot cope with everyday stresses of life and convert this inability into physical symptoms to avoid dealing with reality" (qtd. in Gordon 7). The viewpoint of this judge is specifically cited in White and Thompson's article when referring to those who believe fibromyalgia is driven by "an overly liberal disability compensation system" (1835). Ehrlich further refers to symptoms as "distort[tions]" that reflect "social maladjustment" ("A Virtual Disease" 10). Fibromyalgia symptoms are thus reconfigured as merely an inability to deal with life.

iii. The Unreliable Narrator

Aside from the predominant view of neurasthenia as a weakness of the will, other specific features marked the nineteenth century neurasthenic that coincide with those of fibromyalgia patients. According to nineteenth century social hygienist Adrien Proust and French psychiatrist Gilbert Ballet,[50] neurasthenics presented with "mental symptoms" and "physiological manifestations like persistent *headache…dyspepsia*[51] from gastrointestinal atony,[52] *insomnia*, and 'hyperasthenia,' or *exaggerated sensitivity of the skin to pressure*," along with the "chief complaint" of the "perpetual sensation of *fatigue*" (Rabinbach 159; emphasis added). The symptoms I have emphasized in italics are remarkably akin to the charted symptomology of fibromyalgia: depression and anxiety; headaches, including migraines; sleep problems; fatigue; pain and stiffness (in part assessed by applying pressure to the skin via the tender point test); and possible digestive problems (CDC[53]). This overlap is clearly one that the *Rheumatology* authors have observed, too, with their claims that the diagnostic label FM has replaced the outdated neurasthenia.

Other traits that are categorically less objective include characterizations of the neurasthenic as "a disease of the unreliable subject" (Rabinbach 161). Neurasthenics are labelled as "frequently preoccupied with the minutiae of their condition, producing ever-more elaborate self-diagnoses" with "descriptions [that] were notoriously deceptive" (159). German psychiatrist Emil Kraepelin wrote in 1902 that "[t]here is a tendency to pay undue attention to trifling

[50] Gilbert Ballet worked as Head of the famous Salpêtrière under French neurologist Jean Martin Charcot. Adrien Proust was the father of novelist Marcel Proust, who suffered from chronic asthma at a time when such conditions were often interpreted as nervous disorders associated with neurasthenia. Adrien Proust himself later co-authored a study of neurasthenia with Gilbert Ballet (1897) (Bogousslavsky 2007).
[51] Dyspepsia in lay terms is known as indigestion.
[52] This is also known as ileus and refers to a disruption to the intestine's ability to propel waste out of the body.
[53] At the time of writing, the CDC's listing of symptoms is the first google result with the search term "fibromyalgia symptoms."

symptoms which may appear in any organ" (qtd. in Wessely 42). This characterization of the neurasthenic as hypervigilant of symptoms with the intention to deceive underscores that the distinction between neurasthenia and hysteria is less clear-cut than is suggested above. Hysteria was more explicitly associated with intentional deception and this was one of the key descriptors that distinguished it from neurasthenia, according to Wessely (40). Yet, describing the neurasthenic's reporting of symptoms as "notoriously deceptive" indicates neurasthenia was not immune from this characterization and therefore the distinction between these two disorders is, at times, blurred. The description of neurasthenia as an unreliable narration reflecting a hypervigilance of bodily symptoms returns us to Ehrlich's (2003) account of the FM patient as overly preoccupied with "all manner of associated symptoms or nonsymptoms" as a result of being hyper-focused on "*her*self and *her* discomfort" (1666; emphasis added).

Ehrlich's reference to the gendered nature of fibromyalgia patients ("herself and her discomfort") is similar to how some neurologists felt about neurasthenia. Although there were those who believed neurasthenia was more prevalent among men than women (Rabinbach 157), others such as Kraepelin wrote that in addition to being a product of civilization and afflicting the professional classes, it was also confined to "women of the middle classes" (Wessely 38). The claim that neurasthenia mainly affects white, middle-class women has also been made about CFS. As discussed in chapter 1, Showalter's description of the CFS patient narrows in on white women, claiming that "90% of those diagnosed are white," approximately 75-80% are women, and that CFS is not diagnosed among ethnic minorities (127). However, a 1999 community-based study on the prevalence of CFS among different population groups found that differential access to healthcare across the categories of sex, ethnic identification, and socioeconomic status might explain this discrepancy (Jason et al.). Instead, their study found the incidence of CFS

commonly occurred across ethnic groups and did not support earlier claims that CFS affects primarily white, middle-class individuals. What is important here is the perception that CFS and neurasthenia affected particular groups of people based on gendered notions of weakness in the face of mounting intellectual or societal pressures.[54]

Many of the conditions listed in the DSM that I covered in chapter 1—particularly those that fall under the somatic symptom and related disorders— repeat this viewpoint articulated by Kraepelin that patient narratives are unreliable for the individual is abnormally or excessively fixated on their symptoms. Moreover, the ostensibly deceptive oration of the neurasthenic's symptoms evokes Wolfe's (1997) claims that FM patients have been routinely caught "feigning illness" for the purposes of receiving compensation. In a 2000 editorial Wolfe explicitly ties fibromyalgia to deception with the title "Sayin' 'stand and deliver, for you are a bold deceiver': faking fibromyalgia" (*Journal of Rheumatology*). Such portrayals of fibromyalgia patients have not abated in more recent years, as Vyshali Manivannan (2017) demonstrates in "What We See When We Digitize Pain," where she critiques the persistent framing of the fibromyalgic patient as "an unreliable narrator, already suffering from an unreliable disease" (2).

Similarly cast as the unreliable disease of an unreliable narrator, "[n]eurasthenia created a dilemma for the physician: a virtual maze of shifting and unreliable 'objective' symptoms and even more unreliable 'subjective' monologues in dire need of the trained eye and ear" (Rabinbach 159). These comments reflect the radical paradigm shift in late eighteenth- and nineteenth-century medical views of disease as Foucault famously documented in *The Birth of*

[54] See Whitney Wood, "'The Luxurious Daughters of Artificial Life,'" for a detailed discussion of how gendered constructions of women's "frailty" and "delicacy" shaped assumptions about women's susceptibility to pain, often linked to critiques of "pampered" lifestyles, in the late nineteenth century; see also Love and Sanderson (2023), who illustrate that in the decades surrounding *Machinal*'s 1928 publication, these assumptions persisted in medical and media discourse on childbirth, where women's susceptibility to pain and nervous exhaustion was attributed to race, class, and intellect, with particular emphasis on educated, upper-class white women under the perceived pressures of modern life (182).

the Clinic. In earlier medical frameworks, the patient's account of symptoms formed part of a broader effort to understand illness. Foucault shows that the emergence of clinical medicine reorganized this relationship by shifting attention away from the idea that disease is mobile to instead focus on particular sites within the body where pathology was presumed to be located. He illustrates this shift through a change in the central diagnostic question—from "What is the matter with you?" to "Where does it hurt?"—a transition that privileges the observing gaze and what can be seen over what is said (xxi). With this shift, the patient's account of symptoms was increasingly subordinated to the clinical gaze, which, as Foucault notes, "silently lets things surface…without disturbing them with discourse" (xxi).

In turn, disease gradually took priority over the patient, whose voice receded into the background. Patient testimony was thus reconfigured: no longer central to identifying disease, but secondary to the clinician's task of locating pathology, and, as Archimedes suggests, increasingly devalued within a framework that privileged the physician's interpretive authority (7). As Archimedes further explains, "the shift, then, was from healing the invalid to finding the disease" (7), underscoring how the patient's experience was displaced by the pursuit of pathological evidence. The patient was thus increasingly treated as a bodily vessel harbouring a hidden disease—figuratively split from their own body as that body came under the purview of the medical gaze—and "the doctor became a glorified sleuth acting upon an object rather than a subject" (7). As a result, Archimedes states, "the doctor became a privileged authority," tasked with locating a disease that had "assumed a heightened value," which in turn "[justified] the specialized authority of the [doctor as] 'expert'" (7).

Bestowed with such power, the doctor, not the patient, is granted privileged access to knowledge of disease and their expert-informed 'objective' narration supersedes the unreliable

narrative of their patient. The neurasthenia or fibromyalgia patient, then, is subject to the physician's attempt to tame their unruly and subjectively-biased narratives into a coherent order. Within this medical epistemology, all so-called complaints of symptoms are easily written off as unimportant "lamentations of the invalid" (Rabinbach 159) who is not very good at accurately describing their symptoms anyway, and who might be more interested in deception. In the absence of the physician's desire for objectively-verifiable criteria as a means to diagnose these patients, the doctor relies on their own "interpretive schema" to lend a comforting stabilizing narrative to a supposed chaotic presentation of symptoms (Rabinbach 160). This inclination to stabilize irregularity into a regular order echoes Trotter's attempts to do the same: "[l]ike his predecessors, Trotter uses the concept of predisposition"—that individuals are predisposed to nervous disorders as a result of an inherent susceptibility—"to tame the protean shape of nervous disorders" (Logan 21). Logan observes that it is not the "manifest disease itself" but rather attention to this prior susceptibility that is the subject of Trotter's book on nervous temperament. Accordingly, Porter's introduction to *Nerves and Narratives* emphasizes that while "Victorian narratives sought to overcome the difficulty of the hysterized body" they were also preoccupied with solving "the unreliable tale" (xiii).

5. Conclusion

As this discussion has illustrated, what once were descriptors that enveloped the neurasthenic in the nineteenth century have been conveniently remapped onto those with fibromyalgia and predominantly pain and fatigue-related disorders. Whereas neurasthenics' energy reserves were depleted by modern civilization, fibromyalgics are said to suffer from a psychological feebleness rendering them unable to endure their modern environment. Whether it is cast as nervous exhaustion, a weakness of the will, or a lack of wherewithal to cope, these

descriptors suggest these people are maladjusted to the modern world, their constitutions (or nerves) weakened by urban realities to which they ought to be able to adapt, and their bodyminds unfit for their modern environment. This type of eugenic language, focused on (mal)adaptive behaviours and personalities, permeates the *Rheumatology* authors' descriptions of fibromyalgia just as it once did with neurasthenia.

I will briefly return to how eugenic terminology infuses discussions of fibromyalgia when I address the *Rheumatology* authors' claim in the next chapter that fibromyalgia is an out-of-control epidemic and economic threat, before taking up this issue more fully in chapter 6. And I will further discuss how pain is invalidated as a solution to suspected malingering in chapter 5. What I want to underscore, currently, is how fibromyalgia pain is marginalized by claiming that it reflects a failure to cope with modern life stressors. This claim is underscored by placing fibromyalgia along the continuum of hysterical disorders that were likewise framed as disorders of modernity. Furthermore, the *Rheumatology* authors locate this inability to cope within a particular type of anxious female who is overly preoccupied with her bodily symptoms and whose narration of her symptoms is inherently unreliable. In the next chapter, I extend this analysis of the physician's attempts to tame the individual's seemingly chaotic symptoms, arguing that such attempts reflect an emerging cultural preoccupation in which the body is treated as a signifier of social dis/order, and the fatigued and pained body is read as a sign that undesirable symptoms threaten to infect a society predicated on ideals of unlimited progress and productivity.

Chapter 4:
Inactivity is the Greatest Enemy of Progress

1. Introduction

By expanding on the *Rheumatology* authors' rhetorical alignment with historical nervous disorders in the previous chapter, I can further contextualize the portrayal of fibromyalgia patients as malingerers within a longer genealogy in which pain and fatigue-based symptoms have been repeatedly interpreted as signs of a disordered work ethic and moral failing. Where the previous chapter focused on the implicit claim that fibromyalgia is motivated by secondary gain, this chapter extends that analysis by situating such suspicions within a broader moral economy that ties human worth to value-laden notions of citizenship, productivity, and independence. As with earlier nervous disorders, fibromyalgia is situated within this continuum of conditions characterized as threats to a progressive civilization organized around these same values.

Within this framework, I consider how the disabled figure is constructed as a failed citizen by being pitted against an able-bodied norm of the ideal neoliberal subject—a waged worker who conforms to normative standards of productivity, autonomy, and independence. In such frameworks, broader social and economic structures that produce illness, precarity, or exclusion are obscured, and these structural failings are instead reconfigured as an individual's failure to cope. Those with invisibilized illnesses are then subject to societal ideals that invest value in people's lives based on these norms. In analyzing the *Rheumatology* texts, I trace how these same ideals are implicitly invoked in their discourse. I treat as "rich features" these recurring ways the texts attach moral and civic value to bodies—particularly through their implicit appeals to independence, productivity, progress, and work ethic. I have grouped these

features into thematic clusters (organized into subheadings) that foreground the normative ideals against which fibromyalgia patients are measured.

As a predominantly pain and fatigue-related disorder, fibromyalgia is especially vulnerable to this moralizing logic. I examine how contemporary fibromyalgia discourse reproduces earlier characterizations of neurasthenia in which pain and fatigue, as markers of "inactivity," were framed as enemies to neoliberal values and a threat to ideals of unlimited progress. Fibromyalgia patients are positioned in opposition to these values: they are regarded with suspicion and the diagnostic label itself comes to signify an inverted work ethic. This diagnostic label, the *Rheumatology* authors allege, enables individuals to evade work and withdraw from productive participation in society. Accordingly, the *Rheumatology* articles under analysis demonstrate a fear that the diagnosis of fibromyalgia paves the way for public dependency as they position their patients as unworthy burdens on the healthcare system and undeserving of social supports. I end this chapter by examining the *Rheumatology* authors' claim that the so-called dependency of fibromyalgia patients on public supports has reached epidemic proportions—a concern that I argue has roots in eugenic ideology. This framing of fibromyalgia, like characterizations of neurasthenia, reveals a cultural anxiety that these conditions threaten to undermine the moral and economic foundations of a society organized around productivity and progress and have become a serious economic threat that must be brought under control.

2. Enemies of Progress: Pain and Fatigue

Building on what I noted in the previous chapter, medical discourse often seeks to impose order on unruly symptoms. In the nineteenth century, attempts to bring symptoms into some semblance of order under the diagnostic label of neurasthenia reflect the larger sociocultural

milieu within which the social hygiene movement[55] "sanctioned the view that society was best served by equilibrium and threatened by chaos" (Rabinbach 206). As Archimedes writes, in a medical culture that privileges pathology "over other aspects of physical functioning…the body becomes an important, malleable signifier…for widespread cultural anxieties" (7). The fatigued body of the neurasthenic, then, in all its chaotic rendering, reveals a cultural anxiety regarding the body: the fear that a pathological degree of fatigue was infecting the social body to an extent that threatens to undo a society predicated on ideals of unlimited progress and productivity. The neurasthenic represented everything that society envisioned was undesirable to a progressive future and attempted to cast out. At the same time as fatigue garnered increasing attention with studies accumulating in medical journals, the collection of statistics on crime, deviance, mortality, and morbidity also proliferated.[56] This "increased knowledge," Rabinbach argues, "reinforced the shared perception that cultural crisis was reflected in the rise of both physical and social pathologies" (22). Quoting historian Georges Canguilhem, Rabinbach conveys that it is "[t]hrough the lens of the pathological—as if through a magnifying glass—the truth of the healthy condition is decoded" (22). Increased surveillance of supposed pathology and crime thus acted as a means to uncover the proper, or normal, way forward.

Given these anxieties about fatigue as a threat to industrial productivity and progress, it is perhaps unsurprising that neurasthenia was cast as firmly rooted in so-called developed nations while simultaneously framed as an "atavistic [sensibility]" of "primitive societies" (Rabinbach 171–72). This reflects an evolutionary logic in which 'civilized' nations were aligned with

[55] The language of "social hygiene" circulated widely in late nineteenth- and early twentieth-century public health and reform movements and was intertwined with eugenic ideas about managing social degeneration and population "fitness." Please see the definition of ableism provided in the introduction chapter, which identifies such logics of fitness as rooted in eugenic systems that structure how bodyminds are valued.

[56] On the rise of statistical thinking about populations in the nineteenth century and the emergence of the concept of the "norm", see Lennard J. Davis, *Enforcing Normalcy: Disability, Deafness, and the Body* (1995), especially the chapter "Constructing Normalcy." I further discuss Davis and the norm in chapter 5.

progress, productivity, and advancement, and 'primitive' ones with stagnation and decline. Neurasthenia was viewed as undesirable for the individual, but also for society as a whole. It signified degeneration. Framed in such terms, the neurasthenic was wholly unwelcome and unsuited to a progressive and productive civilization of the future. In fact, because the particular nervosity of neurasthenia was characterized as maladaptive to society and antithetical to future civilization, some, such as Kraepelin, advocated for "a system in which the 'unsuitable' would be left behind," so that, in his own words, "the path would be open to a new species more capable of performance" (Rabinbach 151-52). Kraepelin's formulation articulates eugenic ideology in its emphasis on eliminating the 'unfit' to secure a more productive and 'fit' future population. Other social hygienists such as Adrien Proust "maintained that Europe had to be 'defended' against subversion from within and without" and configured the "litany of social pathologies" as a threat to the nation and a sign of "national decline" (Rabinbach 207). This fixation on the threat of internal decline coincided with the discovery of other diseases, such as smallpox and cholera, the blame for which was placed on "the arrival of immigrants from less temperate climates" (Rabinbach 207). We can begin to see the construction of a binary wherein the virtues of order, progress, productivity, stability, uniformity, and standardization are set against vices of idleness, laziness, fatigue, degeneracy, instability, and irregularity—binary constructions to which specific segments of the population were relegated based on discriminatory views of race, class, gender, and ability.

Technological innovations in the nineteenth century reinforced this binary between order, productivity, and regularity on the one hand, and irregularity and idleness on the other. As the railroad network expanded, the need for a uniform standard time became paramount. In the 1880s, during the height of neurasthenia's popularity, time zones were created to divide the

globe. With the growing importance of synchronized time in an increasingly mobile world, time pieces, such as the watch, began to be mass-produced. This new preoccupation with mechanized orderliness was predictably applied to bodies, as regularity, synchronization, and efficiency became standards against which bodily functioning was measured, segregating humans who conformed to these norms of the body from those who did not. Critiquing this rigid notion of bodily conformity, Alison Kafer states that disabled bodies and minds are expected to "bend…to meet the clock" (qtd. in Samuels "Crip Time," n.p.). Those who did not (and do not) measure up to such regularity were categorized as lazy or too idle and therefore prone to vices such as drinking and crime (Rabinbach 31). In such a climate, work, and especially regular work, was considered a type of prophylactic against such unseemly activities (31).

What was seen as the evasion of work duties, captured within the label of malingering, was therefore associated with immorality and regressive values. Moreover, in this context, Rabinbach recounts how "'idleness and savagery' were synonymous" (30), a linkage that tied irregularity in work and time to the denigration of forms of life cast as disordered, undisciplined, and "uncivilized." This logic is evident in figures such as German geographer Friedrich Ratzel, who in 1888 declared that so-called "uncivilized races" exhibited "no less an amount of work than civilized man" but that they "did not perform it in a regular manner" (qtd. in Rabinbach 30). Ratzel's remarks demonstrate that it is not only about the amount of work that one performs, but *how* it is performed: this new way of measuring, scheduling, and accounting for time played a part in the pathologization of various forms of perceived irregularities to this process. Such irregularities meant there was no clear-cut divide between 'work' and 'leisure' and this absence of rational order ostensibly opened a gateway to all manner of constructed vices that in turn were believed to threaten the populace.

These nineteenth-century discourses linking bodily irregularity, moral character, and social order provide the historical context that continues to shape the conditions under which fibromyalgia patients are understood: when all irregularities of life are pathologized and/or criminalized, the doctor, in a sense, polices the body through attempts to tame symptoms into a coherent order. Moreover, individual bodies were seen to represent a microcosm of the national body (Davis 36). By this logic, a proliferation of 'defects' in the individual citizenry would lead to a defective national body. As Lennard Davis writes, "the eugenic notion that individual variations would accumulate into a composite national identity was a powerful one" (36). "This belief," Davis states, united "with an industrial mentality that saw workers as interchangeable and therefore sought to create a universal worker whose physical characteristics would be uniform, as would the result of their labors—a uniform product" (36). Bodies that challenge such a standardized norm of productivity—or worse, might "fail" to achieve wage-earning work at all—represented a threat to increasingly solidified beliefs about the value of particular bodyminds in an ostensibly progressive, capitalist society. Moreover, anyone who sought compensation for an inability to work based on chronic pain or fatigue was situated as weak and morally corrupt in opposition to the values of independence and productivity that characterized a progressive society.

3. A Pathology of the Will

Neurasthenics were positioned as the opposite of the model universal worker. Like railway spine (and I will later discuss, fibromyalgia), the condition of neurasthenia captured a societal fear that fatigue would threaten to undo the nation. The ultimate enemy of progress, fatigue implies stagnation, a lethargy that some tied to a "pathology of the will" (Rabinbach 165). In an 1884 book on the subject, Théodule-Armand Ribot argued that "the will represents

the highest stage of physiological *and* moral development" in his evolutionary schema (Rabinbach 165). He believed when one's will was "unhealthy," the individual was at risk of becoming afflicted by undesirable and damaging thoughts and images. Defined as an "inhibitive power," the will was thought to fortify an individual against destructive intrusive thoughts (167). Ribot's pathologies of the will were also placed along a "moral continuum" in which the absolute absence of the will indicated moral depravity and the "normally unimpaired will" was highly desired as one of the hallmarks of "the more highly developed conscious forms of mental life" (166). Interpreted as a physical and moral disorder, fatigue in the late nineteenth century was "a sign of [both] weakness and the absence of the will" (Rabinbach 40). Ribot's claims' regarding pathologies of the will reflect a trend that marked late nineteenth century medical thought: "the fear that the cumulative effect of mental fatigue would create a society incapable of moral restraint" (Rabinbach 165). As the quintessential disease of fatigue at the time, the prevalence of neurasthenia diagnoses reinforced the belief that fatigue (and its associations with weakness and moral decay) threatened to, in the words of Russian physician and influential sleep hygiene scientist Marie Manaceine, destroy the very "foundations of the progress of humanity" (qtd. in Rabinbach 165). Fatigue was thus understood not merely as a bodily condition but as a moral failure of will—one that raised suspicions about an individual's capacity or willingness to participate in productive labour.

4. An Inverted Work Ethic

Significantly, the Amish community that was chosen for White and Thompson's study, to which the *Rheumatology* authors are responding, was chosen explicitly because it was determined that there is "a very strong work ethic and sense of independence among the Amish" (1836). This community was therefore seen as a suitable means to test the assumption that those

seeking financial assistance were doing so because of a poor work ethic and lack of moral values that emphasize the ideals of individualism and independence. Although the study disproved the claim that individuals are motivated to seek compensation because of moral depravity (in the form of devaluing or avoiding work duties), the *Rheumatology* authors continued this narrative that fibromyalgia patients were looking for an easier way out of their supposed civic duty to be a useful and economically productive member of society. For instance, Hadler (1997) acknowledges that there are some "people with irremediable work incapacity," but that the "growing numbers with work incapacity…reflects the degree to which they are disaffected, disallowed, or disavowed" (1251). He argues that many people are avoiding work because "self-respect in the workplace is so elusive that the gauntlet of disability determination seems an easier path" (1997, 1251). Here Hadler references his own article published a year earlier, "The Disabled, the Disallowed, The Disaffected, and the Disavowed," in which he attempts to make a distinction between those *unable* to work versus those *unwilling* to work (1996).

In this editorial, Hadler describes the inability to work as an illness in itself—a pathology—that must be avoided. He determines that the diagnostic label of FM enables those who have an aversion to work because they find their workplace environment "demeaning" or uncomfortable since "[t]hey are not liked. Some are not likeable" and "face major challenges to their self-image for the majority of their waking hours" (250). It is for these reasons that he states those who "find their next regional musculoskeletal illness…the straw that broke the camel's back" (250). This claim echoes his statements discussed earlier in which he sees fibromyalgia patients as seeking disability compensation because they have "exhausted their wherewithal to cope" or are buckling under the pressure of modernity and the modern workplace (1669). Hadler says it is not that people "won't work," but that they "can't" because they have been

incapacitated, not by disability or illness, but by their own inability to bear the weight of modern life. In a semantic reworking, Hadler implies that it is not that these people are unwilling to work but that they are essentially disabled by the thought of being "[un]likeable" to themselves and those around them. From here, the logical and most readily available avenue for them to pursue is some form of "income substitution from Social Security Disability Insurance" (250).

In another 2003 editorial authored by Ehrlich and Hadler on "Fibromyalgia and the Conundrum of Disability Determination," they claim that physicians who diagnose individuals with fibromyalgia provide a legitimacy to the condition that "reinforce[s] a belief" which excuses individuals from "work, meeting family and societal responsibilities, and participation in recreational activities" (1031). Hadler and Ehrlich thereby imply that individuals are using their condition to achieve secondary gains that comprise both interpersonal gains and the external incentive of avoiding work—claims that, if true, would satisfy the criteria for malingering. Aside from work, it is unclear what other responsibilities, specifically, these individuals are being relieved of according to Hadler and Ehrlich. In contrast, drawing on lived experience—both my own and ongoing discussions within online chronic illness communities—many individuals describe how isolating it can be to be unable to participate in social activities or public life—whether due to inaccessibility, lack of accommodations, ableism, or illness-related constraints, rather than as a chosen withdrawal from such activities. Yet, Hadler and Ehrlich frame exclusion from participation in family and social life as a reward, describing such activities as duties or obligations.

Their argument also extends to recreational activities, which they suggest individuals with a "disability conviction" may wish to avoid (1030), reflecting an assumption that inactivity is itself desired. This is notable because it recasts activities conventionally framed as leisure—

rather than obligation—as something to be evaded, thereby extending the logic of secondary gain beyond work and into domains not typically associated with duty. In doing so, their account risks collapsing distinctions between obligation and leisure, raising questions about how non-participation in such activities is being construed as a form of secondary gain. Even in cases where individuals may reduce or withdraw from activities because their symptoms make participation difficult or exhausting, this does not transform non-participation into a "reward" in the sense implied by secondary gain. Rather, exclusion from social and recreational life is often experienced as isolating and shaped by constraint rather than choice. Their framing of activities does, however, align with Beard's characterization of neurasthenia which he described as a disorder wrought by the increasing demands and activities associated with modern civilization.

Hadler and Ehrlich also describe "work avoidance" as a "salve" (1030). This is not the first time Ehrlich has used this type of terminology. In his individually-authored 2003 editorial, Ehrlich refers to disability compensation as a "dollar poultice": he muses that without this poultice there would not be the same number of claimants seeking compensation (the number of which he alleges threatens to bankrupt compensation systems worldwide) (1666). Referring to compensation as a balm that speeds the recovery of those in pain was the same language used to disavow claimants seeking compensation following railway accidents—a claim that William Gowers denounced. Yet over a century later, with work avoidance posited as the balm and disability compensation as the bandage to cover it, individuals with less clear-cut illness etiologies are framed as motivated to seek compensation because of the "cure" it provides for those whom they perceive as having an inverted work ethic. Rather than encouraging individuals to work or return to work, they see "disability determination" as offering a solution out of work.

The metaphor of the salve and poultice also implies this is a band-aid-type solution to these individuals' real problems, which are worsened by the legitimizing process of the diagnostic label. In their view, anything that justifies a lack of activity—"including the activity of working"—is detrimental even when it is "under the *guise* of progressive restoration of function" (1031; emphasis added). They claim that encouraging activity is met with resentment by their patients because it suggests their claims lack "veracity." It is the authors' stance that limiting activity only contributes to "their perception that they are too ill to work" (1031). Patients' accounts of their symptoms are derisively described as a "fate with more dismal a narrative of distress than most somatically ill people," while they are at the same time told they should consider themselves "fortunate to be spared organ damage or specific biochemical abnormality" (1031). They ironically follow up this comment stating, "that is not to belittle the pall under which they subsist," which is arguably exactly what creating a hierarchy of disability does whereby pain is presumed to be psychosomatic and of little concern compared to more legitimate physical problems (1031).

"These patients" are therefore not unable to work because of their symptoms; rather, they "perceive themselves incapable of working" as a result of their illness beliefs (1031). Arguing that fibromyalgia patients cannot work due to their own beliefs as opposed to "real" illness echoes statements made about the previous century's nervous disorders. In Cohen's article discussing railway spine, he emphasizes how previous disorders were also blamed on "beliefs and ideas about injury" which were the true barrier to wellness (Cohen 189). In a section on Charcot's account of injury following railway accidents—which Charcot perceived as a manifestation of hysteria (referred to as "traumatic hysteria")—Cohen states that these beliefs and ideas about illness and injury "were held to be potent factors not only in the genesis of the

condition but also in retarding recovery" (Cohen 189). Illness beliefs were therefore blamed for both causing illness and preventing a return to a presumed "normal" state of health. In addition, these beliefs were typically associated with disability "compensation issues" and with individuals perceived to overuse medical care, speak frequently about their symptoms with a "constant repetition of sufferings," or otherwise seek attention for their woes (189).

This characterization of the attention-seeking hysterical patient who is motivated by financial compensation mirrors the collection of *Rheumatology* articles. In chapter 1, I discussed how the mere expressing of symptoms was reframed as a symptom in itself and that the women accused of "excessive talking" were accordingly branded "chronic complainers" (Ehrlich 1666). As Logan writes in his analysis of the nineteenth century nervous body, a central characteristic was "its tendency to talk, especially to talk about itself" (3). That is, "[t]he nervous patient spoke incessantly about her or his body, its pains and sufferings, and its history" (3). Moreover, like the *Rheumatology* authors have claimed, this tendency to narrate "was itself a sign of the condition" (3).

It is difficult to see any discernable difference between characterizations of railway spine, neurasthenia, and fibromyalgia. It does not seem to matter to these *Rheumatology* authors what diagnostic label these symptoms fall under, any expression of chronic and severe pain and fatigue is treated with suspicion, as a means to avoid the duty of work, and to seek financial compensation regardless of what time period or century this discussion is taking place. Across all of these authors' accounts—the *Rheumatology* articles and earlier coverage of railway spine or other nervous disorders—their focus is on the goal of returning the patient/claimant to work. Anything that interferes with this goal, such as a diagnosis, is therefore viewed solely through the lens of erroneously and problematically justifying work avoidance.

Hadler and Ehrlich's comments on fibromyalgia and the debate over work incapacity parrot discussions of neurasthenia in its day. Rabinbach states that while neurasthenia was more likely to be seen simply as a disease of modernity—in much the same way fibromyalgia and CFS are framed—a less emphasized aspect was its conception as "a kind of inverted work ethic, an ethic of resistance to work or activity in all its forms" (168). This "lack of will or energy" is revealed in "the incapacity to work productively" (168). Akin to Hadler's comments that pathologize work incapacity, neurasthenia was viewed as a pathology of the will that manifested in this supposed opposition to any form of work. This is similar to Hadler and Ehrlich's beliefs that discouraging any form of activity, including work, only detracts from the will to recover.

Later, Freud (1892) would distinguish between neurasthenia and hysteria by claiming the former manifested in "*weakness* of will" while hysterical patients revealed a "*perversion* of will"[57] (Freud 123; qtd. in Rabinbach 156; emphasis original). By distinguishing between a supposed "weakness" versus "perversion," neurasthenia is framed as an inherent inability in one's will while hysteria is more of a deliberate deception stemming from one's corrupt morals. The *Rheumatology* articles conflate these two ideas: on the one hand, fibromyalgia patients are posited as being too weakened by modern pressures or lacking "the wherewithal to cope" (Hadler 2003, 1669; Hadler & Greenhalgh 2005, 3); on the other hand, seeking disability compensation is framed as a moral problem that reflects values misaligned with the ethical imperative to independently earn one's income and productively contribute to the economy. They are further morally corrupt for malingering and unjustly receiving compensation as part of the unworthy poor.

[57] Here, "perversion of will" refers to a distortion or corruption of the will rather than its absence.

In 1902, Theodor Dunin wrote that the malady of neurasthenia was characterized by an aversion to work ("Unlust zur Arbeit") and claimed that "inactivity was the greatest enemy of neurasthenia" (Rabinbach 168). Thus, according to this logic, not only would providing financial assistance mean one was dependent on the state, it would also mean one would potentially always be dependent since inactivity or idleness would only perpetuate the condition—leading one to never recover. Like Dunin, and Hadler and Ehrlich, Wolfe (1997) repeats this argument for limiting compensation for fibromyalgia and generalized chronic pain syndrome: he proposes that payments should be "limited to a period of one to two years" to help those going through an assumed temporary difficulty (1249). After this point he states the goal should be to "prepare to return to *her* original job or to work that now might be more physically suitable" and that benefits should be viewed as an "opportunity for retraining or the acquisition of other skills required in the work force" (1249; emphasis added). He further suggests that disability "awards," as he phrases it, do not result in "clinical improvement" (1249).

In other words, the presumption is that once on disability compensation fibromyalgia patients do not return to work. Wolfe implies that the possibility of receiving longer term support leads to perpetual inactivity and allows one to avoid work. Echoing Dunin's claim that "inactivity was the greatest enemy of neurasthenia," one might reframe Wolfe's logic as "inactivity is the greatest enemy of fibromyalgia." His suggestion to limit the compensation period is therefore intended as an incentive (by using the threat of removing financial support altogether) to essentially pull one's self up by the bootstraps and coerce individuals back into the workforce. This type of strategy relies on the logic that ill individuals merely need to address their "perception" of illness, or in other words, address illness behaviours that are the underlying

cause of their ailment. It also assumes that if individuals are given financial support, there will be no incentive to work at all.

5. The Moral Imperative to Return to Work

Methods to pressure individuals back into the workforce are not new. In *Extraordinary Bodies*, Garland-Thomson states that "[n]owhere is the disabled figure more troubling to American ideology and history than in relation to the concept of work": within this economic system "the abstract principles of self-government, self-determination, autonomy, and progress are manifest most completely" (46). By fact of its existence, the disabled figure raises the question of "under what circumstances a person should be held responsible for 'earning a living'" or when they should be absolved of this responsibility due to unforeseen and uncontrollable circumstances (47). This is one of the key questions with which the *Rheumatology* editorials engage: is fibromyalgia a disabling disorder that impedes work and warrants disability compensation or is it a convenient label to justify the avoidance of work and other responsibilities? Hadler claims that "most people with physical incapacities are not…'disabled' [enough]" to justify not working ("Disaffected, Disavowed" 1996, 249). He contrasts these people to those who are recognized by family and friends as without question "incapable of substantial gainful employment" (249). Hadler seems to create a divide between those who are clearly unable to work and those whose illness is not verifiable and thus treated with suspicion.

In *No Right To Be Idle*, which examines the invention of disability between the 1840s and 1930s, Rose (2017) writes that since the Elizabethan Poor Law of 1601, there has been a desire to distinguish between the "deserving" poor—those who cannot work and are 'genuinely' disabled—from the "undeserving" poor—those who can, but are unwilling to work. Individuals who were categorized within the former category were deemed worthy of aid while the latter

were discouraged from receiving assistance (and thereby impelled to work). The *Rheumatology* articles display the same intent on upholding this false binary between these two groups of people by suggesting that fibromyalgia patients cling to the label of disability in order to receive unearned entitlements. Removing the possibility of compensation (which the diagnostic label provides access to) would therefore discourage idleness and incentivize those currently unwilling to work. Fibromyalgia patients are thus firmly placed in the category of malingerers—or those consciously seeking ways to avoid work.

Rose discusses how disabled individuals have always been relegated to either of these two categories and, because of the complexity and mutability of disability, attempts to create clear, fixed categories describing who is "worthy" of aid have always been subject to contention (8). Specific disabilities, in addition, were thought to be inherently suspect and prone to fakery for secondary gain, such as "idiocy" and "insanity" (8). Then, as now, questions remain about who should bear the responsibility of financially supporting disabled individuals who may not be able to work: should it fall to the individual, their families, society, or a combination of these? (8). These factors and proposed remedies, Rose states, "reflected [legislators' and reformers'] fears that disabled people might in fact be lazy rather than truly worthy of aid" (8). Therefore, "policy makers' fears about encouraging dependency, their concerns about state funding capacity, and desires to preserve the distinctions between the deserving and undeserving poor" have had enduring consequences in current debates about disability compensation (8). The debate about whether fibromyalgia patients are worthy of support or are faking for compensatory gains is part of this larger historical discourse on the categorization of disability and the impossibility of clearly defining disability in such a way that would lead to a concrete answer on

who legitimately deserves support. The very nature of disability defies this type of rigid categorization upon which these notions of who deserves support depend.[58]

Wolfe's suggestion that individuals, if they cannot return to their former job, simply need to retrain in a new vocation resonates with policies in the first decades of the twentieth century which were intended to prevent public dependency. For instance, as Rose discusses, the Federal Board for Vocational Education (FBVE) in the US emphasized vocational rehabilitation as a means to "reestablish the disabled soldier or sailor as an independent, self-respecting economic unit"[59] and argued that any policy that deviated from this goal would encourage economic dependency, which was perceived to have "inherent moral and social evils" (195). In addition, the transition to industrial capitalism and urban wage labour, coupled with a demand for interchangeable bodies to satisfy modern, mechanized factory labour, resulted in "render[ing] people with disabilities unproductive citizens in the cultural imagination" (10). Rose states this has been a "concept central to disability policy in the United States during the rest of the twentieth century" (19).

Disability thus became entangled with the idea of "personal immorality and economic dependency" with the couched implication that disability threatened not only an individual's morals but "the nation as a whole" (Rose 21; 19). Moreover, since "good citizenship" was equated with the ability to earn paid work and thereby contribute to the progress of society, disabled people came to be associated with poor citizenship and perceived as unable to work productively (19). Consequently, legislators and reformers were focused on returning individuals

[58] The biomedical model assumes disability to be a fixed and stable condition and monolithic identity category when it is far more mutable. As Garland-Thomson discusses, "[t]he concept of disability unites a highly marked, heterogeneous group whose only commonality is being considered abnormal…" (Extraordinary Bodies 24). For a longer discussion on the category of disability, please refer to pages 13-14 of Ellen Samuels' *Fantasies of Identification.*

[59] As a reminder, the original definition of malingering was specifically applied to soldiers and sailors on the suspicion that they were feigning symptoms to evade work.

to paid work, which was viewed as the path to productivity and self-sufficiency. These were ideals essential to concepts such as the Protestant work ethic, which stressed the moral duty of self-supporting hard work, and the principle of meritocracy which in part promises the merits of hard work will lead to a recognition of achievements.

A pivotal point of Rose's research is that the formation of disability as a distinct identity category in the twentieth century was largely driven by political and economic factors as opposed to mere medical definitions. This was a result of the transition to industrial labour, which redefined how the body was conceived in terms of its ability to contribute effectively and efficiently towards the economy, and newfound perceptions of the body as a "productive, well-operating machine" (Garland-Thomson 39). As disabled individuals were increasingly viewed as unfit and unproductive within an industrial economy and measured against rigid conceptions of productivity and ability, and as public welfare and disability benefits expanded in the early decades of the twentieth century, the association of disability with an inability to work became further entrenched. Therefore, the broad category of "disability identity" arguably functions in certain contexts to signify an inverted work ethic. Such a conceptualization reflects a fear of moral degeneration within a capitalist system that places value on productivity, self-sufficiency, independence, individualism and personal responsibility. Thus, disorders that reveal an "ostensible failure at self-mastery" (Garland-Thomson 39), and especially conditions that are characterized by fatigue and pain which may limit one's ability to perform as the ideal model of the productive neoliberal citizen, stand in direct opposition to these ideals.

6. The Civic Duty to be a Productive Citizen

The preoccupation with distinguishing between the "sick poor" and those seen as the "economically useful" poor, Garland-Thomson states, "gave rise in the eighteenth century to a

dominant ideology" in which "health and physical well-being" became "a civic duty and political objective" (39). Considering the utmost value placed on one's duty to be an independently productive labourer, it is hardly surprising that fatigue in the early 1900s was feared. In fact, fatigue was considered such a grave enemy to progress that in 1904 there was even an attempt to create a fatigue vaccine (Rabinbach 142). Fatigue was understood as placing limits on the body and mind which endangered ideals of unlimited progress. As fatigue was increasingly positioned in opposition to rationality, work, and societal progress, it was considered to pose the ultimate threat to humanity and civilization. Moreover, as stated previously, fatigue in the late nineteenth century "was perceived as *both* a physical and a moral disorder—a sign of weakness and the absence of will" (Rabinbach 40). It was no longer that individuals had to work by necessity, but that economic productivity became a "moral imperative": as a result, moral worth became equated with productive work, and idleness, by contrast, "with depravity" (41; 46-47). Fatigue, and fatigue-related disorders, therefore, represented a pathological deviation from what was otherwise considered the "normal" body and "normal" standards of work and citizenship. The social and political views that fatigue represents a threat to the nation, which was captured and repeated in the historical rhetoric dominating neurasthenia, logically extends to predominantly fatigue and pain-related disorders such as fibromyalgia and CFS.

Garland-Thomson further uses the neologism "normate" to refer to this standard by which "marked bodies" are measured as a deviation against a constructed and imaginary norm.[60]

[60] For clarity, this is Garland-Thomson's definition of normate: "This neologism names the veiled subject position of cultural self, the figure outlined by the array of deviant others whose marked bodies shore up the normate's boundaries. The term *normate* usefully designates the social figure with which people can represent themselves as definitive human beings. Normate, then, is the constructed identity of those who, by way of the bodily configurations and cultural capital they assume, can step into a position of authority and wield the power it grants them. If one attempts to define the normate position by peeling away all the marked traits within the social order at this historical moment, what emerges is a very narrowly defined profile that describes only a minority of actual people" (*Extraordinary Bodies* 8).

The normate, she states, has "four interrelated ideological principles that inform" the ideal American citizen: self-government, self-determination, autonomy, and progress (42). This image of the self "parallels the national ideal" as "each citizen" is seen as "a microcosm of the nation as a whole" (42). Therefore, a "well-regulated self"—a self that is not subject to a pathology of the will—"contributes to a well-regulated nation" (42). However, this ideal depends on the fantasy that the "body is a stable, neutral instrument of the individual will" (42). The disabled figure subverts this ideal by exposing the body's vulnerability, variability, and unpredictability thereby "presenting the ultimate challenge to" central features of the ideology of liberal individualism: "perfection and progress" (46). Disabled figures therefore destabilized central tenets of American society in particular, with their "random and unpredictable characters" codified as "appalling disorder and persistent menace in a social order predicated on self-government" (43).

While Garland-Thomson's discussion of the disabled figure's challenge to the normate focuses on American society writ large, much of her discussion pertains to the specific context of these *Rheumatology* articles. While these editorials are published in a Canadian medical journal, the economic and political ideology of neoliberal capitalism pervades far beyond US borders and is deeply embedded in most Western countries. Certainly, reduced spending on social services (such as unemployment benefits and healthcare) are in part a product of neoliberal economic policies that gained traction in the 1980s. As well, the neoliberal emphasis on the self-sufficient, autonomous and independent individual informs arguments that are against so-called public dependency in the form of providing financial supports. And neoliberal state policies direct disabled people away from social supports and into work: by redefining who qualifies for support; establishing financial limits that "support" existence well below poverty lines; imposing

income thresholds that render individuals ineligible; and rolling back state support overall.[61] The *Rheumatology* authors are committed to the same neoliberal goals when they argue that the focus should be on returning fibromyalgia patients to work and to productive citizenry. As a result, work incapacity or underproductivity in this framework is constructed as a failure of the individual.

The preoccupation with an underperforming body reflects how the body came to be increasingly understood not just as a machine but, moreover, through the economic discourses of productivity and efficiency. In Bruce Cohen's (2016) *Psychiatric Hegemony*, which critiques the expansion of mental illness discourses and analyzes how psychiatry supports a neoliberal capitalist project, he draws attention to the DSM-III released in 1980, which shows a marked increase in references to workplace terminology (105). Many behaviours and personalities were then pathologized on the basis of their supposed limitations that served as impediments to performing the ideal "skills and roles" expected "of workers in the neoliberal workplace" (105). This has been referred to as the "medicalization of underperformance" (Conrad 139; qtd. in Cohen 105). Similarly pointing out the mutually-reinforcing ideologies of neoliberalism and ableism, Dan Goodley has argued that "ableist logics mirror market logics in privileging certain forms of autonomy, self-sufficiency, capacity, and independence" (6). Failure to live up to these ideals places blame on fibromyalgia patients for their supposed pathology instead of recognizing that the blame lies in the ableist expectation that the body conform and submit to the system.

[61] For example, Ontario's Disability Support Program (ODSP) imposes strict income thresholds and benefit levels that fall below established poverty lines, effectively limiting eligibility and incentivizing return to work (Income Security Advocacy Centre 2023). Scholars in disability studies and critical policy analysis have documented how neoliberal welfare regimes restrict eligibility, reduce benefits, and prioritize labour market participation (Russell 2019; Withers 2024). For a broader account of neoliberalism as characterized by the reduction of state welfare provisions, the prioritization of market participation, and the promotion of individual responsibility and labour participation, see David Harvey (2005).

Ironically, while the *Rheumatology* authors recognize the problems with the "medicalization of everyday life" and base much of their argument on denying care to fibromyalgia patients on this basis, they contribute to the pathologization of their patients by suggesting their pain and fatigue experiences are due to a weakened mental state, particular to certain personalities, and worsened by their illness behaviours. Operating within the expectation that it is the individual's responsibility to strengthen their mental fortitude, the *Rheumatology* authors latch onto the idea that their patient's insistence on the physicality of their condition can only be because they are attempting to avoid their civic and societal responsibilities through a means that is perceived as more legitimate. Wolfe quotes Illich stating that "people want to hear the lie that physical illness relieves them of social and political responsibilities" (673). This allows them to think they are "innocent victim[s] of biological mechanisms...." (Wolfe 673). These comments clearly convey a rhetoric of individual responsibility—a key tenet of neoliberalism. Patients are not "innocent victims" of their biology and their struggles are in their control to fix (or endure) and in no way absolve them of societal or work obligations. The *Rheumatology* authors' claims in this respect are reliant on both neoliberal framings of the body as well as historical medical rhetoric that has argued "inactivity is the enemy of" whichever pain and fatigue-condition has captured the attention of these physicians.

7. Neoliberal Subjects and Discourses of State Dependency

The notion that certain individuals are faking illness in order to receive entitlements in the form of financial compensation is part of a larger discourse that pathologizes and positions certain populations of people as undeserved dependents on the state. Neoliberalism promotes the idea that broad social issues are personal problems that are the individual's responsibility to solve instead of receiving public or government supports. Neoliberalism advocates for

privatization of public services and a reduction in government expenditures, resulting in cuts to social programs and services. Correspondingly, neoliberal ideology frames particular population groups who may depend on these services as lazy, immoral, or simply undeserving of support. This is part of the *Rheumatology* authors logic which surrounds their discussions of fibromyalgia patients and the issue of compensation. Very tellingly, Wolfe follows the quote by Illich above with the comment that "diagnosed ill-health provides access to disability programs and access to additional healthcare" (673). Wolfe, knowingly or not, is endorsing neoliberal ideologies by focusing his concern on protecting the state from the burden of unnecessary healthcare expenditures and the economic threat fibromyalgia patients with a diagnosis-in-hand pose as potential dependents on the state.

In *Anatomy of the City*, Jina Kim (2021) engages with the intersections of race, disability, gender, and class to examine how U.S. state discourses of dependency deliberately frame continuing structural violence towards particular population groups as individual and cultural failings. Kim locates rapidly increasing resource privatization and erosion of public funds within the establishment of the figure of the "welfare queen." Kim identifies the welfare queen is a characterization invoked by Ronald Reagan in 1976.[62] It casts black teenage mothers as lazy parasites who were ostensibly conning the system and profiting from state benefits. "Represented as epidemic and threat," Kim states, "teenage motherhood served an important rhetorical function insofar as it enabled the re-allocation of health resources away from the nation's most vulnerable" (69). Relying on the "national mythology" of "deviant black motherhood" and operating through a "rhetoric of personal responsibility," evoking this mythic figure functioned to justify divestment of public resources and instead framed "health, wellbeing, [and] education"

[62] Kim notes that the figure of the welfare queen was prefigured by the 1965 Moynihan Report.

as individual problems, and supposed failings in these areas as the result of bad choices. Kim identifies the welfare queen as "*the* definitive disability narrative of late capitalism" (45; emphasis original).

While the *Rheumatology* articles are not referencing this mythic figure directly, they are using the same rhetorical strategy of pathologizing and rendering deviant marginalized subjects who may rely on national resources of disability compensation by levelling arguments of personal responsibility and state dependency. As I have discussed in chapters 1 and 2, the *Rheumatology* authors' have routinely accused fibromyalgia patients of "choosing to be patients" and their report of symptoms is described as one aspect of their "illness behaviours." The reason fibromyalgia patients are said to suffer is not because of their symptoms of pain, but because of their "bad choice" in choosing to be patients in the first place. Instead of responsibly addressing the root cause of their problems—a combination of psychological factors and compromised coping—they seek external help from physicians and financial compensation in lieu of coping. The *Rheumatology* authors portray the health of their patients as within their own grasp—if they so choose to recognize their reality and the real problems producing their suffering. Similar to what Kim traces as the welfare queen, this framing is intended to divert health resources away from these patients who are cast as undeserving of additional healthcare or financial assistance. As malingerers who are feigning or amplifying their symptoms, any disability compensation within this framing is perceived as a potential con.

Kim identifies that the figure of the welfare queen preceded the Personal Responsibility and Work Opportunity Reconciliation Act of 1996. This legislation's mandate was to "encourage" those who relied on state support to assimilate back into work culture. Taken together, this law and the figure of the welfare queen emphasize the increasing hostility towards

individuals who are seen as unproductive members of society (68). We have seen the same encouragement for fibromyalgia patients who, like neurasthenics, have been constructed as having an inverted work ethic and where longer-term support is argued to perpetuate inactivity and provide an incentive to avoid work altogether (Wolfe 1997). In a neoliberal society, where Kim says a certain "prestige [is] conferred upon productivity and waged labor," the lives of those not adhering to this standard of the ideal citizen are subsequently devalued (85). As Kim puts it, "a value system that idealizes a productive, economically independent, and able-bodied subject…works to empty" certain lives—racialized, disabled, feminized—"of life worth" (80-81). This is a system in which women with unverifiable illness and/or disability are especially targeted as their lives are perceived as inherently less valuable and less worth living. As mentioned in chapter 1, Hadler and Greenhalgh betray this type of thinking when they refer to being diagnosed with a disability (and specifically with fibromyalgia) as having the effect of transforming one from a whole person into a less complete or inferior version of themselves with limited life options (3). Claiming disability, they moreover argue, creates dependency on the state for which these particular individuals are undeserving.

a) Deserving Subjects vs. Undeserving Dependents

Discourses of dependency, Kim explains, are about dividing people "into two distinct categories: deserving subjects and undeserving dependents" (124-25). Those deemed deserving subjects are those who conform to the entrenched values of a neoliberal society, as in they participate in the capitalist marketplace: through work as a waged labourer, consumption, heteronormative (re)production, and also being able-bodied (Kim 15). These ideals of productivity and independence are, Kim states, "defined over and against" racialized, feminized, and disabled subjects—or to use Gloria Anzaldúa's term, the "the left-handed world" (El Mundo

Zurdo): “the colored, the queer, the poor, the female, the physically challenged” (196; qtd. in Kim). Pitted against normative standards of productivity, these segments of the population are configured as “parasitic upon the state” (124). Within this configuration, disabled, racialized, and feminized lives are differentially valued: considered disposable, expendable, and unworthy of investment or support.

Although Kim is talking specifically in U.S. contexts here, the mythology of the idle welfare recipient—and its enmeshment with ableist ideals of productivity—also lurks within these articles. The anti-welfare sentiment Kim speaks of underlies representations of the hystericized fibromyalgia patient who is discursively framed as an unworthy burden on the healthcare system—or in other words, an undeserving dependent. Moreover, in the same way that anti-welfare discourse has claimed “dependency would discourage welfare’s recipients from wage-earning work, trapping them in a cycle of poverty and enabling them to continue self-indulgent lifestyles” (Kim 13-14), the hystericized fibromyalgia patient is accused of seeking compensation for a “common symptom” that would only enable them to, likewise, continue the lifestyle of the ill. Hadler specifically states that “the diagnostic algorithm regarding FM is inherently counterproductive to coping” which only contributes to “foster[ing] a life of somatising” (1997, 1251). This lifestyle is seen as supported by financial compensation that enables one to avoid work, continue an idle lifestyle, and encourage an inescapable cycle of dependency.

One could argue that it is insufficient economic support that traps one in poverty, not reliance on government resources or a lack of will to earn one’s own wages. However, when the socioeconomic structures that produce these circumstances are obfuscated, individuals are instead encouraged to be more resilient and work harder to overcome their individual barriers.

When structural failings are dismissed as an individual's inability to cope and the very personhood of fibromyalgia patients is instead pathologized, blame is individualized in ways that enact and perpetuate structural violence against already marginalized social groups. Within this context—where individuals are expected to overcome their troubles in order to conform to the able-bodied norm of the neoliberal citizen who earns their own wages and functions as an efficiently productive member of society—fibromyalgia patients are vulnerable to portrayals as burdens on the healthcare system and as dependents on state resources. The violence that results as an outcome of these portrayals puts fibromyalgia patients at increased risk of losing healthcare access altogether or any social assistance they might currently have (if they have not already been denied in the first place).

8. CLAIM: Epidemic and Threat

A central claim advanced in the *Rheumatology* editorials is that fibromyalgia is an emerging epidemic that threatens to spread out of control and overwhelm social support systems. This is the same fear that came to dominate discourses on neurasthenia and railway spine in their day. In the nineteenth century, emerging concerns with fatigue, and the related concepts of degeneration and decline which led to an explosion of research in these areas, suggested that medical science was identifying fatigue as an evolving epidemic (Rabinbach 21). The physical realities that fatigue presented to ideals of unlimited progress and productivity resulted in fatigue becoming known as the "nemesis of an industrializing Europe" (Rabinbach 4). As the quintessential fatigue condition, neurasthenia, in particular, was framed as an unchecked disorder that threatened the very foundations of society. Fibromyalgia has been similarly framed by the *Rheumatology* authors; however, the focus is less on the realities of pain and fatigue and more so on the diagnostic label as an emerging epidemic that must be brought under control.

In Wolfe's 1997 editorial, he frames fibromyalgia as a creeping problem that "began almost imperceptibly, but now, after logarithmic growth" has reached the state of being "out of control" (1247). Wolfe portrays fibromyalgia as a chaotic condition that cannot be tamed. His real issue, however, is not the symptoms that define the syndrome but the label itself and the access this provides to compensation claims. Wolfe claims that "FM cases have reached near epidemic proportions in the courts" (1247). Twelve years later in his 2009 editorial he queries, "[c]an we help the patient without spreading FM?" (676). In this same article, Wolfe sees that a fibromyalgia diagnosis offers "short-term legitimacy" and "social benefits" but at the too steep "cost of creating and expanding illness" (676). The type of language Wolfe is using—"epidemic proportions" of FM are being "creat[ed]" and "spreading"—suggests a contagion that is infecting the public and the courts. Hadler and Greenhalgh specifically refer to the FM concept as a "contagion" that has spread out of control and must be stopped before it is too late (1).

Although much of this chapter and the previous have focused on the claim for which White and Thompson's study found no basis—that FM is motivated by secondary gain—an equally important aspect of fibromyalgia's rhetorical construction is that the epidemic of FM is spread through the media. Both Shorter and Showalter have made this claim with Shorter stating "it was diffusion by the media that has given these disease labels such enormous popularity" (374). As discussed in chapter 2, Showalter frames her discussion of CFS and related disorders as media-driven in the subtitle of *Hystories: Hysterical Epidemics and Modern Media*. Revisiting this emphasis in the context of the present discussion of neoliberal media logics, her 2018 tweet underscores the same concern, suggesting it was time to update the book to account for "social media," where epidemic "contagion" is now "infinitely worse" (@ecshowalter 31

March 2018).[63] Hadler and Greenhalgh have also argued "a wide range of actors [are] deeply committed to [FM's] perpetuation" which includes "powerful social forces such as pharmaceutical firms and the media" (1). Fueled by the media, the uncontrollable force of FM is positioned as an enemy that must be controlled.

a) Parasitic Dependence

In a way, the fear that legitimizing fibromyalgia poses a serious threat to compensation systems, as Ehrlich remarks above, echoes similar concerns that led to the rebranding of railway spine as "railway brain." This rebranding functioned to de-legitimize claimants' symptoms as psychogenic and therefore limit the burden they posed to those paying compensation. Ehrlich's comments reveal a preoccupation with the idea that individuals are receiving unearned and unfair rights and privileges that ultimately threaten society. The idea that fibromyalgia patients are a similar drain on limited public resources, with the diagnostic label spreading as a pollutant of epidemic proportions which threaten to collapse the healthcare system, is consistent with nineteenth century eugenic rhetoric which framed particular population groups as financial "burden[s] on the rest" (poster c. 1926, American Philosophical Society). Eugenicists claimed that some people were unproductive burdens who do not contribute to society and therefore these undesirables must be "bred out" of existence. This sentiment reflects how eugenics was fundamentally about determining who constituted a proper citizen and who was situated as a threat to this goal.

[63] Showalter did publish a book chapter in 2020 titled "Hystories Revisited: Hysterical Epidemics and Social Media" in *Performing Hysteria*, edited by Johanna Braun. While she did reference five of the six case studies that comprised her original *Hystories*—Gulf War Syndrome, satantic ritual abuse, multiple personality disorder, alien abduction, and recovered memory—she notably did not mention CFS.

Figure 2. “Some People are Born to be a Burden on the Rest”



[Image Description: Some people are born to be a burden on the rest. This light flashes every 15 seconds. [light bulb] Every 15 seconds $100 of your money goes for the care of persons with bad heredity such as the insane, feebleminded, criminals and other defectives. This light flashes every 16 seconds. [light bulb] Every 16 seconds, a person is born in the United States. This light flashes every 7 1/2 minutes [light bulb] Every 7 1/2 minutes a high grade person is born in the United States who will have ability to do creative work and be fit for leadership. About 4% of all Americans come within this class.]

Unlike early eugenicists, the *Rheumatology* authors are not suggesting their patients are inherently burdensome, born with some hereditary affliction that needs to be erased from the national gene pool lest it degenerate the national stock. What they are suggesting is that a group of “fragile personalities” who are “predominantly women” are innately weakened by the pressures they face in society and therefore susceptible to latching onto medical labels that grant their psychocultural symptoms legitimacy which in turn gives them unfettered access to compensation. They are also suggesting that the fibromyalgia diagnosis itself needs to be erased because, in their view, it “promote[s] dependency” and essentially creates a type of person and

"lifestyle" they do not wish to exist (Gordon WSAIT, 3). Their fear is at least as much about the diagnosis creating a "subculture of invalidism," as Edward Shorter had put it, as it is about dependency on social and government resources. It is not just that dependency is framed as an epidemic, but that the supposed proliferation of fibromyalgia patients—representing an increase in disability—is deemed to be "out of control" as well (Wolfe 1247). This anxiety that disability is uncontrollably and undesirably expanding reflects the fear at the turn of the century of the twentieth century that "a tide of disability from without and within threatened to swamp the nation," writes Barbara Welke, which Samuels identifies is an idea eugenic practices were both responding and contributing to (Welke 119; qtd. in Samuels 3). Similar language encapsulated nineteenth century nervous conditions which, too, were described as so widespread that "they pose a threat to the nation's commercial greatness and independence," an "epidemic" which Trotter warns a century earlier "if not restrained soon, must inevitably sap our physical strength of constitution" and "ultimately convert us into a nation of slaves and ideots" (Logan 16; Trotter xi).

The fibromyalgia diagnosis embodies what Rose has phrased the "specter of potential dependency," which the *Rheumatology* authors are explicitly "combatting" (Ehrlich 1666), and which stands in opposition to ideas of economic productivity that have easily flowed from eugenic arguments. Fears about encouraging dependency have long surrounded discussions of disability and arbitrarily derived distinctions between who qualifies as the deserving or undeserving poor (Rose 9). What the *Rheumatology* articles are articulating is the fear of their own role in encouraging dependency on public resources by legitimizing patient "aches and pains" with a biomedically acceptable diagnosis. Implicating himself in perpetuating the spread, Ehrlich laments "[t]he harm we in rheumatology have done is in providing syndromic names

upon which the lawyers and support groups feed" (276). Ehrlich's language choice of "feed" draws on the metaphor of state parasitism that Kim aptly states encircles those whose lives are devalued and cast as undeserving of support. Described as leeches, fibromyalgia patients, support groups, and their lawyers are collectively taking unfair advantage of "overly liberal disability compensation system[s]" (1835). Patients are further described as "high utilisers" of healthcare, who "place a burden on all medical and surgical services" (Ehrlich "A Virtual Disease" 10). In short, fibromyalgia patients are constructed as illegitimate drains on the system—both ravenous consumers of healthcare and burdens on public supports.

9. Conclusion

Throughout this chapter, I have traced the historical lineage of a specific ideology rooted in nineteenth-century conceptions of medically unexplained illness and disability and their entanglement with work, productivity, and compensation. I have shown how the *Rheumatology* authors recycle these older beliefs—evident in earlier characterizations of neurasthenia and railway spine—and repackage them in their representation of fibromyalgia. As this chapter demonstrates, their rhetoric reproduces moral logics in which inactivity and dependence is figured as a social and economic threat. Their narrative of fibromyalgia merely restates long-standing ideas that link a person's perceived social worth to their capacity for productive labour. In this way, contemporary discourse on fibromyalgia reveals the persistence of an ideology in which human worth is measured through productivity and bodily conformity to norms of work.

In Chapter 6, I will revisit how narratives of state parasitism function to justify denying healthcare and social supports altogether under the guise of being for the good of the patient and for the good of the public. The next chapter will further examine how the *Rheumatology* authors attempt to solve the problem of malingering by medically invaliding non-verifiable symptoms,

overwriting patient narratives, and delegitimizing lived bodily experience. These strategies will be considered within a larger discussion in which healthcare is treated as a commodity, rather than a right, which is in the physicians' paternalistic power to bestow or withhold based on their perception of an individual's conformity to normative expectations of a compliant and deserving patient.

Chapter 5:
Strategies to Solve the Problem of Malingering: Medical Invalidation

1. Introduction

Previous chapters have focused on the *Rheumatology* authors' *claims* about fibromyalgia. This chapter will examine these claims as part of a *strategy* that the authors deploy to deal with the supposed problem of disability fakery and secondary gain. As Garland-Thomson states in *Extraordinary Bodies,* "[m]edical validation of physical incapacity solved the problem of malingering by circumventing the testimony of the individual. Under this confirmation scheme, the doctor sought direct communication with the body regarding its condition, eliminating the patient's ability for self-disclosure and, ultimately, for self-determination" (50; qtd. in Samuels 31). In these articles and editorials (available in the appendix), one of the main strategies the authors use to prevent malingering is to deny patient narratives of illness and medically invalidate fibromyalgia symptoms. This strategy effectively removes the patient's voice and authority to describe their own experiences, while it enables the physician to claim the power to speak directly with the body itself through various biomedical technologies: reading signs and symptoms on the body as if the body itself can reveal an objective truth that either validates or invalidates claims of illness. As self-report was dismissed as unreliable, so too was an individual's right to define their own bodily condition and needs.

The power of medical authority to authenticate or deny an individual's lived experience of illness will be analyzed through Ellen Samuels' concept of biocertification. Biocertification refers to the idea that biology can and must be certified by an external authority. It is a process by which self-identification and self-report are distrusted by default, and individuals must therefore submit to surveillance and documentation to prove that their bodies match the identity

category they claim. In terms of medicine, the examination through the diagnostic gaze determines whether a person with fibromyalgia will be officially recognized as ill or disabled and their individual identity claims validated as real—that is, whether they will receive or be denied biocertification. This dynamic reflects the trend in modern medicine which is premised on what Samuels refers to as an epistemology of visibility: the belief that bodies must be made visible, observable, and authenticated by experts in order for identities to be validated (17). Bodies regarded as ambiguous are inherently suspicious and therefore subject to surveillance through diagnostic testing, which in cases of invisible illness like fibromyalgia, replaces individual testimony with medical authority in an attempt to make visible the truth of a body's status.

One of the tools the *Rheumatology* authors use toward this goal is the use of standardized testing to make pain visible as a tactic to prevent malingering and issue or deny biocertification. I will examine specifically the authors' comments regarding the tender point test for fibromyalgia, which was introduced in the 1990 American College of Rheumatology (ACR) diagnostic criteria. I will then discuss the use of the pain scale as a tool to quantify subjective experiences of pain, along with the revised 2010 ACR criteria which ironically privileges self-report but I argue delimits patient testimony. Further, I explore how these standardized tests are an example of what Coreen McGuire terms mechanical epistemic injustice (17). That is, these standardized tools not only function to validate or invalidate illness claims; in the process, they devalue an individual's own knowledge of their body and replace it with it an overly simplified external measurement of what is considered real. In doing so, this abstract replacement is considered more real than lived experience which in turn contributes to alienating individuals from their own bodies, constituting a form of epistemic injustice.

2. Biocertification

In *Fantasies of Identification,* Samuels documents how in the mid-nineteenth century a profound cultural and political crisis emerged around the identifiability and governability of individual bodies within the broader body politic. Samuels observes that this crisis was driven by factors such as rapidly increasing geographic and class mobility, urbanization, colonialism, the development of the welfare state, and challenges to entrenched racial and gender hierarchies. One central concern was the state's and society's increasing inability to classify and categorize people across categories of meaning in an era where social and physical mobility and the anonymity of the city supplanted older systems of locating and fixing individual identity.

For instance, in rural areas where most everyone presumably has personal knowledge and affiliations with each other—they know their neighbours, their neighbours' families, and backgrounds—identity was more easily fixed upon the individual and enforced and regulated through this surveillance network. However, in the late nineteenth century, the rise of "ambiguous and illegible bodies" prompted a shift toward looking inside the body for truth (Samuels 17). An examination of cultural texts during this time period reveal how this new social world, and the factors listed above, led to "intensifying anxieties regarding embodied social identities, particularly those that differed from the recognizable subject of democracy: women, disabled people, and racial others" (Samuels 1). I discussed this fear in chapter 2 in relation to the *Rheumatology* authors' concerns that the anonymity of the city enabled women too much freedom to masquerade as ill and live an ill lifestyle without social checks on their behaviour that are presumably embedded in rural life. As a result of these same anxieties about ambiguous identities, new means of identity enforcement and regulation emerged and the body became the bearer of meaning while simultaneously locating this meaning within the body (18). This

meaning required an expert's gaze to be revealed (18). Samuels refers to this as the process of biocertification.

Biocertification "describes the massive proliferation of state-issued documents purporting to authenticate a person's biological membership in a regulated group" (9). This process was "less concerned with individual identity than with placing that individual within a legible group" (6). Samuels considers biocertification the mechanism by which the fantasy that biology can definitively determine identity is realized. It is furthermore a fantasy that Samuels states has been "fully institutionalized" in the present day (10). This fantasy is based on an assumption that the surface of the body reflects an inner truth that can yield "essential and reliable information" (Chinn 25; qtd. in Samuels 17). Importantly, the legibility of information that is buried beneath the surface "require[es] expert scrutiny to be revealed" (18).

However, Samuels emphasizes that this process is paradoxical for while it locates meaning within the body it also relies on "commonsense" visual cues to unearth this truth. Language plays a crucial role here in "closing the gap" between the physical appearance of a body and the inner truth it is supposed to reveal, while it also "signif[ies] the multiplicity of cultural responses" to this disparity (17). Thus, there is "a state of perpetual tension between physical and linguistic means of identification" that is "figured by race, mediated through disability, and often inscribed onto contested female bodies" (18). Influencing this tension is the fact that bodily identity is regarded as both visually knowable and potentially deceptive, carrying the unsettling possibility that a body believed to reveal its inner truth might instead be a "misrepresentation" (17). Modern identification systems resolve this tension by granting experts the authority to override not only an individual's bodily appearance but "more disturbingly, her own narrative of bodily and social identity" (17). This logic of biocertification—where bodily

truth is presumed to exist but can only be accessed through expert scrutiny—underpins what Samuels describes as an epistemology of visibility, which I examine in the following section.

a) Epistemology of Visibility & Surveillance

As Samuels observes, "the fantasy of identification…is predicated on an epistemology of visibility, in which identity can be easily read upon the body" (18). The epistemology of visibility refers to the belief that truth about identity can be obtained through what can be seen and measured on the body. This belief assumes that bodies transparently reveal who a person "really" is—whether through physical appearance, medical testing, or other visual markers. Such an epistemology is deeply connected to histories of surveillance and tracking, where technologies of measurement and observation are deployed to make individuals "legible" to systems of authority. The apparatus of legitimation operates on the premise that what we cannot see does not exist, privileging supposedly objective measurement tools over lived experience or self-reports.

This way of knowing is not merely philosophical but embedded in concrete historical practices. Samuels documents how, in the late nineteenth century, increased geographic and social mobility created new anxieties about identity imposture prompting "fantasies of fakery" (18). In response, institutions developed systems to make people visible in standardized ways: tools such as fingerprinting, biometrics, statistics, and identity documents provided new opportunities for coding bodies into trackable, categorizable units. This fixation on stable, measurable identities dovetailed with emerging systems of surveillance in the nineteenth century. Samuels states these fantasies "circulate as anxious dreams" that are preoccupied with "the looming possibility that unknowable bodies in a newly mobile world provide unprecedented possibilities for deception" (18). What was previously a mere possibility of deception shifted to

an assumption that "imposters are everywhere" (18). These fears about disability fakery "intersect[ed] with and sustain[ed] concerns about other forms of identity imposture based on gender, race, and class" (18). Such fears justified expanded systems of surveillance and bodily scrutiny of those who fell outside the norm.

As Lennard Davis has shown in his chapter "Constructing Normalcy," the emergence of statistics in the mid-nineteenth century influenced the concept of the "norm" which entered the English language around the 1840s. The norm reinforced the idea that deviance could be tracked, made visible, and thus controlled. Davis identifies figures such as mathematician and astronomer Adolphe Quetelet, who introduced statistics to the social sciences, and, Francis Galton, who was influenced by Quetelet's work and is known as the "father" of eugenics. Quetelet and Galton treated the human body as a repository of measurable traits that could be numerically recorded, compared against population norms, and ranked along a bell curve. This statistical framing positioned individual variation as either normal or deviant depending on where a trait was plotted on the curve (30). While statistics defined what was "normal," biometric tools provided the means for authorities to locate and track individuals who were perceived to fall outside this norm. These measurement tools provided a seemingly scientific justification for targeting marginalized groups, the poor, immigrants, and disabled people as inherently suspect or dangerous and potential threats to social order that must be monitored (or removed).

Galton's development of fingerprinting exemplifies how this logic translated directly into surveillance practices. Fingerprints were understood as unchanging biological signatures—markers of personal identity that could be catalogued and stored. Davis states that Galton believed they were "seen as a physical marker of parentage, a kind of serial number written on the body" (31). As Samuels argues, fingerprinting fed into "fantasies of marking" (19)—the

belief that the body could carry a permanent, infallible index of identity: a truth inscribed on the skin. Fingerprinting cemented these evolving ideas about identity being encoded in the body. In addition, in the hands of state authorities, fingerprinting became a powerful technology for tracking movement, confirming identity, and rooting out those labeled criminals, deviants, or undesirables. Fingerprinting ultimately reinforced the broader belief (or "fantasy," to use Samuels' term) that identity is fixed, measurable, and inheritable, and that a person's perceived fitness or deviance was coded on their body—that "the body has an identity that coincides with its essence"—which could be "read" by expert authority (31). It is important to note that this way of categorizing and monitoring individuals was not simply a descriptor but a method of control to regulate identity.

b) Social and Cognitive Authority of Medicine

The same assumption which drives state surveillance and systems of identification—the belief that truth about identity can be seen, measured, and proven through visible evidence—also governs medical practice. Just as the state sought to categorize, track, and verify individuals through visible markers like fingerprints and statistical averages, medicine similarly relies on visible, measurable signs to validate illness and identity. That is, the logic of visibility that structures identification systems also structures how doctors determine whether pain or illness is "real." Vyshali Manivannan accurately points out that "[m]odern medicine works by making the body's invisible parts visible" (4). "Within this framework, pain in the fibromyalgic subject becomes an ocular diagnosis, and one that must be machine-detectable in order to be confirmed" as real (Vyshali 2).

Following Goldberg (2017), Emma Sheppard explains in "The Case of Chronic Pain" "the stigma of chronic pain is directly tied to its invisibility" (148). In biomedicine, legitimacy

often depends on a visible lesion, a measurable symptom, or a test result that can prove the existence of disease. For many people with chronic pain, however, “there is no lesion, no sign of injury, and no test result” (Sheppard 148). In such cases, the absence of visual proof invites suspicion. The physician then becomes a kind of detective, “scrutinizing the body for clues that will support or disprove the individual’s claims” about their body “and then issu[ing] or den[ying] biocertification according to his (or occasionally her) findings” (Samuels 18). Samuels’ notes that “medical authority[‘s]” privilege in “validating identity reflects the modern turn toward visualizing bodies” whereby, quoting Foucault, “the ‘glance’ has simply to exercise its right of origin over truth” (*The Birth of the Clinic* 4; Samuels 18).

Wendell (1996) has similarly pointed out that scientific Western medicine holds both *cognitive* and *social* authority in shaping how we “describe our bodies to ourselves and to others” (117). Wendell borrows the term “cognitive authority” from feminist philosopher Kathryn Pyne Addelson to refer to “the authority to have one's descriptions of the world taken seriously, believed, or accepted generally as the truth” (117). Philosopher H. Tristram Englehardt similarly states that “medicine molds the ways in which the world of experience takes shape; it conditions reality for us” (Englehart 157; qtd. in Wendell 117). Susan Sherwin expands on this idea to further emphasize that “the reality that medicine creates is socially accepted; given the power and authority that are awarded to medical expertise, its reality is generally socially dominating” (Sherwin 1992, 191; qtd. in Wendell 117). This cognitive authority underpins the broader social authority of medical professionals, which stems not only from their professional expertise but also from their institutional affiliations, social status, and influence across a wide range of societal structures: “government bureaucracies, insurance companies, courts, schools, charities, rehabilitative organizations, and institutions for long-term care” (Wendell 117).

Wendell further references Irving Kenneth Zola's warning in 1972 that medicine is "becoming the new repository of truth" where "judgments are made by supposedly morally neutral and objective experts" (Zola 487; qtd. in Wendell 118).[64]

Operating within this realm, the *Rheumatology* authors speak of their own power as medical authorities and the importance of their use of specific language in validating a person's claims of bodily status—or issuing biocertification. Wolfe states that "disease is a biomedical term," as opposed to "[i]llness", a "biocultural term that implies social construction" (672). Thus, the deliberate choice of "diagnostic words carry meaning within the biomedical model of disease" (673). Within Wolfe's framing, words such as "diagnosis," "disease," and "disease mechanisms," particularly when they are spoken by physicians, professional organizations, and government, are code words for "real" (673). These words "carry with them the weight of science" (673). In contrast, terms that contain "psychological language carry with them connotations of a condition that is not believed": for example, "'[u]nexplained medical symptoms' is perceived by patients and physicians to mean that the symptoms are psychological in origin" (673). Wolfe admits to the power they, as physicians, hold as ultimate arbiters of truth about their patients and the power of biomedical language in legitimating or denying biocertification. As Sheppard notes above, key to this legitimation of disease is visual proof. Therefore, as Wolfe, Ehrlich, Hadler, and Gordon have shown, a lack of visual proof—determined through diagnostic testing, measurable symptoms, or visible lesion—invites their

[64] This critique of medical authority should not be confused with contemporary populist or anti-scientific rejections of expertise. Whereas populist anti-institutional rhetoric often seeks to discredit scientific authority wholesale or replace it with alternative "hidden" truths, the critiques advanced by Wendell (and Foucault) are not anti-scientific but epistemological and political. They interrogate how medical authority is constituted, whose knowledge it authorizes, and whose it marginalizes. The aim is thus not to deny the value of medicine or scientific knowledge, but to make visible the power relations and social hierarchies through which medical truth is produced and enforced, and to call for more accountable and inclusive forms of expertise, particularly where such authority eclipses patients' own accounts of their bodies and lives.

suspicion of malingering and policing of the borders of disability, all of which is based on an epistemology of visibility that grants them the authority to discount patient claims and withhold care.

c) Surveilling Women with Invisible Illness

Understanding how the history of emerging fears about disability fakery in the nineteenth century converges with new surveillance tools applied to contested bodies and the belief in the visibility of identity is crucial for grasping why women with invisible illnesses continue to face suspicion, surveillance, and denial of appropriate care. As the previous chapters have shown, the nineteenth century saw an increasing fixation with exposing fakers and malingerers, particularly in cases of contested or invisible conditions like hysteria, neurasthenia, or railway spine. Because these illnesses did not conform to the expected visual signs of pathology, they were read through a lens of suspicion: the patient might be exaggerating, lying, or attempting to extract unearned care or compensation. Surveillance and disciplinary tools emerged not only to classify populations but to police individuals whose claims of identity or illness were not easily verifiable.

This legacy reverberates today in the treatment of women with unexplained medical symptoms, like fibromyalgia. Cast as suspected malingerers, women with fibromyalgia are subjected to heightened scrutiny and diagnostic surveillance of their bodies and behaviour. Conforming to neither the expectations of an ideal patient nor the ideal able-bodied citizen who is considered a productive member of society, they are classified as deviant and regarded with suspicion. Because fibromyalgia cannot be captured on imaging scans or blood tests or other means of verifying illness through visible markers, the individual's status as truly ill or disabled is questioned. Rather than listen to patient testimony, physicians use standardized measurement

tools to reinterpret and reshape reported symptoms into something more palatable and easier for physicians and medical institutions to manage. In this way, diagnostic tools become instruments of surveillance, functioning less to validate patient experience than to police the boundaries of what is perceived as legitimate illness. The expectation that women with fibromyalgia submit to continual disclosure and monitoring by physicians, insurers, and even the public echoes nineteenth century fears of fakery and the belief in bodily legibility. In what follows, I will examine how framing fibromyalgia patients as potential malingerers underpins strategies that delegitimize their narratives, most notably through the denial of patient's own accounts of illness and identity in the name of preventing fraud. These personal accounts are instead replaced with the medical authority of diagnostic tools that purport to verify illness claims objectively but which ultimately simplify, devalue, and misrepresent lived experience.

3. Epistemic Invalidation/Epistemological Disablement

In *The Rejected Body*, Wendell explains that when a patient discloses symptoms that their doctor "cannot observe directly or verify independently of what the patient tells them," it is assumed these experiences are invalid (123). This creates a situation in which the lived experience of fibromyalgia is denied because these subjective symptoms cannot currently be proven by the objective measurement tools Western medicine uses to determine illness. Attempts to quantify lived experience of illness, therefore, actually work to delegitimize an individual's understanding of their bodily reality. This is part of the authority of medicine, Wendell states: it "tends to delegitimize our experiences of our bodies as sources of knowledge about them" (119). A person whose bodily experience diverges from medical descriptions of their condition, as is the case for fibromyalgia, is invalidated as a knower (122). Wendell calls this epistemic invalidation (122): our knowledge, measured against medical authority, is presumed to be

lacking. The power of medical authority in this case resides in its ability to write over the body, to superimpose its own version of what counts as "real." In this schema, it's not real unless medicine (or a medical authority) says so.

Anna Mollow has similarly written of this invalidation of patients who have been defined as hysterical. She refers to this process as "epistemological disablement": the assumption that "people with undocumented impairments" are "presumed deficient in self-awareness" and self-knowledge (191). While Wendell describes the invalidation of patient knowledge, Mollow's concept of epistemological disablement highlights the process through which patients are constructed as unreliable knowers in the first place. Mollow states that being defined as hysterical "means to be subjected to [this] process of epistemological disablement" (191). In other words, epistemological disablement is an effective strategy to deny biocertification and the access it could provide to healthcare and other resources. One of the most common methods the *Rheumatology* authors have displayed that epistemologically disables their patients is by invalidating patient narratives.

a) Invaliding Patient Narratives

In chapters 2 and 3, I discussed how fibromyalgia has been placed along a continuum of hysterical nervous disorders—hysteria, neurasthenia, and railway spine—and, just as these disorders were likewise framed, fibromyalgia is characterized as an unreliable disease of an unreliable narrator. In this same section, I wrote of how a patient's accounting of symptoms was reframed as a symptom in itself: talking about symptoms was taken as evidence of hypervigilance and excessive fixation on "symptoms or nonsymptoms" (Ehrlich 2003, 1666). This type of framing serves a purpose: it delegitimizes patient narratives and knowledge of our own bodies and supplants it with a doctor's narrative as the true authority of bodily status and

identity. As mentioned above, Samuels' notes how modern identification systems resolved the inherent contradiction in biocertificative legibility—that bodily identity is presumed to be readable on the body yet also potentially misleading—by supplanting an individual's "own narrative of bodily and social identity" with that of an expert authority (17). In Peter Logan's analysis of nervous bodies in nineteenth century physician Thomas Trotter's (1807) *A View of the Nervous Temperament,* he writes that "Trotter's placement of that same patient narrative at the center of his list of nervous symptoms is…part of a professional strategy to minimize the patient's authority within the new doctor/patient relationship, and his definition of the doctor as narrator is the necessary counterpart to that goal" (38).

Two centuries later, this same strategy is deployed by the *Rheumatology* authors who continually cast doubt about the validity of their patient's narratives. In Ehrlich's 2003 editorial "Fibromyalgia, a virtual disease" he questions assessments of fibromyalgia that use health questionnaires based on "self-report" because "validation" by an expert authority "is difficult or impossible" (9). For Ehrlich, expert authority validation is necessary because of underlying beliefs in disability imposture in which a fibromyalgia diagnosis in particular "could be 'falsely manipulated by the claimant'" (9). Ehrlich often acts as if his patients are manipulating their symptoms for secondary gain and that he is the ultimate arbiter in proving or disproving their claims. That Ehrlich is adopting the role of an expert and morally neutral authority who relies on the supposed truth of the body only scientific knowledge can provide is clear when he states that individuals who "cry" that "I am the evidence" is an "illogic" that "suggests innumeracy and an ignorance of science and logic" ("Pain is Real; Fibromyalgia Isn't" 1666). In making such a statement, Ehrlich is appealing to biomedicine's reliance on scientific objectivity which he positions above any patient declarations of their bodily experiences. The idea that an individual

might have knowledge of their body that medicine cannot validate is perceived as the rantings of an irrational individual who lacks comprehension of basic knowledge structures. This mistrust in patient narratives has led to attempts to circumvent their testimony with some suggesting that it is necessary to discount self-assertions altogether when they are involved in disability claims (Wolfe 1997, 1248).

Strategies that argue for circumventing patient testimonies exemplify Samuels' argument that "fantasies of identification are…predicated upon the rejection of individual identity claims" (18). As Samuels and others have identified, female bodies have long been contested and the bodies of women with medically unexplained symptoms are regarded as sites of potential deception. Always carrying with them this possibility of imposture, the physician uses a combination of diagnostic tools along with their own special "expert" observatory powers to override their patients' accounts and attempt to make these individuals legible from a biomedical standpoint. The *Rheumatology* authors therefore reject their patients lived experience and self-reporting of disabling illness in favour of placing them in a legible group: that of malingerers. They circumvent individual identity claims in order to, as Samuels notes, contain them within a "homogeneous, regularized grouping" that (in their view) seems "obvious" and "common sens[ical]" (Foucault, qtd. in Samuels 7; Samuels 4).

4. Mechanical Epistemic Injustice

As a result of "the human body…no longer [being] trusted as a reliable vector of knowledge," Coreen McGuire (2020) argues in *Measuring Difference, Numbering Normal* that "individual testimony was subsumed through the use of reliable laboratory instruments" (13). Patient testimony was therefore circumvented through these scientifically objective standardized measurement tools, as they offered a means "to make the invisible visible" (25). In doing so,

however, these standardized measurement technologies "commodified personal testimony about the body" and led to a devaluation of that which is difficult to measure or quantify (25). McGuire's argument builds on Graeme Gooday's (2004) insights into the measurement of electrical technologies in the nineteenth century where he notes that privileging easily measurable knowledge results in discriminating against what is less easily quantifiable, viewing such knowledge "as deficient in (numerical) evidential support or even as grounded on mere speculation or delusion" (qtd. in McGuire 12). His latter point—that knowledge lacking numerical support is perceived as delusional—is how the *Rheumatology* authors have portrayed their fibromyalgia patients: as if their bodily knowledge is deficient and their symptoms amplified by an obsession with their health status.

McGuire, in addition, notes how encoding biostatistical data "into machines" produced standardized norms for specific populations. In the process, the classificatory decisions underpinning these norms were obscured, rendering them naturalized, and the data they produced came to be revered as neutral and objective sources of truth (28). While measurement tools, then, provided ostensible "scientific objectivity," their use came at the cost of eliding, even denying, lived experiences. To use McGuire's phrasing, "[i]n making the invisible visible and making the personal visible we are led to situations where objective measures do not correlate with lived experience" (28). Because measurement tools are granted privileged status over personal or patient testimonials "in order to deny compensation, the lived experience of the disabled is denied" (28). McGuire refers to this process as "mechanical epistemic injustice" (28).

a) 1990 ACR Criteria: Tender Points

We can see this process at work in the *Rheumatology* authors debate over tender points as a key diagnostic criterion in diagnosing and legitimizing fibromyalgia. In 1990 the American

College of Rheumatology (ACR), of which Wolfe was the lead author, identified 18 so-called "tender points"—known as the tender point test—that were determined to elicit pain or tenderness upon the exertion of finger-point pressure (Wolfe et al. 1990). With the inclusion of this new 1990 criteria, to be diagnosed with fibromyalgia a patient must have 1) widespread pain (in 4 quadrants of the body) *in combination with* 2) tenderness at 11 or more of the 18 specific tender point sites" (Wolfe et al. 1990, 160; original emphasis). Wolfe et al. explain how the new ACR criteria offered a hitherto absent measurement tool to better study a "diffuse and hard to characterize syndrome" (1671). Tender points were a way to make the invisibility of pain visible to the physician's touch. This effort to locate pain in specific bodily sites closely resembles what Foucault describes in *The Birth of the Clinic* as the modern medical paradigm of spatialized observation, in which illness becomes recognizable only when it can be located within the body and observed by the clinical gaze. In this sense, the tender point system effectively maps pain onto the body, transforming a diffuse and subjective experience into a series of discrete diagnostic sites. Figure 3 depicts the location of these tender points.

Figure 3. The Three Graces

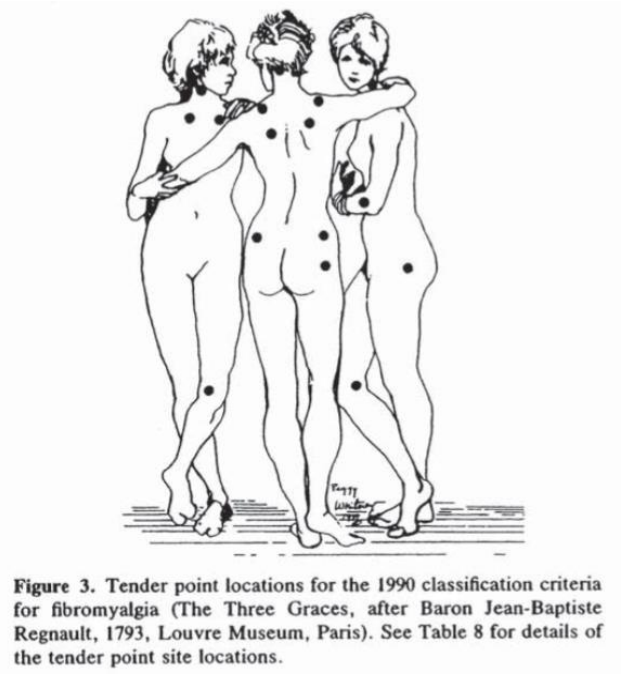


Figure 3. Tender point locations for the 1990 classification criteria for fibromyalgia (The Three Graces, after Baron Jean-Baptiste Regnault, 1793, Louvre Museum, Paris). See Table 8 for details of the tender point site locations.



Interestingly, to illustrate the location of these tender points the authors chose the figure of "The Three Graces," referencing the likeness to Baron Jean-Baptiste's Regnault's 1793 interpretation, an oil on canvas painting which hangs in the Musée du Louvre (as depicted on the right in Figure 3). The Three Graces are mythological goddesses, named Aglaia, Euphrosyne and Thalia by the ancient Greek poet Hesoid in *Theogony*. They have been the subject of many different artistic interpretations throughout the centuries, their forms shifting to reflect the artist's vision of a societal ideal. They always appear together, naked, holding hands and dancing in a circle. Separately, each sister represents youth, creativity, and fertility; together, they personify grace and beauty. In essence, The Three Graces embody qualities that are considered attractive in young women and as such represent the Western feminine ideal. Moreover, the Graces are eroticized figures—youthful, naked, and arranged for visual pleasure—that draw on a Western tradition that aestheticizes and sexualizes the female body as an object for visual consumption. In

this way, the image establishes not only a gendered but also a sexualized norm of femininity against which the fibromyalgia body is implicitly measured. This is a feminine ideal one would assume the fibromyalgia patients described in these articles fall short of. Certainly, the *Rheumatology* authors own descriptions of their female fibromyalgia patients portray them in terms of lacking these qualities. They do not embody grace; rather, they talk and complain too much. They do not exhibit youthfulness: they demonstrate "diminished vigor" and have "no *joie de vivre* [joy of life]"—as Hadler (2003) declares (1668). While fertility is not explicitly invoked in their discourse, the emphasis on diminished vitality and affect nonetheless situates these women as falling short of the culturally valued ideals of youthful, attractive, and heteronormatively reproductive femininity that the Graces symbolically represent.

Wolfe et al. (1990) do not clarify their reasons for choosing this particular image to illustrate these tender points. In a side-by-side analysis with Regnault's painting, one can see that the ACR's illustration of The Three Graces has been slightly modernized: their bodies are slimmer and their hair shorter, presumably updated to reflect prevailing ideals of femininity in the 1990s. It is notable that the authors chose this particular illustration, not only because it is not the clearest depiction of the supposed locations (since they are confusingly depicted across three bodies and, at best, only 15 points are readily visible), but also because it explicitly applies these tender points to young female figures. The authors thereby draw an association between fibromyalgia patients and gender, a characterization of the FM patient as a young woman that the articles under analysis in this chapter demonstrate and which I have discussed in chapter 1.

This emphasis on the gendered aspect of fibromyalgia diagnosis is perhaps not surprising when the tender point test is drawing on a long medical history diagnosing mainly young women with various nervous disorders and hysteria. In one of the first documented cases of its usage,

Walter Johnson's 1849 *Essay on the Diseases of Young Women* describes an examiner exerting pressure on a tender point where "he perceives his patient wince or give some evidence of pain," causing his physician to exclaim "Aha!...there it is" in an assumption that he has found the source of the disease. Dr. William A. Hammond, who authored *Spinal Irritation* (1870) and the first American textbook of neurology *A Treatise on Diseases of the Nervous System* (1871), also regularly used "tender spots" in his diagnosis of women experiencing spinal irritation in his eponymous book.

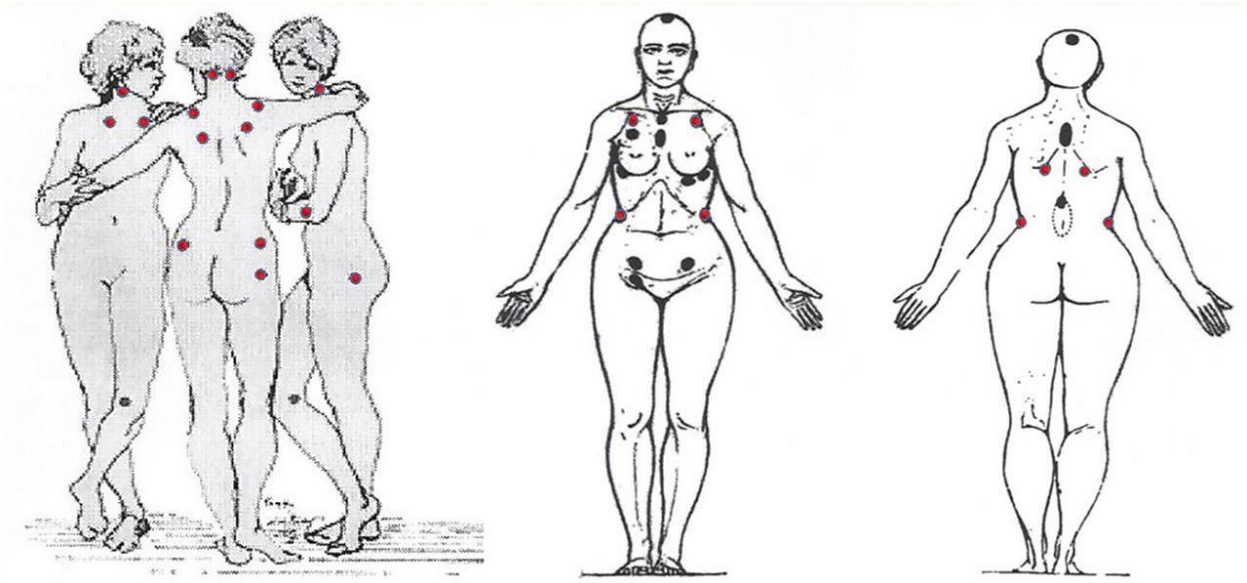
According to Hammond, those predisposed to be afflicted with spinal irritation are, first and foremost, females (in 85% of cases), unmarried women, and fall between the ages of 15-25 (21-22). Although Hammond states the cause of spinal irritation is difficult to ascertain, he does note that in nearly twenty percent of cases it "was obviously and admittedly caused by sexual excesses" (23). Hammond's leading causes of spinal irritation share significant overlap with hysteria as outlined in *A Treatise on Diseases of the Nervous System*: the first predisposing cause being sex (at a ratio of 99% female), followed by age (between the ages of 16-25), and finally among unmarried women. Despite this overlap, Hammond believes that spinal irritation, often subsumed "under the name of neurasthenia," is distinct from hysteria even as he acknowledges "spinal irritation often gives rise to hysteroid symptoms" (1; 20). While he notes that single women are overrepresented in hysterical cases, he believes this has more to do with their "lack of aims in life" instead of any "ungratified sexual desires" (630). He therefore pinpoints "[w]ant of occupation" as "one of the powerful predisposing causes" for he has found in "countries where women work, hysteria is unheard of" (630). Interestingly, where he suggests work is a type of prophylactic to hysteria, he claims that American women, specifically, are more prone to spinal irritation, "to a greater extent than the people of any other country in the world" (1).

Reflecting common beliefs and anxieties about modern life and women in the nineteenth century, Hammond reasoned that women were inherently more fragile and therefore more susceptible to nervous conditions than men and that a sedentary lifestyle contributed to these nervous conditions by weakening the body and spine. American life was also judged for being too demanding and creating too much excitement upon the nerves of women who were already vulnerable to nervous strain. In his own words, "any cause capable of reducing the powers of the system may produce spinal irritation" ("Spinal Irritation" 23). Hammond's comments anticipate George Beard's regarding neurasthenia; as discussed in chapter 3, he also perceived neurasthenia as an American disease particular to the American way of life. Although Hammond attempts to differentiate between hysteria and spinal irritation, his beliefs about lack of physical activity contributing to spinal irritation and lack of work contributing to hysteria echo similar theorized causations for neurasthenia and, later, fibromyalgia. Localized tender spots along the spinal column, however, was the hallmark of spinal irritation and one of the key ways Hammond distinguished it from hysteria.

Less than a decade after Hammond's treatise on nervous disorders was published, tender points as a diagnostic tool resurfaced in French neurologist Jean-Martin Charcot's Salpêtrière. Here they are referred to as "zones hystérogènes" or hysterogenic zones. Charcot theorized there were "circumscribed regions of the body on which pressure or simple rubbing" would produce an aura that commonly precedes a hysterical attack, and if the pressure is persistent, may provoke such hysterical attack (88; qtd. in Micale 153). In addition, "[t]hese points or patches may…be the site of permanent hypersensibility and, before an attack, of spontaneous painful irritation" (88; qtd. in Micale 153). According to Micale, "Charcot believed that these hysterogenic points were usually small, about the diameter of a common coin" (153). Sounding

remarkably akin to the description of fibromyalgia tender points, Charcot's identified hysterogenic zones also share corresponding bodily locations. Tieve et al. (2015) found likewise when they state "[t]hese fibromyalgia tender points are similar to the ones described by Charcot in 1890, defined as "zones hystérogènes"…overlapping perfectly" (2096). Figure 4 is an adaptation of Tieve et al.'s visual comparison of the 1990 ACR tender point diagram with Charcot's hysterogenic zones: the red dots indicate the areas of overlap.

Figure 4. Tender Points v. Hysterogenic Zones



One of Charcot's former students extrapolated from Charcot's use of tender points or hysterogenic zones to propose his own hypothesis. On March 15, 1895, Freud writes to friend Wilhelm Fliess, "I have invented a strange therapy of my own: I search for sensitive areas, press on them, and thus provoke fits of shaking which free her" (Masson 120). In this case, pressing on tender areas not only serves to diagnose a problem, but to cure it. Unlike Charcot who thought hysterogenic zones to have fixed locations, Freud believed there were additional zones which could move about the body, corresponding to some repressed trauma that was his job to uncover. For Freud, hysterogenic zones took on the properties of erogenous zones. In the same year as his

letter to Fliess, Breuer and Freud published *Studies on Hysteria*, in which they state "if one pressed or pinched the hyperalgesic skin and muscles of her legs, her face assumed a peculiar expression, which was one of pleasure rather than pain" (137). They deduce the "stimulation had touched upon a hysterogenical zone" (137). First termed an "erotogenic zone" in an 1896 letter to Wilhelm Fliess, a decade later in *Three Essays on the Theory of Sexuality* Freud made his thoughts regarding the connection between hysterogenic and erogenous zones explicit: "[e]rogenous and hysterogenic zones show the same characteristics" (184). Erogenous zones should sound familiar, as they have entered popular consciousness as areas on the body which excite sexual feelings when stimulated—just as Freud proposed. Their historical linkage with Charcot's hysterogenical zones is likely less well known. Freud's reformulation harkens back to Hammond's original comments regarding these points: that in some cases they indicate "sexual excess." What this meant in practice was that women's reports of bodily pain—and their bodily responses under clinical examination—were increasingly psychologized and sexualized, shifting the clinical encounter away from treating pain as requiring care and toward interpreting it as evidence of hidden emotional or sexual disturbance. While Freud's interpretation of these supposed zones or points later branched into explicitly erogenous territory, the earlier use of tender spots as diagnostic sites nonetheless remains part of the historical legacy underlying the later use of tender points in fibromyalgia diagnosis.

i. Invalidating Tender Points

The reasons for the proposed abandonment of the tender point test for diagnosing fibromyalgia are less peculiar and complex than its adoption. Despite Wolfe being lead author on the 1990 ACR article introducing the efficacy of the tender point test for a fibromyalgia diagnosis, thirteen years later he reverses his standpoint, stating that the criteria are no longer

suitable (Wolfe 2003, 1671). The caveat, according to Wolfe, is that this tool was useful in the 1970s and 80s when the idea of pain, fatigue, and sleep symptomology represented a "new" form of illness category, but the value of these criteria have outlived their usefulness (1671). However, Wolfe's justification for arguing the tender point criteria, specifically, was a mistake is to point to how a "physical examination item" allowed "FM to be seen as mostly a physical illness" and "ignor[ed] the central psychosocial and distress features of the syndrome" (1671). For Wolfe, the problem with tender points is that they are a "distraction from the central psychosocial symptoms of patient distress" (Gordon 1665). It becomes clear that Wolfe's issue with these criteria is that, in his view, it falsely upholds FM as a physical disorder—an opinion that rests on the assumption that FM's central features are psychosocial and distress-based. His beliefs, in this way, echo Hadler's and Ehrlich's.

In their co-authored 2003 editorial discussing the "conundrum of disability determination" for fibromyalgia, Hadler and Ehrlich state that "'[t]ender points" have been co-opted as indicators of the severity of 'disease' and for certifying disability by patients, patient groups, and the plaintiff's bar" (1030). After their adoption in the 1990 ACR diagnostic criteria, tender points had served a legitimizing function for FM, which furthered the understanding of FM as a disabling condition. In other words, tender points provided a means to biocertify patients with fibromyalgia as legitimately disabled. This in turn led to an increase in disability compensation claims. Hadler and Ehrlich state that the use of tender points as diagnostic criteria in the clinic has been "construed as validating the premise that fibromyalgia is a chronic, sometimes disabling, and incurable rheumatic disease" (1030).

After discrediting tender points as "unreliable," "nonspecific," and "irreproducible," Hadler and Ehrlich state they have no value and only contribute to validating the "construct" of

FM (1030). Having dismissed tender points as falsely upholding an objective basis of pathology, they are now able to argue that "the label fibromyalgia denotes nothing more than a patient population experiencing a stereotypical constellation of medically unexplained symptoms" that has "no physical basis on which to infer disability and no objective adjudicative basis on which to premise an indemnity award" (1030). While Hadler and Ehrlich, along with Wolfe, have argued that FM lacks an objective basis of pathology to determine physical impairment (and therefore, in their view, disability), when criteria have been presented that validates physical symptoms they are rather quickly dismissed (Wolfe 2003; Hadler & Ehrlich 2003). I am by no means suggesting that tender points are useful or that their use is not without its problems or even that an objective measure of pain is necessary to prove pain exists. What I do want to interrogate is the authors reasoning for discrediting them altogether.

Significantly, in this editorial Hadler and Ehrlich share that they were "asked by leaders in the insurance industry to consider options relevant to the circumstance of a claim for an indemnity award because of disablement attributed to fibromyalgia" (1030). They state their editorial aimed to broadcast their response to the insurance industry to a "wider audience" (1030). Their admitted involvement in influencing individuals determining insurance claims for those with fibromyalgia is important. It shows that they are invested beyond treating their patients and have an interest in how and who are receiving disability compensation. This might reveal a potential conflict of interest as, by their own admission, their opinions were solicited by insurance industry leaders.

Their editorial includes a section on "The Plight of the Claimant" which is more or less focused on the type of person who claims fibromyalgia. This type of person, they state, is usually in the lower socioeconomic bracket, a frequent user of healthcare with a tendency toward

"hypochondriacal beliefs and a preoccupation with bodily symptoms" (1031). A quarter of these patients, they claim, would qualify for a "primary psychiatric disease"—a claim I would suggest they, as accredited rheumatologists, are not qualified to make (1031). These statements are no different than those I have examined in previous chapters which aim to psychologize symptoms and portray patient narratives as unreliable. Wolfe (2003) makes a similar comment that "[t]he White and Thompson study tells us about tender points but very little about the persons who have these tender points" (1671). All three authors seem to suggest the focus should not be on tender points but instead on who is "hidden," as Hadler and Ehrlich state, behind these criteria; the assumption seems to be that they will reveal a type of personality that they can instead pin down as a chronic complainer who insists on the need for medical treatment.

What the addition of tender points to the diagnostic criteria for fibromyalgia achieved was to differentiate "individuals with the new fibrositis…from healthy people on a quantitative basis" and buffer those who suffered from chronic pain "from accusations of psychogenesis" (Quintner & Cohen, "Fibromyalgia Falls Foul of a Fallacy" 1093). But what Wolfe, Hadler, and Ehrlich are now suggesting is a return to examining the personality and psychology of those with fibromyalgia from which the tender point criteria is detracting its focus. Their questioning of tender points as lacking validity, along with questioning their patient narratives for lacking veracity, is a strategy that situates their own beliefs as the only true account of illness. If they play on repeat that patient narratives and tender points cannot be trusted, then their word supercedes that of their patients' and the diagnostic criteria when it comes to disability compensation. The fact that insurance companies sought their opinion on determining compensation for fibromyalgia demonstrates how highly their word is regarded as arbiters of truth. It furthermore suggests insurance companies themselves have a vested interest in

leveraging these rheumatologists' opinions (as opposed to research) as a means to deny compensation claimants.

Hadler and Ehrlich mention how past "adjudication of claims relied on attestation statements provided by treating physicians" (1030). Now, the physician's statement is "supplemented" by "clinical and diagnostic medical data," which only works well when disease is clear such as in the cases of "rheumatoid arthritis and emphysema" (1030). However, this "process is stymied when there is no readily demonstrable pathology," as in cases of medically unexplained symptoms or "functional somatic syndromes like fibromyalgia" (1030). The authors also heavily imply that some treating physicians can be manipulated by their patients, perceiving the "patient/claimant as 'customer' and preferring to provide services that will please the 'customer'" (1030). These physicians are especially vulnerable to manipulation if they are "unschooled" in the role of the "pathogenesis of disability confounders that derive from the psychosocial context of life inside or outside the workplace" (1032). In a section on "Solutions to the Conundrum," they propose that part of the solution rests with primary care physicians: their role is to "intercede as educators to their patients regarding this potential for social iatrogenesis" (1031). Treating physicians are uniquely positioned to convince their patients their symptoms are reversible and not a "fixed pathology" (1031). Hadler and Ehrlich are articulating that it should ultimately fall to the properly educated and skilled physician to legitimate or deny biocertification based on their expert and morally attuned judgement—regardless of documentary evidence of the tender point test.

However, this solution is secondary to what they first propose. Throughout their editorial, Hadler and Ehrlich have linked disability determination and "indemnity schemes" to the introduction of tender points as a diagnostic criterion. Wolfe and Walitt note that "[b]etween

1996 and 1999, Social Security disability allowances became available to disabled patients with the condition in the US, and fibromyalgia was designated as a 'medically determinable physical impairment' by the presence of tender points" (754). Hadler and Ehrlich state that the main reason leaders in the industry solicited their opinion was because "[a]djudicators employed by private insurers have responded by taking a highly circumspect approach to the treating physician's opinion and relying more on collateral evidence corroborating the claim" (1030). The expert physician's glance as possessing "its right of origin over truth" is being thwarted by the evidence of tender points. This is why part of their solution is for the primary care physician to "educate" their patient before they might seek compensation. When a claim reaches adjudication, the physician's opinion might be undermined or overridden by the evidence of tender points.

Therefore, their first proposed solution to the problem of claiming compensation is to deny all future disability claimants on the basis of fibromyalgia altogether: "[e]xcluding them *sui generis* must be the default posture" (1031). In effect, they are arguing to deny all fibromyalgia patients biocertification. They then suggest a "compromise" might be to "offer indemnity coverage for the functional somatic syndromes as an option"—or rather, a type of premium add-on to the basic healthcare policy that would effectively charge patients more to have their needs covered. Adding the additional cost to the individual directly would presumably lower the cost of the basic policy for everyone else while also acting as a deterrent to claims, thus, "spar[ing] some of these ill individuals the hazards of social iatrogenesis"[65]—that is, the harm they believe results

[65] Iatrogenesis refers to harm caused by medical intervention. Ivan Illich distinguished between clinical, social, and cultural forms of iatrogenesis, with social iatrogenesis referring to the ways medical institutions can produce illness roles or reinforce dependency on medical authority through the broader organization of health care and social systems. See Illich, *Medical Nemesis* (1976).

when medical and compensation systems validate illness claims and thereby grant biocertification (1031).

Hadler and Ehrlich do suggest an alternative solution. This solution would "demand adjudication on the basis of worthiness" (1032). With this suggestion they cite an article Hadler published a year previous that briefly documents the history of the welfare state and includes a discussion of Hadler's opinion on workplace avoidance under a section titled "Enlightened Employment" (409). Hadler implies that people with regional musculoskeletal disorders are a "sizeable population dependent on various income replacement and income substitution schemes" (409). By framing people with musculoskeletal disorders as welfare-dependent, Hadler continues the shift I outlined above from evaluating symptoms to evaluating the moral character of those who report them. He assumes that the 15% "mire[d]" in the welfare state are disaffected by work. This assumption leads him to suggest 3 solutions, which I assume comprise the "alternative solutions" with which Hadler and Ehrlich mysteriously end their 2003 editorial.

First, Hadler says, impairment-based disability determination should be "eschew[ed]" (409). Instead, he states, "[l]et a jury of 'peers' learn the rules, hear the plight, and determine disability" in the same way a jury would perform in a courtroom. He refers to this as being a responsible citizen. He then suggests early education in "life's moral dilemmas" in schools which would prepare "youngsters [that] are able to discuss health adverse behaviours" (409). This education is coupled with "vocational habilitation" which should be the "mainstream curriculum" for it introduces adolescents to "working adult life" (409). Finally, he proposes HR departments that "manage corporate sickness and injury claims" be more proactive (410). This is where he states that "there is a price to be paid" as a result of the disaffected worker and claims this lesson was first learned "from an analysis of the plight of a worker who finds no option to

seek redress for a regional back 'injury'" (410). He outright asserts that "[t]he incidence of regional back 'injuries' is a reflection of disaffection in the workplace" and that "injury" in this context is a "construct," which he emphasizes by the frequent use of scare quotes around the term (409).

All of these solutions, taken together, are focused on morals and values, as if instilling what Hadler believes are proper values will eliminate disability and the related compensation claims from those with musculoskeletal disorders. He essentially suggests societal norms can school the individual, and their peers, into recognizing the value of work, and that where this fails, HR can play a part in proactively dealing with disaffected workers before they claim disability. Given that these are the solutions hinted at in Hadler and Ehrlich's editorial, it is clear that at issue is not so much tender points, but that the presence of tender points might offer a means out of work-related duties by legitimizing and thereby biocertifying disability. Moreover, tender points are determined by the patient's voicing of feeling pain or tenderness upon pressure. They are not a test a physician can determine objectively. If a physician is suspicious of a patient's reporting, they might perceive tender points as easy to fake for secondary gain. Medically invalidating tender points, therefore, is one way to limit disability and compensation claims that Hadler and Ehrlich believe arise from dissatisfaction with work life.

Wolfe's strategy to invalidate tender points is to compare its diagnostic validity to diagnostic criteria used in other chronic conditions. Wolfe suggests that the diagnostic criteria of FM, which measure the severity of symptoms rather than defining the illness by its characteristic clinical features, is absurd by providing the following analogies: "It is as if we were to define rheumatoid arthritis (RA) by requiring 25 swollen joints, or diabetes by requiring diabetic coma"

(1671).[66] These deliberately hyperbolic analogies betray a fallacy of false equivalency as pain and fatigue cannot be measured in the same way as the examples given. The way in which these other illnesses are mentioned takes the form of red herrings as they mislead the reader toward a false and biased conclusion. Through this analogy, Wolfe suggests that pain and fatigue cannot *ever* be considered a legitimate means to diagnosis because *everyone* experiences these symptoms to varying degrees at some point: i.e. pain and fatigue are common and simply an inescapable part of life. As Ehrlich says, "everybody has pain sometimes" (1666). Wolfe, along with Ehrlich and Hadler, seem to reject the premise that pain and/or fatigue could be experienced to an unusual and overwhelming degree, which could in fact be debilitating and disabling. As such, measuring severity of symptoms does make sense. However, they instead present fibromyalgia as a pathologization and medicalization of what they argue are common experiences of pain and fatigue.

Part of the misunderstanding about pain underpinning their comments is the distinction between chronic and acute. Emma Sheppard points out how "[t]his position of chronic pain as meaningless reflects an inadequate explicit differentiation in medicine between acute pain—as sign of injury—and chronic pain" (148). Sheppard notes that "acute pain is visible pain with a known cause" and this pain is therefore "made reasonable" (148). Chronic pain, by contrast, is considered "unreasonable" because of its "invisible (and thus non-existent) injury" (148). Chronic pain confounds "how bodies experience pain" and does not fit within medical expectations of "why pain is experienced" (148). As I explained previously, medicine operates

[66] Another interesting aspect about this comparison to diabetes is that, according to the Chronic Pain Research Alliance (CPRA), in 2014 diabetes research received 35 times the amount of funding from the NIH than vulvodynia, TMDs, IC, fibromyalgia, endometriosis, IBS, chronic tension-type headache, chronic migraine, chronic low back pain, and chronic fatigue syndrome *combined* ($1.06 compared to $35 per person). This disparity is striking given that chronic pain affects over 100 million Americans, compared with approximately 40 million Americans with diabetes (IOM 2011; CDC 2026). Moreover, much of the of the research on chronic pain has focused on finding causal factors in personality disorders or psychological origins.

within an epistemology of visibility, in which pain is treated as legitimate when it can be linked to observable injury or bodily reactions recognizable to the clinical gaze; chronic pain, which often lacks such visible markers, lies outside this knowledge structure. Tender points were a way to make the widespread chronic pain of fibromyalgia visible to the clinical gaze by locating it in specific sites on the body and applying it as a standardized measurement across bodies. But unlike most acute pain, which is typically linked to visible injury and presumed to resolve as that injury heals, chronic pain does not conform to medical expectations that pain should correspond to a visible injury or identifiable cause. This fundamental misunderstanding has led to treating symptoms that do not and cannot subscribe to an easily measurable diagnostic test with suspicion and faulting patients based on physicians' narrow definition of pain.

In part due to this limited understanding of pain and the assumption that chronic pain is the same as acute pain, "medicine has considered pain to be a symptom of disease" (Dusenbery 169). As Maya Dusenbery explains, pain is primarily considered "as a clue pointing toward the underlying problem" (169). The assumption is "cure the disease, and cure the pain" (169). While this approach might work for most underlying causes of acute pain, it does not accurately capture chronic pain. In 2001, the European Federation of IASP Chapters (EFIC) declared that "chronic and recurrent pain…is a disease in its own right" and in 2004 The International Association for the Study of Pain (IASP) recommended their declaration be adopted globally.[67] In a 2011 Institute of Medicine (IOM) report, they state that "[t]his profound recasting means that pain requires direct, appropriate treatment rather than being sidelined while clinicians attempt to

[67] The IASP/EFIC shift toward defining chronic pain as a disease in its own right coincided with, and rhetorically paralleled, a period in which opioid manufacturers—particularly Purdue Pharma—were actively funding pain-advocacy groups to promote this very reframing. While the precise degree of influence on IASP cannot be definitively determined, the alignment between industry messaging and professional declarations underscores the extent to which commercial interests shaped the broader epistemological landscape of pain medicine. The influence of multiple institutional and commercial factors provides important context for how pain was being defined at the time and who was involved in shaping approaches to treatment.

identify some underlying condition that may have caused it" ("Relieving Pain in America" 26). The *Rheumatology* authors insistence, therefore, that treatment of pain is harmful stands in tension with pain experts who argue that pain is a serious and disabling disease that needs prompt treatment.

The notion of mappable tender points provided a new way to biocertify patients, except it backfired when the evidence of tender points was considered over and above the physician's expert opinion, thereby denying them the power to decide who deserves to be issued biocertification and who they believed should be denied. On the surface, tender points provided a seemingly verifiable and standardized way to establish a fibromyalgia diagnosis and prevent malingering. The *Rheumatology* authors, however, argue that it did the opposite by opening the door to increased disability compensation claims. While the tender point test presented itself as a convenient and standardized method to determine fibromyalgia, it relied on the patient's subjective experience that physicians cannot independently verify, and which they claim could easily be faked. Assuming there is no fakery happening, in actuality tender points may have limited who qualified for a diagnosis if they did not experience 11 of the 18 required tender points. So, while the authors' collective argument against the methodological criteria for diagnosing fibromyalgia might be worth considering with respect to the criteria's efficacy, their reasons for rejecting those criteria are fundamentally ideological. The true issue these physicians seem to have with the ACR criteria is the legitimacy it gives to fibromyalgia as a "clinical diagnostic entity" (Gordon 1997, 1247). In giving fibromyalgia diagnostic validity, Wolfe cites four problems: medicolegal, treatment, psychological status, and the disease. Medicolegal is listed as the primary problem as it enables "increasing medicolegal claims for disability entitlement" (1247). After his analogies mentioned above, Wolfe, too, states that "[b]y defining

pain and distress in this special way, we opened the door to the *prima facie* claim of disability" (1671). This concern with claiming disability for secondary gain comes to dominate the discussion, subordinating considerations of patient care.

ii. Simplistic Systems of Categorization

Many of the editorials reference other diseases that are determined through diagnostic testing, in effect setting up a hierarchy of illness wherein illnesses that can be rendered visible through medical testing are considered valid and their diagnostic labeling appropriate, in contrast to fibromyalgia, whose diagnostic label is deemed inappropriate and harmful. Ehrlich argues that the very act of labelling is what creates fibromyalgia as a disease category. He states that "[n]o one has FM until it is diagnosed" (Ehrlich 1666). His contention is that people do experience chronic pain, but that this does not justify a legitimate means to diagnosis. Ehrlich responds to arguments made regarding other syndromes that, similar to fibromyalgia, do not have "verifiable physical features" such as "migraine headache and dyslexia" (1666). His retort to these arguments is that "these are well defined conditions *with exacting criteria*, which FM (and the closely related fatigue syndrome) lacks" (1666-67; emphasis added). Ehrlich's comments here reveal that his concern lies both in the lack of "exacting criteria" and in the complexity of symptoms that characterize fibromyalgia, which he regards as too amorphous or insufficiently "well defined." Thus, Ehrlich exposes his bias towards quantifiable measurements and the ostensible scientific objectivity they provide and accordingly views a deficiency in exacting criteria as grounds for dismissing fibromyalgia altogether. In other words, Ehrlich demonstrates the discrimination towards less easily measurable knowledge McGuire speaks of and uses it as justification for regarding the criteria used to diagnosis fibromyalgia "as grounded on mere speculation or delusion" (McGuire quoting Gooday 12).

Citing historian Ted Porter's research on the emergence of standardized measurement tools in the nineteenth century, McGuire emphasizes Porter's findings that "single numbers" were especially privileged "as representative of truth and objectivity" (23). Not the same as simply numerical values which represent quantities of things that can be described or compared, single numbers compress qualitative realities into one definitive metric. Single numbers are imbued with authority and treated as objective truths, which gives them great social and political power. They transform embodied experiences into a single number that appears authoritative, and these numbers are then used to determine access to insurance, compensation, and other systems. Speaking specifically of IQ tests, which demonstrate the strengthening of the association between single numbers as a prime measure of objectivity in the twentieth century, Porter indicates that these tests were not only used because of their "perceived objectivity, but also because of their convenience and cheapness" (McGuire 23). IQ tests became one of the most influential examples of this logic, helping to establish the authority of single-number metrics more broadly. This is a significant observation about the power of standardized measurements and their growing authority within healthcare, especially when considering the economic measurement of lives in a society that ties life-worth to productivity and where access to compensation systems is based on measurements of capacity.

The rise of statistical measurements and the privileging of single numbers as objective truth had profound consequences for how life, health, and disability were valued. Using the example of life insurance, McGuire demonstrates how single numbers as a tool of objectivity began to creep into other arenas of life and establish itself as a "signature feature of modernity" (Bouk; qtd. in McGuire 23). When calculating life insurance, the worth of a person's life was reduced to a pragmatic calculation of lost income after death. In this cost-benefit formulation,

families were compensated for the loss of the principal wage earner's future earnings, a precise measurement that is conveniently replicated. This cost-benefit logic reinforced the idea that the value of life was tied to economic productivity, a framework that later shaped public health priorities.

McGuire emphasizes that one striking consequence of the privileging of single numbers was the treatment of heart disease: although it was the leading cause of death for both men and women, it was recognized as a public health emergency primarily in men because they tended to die younger, during their working years (23). Women, who often died later in life, were excluded from the same urgency of medical concern, leading to their underrepresentation in heart disease research. What appeared to be objective statistical reasoning was, in fact, a value judgment that privileged "productive" years of life. This reliance on single numbers ultimately obscured women's health needs and perpetuated gendered inequalities in medical research and care—inequalities which persist to this day (McGuire 142; Bosomworth & Khan 2023).

McGuire uses this example to demonstrate how seemingly simple systems of categorization that are used to measure and standardize aspects of human experience are important contributors that shape how disability is classified and perceived. By exposing the reliance on such numerical logics and standardized measurements, McGuire shows how these systems of measurement and categorization influence understandings of what counts as natural, valuable, and who is deserving of care. The problem is not the quantification itself but how these standardized measurements mask the value judgements that underpin them, even as they present themselves as natural and objective measurements of human worth and capacity. I argue the *Rheumatology* editorials rely on these same simplistic systems of categorization to justify continual denial of the lived experience of fibromyalgia in their equation of who is a deserving

healthcare seeker within a cost-benefit analysis which pits the needs of the individual against the interests of the (welfare) state. As touched on above, one consequence of standardized measurements is that the quantification of qualitative and subjective experience tends to obfuscate an individual's lived experience. Technological measurement tools cannot accurately capture these experiences, and instead they supplant their own version of "real" (McGuire). In essence, technological measurements write over the body. Therefore, the quantitative abstraction in the form of a standardized measurement is taken as more real than the actual experience of illness, so much so that in the absence of effective criteria, illness is presupposed to be absent as well.

One major point of contention within the *Rheumatology* articles is that the diagnostic criteria are not effective at proving or disproving illness. I would say that this is possibly true, but instead of using this lack of effective criteria to deny the legitimation of illness as these authors attempt to do, the issues raised concerning the criteria's efficacy should instead point to the problem of attempting to make all illness experiences conform to an objective measurement. As Hadler says of fibromyalgia in 2013, "there remains no 'objective' finding that cements the diagnosis or quantifies its degree" (217). The idea that measurement tools do not provide an accurate account of illness experiences is arguably overlooked by these authors because the bias toward objective measurement tools within an epistemology of visibility is so ingrained in healthcare as the only way to account for disability. This factor is also unlikely to be considered because the authors' analysis is shaped by their own preoccupation with disability claims and work avoidance, as demonstrated in Hadler's framing of regional back injury as a construct of workplace disaffection and Wolfe's warning that diagnosis itself enables claims—a logic that, as

argued above, underlies the medical invalidation of tender points as a means of limiting entitlements.

What these editorials reveal then is how modern healthcare is overly-reliant on measurement systems to determine illness and disability. As discussed above, this was not always the case. And according to Maya Dusenbery's research, this is not always the case for all individuals. Dusenbery notes how even in the absence of objective criteria or "proof," men tend to be believed routinely for their recounting of symptoms while women are not granted the same respect and must also defend their mental state (412). This automatic disbelief of reported pain symptoms is exacerbated for racialized women who experience profound barriers to accessing healthcare as medical racism compounds sexism—often resulting in untreated or undertreated pain and, in some situations, even death (Spear). The inclination to disbelieve some individual identity claims over others aligns with Samuels' observation that biocertification regulates "unknowable," "ambiguous," and "contested female bodies" (18). Essentially, biocertification targets bodies that are othered against a normative bodily standard, which places women seeking healthcare in the position of having to prove their identity claims, scientifically, to receive medical validation.

b) The Pain Scale

The signature symptom of fibromyalgia is pain. This is what the tender point test attempted to measure and standardize. However, following its repeated and published criticisms, the tender point test fell out of favour and was more or less abandoned as part of the diagnostic criteria in 2010, twenty years after its introduction.[68] The pain scale was never officially part of

[68] The 2010 revision of diagnostic criteria specifies it was intended as an alternative to the previous criteria and "[e]ven though the new criteria do not include a physical examination criterion, all of the patients being diagnosed should have a physical examination, which may include examination of tender point sites" (Wolfe et al. 609).

the diagnostic criteria for fibromyalgia; yet, it is still widely used as a tool for tracking pain intensity and informing a doctor's perception of their patient's experience of pain. The use of the pain scale is not fibromyalgia-specific and does not contribute to a diagnosis of fibromyalgia. But that does not mean it has not played a crucial role in determining severity of pain and as a way to track a patient's subjective perception of pain—or as Ehrlich might phrase it, their "illness beliefs." Although the pain scale itself is not part of the diagnostic criteria, the revised 2010 criteria incorporate a similar logic by translating patient-reported symptoms into numerical scores.

The pain scale is another standardized measurement that attempts to quantify subjective symptoms. While pain scales are often presented in terms of their intended clinical utility[69]—as tools for standardizing and communicating subjective pain—I examine how this standardization operates in practice and the *effects* it produces, particularly how it shapes the interpretation, validation, and dismissal of chronic pain within clinical encounters. The pain scale further illustrates the dominance of single numerical measures in medicine, translating subjective experiences of pain into convenient numbers that can be interpreted and validated by clinical authority. In this sense, it exemplifies the reliance on "single numbers" that McGuire identifies as a defining feature of modern measurement systems, in which complex bodily experiences are compressed into a single numerical value presumed to represent objective truth. As McGuire argues, such measurement systems can produce a form of mechanical epistemic injustice, wherein the output of a standardized tool is treated as more authoritative—and more "real"—

[69] The widespread adoption of numerical pain scales in North American clinical practice cannot be understood apart from broader efforts to standardize pain assessment in the mid–late 1990s and early 2000s, including initiatives by organizations such as the American Pain Society, which promoted the concept of "pain as the fifth vital sign," alongside campaigns supported by pharmaceutical companies, notably Purdue Pharma, that encouraged routine pain quantification as part of broader efforts to expand opioid prescribing. See Van Zee (2009); Bowra et al. (2024).

than the patient's own account of their body. The use of the pain scale is highly contested amongst those of us who experience chronic pain, which I will explain below. Drawing on my own experience with the pain scale, alongside accounts from others living with fibromyalgia and chronic pain, helps illustrate how reliance on seemingly straightforward numerical measures fails to capture the complexity of fibromyalgia and reveals the biases embedded in diagnostic practices that privilege quantifiable evidence.

The pain scale asks you to rate your level of pain from, typically, zero to ten. These single numbers are supposed to reflect a standardized measurement from which an outsider can objectively assess an individual's subjective experience of pain. Such a scale seems to exist under the premise that simply stating one is in pain is not enough to determine whether one is in severe enough pain to warrant treatment. This pain must therefore be verified by a physician in order to be considered real. There are, of course, a number of problems with this approach. This assumption reflects mechanical epistemic injustice as the patient's account of pain is not treated as valid as the numerical representation. As I have been discussing, standardized measurements detract from the actual experience of pain. Is a number on a scale more legible than a description of pain? A number might simplify pain into something more palatable and make it easier to categorize those experiencing pain into groups, but for what purpose? To make pain visible and legible to the outside observer.

As Eula Biss writes in their poetic essay on "The Pain Scale," "[t]here was nothing to illustrate my pain except a number, which I was told to choose from between zero and ten. My proof" (75). Biss critiques the scales greatest flaw for measuring only intensity of pain, not duration, which they emphasize with the following example: "[t]he suffering of Hell is terrifying not because of any specific torture, but because it is eternal" (79). Pain scales do not account for

fluctuating, chronic pain, as they assume that pain is fixed and stable in the moment. Anyone (everyone) who has experienced pain should know this is not true, even in cases of acute pain.

i. A Personal Tour Through the Pain Scale

Pain is not necessarily fixed in one place on the body, an assumption that certainly arises from understandings of acute but not chronic pain. How is one to rate pain in their shoulder, pain in their hip, and pain in their head separately and ignore the fact that these individual pains themselves might contribute to an all-over greater experience of pain? Drawing from my own experiences, the last time I was asked to rate my pain I was given a diagram of a body—a hybrid of a tender-point-style localization tool and a numerical pain scale—requiring me to assign zero-to-ten values to different parts of my body. I recall being at a loss of how to do this accurately when my left shoulder might feel like a "2" today but could cross into unbearable at any point. Which pain was I then rating? How I felt in the moment or an average of how I remember it usually feels? And this process was repeated for every area I could label as painful, prompting the question "Where does pain worth measuring begin?" (Biss 68). What about where my hip pain connects to the pain in my ribcage and from there spreads out through the left side of my chest to then tighten, impossibly, into my neck fuelling brain fog and tension headaches? How can I reduce all these different types of pain—throbbing, aching, stabbing, burning, squeezing, ebbing and flowing—into one simple number that is supposed to convey any kind of meaning? How can the standardized measurement of the scale express these nuances as it attempts to fit pain into a linear narrative?

The McGill Pain Scale shown in Figure 5 below diverges from the ten-rating model. It places fibromyalgia near chronic migraine, as slightly more painful than non-terminal cancer, and only a couple points less painful than prepared childbirth. It is not nearly as painful as

amputation of a digit, however, or the notorious pain of passing kidney stones. The value of this particular scale lies in giving more credence to misunderstood pains, such as fibromyalgia, and the highest on this scale, complex regional pain syndrome, which is rated as even higher than having one's finger amputated. Placing different experiences of pain as relative to each other might also illuminate how someone else experiences pain if you've experienced one of these listed but not another.

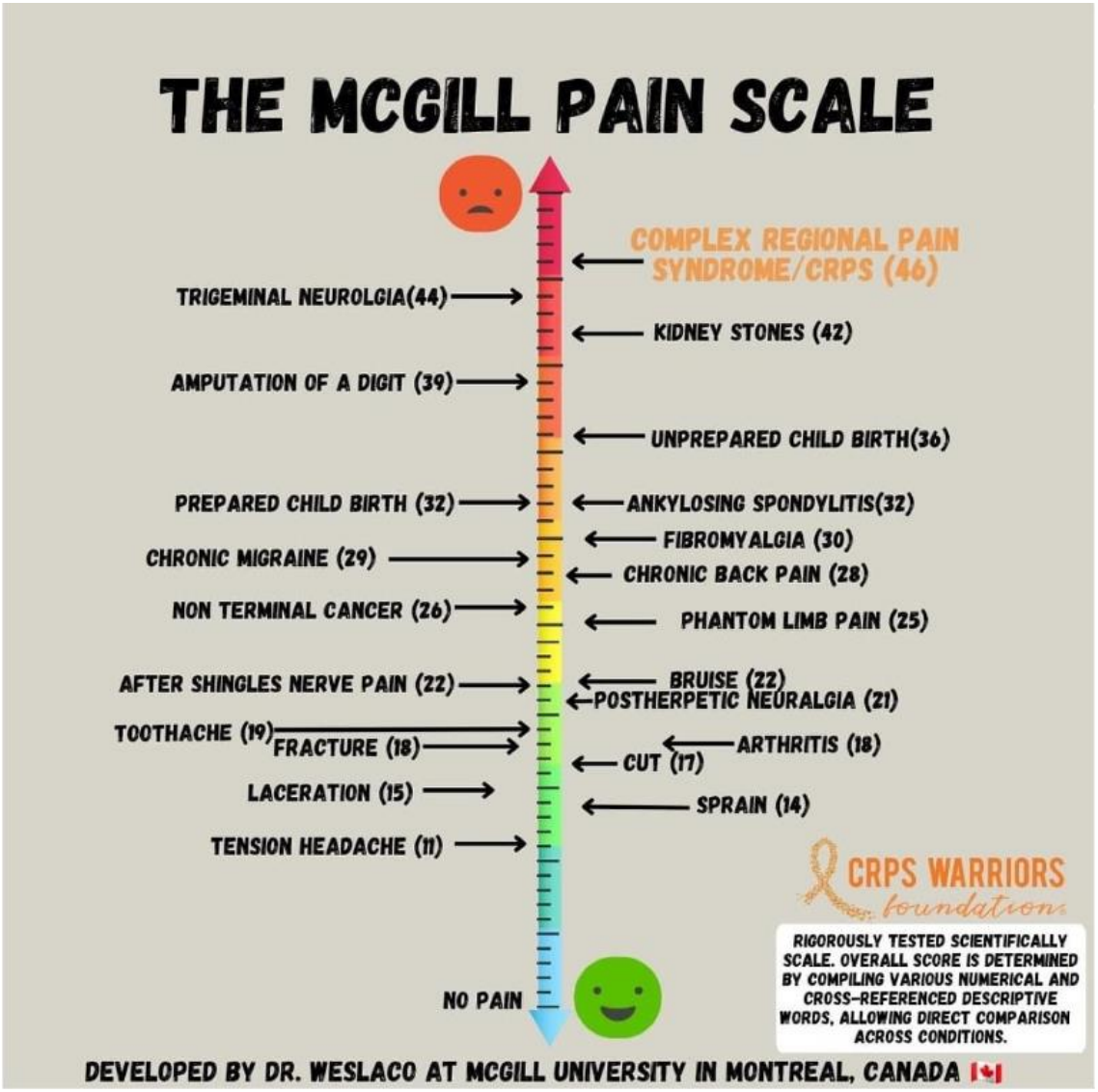
But this scale also assumes all people who have fibromyalgia, for instance, experience the same amount or type of pain and that the pain of fibromyalgia is stable. Chronic migraine is rated as nearly the same pain level as fibromyalgia and yet my own experiences of both cannot relate to these numbers on the chart for they differ not only from each other but themselves in the day to day and even year to year. What I might have rated on the scale as an 8 years ago, I might now rate as a 4. When being in pain becomes normalized as part of our everyday existence, we tend to adapt to it and develop a baseline from which we measure. This doesn't mean it gets 'easier' but that our perception might change. I am never at a "0" and I can't even begin to understand what that might feel like. Relatedly, if someone has not experienced much pain or illness in their life they might rate their pain as much higher on the scale than someone who experiences pain chronically.

Chronic migraines are something you might in some way learn to live with to the point that you don't perceive how you would rate this pain until you literally collapse from it, sobbing, as you tip over some invisible line into agony. Fearing how long the pain will endure at this point is, indeed, what I would call Hell (Biss). Chronic migraine, moreover, is often encapsulated as a symptom of fibromyalgia, as is chronic back pain, but on The McGill Pain Scale they are listed separately. If you, my reader, reflect on your own pain experiences in relation to this scale, do

you find the numbers accurately align with your experiences? How do you feel about the placement of different pain experiences? Do you object at their ordering? My point is we all approach this chart differently, relative to our own experiences, and this raises questions about the scale's collapsing of painful experiences into definitive measurements.

What about fatigue? Another hallmark symptom of fibromyalgia and one I find impossible to separate from pain because fibromyalgia fatigue *is* pain. And yet how do I rate it on this scale in a way that encapsulates what I mean? Biss states that "[h]earing someone describe their pain as a ten is much easier than hearing them describe it as a hot poker driven through their eyeball into their brain" (83). But is the metaphor not easier to understand and potentially relate to? As Manivannan states in her Foreward to "Hollow Me, Hollow Me" "for patients who rely on metaphor to describe the embodied experience of chronic pain" language that has been stripped of embodiment has material consequences, especially for "disabled women…whose pain is regularly considered suspect" (n.p.). Manivannan illustrates this concept through an analysis of her medical chart wherein the physicians attending to her care continually overwrite her experience. Part of the problem with the pain scale is it detaches the pain from the person experiencing it. Pain is equivocated by standardized scales, lending the false impression that one's experience of fibromyalgia is the same as another's, which inevitably leads one to encounter assertions from others that 'they know so and so with fibromyalgia and they can manage to do x so why can't you?'.

Figure 5. The McGill Pain Scale



Some other scales attempt to put a face to pain. The widely-used Wong-Baker Faces Pain Scale shown in Figure 6 combines numbers, phrases, and facial expressions to help rate pain.

Figure 6. Wong-Baker Faces Pain Scale



This scale is intended to be more accessible to children who would not know how to express their pain in a number alone (do any of us?). It is also intended to be more expressive than quantitative. The facial expressions on the scale become increasingly distressed with the rise of the number. They are meant to correspond to an expression you might use if in pain. There are many problems with this. For instance, a number 9-10 on the scale shows people crying or screaming from pain. Many people will not express extreme pain in this manner. Many factors will influence how people show pain, including culture, neurodivergence (such as autism), gender, etc. Manivannan has cautioned, "we need to recognize the limitations of standardized expressions of chronic pain" ("What We See When We Digitize Pain," 5). Manivannan writes of how the decision to take pain seriously by a medical practitioner rests partly on performance: "The decision to image the body is contingent on what the medical gaze sees as significant and not what I say, so that certain outward expressions of affect become medical currency, a permission slip for biomedical intervention" (8). If you therefore say that your pain is at a level of 10 but your facial expressions fail to match the expectation of crying/screaming, then it is very likely a physician will not believe your pain level to be at a 10. This is what happened to Manivannan: as "[they] don't outwardly grimace or wince," they describe having to "perform an externalization of [their] lived experience, a kind of disability masquerade to visually and vocally

demonstrate physician expectations of pain [they] feel" (3). Tobin Siebers has likewise described the disability masquerade that requires disabled bodies "[perform] to stereotypical expectations…in order to deflect the suspicious gaze" (96-104; qtd. in Samuels 133).

Manivannan also writes of the need to mask pain: the assumption that extreme pain must be visible on the body or via facial expressions she describes as "an attitude that fails to consider how sensory perception and manifestation change when pain is a normal, ordinary feature of existence, one I can't make visible as often as I feel it without threatening my social and professional stability" (3). Many of us are put in this situation where it would be perceived as inappropriate or unprofessional to visibilize the actual level of pain we feel. There is the further risk of doing so in workplace environments which could lead to stigma and ableist judgements about productivity, as well as unwanted vulnerability that comes with disability disclosure. In these cases, masking or keeping pain invisible might be the more strategic move to avoid the consequences that might come with making pain visible. At the same time, however, when "[t]he pain is a roar that cannot be ignored" it is assumed that pain "has to be visible" or it cannot be real (Manivannan 3). It is a catch-22.

The ceiling of a rating of 10 is also obviously false. One person's experience of the most extreme pain depends on what they have experienced. This makes the numbers relatively meaningless when the scale is always sliding based on what most extreme pain circumstance one has endured. Even if a physician recognized the relative and shifting nature of the scale for each individual patient and adjusted their interpretation accordingly, the patient themselves experiences this shift in calibration. As mentioned above, after years of living with chronic pain we may rate our pain as lower over time, even when the actual intensity of that pain has increased. This means that even attempts to track pain longitudinally through numerical ratings

are unreliable, because the numbers themselves no longer correspond consistently to what the scale is meant to represent. This instability therefore exposes the limits of the pain scale as an accurate or useful reflection of levels of pain.

Many of us with chronic pain have had to memorize detailed explanations of pain scale numbers because we often underestimate how our level of pain registers on the chart, leading doctors to believe it is not that bad. Even if we rate our pain as accurately as possible against the scale, doctors tend to believe women's pain is less severe than men's even when expressing identical pain levels (Zhang et al.). If we are honest about our pain and rate it highly, and especially if we are not showing proper affect to match the rating, doctors might assume we are catastrophizing and instead offer treatment such as cognitive behavioural therapy (CBT) to manage our "perception" of pain rather than treating the pain itself. Pain then becomes a result of a "disability conviction" that CBT can cure if only "patients [are] willing to unlearn" their illness behaviours (Hadler and Ehrlich 2003, 1031).

Another consequence of reporting a high pain number on the scale is you might be accused of drug-seeking behaviour. Racialized women are especially vulnerable to having their pain dismissed based on this racist stereotype. In *Doing Harm*, Dusenbery recounts Jackie's story as a young black woman who, even with a diagnosis of lupus, was routinely accused of drug seeking behaviour and that this stereotype functioned as her biggest barrier to accessing healthcare (160). Jackie further noted how gender and class compounded her mistreatment where if she cried or visibly showed pain, she was labelled a "hysterical drug seeker" but if she remained "stoic" she must not really be in that much pain (160). After being denied prescribed pain management while in hospital, Jackie observed the only thing that made a difference to receiving proper pain treatment was by mentioning that she was a professor. This revelation

distinguished her from the stereotype the doctor held that she was "impoverished and coming off the street just to get a meal and some drugs" (160). Jackie's story illuminates that the numbers on a pain scale become even more redundant if reporting is likely to be dismissed based on factors such as race, gender, and class.

Even the pain scale is at odds with the traditional medical definition of pain. The International Association for the Study of Pain (IASP) originally defined pain as "an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage" (1979). This definition reflects a longstanding neurobiological model in which pain evolved as a signalling system that warns the body of actual or potential injury. Yet this definition sits uneasily alongside many conditions recognized as producing severe pain. The McGill Pain Scale includes conditions that are widely recognized as painful, yet many of these conditions do not involve tissue damage. While migraines are known to sometimes cause white matter lesions in the brain (Eikermann-Haerter & Huang), many conditions listed on the scale do not. Those with fibromyalgia, for instance, have been assured that "despite potentially disabling body pain, patients with fibromyalgia do not develop tissue damage or deformity" (Jahan et al.). How, then, are we to reconcile the recognition of such conditions on widely used pain scales with a definition of pain that frames the experience in relation to bodily injury? As Biss writes, "Pain that does not signal tissue damage is not, technically, pain" (80).

In response to precisely this tension, the IASP updated its definition in 2020 to describe pain as "an unpleasant sensory and emotional experience associated with, or resembling that associated with, actual or potential tissue damage." The inclusion of the term "resembling" was intended to address this problem by acknowledging that the signalling system associated with injury can also produce pain even when no tissue damage is present. The revision responded to

concerns that earlier definitions were too readily interpreted by physicians as requiring demonstrable tissue damage in order for pain to be considered legitimate (IOM Report). By introducing the term "resembling," the updated definition attempts to acknowledge that pain may occur even when no such damage can be identified. Yet despite this attempt to broaden the concept of pain, the updated definition still implies this link. While the addition of "resembling" seeks to legitimize pain that lacks visible pathology, the wording still anchors pain to the model of bodily damage from which it emerged. Moreover, the wording of the definition inadvertently opens the door to interpretations in which the experience of pain is recognized as real while its origin is attributed to psychogenic factors. For example, clinicians can acknowledge that patients genuinely experience pain while still interpreting that pain as resembling injury only in the patient's perception. This dynamic becomes particularly significant when considered alongside the DSM-V's category of somatic symptom and related disorders, discussed in chapter 1, which similarly emphasizes that physical symptoms may be experienced as real even when understood to originate in psychological processes. The *Rheumatology* authors likewise insist that they understand the pain their patients feel is real even if it is a result of psychogenesis.

The new definition also raises the question of why pain must still be described in relation to damage in order to be considered valid. This difficulty reflects the challenge of describing chronic pain within the biomedical model. While the newest definition widens the understanding of pain and attempts to untangle it from the biomedical insistence on damage, it is still tethered to this idea of tissue damage as a means of making pain visible and clinically measurable. Even though the definition has expanded to attempt to lend legitimacy to "invisible" pain, the language of "resemblance" still situates pain within frameworks that make it observable and classifiable within clinical practice. The definition retains a biomedical touchstone that demonstrates how

pain continues to be questioned without objective verification, whether through an obvious visible pathology or through measurement frameworks such as the pain scale. That is, despite these attempts to improve the definition, it still operates within an epistemology of visibility. The real question then is why pain needs to fit within such a framework. If I say my back hurts, why does it need to be independently verified in order to be proven real? One answer lies in the suspicion of malingering. Scales like these are a means of proving or disproving malingering when patient testimony is not good enough and visibility demarcates what is real.

c) 2010 ACR Criteria: Widespread Pain Index (WPI) & Symptom Severity (SS) Scale

One can see how the tender point test was grounded in the idea that pain must be physically detectable on the body, which coincides with the older definition of pain as actual or potential tissue damage. As definitions of pain changed to acknowledge the invisible, the diagnostic criteria for fibromyalgia that replaced tender points in 2010 put more focus on subjective experiences of pain. These criteria used a version of the pain scale to document and standardize pain. The 1990 diagnostic criteria for fibromyalgia required 1) widespread pain for at least 3 months and in 4 quadrants of the body, and 2) 11 out of 18 tender points. In 2010, these criteria were replaced with 1) the Widespread Pain Index (WPI), which includes a checklist of areas with pain (nineteen) which are not rated for severity, and 2) the Symptom Severity (SS) Scale which measures fatigue, unrefreshing sleep, and cognitive symptoms on a scale of 0 (corresponding with no problem) to 3 (indicating severe). Part b of the SS scale also includes other somatic symptoms (a list of forty) that range from itching to irritable bowel syndrome to seizures. Answers across the index and scale are scored[70] and meet the criteria for fibromyalgia if

[70] The conditions that must be met for fibromyalgia criteria: 1a) The WIP score is greater than or equal to 7 **and** the SS score is greater than or equal to 5 **OR** 1b) The WPI score is from 3 to 6 **and** the SS score is greater than or equal

the score threshold is met or exceeded. Wolfe was also lead author on the revised 2010 diagnostic criteria.

Very obviously the biggest change in the criteria from 1990 is the diagnosis shifted toward self-reported symptoms. Another major change is the movement away from fibromyalgia as 'just pain' to instead encompass a very wide range of symptom clusters. These revised criteria are intended to reflect a broader and more patient-centered approach to diagnosis as they also recognize fibromyalgia to be a multisystem condition with far-ranging symptoms. The new criteria also offer the opportunity to include those who would have been excluded from diagnosis because of the limitations with the tender point test. On the surface, these changes are good—they acknowledge fibromyalgia is a complex pain condition, they remove the expectation that pain must be associated with tenderness and made visible through palpation, and they privilege self-reporting of symptoms.

However, we cannot forget that these changes are still occurring within a system that does privilege an epistemology of visibility and has been inclined to discount self-reporting of pain symptoms. As I have documented throughout this dissertation, these *Rheumatology* authors (including the lead author of this revised criteria, Wolfe) have continually shown their doubt of patient testimony and their resistance to the idea that fibromyalgia is not merely a social construct and argue that its legitimacy as a "real disease" should be removed. By removing the tender point test, they have eliminated one of the key criteria that, they have argued, was providing legitimacy to the diagnosis and increasing claims of disability. Now that diagnosis is solely reliant on self-reports through WPI and SS, it seems that patients might be even more

to 9. 2) Symptoms have been present at a similar level for at least 3 months. 3) The patient does not have a disorder that would otherwise explain the pain. The worksheet for the 2010 diagnostic criteria is available in the appendix and at this link: https://www.umassmed.edu/globalassets/office-of-continuing-medical-education/pdfs/cme-primary-care-days/c1-handout-fibromyalgia.pdf

vulnerable to physician dismissal. Removing tender points and focusing on pain narratives might make it easier for physicians to invalidate pain. I am obviously not arguing that we should not consider self-reports. If self-reporting was believed as a legitimate means to validating illness, that would be ideal. But these physicians still hold the power to deny this legitimacy and have made clear they are concerned with malingering. In the articles and editorials I have been examining, they have demonstrated an underlying preoccupation with how to stop fraudulent claims of disability.

So, what does it mean that self-reporting of symptoms has replaced previous criteria when fibromyalgia patients are simultaneously portrayed as unreliable narrators? In a medical culture that values objectivity and visible pathology, relying on self-report might open patients to greater suspicion. If the only evidence is their word, and their word is considered untrustworthy, then physicians predisposed to doubt may have all the more ammunition to discount patient testimony of symptoms as evidence of psychosomatic illness, hyperbole, or malingering. Therefore, while greater weight is leant to self-reporting in the 2010 criteria, this does not solve the underlying cultural problem that pain without visible pathology continues to be distrusted. And it does not account for persistent biases in a medical culture that continues to dismiss and psychologize the pain of women and other marginalized groups.

Moreover, the 2010 criteria do not merely give patients carte blanche to subjectively describe their symptoms. These criteria are molded into carefully structured self-report tools that effectively transform subjective symptoms into standardized scores. They provide numeric thresholds for diagnosis and quantify pain and symptom severity. This provides physicians with a standardized framework from which to interpret a patient's testimony. Self-reports are therefore mediated through a structured format in an attempt to make invisible pain legible in

order to weed out who is "really" disabled or in pain. These structured self-reports demonstrate McGuire's point that standardized measurement technologies subsume and commodify personal testimony, a process that devalues or denies the lived experience of disability.

On the one hand, the revised 2010 criteria appears more patient-centered because it recognizes self-report, yet it continues to subject patients' reports to a bureaucratic form—through checklists, scores, and numerical thresholds—that strips narrative complexity. Even though it may seem like patient testimony is being given greater credence, their testimony is now confined within checklists rather than the previous tender point exam. Whereas the 1990 tender point test converted patients' subjective pain into a physician-controlled physical exam, producing a visible count (11 out of 18 points), the 2010 criteria quantifies self-reported symptoms into numerical thresholds that must be met for subjective experiences to be considered valid. Patient narratives are therefore still constrained.

These checklists and numerical thresholds were moreover deliberately made to be simple: the developers of the criteria state their goal was to provide "improved quantitative measures of body pain" with "simple categorical scales" that can be easily replicated in the clinic (608-09). The focus is not on accurately capturing the lived experience of fibromyalgia, but on making the test convenient and simple for physicians to use. This reflects Porter's observation that it is not just objectivity these criteria seemingly offer: it is their convenience and cheapness that makes them appealing. As I have already discussed with McGuire's critique of single numbers, simple systems of categorization standardize human experience, shape what experiences are considered natural, and transpose the complex lived experience of illness into single numbers as a measure of what counts as real (McGuire).

Just like the pain scale, the 2010 criteria revision functions as an abstraction of pain. McGuire notes how this very process of abstraction and standardization strips a fundamental piece of knowledge in ways that both misrepresents illness and results in alienating people from their own bodily experience. In effect, while lending a veneer of centering patient narratives, the 2010 criteria disciplines patient voices: acceptable testimony must conform to quantifiable boxes. To be diagnosed with fibromyalgia and have one's pain medically validated as real is contingent on converting illness experiences into legible, standardized data. Rather than outright silence patients, these requirements structure how individuals can speak and be heard. When legitimacy is only offered through this carefully structured and bureaucratized process of self-reporting, the belief system that underlies a mistrust of non-visible pain is reinforced and a person's own understanding and knowledge of their body is, as Wendell says, delegitimized (119). The messy, fluctuating lived experience of fibromyalgia is instead transformed into something legible to physicians and administrators—a process that not only fails to capture the nuances of lived disability but binds the truth of that experience to items on a checklist. The credibility of a patient's testimony is then tied to reproducing their truth through this standardized checklist. Suspicions of malingering have therefore not disappeared with the new criteria since a patient's testimony is not believed on their own terms but rather filtered, confined and managed through this standardized administrative process that only grants legitimacy of diagnosis (or biocertification) to those who can map their symptoms correctly onto a regulated form.

Despite these shortcomings, major revisions to the fibromyalgia diagnostic criteria have been lauded for centering patient voices, acknowledging that pain without visible pathology is real, and expanding on the understanding that fibromyalgia is more than a pain condition; rather,

it is a complex, multidimensional disorder. This latter point is captured by the inclusion of the expansive 40 symptom checklist on the symptom severity scale. However, these changes that seem to center self-reports are surprisingly at odds with the *Rheumatology* authors' prior insistence that patients are too easily able to claim disabling symptoms and gain access to "disability rewards" without outside verification. Even though Wolfe (1997; 2000) has questioned the ease with which individuals can fake fibromyalgia symptoms for rewards, he is first author on the very symptom checklist that expanded fibromyalgia's scope.

Three years after revising and expanding the diagnostic criteria, Wolfe and Walitt published an article that uses this expansion of the symptom checklist as evidence that fibromyalgia resembles neurasthenia, a historically discredited disorder they place alongside hysteria and railway spine, all of which they state are now understood to have been "almost always psychogenic disorders" (754). Fibromyalgia's evolution from "a regional pain disorder to a multiple system disorder"— a shift the expansive list in the 2010 criteria sought to capture by recognizing a wider range of symptoms as important (609)—is used to fuel their argument that "[t]he current description of [fibromyalgia] is indistinguishable in most respects from neurasthenia" (751). In making this maneuver, any legitimacy given to patient self-reporting is undercut and the recognition gained that fibromyalgia is a complex, multisystem disorder now invites criticism that fibromyalgia has become too vague and the diagnosis too socially constructed.

By linking fibromyalgia explicitly to neurasthenia based on these new criteria, Wolfe and Walitt reinscribe the suspicion that patients are suffering from a psychosomatic or culturally-mediated condition. Their argument that fibromyalgia should be recognized as neurasthenia risks re-stigmatizing patients as malingerers or complainers. Therefore, any credibility gained from

the 2010 criteria has three short years later been undermined, with women's pain again dismissed as psychosomatic, as merely representing "a narrative of distress" (Hadler 2013, 217), and the diagnosis accused of being "strongly influenced by social forces" (Wolfe and Walitt 751)—and ironically by the same individual who took part in devising the new criteria in the first place. The quick turnaround in discrediting these symptoms reveals how vulnerable the fibromyalgia criteria are to strategic rhetorical framing that can either validate suffering or delegitimize it depending on how it is narrated and who is doing the narrating. Moreover, the ease with which these criteria went from showing recognition to being used as evidence that the diagnosis lacks validity demonstrates how systems of categorization that attempt to make illness legible can just as easily be used against individuals to render them suspect.

d) Tools of Surveillance

Nearly since its inception, the tender point test was criticized for lending false legitimacy to a psychosomatic condition. While the tender point test had roots in being applied to supposed historical nervous disorders, its use for fibromyalgia did not do a good job of shielding against malingering and instead, in the author's minds, increased it. The expanded 2010 symptom checklist, however, made it easier to circle back to the argument that fibromyalgia is merely the latest in a long line of hysterical nervous disorders. Therefore, while the 2010 criteria did seemingly grant more power to patient testimony, it also enabled the *Rheumatology* authors to more explicitly disregard fibromyalgia and claim it is a psychogenic disorder. It therefore does not matter that one might meet the requirements for a fibromyalgia diagnosis according to these criteria if the diagnosis itself is being rebranded as code for a hysterical nervous disorder. It is impossible to determine if the revised 2010 criteria were deliberately set up to later argue for the psychogenic nature of fibromyalgia, but the effect of including such a vast expansion of potential

symptoms has been an effective strategy to keep the debate about fibromyalgia as a contested illness alive.

Tools such as the tender point test and the pain scale were always about trying to determine if one's pain was real, part of a deception, or significant enough to warrant treatment. These tools were a means to set up biocertificative legibility: to standardize human experiences based on faulty assumptions that bodies and identifies are stable. They were also importantly a way to root out fraudulent claims of disability. Standardized measurements are a means to certify or deny one's human experiences. They are surveillance tools seeking to "authenticate a person's biological membership in a regulated group" (Samuels 9), a status which is granted only by meeting pre-determined criteria. Tender points as a standardized diagnostic tool began to be questioned because they allowed too many people in: they "opened the door *prima facie* to claims of disability" (Wolfe 1671). To its critics, this test failed to shield against malingering, a key goal of objective measurement tools according to McGuire: it was believed the test could be abused by malingerers. Wolfe clearly thinks this when he states the test is "a notoriously unreliable and manipulable exercise" (1997). Malingerers could then fake subjective symptoms to which the test lent a veneer of objectivity which outweighed a physician's own opinion in disability compensation cases. A lot of effort was expended in repeated publications disavowing tender points for this stated reason. They too easily legitimized pain. And they took power away from the physician's assessment of whether or not their patient's pain was being fabricated for secondary gain.

The revised 2010 criteria, while seeming to offer more legitimacy to patient testimony, were then reframed as evidence of fibromyalgia's resemblance to neurasthenia to further the argument that fibromyalgia is a psychogenic condition. Even if one's documented symptoms

meet the criteria's threshold, it is uncertain which legible group they are being placed within. Satisfying the requirements for a fibromyalgia diagnosis according to the 2010 criteria does not result in the biocertified status of being legitimately ill. Rather, meeting these requirements has been configured to place one within a different grouping altogether: as a neurasthenic, now code for psychogenic disorder, and this condition's implicit association with suspicions of malingering. You could say that instead of removing suspicions of malingering from a fibromyalgia diagnosis, the new criteria, especially the expansive checklist of symptoms, has encoded it. The checklist therefore functions as a means to document a suspected psychogenic condition historically associated with malingering. An individual, having met the requirements, can be denied access to healthcare resources and potential disability supports.

5. Conclusion

This chapter has examined the *Rheumatology* authors' claims about fibromyalgia as part of a broader strategy through which they attempt to address the perceived problem of malingering and secondary gain. By analyzing their critiques of the tender point test, their responses to the revised 2010 criteria, and the use of standardized tools such as the pain scale, I have shown how these diagnostic frameworks function as mechanisms that determine whose accounts of illness are recognized as legitimate. Operating within an epistemology of visibility, these tools shift authority away from patient testimony and toward externally validated measurements that are presumed to reveal the body's "true" condition. As a result, subjective reports of pain are subordinated to simplified numerical representations that compress complex bodily experiences into standardized metrics. Read through the concept of biocertification, these diagnostic tools operate as forms of surveillance that determine whether individuals with fibromyalgia can be recognized as legitimately ill or disabled. At the same time, the privileging

of standardized measurement systems reproduces what McGuire terms mechanical epistemic injustice in which numerical outputs generated by diagnostic tools are treated as more authoritative than patients' own knowledge of their bodies. These dynamics demonstrate how the medical invalidation of fibromyalgia is sustained not only through explicit claims about psychogenesis but also through the diagnostic technologies and epistemic frameworks that determine how illness is recognized in the first place.

In the next chapter, I will examine more closely how issuing or denying biocertification functions as a means to classify who is worthy of care, rights, and recognition. I will expand on what Samuels notes is one of the current primary roles of biocertification in disability determinations: to restrict access to accommodations and resources. My previous discussions of the *Rheumatology* authors' framing of fibromyalgia patients within discourses of dependency, as malingerers who are costs to the healthcare system, and as epidemic threats who are emblematic of a breakdown in societal values, I will argue function to justify the removal of health resources altogether. These portrayals are not incidental but operate as additional strategies through which the *Rheumatology* authors rationalize their medical invalidation of fibromyalgia. In this framework, they situate healthcare as a commodity, rather than a right, that is bestowed or withheld at the physician's paternalistic discretion.

Chapter 6:
Strategies to Justify Medical Invalidation: Benevolent "Care"

1. Introduction

In the previous chapter, I argued that the *Rheumatology* authors' claims about fibromyalgia can be understood as part of a broader discursive *strategy* that functions to "solve the problem of malingering" (Garland-Thomson). One of the central ways this strategy operates to guard against malingering is by systematically overriding patient testimony and medically invalidating fibromyalgia symptoms through practices of biocertification. As I discussed in the last chapter, biocertification functions to validate or deny an individual's claim to illness. Within our current medical system, I argue that biocertified status is a necessary precondition to access even basic care and supports. In this chapter, I will examine more closely Ellen Samuels' observation that a key function of biocertification of disability is to restrict access to accommodations and supports (179). Withholding biocertified status is therefore a potential means to control suspected malingering. The claims examined in previous chapters, which collectively frame fibromyalgia patients within discourses of dependency, as suspected malingerers who are burdensome "costs" to the healthcare system, and as epidemic threats who are emblematic of a breakdown in societal values, thus function to justify the removal of health resources altogether—a rhetorical logic that extends beyond fibromyalgia to other invisibilized or medically unexplained illnesses.

The latter half of this chapter considers how the authors rationalize their invalidation of fibromyalgia and justify their denial of medical care and other supports through the rhetorically persuasive strategy of benevolence: the authors contend their withholding of appropriate care and restrictions on access are for the patient's own good and motivated by a concern for the good of

society. In classifying fibromyalgia patients as unworthy of medical care, the authors argue they are protecting individuals from themselves, preventing the public from falling prey to the epidemic "FM construct," and saving disability compensation systems from undeserving claimants who threaten the system's total ruin. I will consider their benevolent framing within the larger structure of modern medicine which treats healthcare not as a right but as a charitable commodity that one must earn access to and which is within the physician's paternalistic discretion to bestow or withhold. Within this framework, the authors rely on their framing of fibromyalgia patients as costly dependents, transforming their need for care into a pathology and a form of charity, to argue they are merely safeguarding the public and compensation systems from a wave of epidemic dependency. I argue that this alarmist framing of dependency as an epidemic threat is grounded in the myth of independence: the false belief that anyone in society can be truly self-sufficient or self-supporting. This fantasy pathologizes some people's need for care by casting it within the pejorative category of "dependency," obscuring the reality that all lives are sustained through interdependent networks of care.

2. Disability Claims and Fraud

The following sections trace the historical development of compensation systems to show how legal and medical discourses became increasingly intertwined in regulating access to welfare, compensation, and social benefits. As institutions sought mechanisms for adjudicating claims to support, medical authority emerged as a key means of verifying incapacity and determining eligibility for care, compensation, and social support.

a) From Poor Laws to Compensation Systems: The Genealogy of the Malingerer

While earlier chapters examined malingering primarily within contemporary medical and psychiatric discourse, this section briefly traces the longer cultural history of the malingerer.

Tracing this longer genealogy helps demonstrate how suspicions of malingering became historically linked to efforts to regulate access to care, resources, and social support—a dynamic that continues to shape contemporary debates about disability and conditions with medically unexplained symptoms. Although the term malingering only first entered the English language in the 1860s, the figure of the malingerer was established centuries earlier in the early colonial period. In "From Poor Laws to Pensions: The Evolution of Economic Support for the Aged in England and America," Jill Quadagno traces how the English poor relief tradition laid the groundwork for modern social welfare. The Elizabethan Poor Law of 1601 "represented a major turning point in the history of welfare in that it recognized state responsibility for the indigent" (Quadagno 418). Relief at this time was administered locally—by independent parishes—and for the first time local citizens were taxed and obligated to contribute to the relief of the poor in their community. As I mentioned in chapter 4, the Elizabethan Poor Law of 1601 (and its later amendments) established the moral distinction between the "deserving" and undeserving" poor—or to use the terms of the time, the "impotent poor" and the able-bodied or "idle poor." This distinction meant that individuals seeking relief outside the family had to demonstrate that they belonged to the former category rather than the latter, creating a persistent suspicion that claimants might feign infirmity to avoid labour.

The Poor laws instituted mechanisms of inspection and surveillance designed to detect deceit or idleness. The enactment of the Poor Law Amendment Act 1834 (or "New Poor Law") institutionalized two central administrative and moral principles: the workhouse test and the principle of less eligibility. The workhouse test meant that able-bodied paupers seeking relief

would be required to enter a workhouse rather than receive outdoor relief. [71] The "threat of the workhouse was supposed to have the effect of 'encouraging' the poor to work harder to support themselves" with the intention of returning these individuals "to a condition of economic and moral independence" (Wildman n.p.; Quadagno 419). The idea was "only the destitute would contemplate entering the workhouse," and when threatened by the workhouse the assumption was "their relatives would come forward to maintain them" (Wildman n.p.; Quadagno 420). Further, the level of support each person received was to be "worse than the condition of the poorest, independent, self-supporting labourer," known as the principle of less eligibility (Quadagno 419). These two principles made relief deliberately harsh and unappealing, turning welfare into a deterrent device as much as a safety net. The 1834 reforms intensified the suspicion that the poor might feign illness to avoid labour and reinforced the assumption that need for relief must be proven through bodily evidence and moral compliance. The 1834 reforms also consolidated local responsibility for relief into unions and placed them under the oversight of the Poor Law Commission. This shift marked the transition from community-based relief toward a more bureaucratic and centralized governance of the poor and aged. In this way, suspicion of feigned incapacity became embedded within the administrative logic of welfare systems themselves in which relief was structured not simply to provide support but to deter those suspected of falsely claiming it.

Quadagno shows how the moral judgements and administrative control of relief systems—with conflicts over who is responsible for the poor, eligibility criteria, and levels of support—persisted into later welfare systems which were increasingly bureaucratized as they

[71] Outdoor relief refers to assistance given to the poor in their own homes or in the community, rather than in an institution like the workhouse. Some reformers "denounced outdoor relief as an inducement to dependency" (Quadagno 430).

transitioned from local community relief to national welfare administration. This historical context of formalised relief rules and moral hierarchies set the stage for the emergence of the nineteenth century figure of the malingerer and the scrutiny of labour incapacity. This figure drew on the moral prototype outlined in the English Poor Laws which laid the groundwork for compensation systems that placed suspicion on one's ability to work, requiring verification of illness and imposing thresholds of incapacity, and differentiating "paupers into categories" of deserving and undeserving recipients of relief (Quadagno 421).

When the term "malingering" (or its cognates) *officially* appeared is a matter of some debate;[72] yet, in general, use of the term ramped up drastically in the late nineteenth century[73] (Chaney 133). While the term has been commonly associated with military conduct during the French Revolutionary and Napoleonic Wars (1792-1815) and military discourse in general preceding this time period, Sarah Chaney (2013) has observed that this association does not fully explain the rapid increase in its use during the late nineteenth century (134). Chaney notes that the "surge in interest" surrounding both the concept of malingering and the term itself stemmed from its growing application to civilian populations. Notably, this expansion of malingering's application to civilians was closely associated with "the rise of health insurance systems across Europe: the introduction of accident insurance in Germany in 1871 and the Employer's Liability Act of 1880 and the subsequent Workmen's Compensation Acts in England" (Chaney 134-5). Chaney highlights that the focus on costs to the system and the assessment of a worker's entitlement to compensation "made malingering class-oriented from the outset" as it was always

[72] For a fuller discussion of the theories of its emergence, see Sarah Chaney's (2013) Self-Mutilation and Psychiatry: Impulse, Identity and the Unconscious in British Explanations of Self-Inflicted Injury, c. 1864 –1914, pages 133-135.

[73] Increasing use of the term coincided with the emergence of the norm in the mid-1800s. The concept of malingering inherently implies behaviour that deviates from an established norm. I discussed the norm in more depth in chp. 5, under section "2.a) Epistemology of Visibility & Surveillance."

the worker and not the employer "accused of attempting to cheat the system" (135). And it was the physician who became involved in policing this system, legitimating the distinction between deserving and undeserving claimants.

As physicians assumed new authority in policing the boundaries of legitimate disability within these emerging compensation systems, the idea of malingering also began to take on wider cultural and medical significance. Initially most closely associated with military medicine, where it denoted soldiers feigning illness to shirk duty, the term *malinger* expanded over the course of the nineteenth century to permeate other domains (Chaney). By the late century, malingering had become a general diagnostic and moral category operating across medical, industrial, welfare, and military settings (Chaney). This expansion coincided with growing anxieties about unverifiable illness and the perceived threat of fraudulent claims on state and employer-funded compensation systems. It also occurred at a moment when conditions like railway spine, hysteria, and neurasthenia challenged the medical model that tied disease to visible lesions. Physicians suddenly faced a growing number of patients reporting debilitating symptoms that had no clear pathology. The term thus reflected and condensed wider cultural fears about dependency, deceit, and the legitimacy of suffering. These suspicions of deception were evident in Jean-Martin Charcot's studies on hysteria at the Salpêtrière, where he sought to distinguish between involuntary, pathological symptoms and conscious feigning (Goetz 2016). Likewise, as discussed in chapter 3, Sir John Eric Erichsen's work on railway spine revealed traumatic, invisible injuries to be a major medico-legal issue as workers sought compensation through the courts. Such debates continually raised the specter of malingering: were claimants genuinely injured or ill or were they simulating for undeserved financial or other gain?

Mid to late-nineteenth century concerns with malingering continued into the twentieth century and were magnified during World War 1. Soldiers experiencing various unverifiable symptoms (attributed to shell shock) were likewise suspected of malingering (evasion of duties) and thereby accused of cowardice or desertion—executable crimes during and following WW1. A famous case is the conviction and execution of Harry T. Farr, an English soldier who experienced shell shock and was accused of desertion when he refused to return to the Western Front (Wessely 2006). Military doctors frequently invoked the language of malingering to differentiate between authentic trauma and supposed cowardice or deceit (Linden et al. 2013; Tatu & Bogousslavsky 2016). Throughout the First World War, British medical officers struggled with distinguishing genuine psychological trauma from suspected malingering or cowardice, and by 1922 official policy endorsed expert medical panels for resolving doubtful or potentially feigned cases (War Office Committee Enquiry 1922). Such professional judgments over legitimacy had profound implications for veterans' post-war lives where many psychiatrists viewed "war neurotics" as malingerers, and psychological disability pensions were often downgraded or denied because shell shock lacked visible pathology, leading to financial hardship and social stigma for those affected (Reid 2019).

In particular, "[m]ilitary psychiatrists were firmly of the belief that war neurotics were malingerers, degenerates or frauds and that awarding them a pension would only encourage their symptoms" (Reid n.p.). There was suspicion that "trauma was not directly caused by the war," but "rather due to the unwillingness of the soldier to take part in the war" (Tatu & Bogousslavsky, abstract). This "permanent suspicion of malingering" led to "the establishment of a wide range of medical experiments," including the aggressive treatment of electrotherapy (Tatu & Bogousslavsky). Such treatment was not only used to "force soldiers back to the front as

quickly as possible" (Tatu & Bogousslavsky), but also served as a form of medical validation: the suggestion of a painful intervention could operate as a test through which soldiers suspected of not being truly ill might be exposed as malingerers or deserters. This is not unlike the threat the workhouse was supposed to represent to the undeserving poor. Even in the post-war period, Reid explains, there was "a growing suspicion of shell-shocked men" and the "wartime belief that war neurotics were faking, malingering or exaggerating was never fully dispelled, rather it became more pronounced as time went by" (Reid n.p.). Thus, malingering was not merely a medical diagnosis but, as evident in poor law discourse, a moral and political judgement, with a soldier's honour and compensation hinging on the verdict. It was also a term that was seemingly gaining traction as a mechanism for managing the uncertainty of unverifiable conditions with the fear of fraudulent claims.

This history and the growing linkage between medical diagnosis and eligibility for monetary compensation in the late nineteenth and early twentieth centuries increased anxieties about potential fraud. As the twentieth century progressed, the rhetoric of malingering crept into other compensation systems, such as workers compensation boards, veterans' disability systems, and insurance companies which institutionalized procedures for surveillance and embedded suspicion of malingering into the bureaucratic structure of disability adjudication (Chaney 2013; Reid 2019). Physicians, courts, and insurers leaned on malingering rhetoric to delegitimize subjective suffering and to ostensibly protect vulnerable financial systems from "undeserving" claimants (Chaney 134-5; Rogers & Payne 2006). This is the same concern raised by the *Rheumatology* authors: that disability claimants for fibromyalgia threaten to overwhelm "compensation systems in the Western world" (Ehrlich 1666). The term malingering, therefore, functioned as a socio-medical tool that allowed physicians, employers, and insurers to police the

line between authentic illness and fraudulent performance. The expansion of disability pensions for soldiers, industrial injury claims, and insurance settlements were perceived to create incentives for individuals to seek redress for their suffering, while these incentives simultaneously produced an imperative to guard against fraud.

As the preceding discussion suggests, physicians played a central role in this imperative: they were not only tasked with treating their patient but also assumed the role of verifying incapacity and protecting the state or employer against suspected deception (a task complicated by the fact that, as employees of these same institutions, insurers, or the state, they were also protecting their own interests). The *Rheumatology* authors likewise have assumed this role by focusing much of their discussion of fibromyalgia on their suspicions of undeserved claims to compensation. As Hadler questioned in 1996, "how do we distinguish those who are deserving from those who are lazy, unworthy, or otherwise taking advantage" (247). In his 2013 editorial, Hadler concedes a "personal bias" and a decades-long "fascination" with fibromyalgia and the denial of workers' compensation claims (216). This fascination, he explains, "has captured a great deal of [his] scholarly efforts for many decades" and stems from what he believes these compensation cases reveal about "the social construction of illness" and "the role of the physician in determination of disability" (216). Hadler is aware of the physician's power in determining whether their patient is "truly disabled" and the part this determination plays in the success of compensation cases, as well as the larger debate over the truth of fibromyalgia as a real or compensable condition.

The physicians' involvement in determining disability or deception turns the clinic into a site of surveillance of suspicious bodies. Malingering thus became a useful medicalized and social label through which medicine could reinforce its authority to judge the authenticity of

identity while entrenching the dichotomy between the "truly disabled" and the faker that was institutionalized in the nineteenth century. First rooted in early seventeenth-century suspicions that the "idle poor" were receiving undeserved relief, and later expanded into a nineteenth century response to unverifiable illness and the problem of compensation, the persistence of the concept of malingering exposes how deeply Western culture has internalized doubt toward unproven illness and incapacity to work. The rhetoric of malingering instills a sustained cultural suspicion of invisible illnesses which continues to carry material consequences for individuals with symptoms that are too easily dismissed through biocertificative methods. Placing an individual within the category of malingerer pathologizes diagnostically unverifiable conditions and is a method of medical invalidation which functions to mitigate compensation claims. In this way, labelling an individual as a malingerer is a means to deny biocertification: it is another way of stating that their claim to disability or illness has failed the test of legitimacy.

b) Biocertification: A Tool to Restrict Access

Samuels notes that "[t]he biocertification of disability in particular now functions as a method to limit access to accommodations and resources" (179). As discussed in the previous chapter, biocertification is essentially a process that converts bodily identity into paperwork that validates or invalidates individual identity claims thereby granting or denying access to rights, resources, and recognition. Official recognition that a condition other aspect of identity is "real"—or biocertification—is necessary to securing entitlements and access to resources. The standardized and objectively verifiable measurements that I discussed in the last chapter are, Samuels notes, "often presented as a necessary gatekeeping device in order to prevent widespread fraud" (179). The "burden of proof" is then "placed upon the disabled claimant" who

is scrutinized for their eligibility "with a strong presumption of fraud underlying each step of the process" (181). All of these steps are further opportunities to halt presumed fraud.

Evidence shows that this presumption of fraud is vastly disproportionate to its actual incidence. A September 2018 report addressing "10 myths and 10 realities of social assistance in Ontario" found that "less than a tenth of a percent (0.06%) of the total number of people receiving assistance were convicted of some form of fraudulent activity," directly contradicting the claim that social assistance is "rife with fraud" (Income Security Advocacy Centre 3). The ISAC report further notes that "there is no evidence of any more fraud in the social assistance system than in any other realm of life" (3). Closer to the time of the *Rheumatology* authors' publications, in 2000–2001 only 430 people in Ontario were criminally convicted of welfare fraud despite over 52 000 investigations (Ministry of Community, Family and Children's Services 2001; Income Security Advocacy Centre 2002). This period coincided with Ontario's "Zero Tolerance Policy," which on April 1, 2000 imposed a lifetime ban on social assistance for fraud convictions and later became the subject of an inquest following the death of Kimberly Rogers while under house arrest (ISAC 2002). A national audit conducted in 2002 estimated fraud in Ontario's welfare budget to be approximately 3 percent—a small proportion relative to the severity of the policy response (Provincial Auditor's Report 2002). By comparison, the Ontario Provincial Auditor reported that fraud in the tax system was approximately twenty times higher than the rate of fraud in the welfare system, noting that roughly half of corporations (355 000 of 763 000) failed to file required returns (Pay the Rent and Feed the Kids 2003; Provincial Auditor's Report 2002). At the same time, income support under Ontario Works and the Ontario Disability Support Program remained well below established poverty thresholds (Altaf and Ochs

2019). Together, these figures suggest that the spectre of fraud functions less as a reality than as a narrative used to rationalize restriction and surveillance.

These figures help clarify how biocertification functions as a gatekeeping apparatus, not as a proportionate response to actual fraud, but rather as a system organized around the presumption that claims must be continually verified, restricted, and policed. Diagnostic labels do not just give some measure of legitimacy to symptoms, they also make it possible to access accommodations and other social supports. For fibromyalgia patients, since their testimony is dismissed, and they are forced to prove their symptoms through standardized measurements that delegitimize them, they are especially vulnerable to being denied certification, branded malingerers, and consequently prevented from accessing healthcare resources and other supports. Samuels observes that disability entitlements "invoke[e] both a *model of scarcity*, in which resources must be reserved for those who truly deserve them, and a *distrust of self-identification*, in which statements of identity are automatically suspect unless and until validated by an outside authority, a validation that commonly takes the form of biocertification" (179; emphasis original). This means that even with the many flaws I emphasized with standardized testing for fibromyalgia, biocertificative eligibility is inescapable when seeking basic access to care since only those who can prove their disability through external validation are seen as deserving of support.

The logics of fraud and scarcity work together to sustain restrictive gatekeeping. The *Rheumatology* authors' concern that disability claimants "threaten to bankrupt disability compensation systems" (Ehrlich 1666) reflects this trend to position claimants as fraudulently taking more than their fair share of resources that are both scarce and "figured as valuable and 'special'"—a quality that I would argue is evoked every time disability supports are termed

"rewards" (Samuels 179). "The expectation of a horde of claimants overwhelming the available resources," Samuels notes, echoes historical rhetoric in the early nineteenth century that "a tide of disability from without and within threatened to swamp the nation" (Welke; qtd. in Samuels 180). This is the same rhetoric the *Rheumatology* authors lean into when describing their fear that disability claimants threaten to overwhelm the system (Ehrlich 1666). While there is a certain reality to the availability of resources, this kind of scarcity framing justifies intense inspection of claimants in a seemingly never-ending process of extensive documentation.

All of these barriers erected to limit access to scarce resources fuels the "common misperception" that some identities like "disabled" are "lucrative commodities" (181). One is assumed to receive something, an entitlement or reward, for being disabled whether that is financial, interpersonal, or freedom from work and other responsibilities. The idea that disabled people are granted "special" rewards relies on the framing of social supports within a zero-sum logic in which resources are figured as finite and scarce. In this framework, one person's gain inherently comes at the cost of another's loss. Social supports are thus framed as a competition for a fixed (and limited) pool of resources. Casting fibromyalgia patients as tax burdens and drains on the system therefore pits them against other citizens and suggests that "these people" are taking more than their fair share of collectively funded resources. And they're taking that share directly from your pocket. It's "us" against "them" in a competition for scarce resources. Moreover, compensation users are often portrayed as incapable of contributing anything of value to society, which reinforces the perception that supporting them is a waste of limited resources.

What is striking about this framing is not only its hostility, but its selectivity: many other publicly funded health practices—pregnancy and childbirth, vaccination, cancer treatment, emergency trauma care—are not routinely described as "drains," "burdens," or threats to the

system, even when they may be far more expensive and rely on the same collective resources. While these services may be discussed in terms of healthcare costs or system expenditures, the patients who require them are not typically constructed as personally "draining" the system in the way fibromyalgia patients are. This selective framing reveals that the zero-sum logic is not applied to healthcare in general, but is disproportionately attached to particular kinds of patients. The construction of fibromyalgia patients as drains thus reveals less about actual scarcity than about which bodies are positioned as legitimate recipients of care and which are cast as suspect, excessive, or undeserving. While similar rhetoric about healthcare costs appears in many national contexts, it takes a somewhat different form in the United States, where healthcare is largely privately funded and insurance-based. In Canada, where healthcare is publicly funded and framed as a collective resource, this dynamic can take on particular force as appeals to "strains on the system" become a potent way of moralizing access to care and re-inscribing boundaries of deservingness. Such rhetoric functions as an effective tactic for justifying reallocation of social supports away from this population.

This fear that diagnosis opens the door to unjust claims of compensation is perhaps best encapsulated by the following statement by Ehrlich: "Without the dollar poultice, would these patients be separated from the rest of humanity and threaten to bankrupt disability compensation systems in the Western world?" (1666). It is notable that Ehrlich positions these patients as "[separate] from the rest of humanity," as if seeking disability compensation automatically puts into question one's status as a citizen-subject, and plies that recognition of belonging to the human community is conditional on conformity to the neoliberal ideal of an independent, productive, and individually-successful citizen. His statement is undeniably "othering" or dehumanizing—framing the need for care as a pathology—while suggesting that the very

existence of disabled people who might claim supports threatens to overwhelm the very system that supports us all. He is quite obviously leaning into a discourse of scarcity by suggesting supporting people financially threatens to bankrupt the whole system, which is a view that would only presumably gain greater traction when exacerbated by increasing income inequality.

A recent *Guardian* article illustrates this very dynamic, noting that welfare cuts have helped drive the rise of far-right and populist movements that invoke scarcity to rationalize reducing social supports (Kassam 2025). As income inequality grows, people are increasingly set in competition with one another for supposedly limited resources—conditions that populist parties exploit by promising to cut costs through reducing funding for those deemed "burdensome" to society. Conveying the findings of the UN special rapporteur on Extreme Poverty and Human Rights, the article reported that "a one-point increase in income inequality corresponded to a one-point increase in support for populist parties" (Kassam). Thus, a rhetoric of scarcity, combined with the realities of income inequality—which Statistics Canada reported reached a record high in the first quarter of 2025—plays on public vulnerabilities by framing social supports as taking money directly from you personally. This is the same appeal Ehrlich is relying on in his statement above and which bolsters the belief that disabled claimants are receiving unfair financial privileges.

This logic—that disability is a valuable identity claim and results in access to limited awards—exaggerates the perceived material benefits of biocertified status as it simultaneously sustains surveillance and suspicion of those taking from the limited pie of resources (Samuels 181). Samuels points out the consequences of this circular logic: the more tightly boundaries are policed, the more they seem valuable, and the more justified the surveillance appears (181). In other words, because resources are framed as finite, the assumption is disabled people are taking

from a fixed pie. This in turn fuels the perception that being disabled is advantageous, as one is assumed to gain money, exemption from civic duties, or sympathy from claiming disability—these are all secondary gains. To prevent people from taking advantage of this system, access to resources (or diagnosis) is made more restrictive through eligibility criteria, heightened surveillance, and other bureaucratic hurdles. This makes the status of disability seem even more exclusive and valuable, thus reaffirming the belief that people must be seeking disability status for its supposed awards. And this feeds back into the suspicion that disabled people are gaming the system, thereby justifying ever increasing restrictions and policing of their bodies.

As Samuels argues, while biocertification emerged as a method to stabilize social categories that were becoming increasingly unstable in the modern world, instead of resolving this uncertainty about bodily identity it reproduced and amplified it. Ultimately, the power of biocertification lies not in any scientific accuracy, but rather in its cultural authority to reinforce the idea that biology can guarantee identity and determine who is worthy of care, rights, and recognition. One of the central functions of biocertification is to restrict access to care and accommodation. Therefore, the *Rheumatology* authors' continual denial of medical validation of fibromyalgia functions to deny not only legitimacy but also, importantly, access. The questioning of fibromyalgia's validity works in conjunction with their portrayals of patients as potential malingerers, costly dependents on the state, and as signs of moral or social decay. These are deliberate strategies that work to legitimize the withdrawal of resources from populations deemed undeserving of care within a capitalist society deeply invested in neoliberal values.

c) Charitable Compensation and Punitive Suspicion

In talking about what I have referred to throughout this project as invisible or invisibilized illnesses, Mollow replaces these popularly used terms with "undocumented

disabilities" to emphasize the importance that is placed on documenting identity in the process of bodily validation. This use resonates with Samuels's concept of biocertification, which she defines as "the massive proliferation of state-issued documents purporting to authenticate a person's biological membership in a regulated group" (9). As Samuels' definition of biocertification emphasizes, the two concepts together highlight how capitalist societies demand proof of bodily identity before granting access to rights or resources. For Mollow, the controversy over disability benefits shares similarities with anxieties about undocumented workers: in each case, people are excluded from the "privileges" of either working or not working because they cannot provide the required documentation to legitimize their status.

This linkage underscores how biocertification functions as a gatekeeping tool, reinforcing the imperative to work by casting suspicion on those who seek exemption through disability claims. Within this framework, claims of illness without visible or measurable proof—such as fibromyalgia—are treated as potential fraud and imagined as attempts to evade the moral and economic duty of labour. Mollow further says her use of the term "[u]ndocumented disabilities" as a substitute for the stigmatizing and pathologizing language of "hysteria" and "psychosomatic illness" does similar cultural work to the substitution of "undocumented workers" for the criminalizing label "illegal aliens" (186). In using this term, she is drawing attention to how "societies' impossible demands for 'documentation' delegitimize subjects' experiences of physical need and bodily distress'" (186). This obsession with documentation is less about the truth of identity and more about preserving capitalist norms that tether social worth to labour and delegitimize those who fall outside these norms.

The capitalist moral framework that equates documentation with legitimacy also shapes how disability policy has defined disability in relation to labour and economic worth. In her

discussion of how disability has been constructed against an able-bodied norm, Garland-Thomson shows how U.S. disability policy has historically been organized around the twin myths of bodily wholeness (the presumed natural state) and bodily lack (the idea that disability is a violation of this wholeness). She identifies these myths as underpinning the compensation model of disability which structured the state's response to disability pre-1990 when the Americans with Disabilities Act (ADA) was signed into law. Within this system, disability became a legal and social category defined by exemption from wage labor. Garland-Thomson states those *unable* to work were cast as "proper paupers" who deserve aid. Simultaneously, however, this "new, clinically disabled category defined the person with a disability as a figure excluded from economic opportunities and therefore without free agency, self-determinism, and self-possession, the ennobling attributes of the liberal American individual" (50). Economic relief, then, operates under a type of charitable generosity seen as "mercy" but also functions as an exclusion. In attempts to acknowledge human limitations, this compensation model might relieve the "sick poor" from "the obligation of productive labor" with the result of removing them from the public realm and "into [the] private sphere of charity" (48). This also has the consequence of being "excluded from the privilege of laboring" in a culture that equates moral worth with participation in wage labour[74] (51).

Within this compensation framework, following from precedents established during the English Poor Laws, public policy continually tried to distinguish between people who were genuinely prevented from wage labour (and deserving of compassion and aid) and those thought to be unwilling to work (and deserving of discipline or punishment). This distinction carried with

[74] It is worth noting this same exclusionary logic underlies employment income limits for disability claimants in Ontario, Canada. Reporting income over the (already sub-poverty) threshold overrides previous biocertification of disability and disqualifies beneficiaries from care and financial support. Thus, exceeding the earnings threshold invalidates one's status as disabled, reinforcing the idea that one cannot both be disabled and economically active.

it a deep suspicion of malingering so that policy toward disabled people was always shadowed by the need to police fraud. With the rise of science and new medical technologies in the nineteenth century, such as the stethoscope and X-ray, medicine assumed authority over these judgements by purportedly offering the means to "objective[ly] and quantitative[ly] measure…a person's physical capability for work" (Garland-Thomson 77). While these tools promised objective proof of incapacity and the hope of equitably resolving the longstanding issue of compensation in welfare policy since their inception, in practice they silenced patient voices and reinforced paternalistic judgements about who was truly capable of work. Disabled people were rendered objects of expert interpretation rather than self-determining subjects.

The presumed medical objectivity underpinning judgements of capacity informed how disability became codified in the twentieth-century welfare state. Disability was transformed into a "medicalized category by which the state could administer economic relief in a seemingly objective and equitable manner" (Garland Thomson 78). These seemingly equitable measures, however, were always reliant on false delineations that collapsed individual variance into a monolithic category of disability which falsely uphold the rigid dichotomy between the "truly disabled" and the "frauds" "who merited punishment" (50). Crucially, this dichotomy reinscribed the figure of the malingerer, transforming older moral anxieties about idleness into bureaucratic mechanisms of verification and exclusion. Thus, anyone who failed to meet the medicalized standards of biocertification was not only left unrecognized but was actively cast as fraudulent, a burden on the state, and a violator of the work ethic that undergirds capitalist value. Of particular import for this chapter is Garland-Thomson's observation that resource distribution to disabled individuals has always been marked by "the punitive and the paternalistic as well as the compassionate and the just" (50). Even where policy was motivated by seemingly benevolent

impulses of charity, compassion, or justice—as was the motivation behind early English Poor Law relief—it simultaneously reinforced suspicion and imposed punishment on those deemed undeserving of such mercy; thus, revealing how paternalism and generosity were always intertwined.

These motivations underlie ongoing efforts to separate the "deserving" from the "undeserving," with the specter of malingering continually invoked to legitimize ever more restrictive forms of surveillance and biocertification. As Garland-Thomson shows, this logic combines charitable impulses with punitive suspicion so that policies which appear generous are also mechanisms of discipline. The same system that classifies the "truly disabled" as proper recipients of compassion and care also uses the fear of fraud to justify punitive treatment and exclusion from aid. Critically, as I will discuss in the next section, even such exclusions are often reframed as acts of protection: individuals are ostensibly safeguarded from unnecessary treatment, dependency, or false hopes of cure, while the integrity of compensations systems is simultaneously preserved from undeserving claimants. Exclusions from care and accommodations are therefore rationalized not as acts of denying care but as forms of protection that are justified as being in the best interests of the individual and the public. In this way, paternalism cloaks these punitive measures in the language of care. In the next section, I will discuss how the *Rheumatology* authors rationalize restricting access to treatment and aid for fibromyalgia patients under the guise of responsible stewardship and altruistic intentions. They do so by arguing that they are not only protecting vulnerable individuals from falling victim to the diagnostic label, but also protecting the broader public and compensation systems from the threat this group poses. I refer to this strategy as benevolent oppression.

3. Benevolent Oppression

Benevolent oppression is a term I first picked up from Mia Mingus via her blog "Leaving Evidence." Mingus does not use a formal definition of benevolent oppression; rather, the idea is threaded through her discussion of experiences with forced intimacy and ableism. Mingus puts it like this:

> Forced intimacy is a cornerstone of how ableism functions in an able bodied supremacist world. Disabled people are expected to "strip down" and "show all our cards" metaphorically in order to get the basic access we need in order to survive. We are the ones who must be vulnerable—whether we want to or not—about ourselves, our bodyminds and our abilities. Forced intimacy was one of the many ways I learned that consent does not exist for my disabled asian girl bodymind. People are allowed to ask me intrusive questions about my body, make me "prove" my disability or expect me to share with them every aspect of my accessibility needs. I learned how to simultaneously shrink myself and nonconsensually open myself up as a disabled girl of color every damn day. ("Ableism")

One of the key issues Mingus' comments highlight is the pervasive lack of consent. This, I would argue, is central to how benevolent oppression operates. Although Mingus does not explicitly define benevolent oppression, it refers to the social and institutional structures that justify domination, control, and intrusion under the guise of care, compassion, or help. It is benevolent in the sense that it presents itself as altruistic or protective, but oppressive because it denies the very autonomy and agency it claims to support. Benevolent oppression frames much of the forced intimacy Mingus describes as helpful or kind. These practices are often understood by able-bodied people as being helpful, supportive, well-intentioned, or motivated by kindness,

but they still impose on disabled people's privacy, boundaries, and agency by overriding their right to choose what happens to or around them. This lack of consent is built into social expectations that disabled people should accept unsolicited assistance, answer intrusive questions, or disclose personal details for the comfort or reassurance of nondisabled people. These expectations also implicitly undermine bodily autonomy, suggesting that disabled people's bodies and private experiences are available for others' observation or management in the name of care.

Modern medicine operates within this same structure by demanding extensive documentation for biocertification, and this documentation in itself often requires time-consuming and invasive testing. These requirements reinforce the idea that the disabled body is a site of scrutiny and control rather than an autonomous subject. In addition, the circumventing of patient testimony positions disabled bodies as passive objects to be studied, removing both their agency and their voice. Here, the erosion of bodily autonomy and consent converge as patients must repeatedly expose and justify their bodies to be recognized as legitimate subjects of care. In effect, benevolent oppression becomes a kind of mask or rationalization for what is actually a power imbalance. Oppressive dynamics are essentially repackaged as care. Mingus sees it as part of why disabled folks are expected to tolerate certain discomforts or intrusions—because people believe they are "helping" or being compassionate—but the impact remains oppressive. Within this medical context, consent is frequently treated as procedural rather than substantive, reinforcing the expectation that patients must comply rather than collaborate.

Thus, in the medical industrial complex,[75] consent is often presumed. We must submit ourselves often to procedures or interventions, to justify symptoms, tolerate invasive questions,

[75] Mingus describes the medical industrial complex (MIC) as "a major site where ableism [continues to be] manufactured, perpetuated and fed" and as a massive system that connects to "*all* systems of oppression." A visual

and to accept treatments without genuine negotiation or full information just to access care. If we resist or assert boundaries, "care" is quickly withdrawn, and we are then at additional risk of being labelled a non-compliant patient. If you recall in chapter 1, I discussed how the DSM-V suggested malingering should be *strongly* suspected if a patient is non-compliant: they are not cooperating during diagnostic evaluation and not following a physician's prescribed treatment (727). Consent in these circumstances is coercive; compliance is expected to receive basic access. And compliance means expectations to answer intrusive questions, explain one's body and "prove" one's disability. In this way, the erosion of consent is normalized as part of care itself. This shows how ableism often functions not only overtly, but also through the normalization of care practices that disregard disabled people's agency and presume consent. Mingus points out that it is not enough to "simply fight for the right to receive care"; we must also fight "for the right to *refuse* care" ("medical industrial complex visual").

Benevolent oppression operates as a recurring trend within modern medical practices, illustrating Garland-Thomson's account of disability policy under a compensation model in which charitable compassion and punitive suspicion have long worked together to shape disabled people's access to resources, producing a system where exclusion is recast as protection. Where Garland-Thomson shows how policy rendered disabled people as dependent recipients of mercy, Mingus highlights how these dynamics are reproduced interpersonally and medically through coercive consent and expectations of compliance. They both underscore how disabled people are positioned as passive objects of regulation or intervention rather than self-determining agents. Together, they clarify how suspicion and paternalism are ideologies embedded in these care

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of the complexity of the medical industrial complex is available at this link: https://web.archive.org/web/20250927070338/https://leavingevidence.wordpress.com/2015/02/06/medical-industrial-complex-visual/

practices which are masked by a rhetoric of benevolence, whether it is in welfare policy or the clinic. This framing is crucial for understanding how the *Rheumatology* authors cast fibromyalgia patients as suspected malingerers and rationalize withholding care as a protective act.

In what follows, I will examine how the *Rheumatology* authors embody benevolent oppression when they use their power and status to argue their patients are undeserving recipients of medical care and that it is in their own benefit to concede they are not truly ill. I will consider how they position their denial of care not as abandonment but as guidance that is in their patient's supposed best interest to accept. This rhetorical framing not only protects the authors from accusations that they are outright dismissing their patients' symptoms and refusing to provide care, but also serves as a persuasive tactic to convince both their patients and their professional readers of their benevolent intentions. Moreover, benevolent oppression functions here not merely as a post hoc justification but as an active strategy used to secure patient compliance.

a) Undeserving Recipients in the Charity Model of Care

Through their previous claims and framing, the *Rheumatology* authors imply that fibromyalgia patients are undeserving recipients of medical care. They do so by suggesting that patients need to "unlearn illness behaviours," accept that their symptoms are temporary physical manifestations of "psychosocial" issues, and that fibromyalgia in general is a social construction, i.e. not a "real" medical condition (Wolfe 1997, 2003, 2009; Hadler 1996, 1997, 2003; Ehrlich 2003; Gordon 2003). Because of these claims—and the underlying logic to support them—medical treatment is posited as unnecessary and even harmful because, they argue, it reinforces the legitimacy that fibromyalgia is a real disorder—a claim I have argued they collectively deny.

As I discussed in chapters 3 and 4, these editorials re-articulate the notion that patients with fibromyalgia (particularly women) are frequent healthcare seekers who abuse the system for their own gain, whether for increased attention or disability compensation. Treatment in these scenarios is virtually non-existent and often only given to those who "earn" this access through behaviour that conforms to a normative expectation of a compliant patient. Once believed to be deserving, such treatment often takes the form of advice to increase exercise, improve diet, and address "psychogenic factors"—all of which is benevolently bestowed for the patient's own good. Notably, their "treatment" advice is focused on individual behaviours, putting the onus on the patient to solve their problem, while relinquishing themselves of their duty to provide care.

Within this context, where one must earn access to appropriate healthcare, medical treatment is not treated as a right, but as a gift that is within the physician's power to bestow—or withhold. This approach reveals how care is treated as a commodity within a system that perceives care as a form of charity. These editorials thus reflect and perpetuate what disability justice activist Leah Lakshmi Piepzna-Samarasinha describes as a "model of charity and gratitude" (41) whereby individuals who are perceived as a burden to the healthcare system are expected to be grateful for any crumbs of care they receive, even if that care is wholly inappropriate. Mingus similarly writes of this ableist notion that disabled people are not only expected to be grateful for "whatever we [can] get" but that they must additionally be likeable otherwise able-bodied people will not help them with access. She says this is a main reason forced intimacy exists. This type of thinking underpins encounters within the medical industrial complex. I have already shown in previous chapters how fibromyalgia patients are portrayed as very unlikeable: complainers, leeches, weak, difficult, and a growing problem. These descriptors position them as undeserving of care.

The idea that disabled people must be deferent, compliant, and express appreciation is part of the paternalistic structure of medicine. The very structures that govern patient access to medical care assume that physicians know best, which sets the terms under which care will be granted. Patients cannot even access basic testing or referrals without physicians' approval, which positions the latter as gatekeepers based on their perception of need. Their distrust of patient testimony, especially in cases of invisible illness, reinforces the idea that patients are unreliable narrators of their own bodies and that the physician's own expert opinion supersedes theirs. Disability benefits (along with drug prescriptions and insurance systems) are structured around compliance with medical authority, which requires patients prove their suffering or disability in ways that are legible by conforming to medical categories. Patients are furthermore cast as "good" when they are compliant and "difficult" or malingering when they assert their own knowledge or resist prescribed treatments. Within this model, patients are told that restrictions on their autonomy are for their own good while the medical system claims neutrality and expertise. Rather than see these restrictions as mechanisms of control, they are reframed as protective safeguards: discounting patient testimony is cast as ensuring validity and accuracy, and coercing patients through expectations of compliance is understood as the doctor guiding best outcomes for success. Patient choices are limited, but it is claimed to be for their own benefit or to protect them from further harm.

The result is that patients' access to treatment becomes contingent upon accepting this unequal power dynamic where medical authority claims a kind of moral high ground in deciding what is "best." Such a model in which patients are viewed as subordinates who must ask nicely for permission to access any care "connote[s] moral superiority of the giver over the receiver" (Peipzna-Samarasinha 41). Accordingly, the *Rheumatology* authors frame their suggestion that

patients merely need to accept their illness is psychogenic as helpful advice—if they choose to accept it. In actuality, the authors are dismissing and psychologizing their patients' symptoms under the guise of doing so in their best interests. While Irving Kenneth Zola's caution in 1972 stated that medicine was becoming an authority on truth with "supposedly morally neutral judgments" made by "objective experts" (qtd. in Wendell 118), the *Rheumatology* authors bequeath their advice in a way that undermines any impartiality and reads as barely contained condescension toward their patients. This is not simply a matter of individual attitude, but reflects broader professional acculturation within medicine that normalizes such hierarchies of authority and judgement. In addition, their authority is reinforced by positioning themselves as generous givers whose interventions—no matter how minimal, coercive, or dismissive—are cast as benevolent advice.

b) For Their Own Good

These editorials demonstrate their supposed moral superiority in various ways, one of which is through manufactured scenarios riddled with patronizing rhetoric. In one example, the author imagines an exchange with a patient where the physician admits "maybe he's wrong" but uses this disingenuous statement to set up an argument that "it's harder to prove a psychosocial or sociocultural theory" and that this cannot be done until the "social construction represented by FM" and "other functional somatic syndrome labels" (such as CFS) is "dismantle[ed]" (Hadler 1669). Only "then," he states, will a patient be able to accept "[c]ould it be in my mind?" Continuing with this imagined anecdote, Hadler places himself within the role of offering charitable advice where he can then respond to a patient's question of whether it is in their head with "I hope so. That's a lot better than leukemia, or renal failure, or lupus or the like" (1669).

The point of this exchange is to posit the physician as being helpful by suggesting their patient just needs to accept that they are not truly ill and that their doctor has their best interests at heart. Hadler suggests they should be grateful to be told it is in their head and their symptoms are therefore supposedly controllable and not nearly as bad as a "real" disease. In effect, Hadler trivializes his patient's symptoms and suffering, essentially gaslighting them, under the guise that doing so is for their own benefit. All the while, he is presenting this fabricated story as if it is a truth that the patient is unwilling to acknowledge—a truth that is ultimately in the patient's best interests to accept. The *Rheumatology* authors often speak to this aspect where a patient is portrayed as reluctant to accept the truth of their circumstance of which the physician has superior knowledge. Thus, they rationalize their judgement that their patient does not need care as helpful advice.

Use of psychogenic diagnosis is often and increasingly used as an excuse for poor care in overburdened healthcare systems. Mental health is, for one, treated as less significant than physical illness—as Hadler's comments above suggest, "it's a lot better than leukemia, or renal failure, or lupus" (1669). However, Hadler is not simply suggesting that this is a psychological problem. In fact, in their 2003 co-authored editorial Hadler and Ehrlich state that the patient's symptoms are "a manifestation of a *reversible* functional disturbance rather than [a] fixed pathology of a *purely* psychological nature" (1031; emphasis added). Hadler and Ehrlich want to disavow their patients of the notion that their symptoms are reflective of a serious and permanent disease. Instead, they stress that their symptoms are "reversible" if only the patient will accept this framing. The way that these symptoms can be reversed, they subtly imply, is through the patient's own reinterpretation. If they simply understand their condition differently, they might improve. Hadler and Ehrlich put themselves in the position as "educator," stating that physicians

play a vital role in helping their patients with this reframing of their symptoms as reversible and temporary. After all, they only want to use their wisdom to gently encourage their patients accept they do not need to suffer if they make the choice to get better. It is all about mental fortitude, or so they say.

Another key part of Hadler and Ehrlich's framing of FM in the quotation above is the emphasis that this condition is not "purely" psychological. To be "purely" psychological would imply it is "fixed" and the patient is at the whim of their psychological neuroses. Rather, FM is a psychosocially-mediated condition which is self-perpetuated by illness beliefs. This is why they see the physician's task as re-educating the patient to reshape their understanding of symptoms as manageable. This rhetorical maneuver protects them from accusations they are outright dismissing FM as hysterical even despite Hadler's analogy above which implies that patients should be willing to accept it might be "in their mind" or at least within their control.[76] By leaning into the framing that FM is a functional disturbance—i.e. psychogenic—they can instead acknowledge symptoms are felt as real, thereby offering the pretense of sympathy, and still argue they arise from psychological stressors affecting the body or dysregulated coping mechanisms. This framing allows them to do several things: for one, it positions them as compassionate and their argument as scientifically-grounded—"these symptoms are real, but reversible"—while still psychologizing the illness and pathologizing the individual since the problem lies in their interpretation and coping style rather than the body itself. Medication in this instance can help "attend to the psychological aspects" as they caution "medical investigation and intervention…must be tailored so as to minimize the risk" of reinforcing a patient's illness beliefs and medical convictions (2003).

[76] Hadler has published several editorials that outright claim fibromyalgia is "in the mind," including a 1999 editorial for the website Rheuma21st.com titled "Fibromyalgia: Could It Be In Your Mind?"

Secondly, Hadler and Ehrlich use this reframing of physical symptoms as reversible and merely complicated by "psychological aspects" to place the responsibility for care back onto the individual. They effectively place the burden of improvement on the patient's beliefs and coping behaviors, rather than on medical intervention, which is a subtler psychologization of the illness. This is one of the ways the *Rheumatology* authors abdicate their own responsibility and solve the problem of malingering by suggesting their patient's health is in their own power to control: it is up to the patient to fortify their mental resilience and proactively make good choices to support a positive mental outlook. Patients are then positioned as their own greatest barrier to getting better. The idea that an individual is personally responsible for their health and well-being functions to divert health resources away from these individuals since they supposedly only need to address their underlying motivations for seeking care. Moreover, it is their civic duty to do so, so as not to unnecessarily burden an already taxed healthcare system. This is a very convenient way for the physician to argue it is not within their purview to treat their patient and justify continual denial of appropriate care.

Not only do the *Rheumatology* authors deny the need for treatment ostensibly for their patient's own good, they also postulate that the diagnosis itself is causing harm. In the following passage, Hadler overtly states that fibromyalgia is created through the diagnostic label:

> The fate of patients with persistent widespread pain labeled as FM stands in reproach to whatever theory underpins this sophistical treatment act. In the community, the majority of people with persistent widespread pain improve with time. That is not the fate of those who become patients and are labeled FM. Based on the science that pertains to the regional musculoskeletal disorders, I would suggest that this unhappy fate is not solely a reflection of the intensity of their symptoms or the pervasiveness of the psychosocial

> factors that confounded their coping so that they chose to be patients in the first place. I would suggest that the treatment acts, dripping with empty promises of elucidation and unproved promises of palliation, are iatrogenic. I would further suggest that these circular treatment acts will exacerbate whatever mood or thought disorder is complicating the plight of these patients. (Hadler 1670)

In chapter 2, I have already discussed how Hadler argues that "treatment acts"—following from a diagnosis of fibromyalgia—are "iatrogenic" (1670). That is to say, he claims fibromyalgia is caused by medical diagnosis and treatment. Treatment reinforces the patient's medical convictions. In his belief, those with chronic pain who do not receive treatment improve with time while those who receive a diagnosis of fibromyalgia do not see improvement in their pain—and this lack of improvement is posted as a direct result of being categorized by this medical label. By this logic, fibromyalgia does not exist until it is given a name. It is merely pain that "everybody has…sometimes" (Ehrlich 1666). If diagnosis itself produces the illness, then refusing to diagnose or treat fibromyalgia can be reframed as an act of medical responsibility rather than neglect.

The study Hadler cites to prove his point specifies that the higher incidence of symptoms associated with fibromyalgia (such as high tender point count and high levels of fatigue) were less likely to resolve in the community. The authors of the study concluded that those with symptoms associated with fibromyalgia syndrome were more likely to experience chronic widespread pain two years later. These findings are consistent with the IOM's position that pain often persists and should be recognized and treated as a condition in its own right, rather than assumed to magically resolve in time (2011). In addition, the authors of this study on chronic widespread pain do not specifically mention a diagnosis of fibromyalgia, merely symptoms that

are known to be associated with fibromyalgia. Yet, Hadler misrepresents the study's findings to imply that fibromyalgia patients are worse off for their diagnosis when the study itself found that additional factors beyond simply widespread chronic pain accounted for their lack of relief over time.

Hadler's argument is in part premised on misconstruing this study's findings in order to further his own view that "circular treatment acts will exacerbate whatever mood or thought disorder is complicating the plight of these patients" (1670). He argues that treatment only worsens patient outcomes and heavily suggests that fibromyalgia is at the very least associated with a "mood or thought disorder"—again citing a study as evidence of this claim but leaving out the study's explicit statement that it cannot "demonstrate a cause-and-effect relationship" between pain disorders and "mental disorders" (Benjamin et al.). Furthermore, evident in this passage and repeated throughout his article, Hadler uses the iterations of the phrase that "these people choose to be patients" (1669) rather than presumably accept their pain will resolve in time, despite that the very study Hadler cites above demonstrates the opposite.

I have already talked about how the *Rheumatology* authors position their patients as suffering from a psychogenic condition they are reluctant to acknowledge. What I want to focus on here is how continual portrayals of patients with fibromyalgia as unwilling or unable to recognize their real "plight"—psychogenic causes and overmedicalization—allows Hadler to position himself as the benevolent giver of a truth that patients may not want to hear but is intended for their own good. He contends that giving *any* treatment lends legitimacy to their pain, to the diagnosis itself, and that in doing so "the person suffering persistent widespread pain learns to be a patient with 'fibromyalgia'" (1669). Treatment merely feeds into a patient's illness beliefs. He further argues treatment is creating a worse problem by giving false hopes of cure for

a condition he believes does not truly exist. The cure for Hadler is within the patient's own grasp if they are willing to accept their own role in self-perpetuating their symptoms. Denying care and withholding validation of symptoms is, then, posited as helpful to patients in the long term who he states need "succor instead of medicalization" (1669). In short, Hadler reframes fibromyalgia as a problem of patient interpretation and social contagion of the concept. The physician's authority is to intervene not with treatment, but with corrections to the patient's worldview. This is a profoundly moralizing and psychologizing stance disguised as benevolent education. This type of for-your-own-good logic legitimates the practitioner's continual denial of care to those with diagnostically unverifiable chronic pain.

c) For the Good of Society

In addition to claiming that abolishing the diagnostic label of fibromyalgia is for the good of the patient, the *Rheumatology* authors go further to argue denying care is for the common good. The for-your-own-good logic is therefore expanded outward: denying recognition of fibromyalgia is framed as safeguarding the public from forms of dependence portrayed as both socially harmful and economically wasteful. Just as Hadler imagines himself as the compassionate truth-teller who helps patients accept that their illness arises from their own failures at coping, Ehrlich casts the abolishment of fibromyalgia as an act of protection for society at large. He states "[t]he sooner we abandon the diagnosis, fibromyalgia, disband the patient advocacy organizations, and stop the irresponsible publications, the better we serve the public" (1666). Here the physician is no longer merely helping an individual patient come to terms with their supposed psychosocial suffering but protecting the public from the proliferation of illness identities. The doctor becomes the guardian of collective well-being, charged with dismantling dangerous diagnostic categories in the name of social health.

Hadler makes explicit his views on how the supposed harm of a fibromyalgia diagnosis extends from the individual to the social body. He insists that a fibromyalgia diagnosis is not only false but actively damaging, claiming that "treatment acts, dripping with empty promises of elucidation and unproved promises of palliation, are iatrogenic" (1670). By this reasoning, the diagnosis itself generates pathology: those who might otherwise improve with time instead suffer worse outcomes once they are labelled with FM. What is framed as for the good of the individual—shielding patients from the damage of false hope—scales up into a "for the good of society" argument in which it is a civic duty to eliminate the diagnosis altogether. As Hadler and Greenhalgh later summarize, "however well it serves its adherents, the fibromyalgia construct poses dangers for patients so labeled and for those likely to suffer that fate. The contagion of the concept reflects the medicalization of psychosocial problems for which biomedicine has few solutions" (1). To say the diagnosis "poses dangers" recasts patient recognition as a social threat, while describing it as a "contagion" figures fibromyalgia not as an illness but as a contaminant—something that spreads, infects, and weakens the social body unless checked and excised from the social body. The inclusion of "those likely to suffer that fate" moreover suggests it is not just those currently "labeled" but the diagnosis itself is a danger to those vulnerable to succumbing to this label in the future. Thus, the diagnosis poses a threat to potentially everyone.

Ehrlich reinforces this same point about the danger of the diagnosis when he trivializes pain as a universal human condition we all experience "sometimes," but claims it becomes a problem only when it is granted a diagnostic label (1666). In this framing, the true danger is not widespread pain—which he casts as ordinary and benign—but the medical act of naming, which he accuses of transforming everyday discomforts into pathological claims. Ehrlich casts the diagnostic label itself as a contaminant, claiming that "giving a name to the pains has spawned

the very symptom amplification and imitative behavior the rheumatologic profession should be combating" (1666). Patients are described as undesirably reproducing under this label with their very existence imagined as an iatrogenic by-product of medical recognition. The problem for the *Rheumatology* authors, therefore, is not simply misdiagnosis but the monstrous "breeding" of an illness culture—a proliferating wave of dependency imagined as contaminating both the healthcare system and the courts. Once given a label, these pains supposedly multiply into "epidemics," spawning dependent patients and networks of advocacy that drain public resources. The rhetorical inversion here is striking: the symptoms are naturalized as normal, while the diagnosis becomes pathological.

In their co-authored paper, Hadler and Ehrlich (2003) argue that abolishing the FM label will "spare some of these ill individuals the hazards of social iatrogenesis" (1031). The patient becomes a passive victim by the act of naming which is pinpointed as the culprit in proliferating an epidemic of dependency. The language of "spawn" Ehrlich chooses is particularly telling: it evokes an uncontrollable reproduction that taps into fears of contagion and degeneration in which populations deemed unfit were described as multiplying beyond control and threatening to overwhelm the healthy body politic. Fibromyalgia patients have similarly been deemed to be "unfit": as I discussed at the end of chapter 3, the *Rheumatology* authors describe their patients ("mostly women") as suffering from a problem of coping because of their inherently weaker disposition that makes them susceptible to social contagion of the FM concept. Removing the diagnosis, then, is an act of kindness that will "spare" these weakened individuals from the temptation to identity as disabled and save "a nation in peril from the unfit" (Welke 118).

What emerges from their rhetoric is a disturbing double-bind in which patients are told that abolishing the very label that recognizes their suffering and enables access to resources is in

their best interest, while the broader public is assured that such erasure protects the common good. This reasoning is suffused with the same eugenic logic I hinted at above that once framed sterilization or institutionalization as "for their own good" and for the good of the human race. This is a familiar maneuver within eugenic thought, where the denial of resources or recognition is reframed not as cruelty, but as benevolence. Interventions such as forced sterilization and institutionalization were likewise justified as acts of mercy—both sparing individuals from a life of suffering and preventing their supposed deficiencies from burdening society (Mitchell & Snyder 2010, 857; Garland-Thomson 2015; Lombardo 2008; Rembis 2010)—just as efforts to eliminate fibromyalgia patients are framed as "spar[ing] these ill individuals from" a life of unnecessary suffering and dependency (Hadler and Ehrlich 1031). It is important to remember that the aim of eugenics was to "eliminate devalued human traits in the interest of reducing human suffering, increasing life quality, and building a more desirable citizenry" (Garland-Thomson 134, "Eugenic World Building"). The language the *Rheumatology* authors are therefore using—to reduce suffering, to deny recognition of symptoms in order to help individuals live a better life, and the implied comments about disabled people being an undesirable make-up of the citizenry—are very similar to arguments that justified eugenic practices. In both past and present, their ostensibly benevolent motivations cast the stripping away of recognition and care as protective, or even generous.

I therefore argue that Ehrlich's insistence that abandoning the diagnosis is in service to the individual and the public draws directly on this eugenic heritage. As Angus McLaren (1990) notes, most eugenicists "were activists anxious to intervene in the lives of the poor and ill to prevent not just the spread but the emergence of social problems" (166). In the same vein, Ehrlich positions the fibromyalgia diagnosis as a modern ill that must be eliminated before it

multiplies further and before its advocacy groups and networks of support gain even greater traction. By presenting fibromyalgia as a menace that threatens to "spawn" ever more patients, Ehrlich portrays erasure not as neglect or desertion of these patients, but as pre-emptive intervention to contain the epidemic before it is too late. This is an intervention in which Ehrlich positions the physician as playing an integral role in prevention. Quoted above, he says they should be "combating" recognition, placing himself and his colleagues in the role of saviours. The physician's role shifts from healer to a regulator. Defending the population from the dangers of fibromyalgia is transformed into a professional moral mission. Even if their patients don't like it, the doctor's are merely trying to help because they know best.

Within this logic, fibromyalgia patients are reclassified not as patients in need of care but as "social problems"—evidence of "maladjustments" that medicine is "ill-prepared to deal with" (Ehrlich 2003, 10). Their pain is acknowledged only to be dismissed as unverifiable and self-generated through "rumination" and "symptom amplification" (Ehrlich 1666). By casting chronic pain as a moral, psychological, and behavioural defect, this discourse reproduces eugenic rationales that cast people as social problems and interventions as humane and compassionate safeguards against their own presumed lack of judgement and the imagined dangers they pose to society. Denial of autonomy in both cases is reframed as help and erasure of recognition recast as care.

i. Epidemic Metaphors

Welke's observation that the end of the nineteenth century revealed a "fear that a tide of disability threatened to swamp the nation" continues to shape the *Rheumatology* authors discourse on fibromyalgia (118). At the end of chapter 4, I argued that the *Rheumatology* authors describe fibromyalgia as an epidemic contagion that is "out of control" and threatens to bankrupt

disability compensation systems worldwide (Wolfe 1997; Ehrlich 1666). I do not intend to tread the same ground I did there but do want to re-emphasize that their claim of epidemic contagion is a deliberate strategy to justify their restrictions on accessing appropriating care. Depicting fibromyalgia as evidence of social decline and a looming drain on healthcare resources supports actions to stop the diagnosis. This type of rhetoric not only dehumanizes this population group by marginalizing their voices and reducing individuals to statistics in a monolithic category, it importantly creates a sense of threat that must be responded to.

The epidemic contagion metaphor the *Rheumatology* authors are drawing on has long been a tool of social control. It portrays a group of people as not just undesirable but dangerous: as dehumanized "things" that spread, "spawn," infect, and destabilize the "healthy" social body. When the *Rheumatology* authors describe fibromyalgia as a "contagion" or "epidemic," they are tapping into the same rhetorical arsenal historically mobilized against other marginalized communities, such as immigrants, racialized groups, and the poor (Dolmage 2018, 17). When Wolfe speaks of "snuffing out" an epidemic of disability claims, or Hadler and Greenhalgh describe fibromyalgia as a "contagion of the concept" (referring to the diagnosis itself), their metaphors are not uttered in isolation or confined to medical contexts. Their linguistic choices align with a broader cultural discourse which constructs vulnerable groups as infectious threats whose very existence endangers the collective. It is a rhetorical move that has historically licensed persecution, segregation, and exclusion. Anti-immigrant discourse, for example, has frequently invoked the specter of contagion to justify exclusionary policies as it depicts newcomers as carriers of disease who endanger the purity and stability of the host nation (Dolmage 2018). In much the same way, fibromyalgia patients are framed not as individuals experiencing pain but as a proliferating category whose very recognition "spawns" further cases

and drains collective resources. The disavowal of fibromyalgia is cast as necessary to prevent the rising tide of invalidism and the threats potential patients pose to compensation systems. This exclusion is then moralized as protection.

By invoking epidemic metaphors, the authors situate fibromyalgia as a problem requiring containment, even eradication. Wolfe is explicit about this when he writes that "[t]he Israeli experience, where work disability is not approved of, and the Australian experience, where small changes in the law snuffed out an epidemic of repetitive strain injury claims, suggest that we may be able to control the incipient FM epidemic as well" (1997). In this framing, Hadler's "contagion" becomes Wolfe's "epidemic": both redeploy the same imagery of pathological spread, casting the diagnosis as a social infection that must be eradicated through legal, medical, and cultural quarantine. Here the echoes of earlier eugenic policy are unmistakable. As McLaren has shown, eugenic interventions were routinely defended as "preventing the emergence of social problems" (166), where the denial of autonomy or recognition was justified through prudent measures to protect the social body. The same logic animates these *Rheumatology* editorials: eliminating fibromyalgia is not abandonment but a prophylactic. Eradicating the label of fibromyalgia is the way forward to prevent a future epidemic of dependency. The problem, as they frame it, is quickly becoming less about individual malingering and more about the uncontrolled and pathological spread of an entire diagnostic category. Metaphors of overwhelming tides and epidemics are deliberately drawn on to justify increasingly restrictive regimes of biocertification designed to withhold care from those deemed undeserving.

Wolfe's comments above frame care and support as contributing to pathological spread. The authors suggest removing supports will eradicate the epidemic—as if FM is primarily motivated by secondary gain—instead of recognizing that a lack of supports has not eradicated

individuals' needs but merely failed to acknowledge them and provide care. Care is instead reimagined as based upon a dangerous collusion—a "collaborat[ion]" between "[s]ome rheumatologists," desperate "patients…and powerful social forces such as pharmaceutical firms and the media" (Hadler and Greenhalgh 1)—where supports become indulgence of a sick lifestyle and treatment becomes a waste of resources. The result is a discursive sleight of hand in which the withholding of care is framed not as desertion but as protection, both for the patient and for society at large. Just as eugenic practices were framed as protecting future generations from the "burden" of defective heredity, so too is the erasure of fibromyalgia positioned as protecting society from the "tide" of proliferating invalidism. Abolishing the label and denying care is refigured as an act of social hygiene, purging the system of a diagnosis imagined as polluting and contagious.

These "for-your-own-good" and "for-the-good-of-society" arguments are therefore intentional rhetorical strategies. On the individual level, patients are gaslit into believing denial of treatment is based in compassion for their well-being. The harm that results from denying care is disguised under this reframing. On the collective level, the public is persuaded that dismantling the diagnosis of fibromyalgia and withholding care is an act of protection. Both arguments depend on the same logic of benevolent erasure: stripping recognition and resources is not framed as neglect but as service, both to the patient and to the social body imagined as under siege by an epidemic of dependency. As disability blogger Andrew Pulrang observes, relying on claims that denying supports benefit larger society is a common strategy: "ableism justifies eugenicist policies that make disabled people dispensable, and cast efforts to support them as wasteful and actually bad for society" ("3 Forms of Gaslighting"). In this way, the call to abolish fibromyalgia is elevated to a moral imperative in that it safeguards not only scarce medical

resources but the very health of society. In this framework, withholding care is not only defensible but virtuous.

4. Reclaiming Care

a) The Myth of Independence

Marking certain bodies as undesirable or a burden is rooted in ableist and eugenic ideology that creates a hierarchy of human worth. This hierarchy ranks some lives as expendable, burdensome, and their disposability justified. Questions about who is determined to be worthy of support versus who is configured as a cost to the system are questions about whose lives society considers valuable. In the Canadian context, austerity politics have deepened these divisions by promoting the myth of scarcity.[77] Austerity measures which prioritize deficit reduction over public services and social well-being produce a misleading and false impression that there is not enough public funding to go towards public services, healthcare, and social support; thus, undermining societal safeguards. Austerity is less a neutral fiscal necessity than a deliberate political strategy that shifts responsibility away from the state and onto individuals while eroding the public services that sustain social well-being. By framing public resources as scarce, austerity measures foster hierarchies of human worth in which certain bodies are marked as too costly to sustain. These logics are further reinforced through the continual specter of malingering and the depiction of disability claims as contagious threats to the system.

As I have argued, fibromyalgia patients are frequently positioned within this framework: as drains on the state and as undeserving of care. Their claims to care are undermined through

[77] For example, in outlining Canada's 2025 federal budget, Prime Minister Mark Carney publicly stated that Canadians should be ready to make necessary "sacrifices" as part of the government's fiscal strategy, even as that strategy included significant reductions in the size of the federal civil service and cuts to public-service spending (Major, CBC News 2025). This illustrates how austerity rhetoric is deployed in Canadian political discourse to construct a sense of scarcity and thereby justify reductions in public service spending.

discourses of dependency. Jina Kim argues that this framing casts dependency in pejorative and punitive terms. It is through figures of state parasitism and related discourses of dependency that values such as individualism are defined and propped up. In a quote I have referenced several times in this chapter, Ehrlich's warning that "without the dollar poultice" fibromyalgia patients might "be separated from the rest of humanity and threaten to bankrupt disability compensation systems in the Western world" (1666) reproduces the same logic Jina Kim identifies in welfare reform discourse where dependency is imagined as a moral contagion that imperils civilization itself. As Kim notes, "policy ideologues like Charles Murray, Daniel Patrick Moynihan, and Lawrence Mead" equated independence with waged labor and framed reliance on welfare as a form of social decay that could bring about "the end of Western civilization" (Mead 237; qtd. in Kim 13). Ehrlich's patients, cast as undeserving, economically parasitic and an existential threat, occupy the same symbolic position as welfare recipients: their dependence on public resources renders them less than fully human and justifies their abandonment in the name of preserving social order. This "pathologization of certain population groups and spaces," Kim states, "justifies their expendability" (142). This "logic of disposability" (Kim 40) exposes the violence embedded in the framing used by people like Ehrlich. His language, separating patients from "the rest of humanity," is an economic rationalization of dehumanization where certain bodies are "deemed abject" (Kim 40) and disposable when they no longer conform to the demands of productive independence. Ehrlich's rhetoric exemplifies the broader neoliberal fantasy of independence that Kim argues denies our shared dependency on social and material infrastructures of care (21).

Kim states that devalued subjects who are positioned within narratives of dependence "become the scaffolding—the human infrastructure—for others' fantasies of *in*dependence" (55).

In other words, dependency discourse shores up the myth of independence. Discourses of dependency appeal to the notion that some people exist in society independently: they are self-sufficient and self-supportive. This idea is based on a fantasy that there is any individual in society who is truly independent. Kim draws on feminist philosopher Eva Kittay who highlights the problems underlying this myth: "[b]ut who in any complex society is not dependent on others, for the production of our food, for our mobility, for a multitude of tasks that make it possible for each of us to function in our work and daily living?" ("When Caring is Just" 267–268; qtd. in Kim 21). Kittay's comments puncture through the logic that self-supporting individuals even exist. As Garland-Thomson states in "Integrating Disability, Transforming Feminist Theory," "[o]ur bodies need care; we all need assistance to live" (21).

Discourses of dependency, however, target certain population groups as pathologically dependent while obscuring the fact that everyone in society is reliant, or dependent, on each other. As Kittay's observations above demonstrate, many of the supports people utilize daily are built into societal infrastructures and naturalized in such a way so as to gloss over the integral role they play in being able to live our lives seemingly independently but more accurately, interdependently. All people are interdependent with each other in networks of care, support, and resource-sharing. As Kim says, all individuals are "universally vulnerable" to dependency "albeit to varying degrees" (21). While some people might have a "heightened awareness of the social, material, and prosthetic supports that enable them to navigate the world," there is no form of dependence that makes one's life less worth living (21). Being able to recognize these networks of interdependence we all rely on emphasizes how support is demonized and denied to only certain groups of people. If all bodies need care and all lives are scaffolded by infrastructures of support, then Ehrlich's horror of the dependent body reveals a refusal to acknowledge this

"shared contingency" (Kim 22). By rendering dependency as a pathological state attributed to certain groups the state is able to disavow its own structures of support and legitimize the dismantling of collective care systems.

Interdependence, in contrast, "moves us away from only knowing disability" through the pejorative notion of dependence, which Mingus says, "paints disabled bodies as being a burden to others, at the mercy of able-bodied people's benevolence" and as "charity-cases" ("Access Intimacy"). In this framework as charitable dependents, "able-bodied people" are offered a way "to feel better about themselves and we in turn, internalize our sense of being a burden" (Mingus). This leads to a dynamic in which "disabled people feel like we have to be 'liked' in order to receive basic daily access to live and where able bodied people feel entitled to receive praise and recognition for providing access" (Mingus). Mingus points out this dynamic "is the foundation upon which so much domination, control, violence and abuse happens" ("Access Intimacy"). Mingus's account highlights how access is often treated as something granted at the discretion of those in positions of power rather than as a basic entitlement. The *Rheumatology* authors, knowingly or not, operate within this same dynamic when they cast their authority as care, their denial of treatment as moral stewardship, and their restriction of access as an act of protecting society from the burden of dependency. This pejorative vision of dependency allows the authors to blame individuals for their supposed inability to cope and reframe their need for care as pathological, thereby leaving the structural violence that results from these framings unacknowledged.

Kim, therefore, advocates for a revisioning of dependency. This revisioning is necessary to "[assert] the value of racialized, low-income, and disabled lives" that are routinely subject to accusations of state parasitism and to disrupt systems of power that differentially values these

lives and benefits the very few (Kim 23). A recognition of our "body's dependency on systems of assistance" undermines liberal myths of self-sufficiency and exposes how care, when withheld or unevenly distributed, becomes a mechanism of exclusion and control (22). This is not just about "mere *recognition* of support networks" but about "identifying the *uneven* economy of assistance that deems certain subjects unworthy of support" (23; all emphasis original). As Kim also argues, rather than appeal to calls for independence—which is still working within the "fantasy of self-support" underpinning welfare discourse—we should instead be reshaping our understanding of need and care not as weakness but as a universal social relation for human survival that depends on these shared networks of assistance (Kim 22). Where Ehrlich pathologizes need, a model of care grounded in interdependent relations redefines humanity through mutual care rather than productivity. This revisioning challenges the *Rheumatology* authors' claims to be protecting society from the epidemic of dependency that underpins their argument by revealing the "uneven economy of assistance" Kim speaks of where only some subjects are deemed to be unworthy of supports.

b) Rights vs. Justice

Kim's advocacy for a reconceptualization of dependency as interdependency is aligned with disability justice movements that identify interdependence as one of its 10 principles.[78] Patty Berne and Sins Invalid define interdependence as "work[ing] to meet each other's needs as we build toward liberation, without always reaching for state solutions which inevitably extend

[78] The 10 Principles of Disability Justice are 1) Intersectionality 2) Leadership of the Most Impacted 3) Anti-capitalist Politics 4) Cross-movement Solidarity 5) Recognizing Wholeness 6) Sustainability 7) Commitment to Cross-disability Solidarity 8) Interdependence 9) Collective Access 10) Collective Liberation. Their definitions are available here: https://sinsinvalid.org/10-principles-of-disability-justice/. The expanded version of the principles are available here: https://static1.squarespace.com/static/5bed3674f8370ad8c02efd9a/t/5f1f0783916d8a179c46126d/1595869064521/10_Principles_of_DJ-2ndEd.pdf

state control further into our lives" ("10 Principles of Disability Justice"). This explanation emphasizes the important difference between state-sanctioned *rights* and mutual support systems as a key part of *justice*. I find this distinction between rights vs. justice to be best articulated by Leah Lakshmi Piepzna-Samarasinha in the following example:

> A rights framework says that the ADA and other pieces of civil rights legislation give disabled 'citizens' our rights: we simply state the law and get our needs met. Disability justice says: What if you're disabled and undocumented? What if you think the settler colonial nation we live in is farce and a hallucination? What if you don't have money to sue an inaccessible business? What if the people giving you accommodations and access technology—or not—are not paid for by the state but part of your community? (*Care Work* 75)

Piepzna-Samarasinha raises a very important point about how a rights framework functions and a how a justice framework exposes key limitations in how access to medical care is conceptualized and distributed within it. In a rights framework, care is imagined as a legal or institutional entitlement. If one meets the proper diagnostic or bureaucratic criteria, one "earns" access to treatment or support. In this model, care is transactional and only provided if one meets predetermined standardized thresholds—and this of course does not mean that care *will* be provided or that it will be appropriate. This is precisely the dynamic at work in the *Rheumatology* authors' insistence on biocertification—the notion that patients must *prove* their illness in order to deserve care. Those whose suffering cannot be made visible or measurable and whose illnesses are contested are excluded, much like those who, in Piepzna-Samarasinha's example, cannot access rights because they are undocumented, uninsured, or unable to afford legal recourse. When access is withheld, rights are often only obtained through a complaints-

based system that is not feasible for many of us because of time, money, perceived worthiness and other structures of power that deliberately make fighting for our rights inaccessible. In this framework, the burden is placed on individuals to fight for formal recognition of rights on an individual basis rather than placing the onus on institutions to guarantee inclusion. If one is further branded a malingerer (a designation that might even be recorded in their diagnostic chart), this makes fighting for access to healthcare nearly impossible. This model therefore privileges those who can navigate the system's legal and diagnostic hurdles and expectations of compliance. While we should all have access to healthcare and state supports, my analysis of the *Rheumatology* articles has emphasized that our right to access care and support is easily undermined through strategies that justify their denial under rhetorics of benevolent invalidation.

By contrast, a justice-oriented framework exposes the moral and structural limits of this system by shifting the focus from eligibility to equity and interdependence. It asks not whether patients can satisfy institutional requirements, but why access to care is conditional in the first place. It asks not only who has a legal or biocertified right to care but who is structurally excluded from this care. Leah's vision of disability justice—rooted in collective care and mutual accountability—rejects the paternalistic idea that care must be deserved or granted at the discretion of authority figures. Seen through this lens, the *Rheumatology* authors' "benevolent" denial of care is a classic expression of a rights-only system: one that upholds the physician's authority to withhold care in the name of protecting the public good, and that treats healthcare as a limited privilege rather than a shared responsibility. Her critique helps illuminate how this type of medical model operates through conditional inclusion where access is contingent upon one's ability to satisfy institutional standards of legitimacy and credibility. Mia Mingus has similarly advocated for moving beyond the rights-based model which expands access to a few, giving

some a few “more privilege crumbs to subsist on,” but that this is very individualized and does nothing to expand access for everyone (Interview). In her words, “simply expanding the ranks of the privileged to add a few more people has never led to a just world” (Interview).

5. Conclusion

The *Rheumatology* authors’ insistence that withholding care is an act of protection reflects a benevolent logic grounded in a rights-based model of medicine that treats access to care as a conditional privilege rather than a collective responsibility. Within this framework, physicians imagine themselves as guardians of public welfare, tasked with safeguarding the system from dependency rather than attending to the needs of those within it. A justice-oriented approach would reverse this orientation. If the *Rheumatology* authors genuinely wished to act in the public’s interest, what might a justice-oriented medical ethics require of them? What if, instead of guarding against dependency, they recognized interdependence as a shared human condition? What if they shifted their ethical focus from protecting systems of exclusion to sustaining and enriching the lives within them? Instead of policing the boundaries of deservingness, they might recognize a human obligation to respond to patients’ articulated needs without filtering those needs through moral hierarchies of productivity or worth. Rather than viewing dependence on medical or financial supports as evidence of pathology, living a self-indulgent lifestyle, or civic failure, they could understand such supports as necessary conditions for meaningful participation in society and as collective investments in people rather than drains on resources. Letting go of the presumption that they “know best” would further require acknowledging how medical authority is shaped by ableist norms that equate health with conformity and independence. It moreover demands an awareness of how a rights- and entitlement-based model can perpetuate eugenic logics by defining whose lives merit care and

whose are framed as excessive or expendable. A justice-oriented approach, then, would begin with listening: with believing patients' accounts of pain, recognizing dependency as a shared and variable human condition, and understanding care not as a discretionary privilege but as a reciprocal practice of sustaining one another.

Coda:
Consequences of Restricting Access to Care: MAiD

Although the initial archive I examine in this dissertation is relatively small—a series of editorials in a single issue of a medical journal—it is important to emphasize that this corpus functions as a focal lens through which I analyzed the epistemic and cultural logics that shape skepticism toward contested illness and influence whose suffering is recognized as legitimate and whose lives are deemed worthy of care. In short, this archive helps reveal the cultural assumptions that lead people to doubt invisibilized illnesses. My analysis draws on decades of the *Rheumatology* authors' related publications across multiple medical journals, as well as on nineteenth-century medical, legal, and cultural texts, and contemporary policy and media discourse. These materials allow me to situate the *Rheumatology* articles within longer genealogies of malingering, nervous disorders, dependency, and productivity, and within the specific ideological formations of late capitalism and neoliberal governance.

As an analytically-rich site, these editorials do not simply generate new narratives but take up, distill, and rearticulate already circulating assumptions about disability, dependency, and credibility. These editorials therefore provide an entry point into understanding longer medical histories of contested illnesses and broader ideological formations underlying current attitudes and assumptions that contribute to the differential valuing of lives. Reading this archive genealogically reveals that the stakes of these representations far exceed the pages in which they appear. These same moral and fiscal logics I have uncovered and argued are used to justify exclusion from care—suspicion, dependency, productivity, benevolence, cost/benefit frameworks—reappear in contemporary debates over welfare reform, disability benefits, and end-of-life care with real, material consequences for the lives they shape.

To truly understand the stakes of this project, and to situate this project within its contemporary ethical, political, and cultural terrain, this coda extends my analysis of how medical and cultural discourses regulate whose suffering is recognized, legitimized, and deemed worthy of care into the context of a current biomedical and economic policy issue: Medical Assistance in Dying (MAiD). MAiD was legalized in Canada with the passage of Bill C-14 in 2016, permitting assisted death for eligible adults with a "grievous and irremediable medical condition" whose natural death was reasonably foreseeable. In 2021, Bill C-7 amended this framework by removing the end-of-life requirement, thereby expanding eligibility to individuals whose suffering is enduring and intolerable but whose death is not reasonably foreseeable. This change established a two-track system. This expansion has had significant consequences: Canada now reports the highest rate of medically assisted death globally, with MAiD accounting for the fifth leading cause of death nationally (Health Canada 2024).[79] The following discussion mainly focuses on Bill C-7, also known as Track 2.

This coda returns to the dissertation's central arguments by tracing how the moral and epistemic logics that structure skepticism toward fibromyalgia inform contemporary framings of assisted death with material consequences for the lives of those affected. Chapter 1 examined how accusations of malingering establish a default posture of disbelief toward disabled subjects whose suffering lacks biomedical visibility. Chapter 2 showed how these suspicions are interpreted through feminized cultural frames, positioning fibromyalgia as a contemporary iteration of the "new hysteria" and rendering women's pain excessive, psychological, or culturally produced. Chapter 3 traced the historical genealogy of these suspicions through

[79] Statistics Canada does not classify Medical Assistance in Dying (MAiD) as a cause of death. Instead, deaths involving MAiD are recorded under the underlying illness or condition that prompted the request. This reporting convention complicates efforts to assess MAiD's scale alongside other causes of death and may obscure analyses of its growth over time.

nineteenth- and early twentieth-century nervous disorders—such as railway spine and neurasthenia—demonstrating how narratives of entitlement, credibility, and secondary gain positioned disabled people as undeservedly seeking support. Chapter 4 demonstrated how neoliberal productivity norms transform dependency into moral failure, while Chapters 5 and 6 analyzed how these judgments are institutionalized through biocertification and benevolent care, where medical authority withholds recognition while framing such refusal as ethical and responsible. Taken together, these chapters reveal a cultural landscape in which lives that require ongoing support are systematically devalued. The coda turns to MAiD as a limit case that renders the stakes of these logics visible, revealing how the same frameworks that invalidate and abandon disabled lives produce conditions of vulnerability under which death can come to be normalized as care.

This analysis does not introduce a new problem so much as trace the endpoint of an existing one: people who are invalidated, treated as burdensome, or undeserving of support through medical and institutional practices are later positioned as appropriate candidates for assisted death. Whereas this dissertation traced how the hystericization of fibromyalgia and related contested illnesses functions to deny legitimacy, care, and support, this coda asks what happens to those who are repeatedly disbelieved and abandoned? Drawing on Susan Wendell's account of epistemic and medical invalidation, I show how the undermining of patient credibility extends far beyond the clinic to produce "private and public invalidation by others" (122) that gradually alienates people from networks of care, reciprocity, and belonging; thereby, producing the very conditions of vulnerability within which MAiD operates. Read in this light, MAiD can be seen as a foreseeable consequence of longstanding practices of medical invalidation and

social abandonment, through which lives deemed unsupportable and unworthy become vulnerable to being offered death framed as care.

1. Epistemic Invalidation and Cultural Narratives of Being a Burden

A core argument of this dissertation has been that epistemic invalidation operates as a form of structural violence. When physicians and institutions refuse to recognize certain forms of pain or impairment as real, patients are not merely denied medical care, they are also denied the social legitimacy that medical validation confers. As some scholars argue—Wendell (1996) most centrally, but also Mollow (2014)—this lack of recognition may produce social isolation or social abandonment where individuals find themselves cut off from networks of support because friends, family (and employers) doubt the credibility of their illness in the absence of biomedical certification (or biocertification). This can lead people to feel like burdens on family and friends when they do need accommodations and care. This process can be described as internalized ableism: when disabled people absorb society's negative and biased views of disability, and come to see themselves as defective, burdensome, and less deserving, and unconsciously equate their worth with ableist expectations. This is an essential dynamic that intimately shapes the context in which MAiD is offered and taken up.

This dissertation has already shown how medical invalidation of invisibilized illnesses constructs patients as irresponsible, overly dependent, or morally suspect. The result can be that individuals come to view themselves as burdens, whose needs exceed what society should be expected to support. When individuals internalize this worldview, the decision to pursue MAiD may appear morally responsible: as a way to avoid imposing on loved ones, to spare partners or children from caregiving, or to uphold an ideal of dignity grounded in bodily autonomy. This internalized ableism is reflected in reported reasons for requesting MAiD, as documented in

federal reporting data. For instance, according to 2023 federal data, a significant proportion of people who consider MAiD explicitly cite being "a burden on family, friends, or caregivers" as a form of suffering compelling their choice (Health Canada 2024). This is roughly half (49%) of Track 2 applicants. Relatedly, nearly as many (47%) reported isolation or loneliness as underlying reasons for choosing MAiD (Health Canada 2024). Feeling like a burden is so pervasive that, in the UK, a proposed amendment to the Terminally Ill Adults (End of Life) Bill passed in 2025 sought to exclude eligibility where a request for euthanasia was motivated by feeling like a burden, mental illness (including depression), disability, financial hardship, inadequate housing, lack of access to treatment, or suicidal ideation (UK Parliament 2025, NC16). The amendment was rejected for reasons that are unclear, but the proposal nonetheless underscores the recognized vulnerability of applicants and the material consequences of framing disabled people as burdensome members of society ("MPs vote to reject amendment on 'being a burden'", *The Guardian*).

Framing disabled people with care needs as drains on public resources—and thus as socially suspect—is a main strategy I identified in the *Rheumatology* authors' rhetoric, and which I demonstrated is far from confined to medical discourse. This cultural logic has circulated widely in contemporary media, where disability and economic inactivity, or "idleness," are repeatedly cast as moral and fiscal threats. Recent *Telegraph* coverage,[80] for example, links those who "can't or won't work" to social disorder (Warner) and another article depicts the "costs" of supporting disabled and sick populations as increasingly "unbearable"—inviting readers to view welfare spending, particularly disability benefits, as an excessive burden on wage earners (Clark

[80] Jeremy Warner, "Idle Britain is becoming fertile ground for violence, resentment, and crime." *The Telegraph*, August 14, 2024; Alex Clark and Tom Haynes. "Exactly how much of your salary goes toward Britain's growing welfare state." *The Telegraph*, September 21, 2023.

and Haynes). Within this framing, the problem is not the absence of adequate care, accessible work, or meaningful support, but the existence of people who require support at all.

As Disability Rights UK has argued in a formal press complaint to the Independent Press Standards Organisation, such reporting misrepresents disabled people and fuels stigma by portraying them as drains on collective resources rather than as citizens entitled to care (Disability Rights UK 2024). This is precisely the moral economy disability scholars have long identified as enabling the withdrawal of state support and the erosion of collective responsibility (Russel 2019). In this cultural and discursive landscape, feeling like a burden is not simply a private emotion but a socially-reinforced moral identity that can make withdrawal from life appear responsible, altruistic, or even necessary. These types of narratives were circulating in mainstream UK media at the very moment the *Terminally Ill Adults (End of Life) Bill* was under parliamentary discussion, situating these narratives of burden alongside active debates about assisted dying. As Alexandre Baril argued in a 2017 critique of Canada's original MAiD legislation, the law operates within an "'ableist, ageist, capitalist, neoliberal perspective' that rationalizes assisted suicide for subjects with 'no future' who are constructed as economically 'unproductive'" (qtd. in Frazee 121). It is against this backdrop Baril illuminates—where dependency is construed as social failure and need for support as excessive—that assisted dying is offered as a solution to suffering that is, in fact, structurally produced.

2. Determining Who is Worthy of Support

Just as the *Telegraph* articles locate the problem of "idleness" within individuals while erasing the absence of adequate social support as a structural cause, MAiD policy similarly frames assisted death as a response to individual suffering while omitting any engagement with the social conditions that produce that suffering. Feeling like a burden, a narrative perpetuated in

media discourse, is compounded by social neglect and a lack of social supports. Disability activists have repeatedly emphasized that decisions to pursue MAiD cannot be understood apart from the broader context of structural abandonment and inadequate support for disabled people's lives. In "Disability, Death & the Fight for Justice," for example, Megan Linton documents how chronically low social assistance rates and insufficient access to basic necessities—including housing, food, care, and pain management—push disabled people into sustained poverty and material insecurity, such that some report considering assisted death because they "simply cannot afford to keep on living." Similarly, in "Dying a 'Good' Death: Disability and the Assisted Suicide Debate," disability community members describe how medical neglect, dismissal by clinicians, and the continual framing of disabled people's lives as less worthy of support shape some individuals' engagement with assisted-suicide programs (Schroeder). Together, these narratives situate MAiD not as an isolated, purely personal choice but as one embedded in a social landscape marked by persistent under-investment in supports that are necessary to make life livable. In this way, lack of treatment access and financial hardship operate not just as background conditions but as forms of suffering that position death as the only viable resolution to unmet needs. Notably, this is the structural context that the rejected UK amendment above gestures toward as significant reasons one might be compelled to choose assisted suicide and that should be safeguarded against.

And yet, media sources have documented countless stories of individuals pursuing MAiD precisely for these very reasons. In 2023, Stephanie Lavoie, a 30 yr-old woman with untreated Lyme disease, weighed only 59 lbs when she "chose" MAiD after her request for at-home medical care for intravenous nutrition was denied (Laframboise 2024). In a *Global News* article, her sister describes how many people did not believe her, how medical professionals dismissed

her even as her health declined, and how some assumed she was using her symptoms to seek attention. In a recording for a journalist before she died, Lavoie asked "Is it ethical to let someone die because they do not fit into one of the famous checkboxes?" (Laframboise 2024). Her question directly echoes the classificatory criteria examined in Chapter 5, in which standardized diagnostic criteria invalidate suffering that resists quantification, barring access to life-sustaining care even as she was later deemed eligible for MAiD.

On Twitter in 2022, Disabled Ontarian (@Disabled Ontari1) posted that they were approved for MAiD a second time and wanted to be clear they were choosing MAiD solely because they could not afford to live on Ontario Disability Support Program (ODSP) payments. They referred to MAiD as "the only help offered" and explained that they could not afford to wait for changes to be made to ODSP (Disabled Ontarian 2022). As of 2025, maximum ODSP payments for a single person are $1408 per month (calculated as $809 for basic needs and $599 for shelter).[81] By contrast, the official poverty line in Ontario, measured using the Market Basket Measure, is $2302 per month ($27 631 annually), with incomes below $1727 per month ($20 723 annually) classified as deep poverty (United Way Waterloo Region Communities 2024)). For additional context, the average market-rate one-bedroom apartment in Waterloo Region now rents for approximately $1700 per month (United Way Waterloo Region Communities 2024).

Some have dismissed the personal stories of accessing MAiD I discussed above as hyperbolic anecdotes (Frazee 1), but recent scholarship has also documented that requests for MAiD are being driven by the systematic denial of the social and material supports necessary to

[81] It is worth noting that in 2020 the federal government set the Canada Emergency Response Benefit (CERB) at $2,000 per month—a figure that implicitly acknowledged a minimum income necessary to sustain life during a period of crisis. Eligibility for CERB was revealingly restricted to those with recent participation in waged labour. For many, the program exposed the fiction that "there is not enough money," particularly when contrasted with the substantially lower rates provided through ODSP. This contrast illustrates a two-tiered valuation of lives organized around capacity to work: whereas disability is treated as a private misfortune to be managed cheaply, interrupted labour is treated as a public emergency requiring robust support.

make life livable. In “Legislated Ableism,” Isabel Grant argues that “it is impossible to separate suffering caused by an irremediable disability and suffering caused by the impacts of systemic ableism,” including poverty, housing insecurity, social isolation, and exclusion, and that the state increasingly offers death while failing to provide the conditions that would alleviate that suffering (259). Grant documents multiple accounts in which individuals explicitly sought MAiD because basic supports were unavailable. “Denise,”[82] for example, applied for MAiD because she could not tolerate her chemically unsafe apartment and could not afford accessible housing on disability benefits. “Sophia,” who had severe chemical sensitives, pursued MAiD after years of unsuccessful attempts to secure safe housing. In a video filmed eight days before her death, “Sophia” said “[t]he government sees me as expendable trash, a complainer, useless and a pain in the ass” (Favaro 2022). Her comments reflect the same moralized framing of disabled women with complex illness as nuisances or “chronic complainers” that has structured medical skepticism toward fibromyalgia. And Sathya Dhara Kovac wrote prior to her death that “it was not a genetic disease that took me out, it was a system,” after being unable to obtain the home care she needed to live with ALS (qtd. in Grant 269). Similarly, Jean Truchon only developed a desire to die after his request for adequate home care was denied, writing that had he received sufficient support, he “would have preferred to stay in [his] home and possibly… not have had the same desire to die” (qtd. in Grant 278). Grant situates these cases within a broader pattern in which people with disabilities may come to view assisted death as their only viable option when the state withholds housing, income, and care.

[82] Names placed in quotation marks indicate pseudonyms used to protect the identities of MAiD recipients.

3. Waiting for Care

Documented wait times for the very supports that might alleviate suffering routinely extend far beyond the timelines built into Canada's MAiD policy. Access to publicly funded chronic pain clinics in Canada typically involve waits of several months (5-6), with many patients waiting several years (4-6) before their first appointment (Liddy et al. 2024). Coehlo et al. note significant gaps in public funding for healthcare services and long wait times for medical services and disability supports, such that, quoting former Disability Inclusion Minister Carla Qualtrough, "it is easier to access MAiD than to get a wheelchair in some parts of the country" (873). In effect, "[p]atients are…being guaranteed MAiD but not mental health care, palliative care, disability supports, and myriad other essential health services" (873).

Housing supports are also constrained with waitlists measured in years: subsidized or rent-geared-to-income housing in Ontario commonly spans waits of four to ten years or longer, with supportive housing and disability-related services likewise characterized by multi-year backlogs affecting tens of thousands of people (District Municipality of Muskoka; Region of Peel; Community Living Ontario 2024). These prolonged delays stand in stark contrast to the MAiD Track 2 framework, which requires a minimum assessment period of only ninety days. The disparity highlights a policy environment in which pain care, housing, and other essential supports remain subject to prolonged scarcity and delay, while access to assisted death is comparatively swift. In such a policy landscape, MAiD emerges as the most readily available state response to suffering and as more accessible than the material conditions required to sustain life.

The extent to which MAiD is increasingly conceptualized as a response to structural deprivation is reflected in a 2023 Angus Reid survey, circulated by Polling Canada,[83] that asked whether assisted death should be available to those unable to afford housing (Polling Canada 2023)—an ethically stark prompt that indicates how the substitution of MAiD for unmet social supports has already entered the realm of publicly imaginable policy scenarios. This disparity prompts the question: if Track 2 is pitched as a compassionate response to alleviate suffering, why is the primary response to this suffering the provision of death rather than sustained investment in the conditions that make life livable? Bill C-7 framed expanded access to MAiD as a rights-based matter that was grounded in claims of unjust exclusion, deservingness, and equality; yet, this language is notably absent from discussions of access to care *in life*, where there has been no comparable legislative effort to guarantee access to the supports—such as housing, income, or care—that would alleviate suffering.

4. Economic Rationality of Disposable Lives

When assisted death is increasingly understood as a response to structural deprivation, it becomes subject to economic reasoning, situating lives marked by dependency within cost-benefit frameworks. Early government analyses have already acknowledged that MAiD produces measurable cost savings within Canada's healthcare system, even under relatively narrow eligibility criteria. The Parliamentary Budget Officer's Cost Estimate for Medical Assistance in Dying reports that existing MAiD legislation, combined with the expansion under Bill C-7,

[83] Polling Canada compiles and republishes individual survey questions and results drawn from polling conducted by organizations such as the Angus Reid Institute. As such, Polling Canada sometimes circulates questions or results that do not appear in the polling firm's public-facing reports or press releases, which typically highlight only a subset of survey items. The housing-related MAiD question referenced here was attributed by Polling Canada to a September 2023 Angus Reid Institute survey conducted in partnership with Cardus. While this item does not appear in the published summaries of that survey, its circulation by a national polling aggregator is analytically significant insofar as it indicates that MAiD has become thinkable as a response to unmet basic needs such as housing insecurity.

would result in a net reduction of $149.0 million, an amount representing 0.08% of provincial health care spending in 2021 (approximately $187.1 billion) (Giroux 2020). While the PBO characterizes MAiD as producing a "net reduction in health care costs," it also cautions that the overall fiscal impact is "negligible" and that "additional data on the patients requesting MAID is needed" to fully assess its implications (Giroux). Although the PBO frames MAiD savings as modest, its cost-accounting nonetheless demonstrates how assisted death can be made to appear fiscally rational within an overburdened healthcare system, particularly when compared to the far higher costs of sustained care and social supports— costs that are excluded from the cited $149 million and whose inclusion would substantially increase the apparent savings to the state.

Disability scholars have warned that even modest savings carry significant ethical weight when they arise from unmet need. As Grant observes, "offering autonomy over death to those who may not have access to what they need to live does not enhance equality or autonomy; it simply provides an exit ramp from the state sanctioned misery of their lives—an exit ramp that will save the state millions of dollars in healthcare and social supports" (333). She further notes the stark asymmetry that "MAiD is fully covered by state-provided healthcare in Canada when so many of the supports needed to live are not," cautioning that when death is guaranteed but care is not, MAiD risks functioning as a "cheaper and quicker escape route rather than as true equality" (334; 269). This concern is echoed by suicide-prevention advocates, with Sean Krausert of the Canadian Association for Suicide Prevention warning that "ending the life of someone with complex mental health problems is simpler and likely much less expensive than offering outstanding ongoing care," a dynamic that "creates a perverse incentive for the health system to encourage the use of MAID at the expense of providing adequate resources to patients" (qtd. in Frazee 107). As Grant further observes, even prior to the introduction of Track

2 MAiD, estimated healthcare savings were already in the millions annually, and that "as the numbers of Track 2 cases expand, including those based on mental illness, there is also the potential for savings in social welfare spending" (334).

Jamil and Pearce (2025) tackle this concern directly by framing the expansion of MAiD within a logic of austerity and fiscal burden. They calculate that extending eligibility to populations positioned as net economic "costs"—including people with severe mental illness, the homeless, the elderly, and indigenous groups—could yield tens of billions in savings under voluntary scenarios and more than CAD $1.2 trillion under non-voluntary[84] ones by 2047 (20). While presented as an economic modeling exercise, the authors warn that financially incentivizing MAiD risks devaluing vulnerable lives, shifting healthcare priorities away from care and toward efficiency, and normalizing assisted death as a policy solution to structural failures in healthcare, housing, and social support (20). They emphasize that vulnerable groups may feel pressured to choose MAiD within such conditions, as people come to feel like a burden and internalize ideas of uselessness, costliness, or expendability (20). As Jamil and Pearce caution in their conclusion, framing MAiD as a source of large-scale cost savings creates a "deeply troubling ethical dilemma" that risks reorienting healthcare systems toward promoting assisted death as a "financially attractive option" rather than ensuring necessary care and support (20).

Similarly, in a 2023 public commentary, Bill Gardner observed that "MAID is inexpensive, completely effective, and easily delivered," warning that if left unchecked, "the

[84] Jamil and Pearce's distinction between "voluntary" and "non-voluntary" scenarios are used analytically to expose how, once MAiD is justified in economic terms, safeguards around consent become increasingly fragile, fiscal incentives intensify pressure on vulnerable populations, and the boundary between choice and administration becomes politically unstable under conditions of austerity.

system will, as if pulled by gravity, increasingly provide suicide and euthanasia instead of healing for the poor, elderly, and severely ill" (qtd. in Frazee 147). That this dynamic is not merely theoretical is reflected in public concern: a majority of Canadians (55%) report that they "worry about MAID taking the place of improvements in social service," while supplementary polling in September 2023 found that "half of Canadians (52%) worry that treating mental health will not be a priority" if MAiD eligibility is expanded to include individuals whose sole underlying condition is mental illness (Frazee 122). These concerns underscore the risk that MAiD expansion functions not alongside, but in place of, meaningful investment in social supports.

5. Myth of Independence

These economic dynamics operate alongside a deeply entrenched cultural ideal of independence, in which reliance on care is framed not only as costly but as a form of suffering in itself. Parliamentary hearings reviewing Canada's MAiD law expose how deeply the myth of independence structures legislative understandings of suffering, positioning reliance on care and institutional support as intolerable forms of existence. Grant emphasizes the disturbing regularity with which witnesses and committee members at the Joint Committee hearings reviewing Canada's MAiD laws stated that they would prefer death over incontinence, reliance on personal care, or institutional living (297). Grant notes how disabled people listened as legislators speculated, on the public record, that their lives might be worse than death (297).

Grant states these comments starkly reveal the ableist conflation between disability and suffering. The definition of ableism from the former UN Special Rapporteur on the Rights of Persons with Disabilities notes that "ableist ways of thinking consider the disability experience as a misfortune that leads to suffering and disadvantage and invariably devalues human life"

(qtd. in Grant 293). Ameil Joseph, a professor of social work, refers to this ableist conflation of disability with suffering as a political strategy to compartmentalize suffering as if it can be "distinguished from the social and political factors" that contribute to suffering (2021). In other words, ableist ideas that equate disability with suffering—and which underly viewing MAiD as an "insurance policy" to avoid the supposed suffering inherent to disability—ignores the social contexts that produce suffering and which blame individuals for these structural failings. These comments additionally reveal a fear of and discomfort with dependency, as if relying on support to live makes that life inherently less valuable. The cultural expectation that worthy lives are independent lives is one I examined extensively in my analysis of the denial of medical legitimacy to fibromyalgia patients, and it is a myth that reasserts itself with particular force in discussions of MAiD.

Disability scholars and activists have long challenged what Catherine Frazee describes as "the debilitating fiction of the independent human," a cultural mythology that "underpins the devaluation of disabled lives" and that I examine in this dissertation as the myth of independence (Frazee 75). This myth is inseparable from moralized ideas of worth rooted in productivity and self-sufficiency, in which the ideal citizen is imagined as autonomous, economically-independent, and minimally reliant on care or collective support. In legislative debates, independence repeatedly emerges as an implicit threshold for an acceptable life, with reliance on care, assistance with toileting, or institutional support framed as evidence of intolerable suffering rather than as ordinary features of human interdependence. Frazee observes that this eligibility boundary for MAiD expansion rests not on medical necessity but on what she describes as an ableist worldview in which intolerable suffering is defined less by medical condition than by social and cultural norms (75). Shaped by this myth of independence, suffering that is formally

recognized as intolerable is narrowly medical, while suffering arising from social and cultural conditions—such as stigma, enforced dependency, and lack of supports—is deliberately bracketed out of policy consideration, even as its effects are implicitly treated as grounds for assisted death. The consequences of this logic are evident in official reporting: in the Fifth Annual Report on Medical Assistance in Dying in Canada (2023), 70.4% of Track 2 cases cited "loss of dignity" as a primary form of suffering, revealing how dignity is routinely defined through notions of independence, bodily control, and freedom from care.

In "Sounding the Five Minute Entreaty," Frazee assembles testimonial statements entered into the parliamentary record by disabled and disability-aligned citizens prior to the expansion of Canada's MAiD law, preserving their voices and warnings in the historical record. These accounts, grounded in lived experience, expose how cultural ideals of autonomy and independence obscure the material realities of disabled life and reinforce ableist assumptions about dignity. Disability activists have directly confronted this equation of dignity with independence by exposing its material harms and role in devaluing (inter)dependent lives. In her testimony on Bill C-7 before the Senate Standing Committee on Legal and Constitutional Affairs, Gabrielle Peters recounts the bureaucratic barriers she faced in attempting to secure state funding for a replacement cover for a urine-soaked wheelchair cushion—an account that Frazee says "expose[s] the hubris of independent toileting as the pinnacle of human dignity" (77). Such testimony punctures the sanitized language of autonomy by revealing the everyday realities of disabled poverty and dependence that MAiD expansion discourse often obscures. As Frazee notes, these interventions highlight how MAiD policy increasingly caters to "the desires and fantasies of those who have never had to concern themselves with hunger, homelessness, or dependence on state welfare," while positioning lives shaped by care needs and material

precarity as falling below the threshold of acceptability (78). Grant is explicit that "[t]he suggestion that the dignity of a life is diminished if one lacks full independence is…ableist" (301). Dependence on caregivers does not diminish dignity, she argues; rather, dignity is eroded when society repeatedly insists that dependence should diminish it, and then withholds the supports necessary to live well (301). As I argued previously in this dissertation, the myth of independence obscures that we all rely on supports and instead recasts support for some as excessive and burdensome. This fantasy pathologizes some people's need for care by recoding it as "dependency," obscuring the reality that all lives are sustained through interdependent networks of care.

6. Freedom of Choice

Frazee and others argue that the medicalization of suffering and the individualized framing of "choice" conceals the state's coercive role in producing intolerable conditions of life. Kerri Joffe, a lawyer in disability rights, notes there is "no real, free choice" for disabled people living in pervasive socio-economic deprivation without meaningful alternatives (qtd. in Frazee 28), and that offering autonomy over death in the absence of offering more autonomy over life merely provides a sanctioned means of escape from conditions of state-produced suffering (Grant 333). In this formulation, the state's offer of death is reframed as respect for individual freedom of choice. This framing obscures structural neglect and treats death as a naturalized and compassionate response to suffering.

Advocates for extending MAiD beyond end-of-life contexts frame the policy as an expansion of freedom and equality, arguing that it offers people with disabilities a benefit rather than a harm. This logic underpins the government's Charter justification for Bill C-7 and is repeatedly invoked to defend the expansion of MAiD to people with mental illness on the

grounds that denying access would itself be discriminatory. As Grant explains, proponents insist that MAiD merely adds "one more choice" to the range of options available to disabled people (324). Yet choice cannot be meaningfully disentangled from the social conditions under which it is exercised. Grant argues that while Bill C-14 may plausibly be understood as "easing people into a death that is already close" for those at the end of life, extending MAiD under Bill C-7 to non-end-of-life contexts (Track 2) rests on an ableist premise that frames disability-related suffering as worse than death and treats death itself as a medical "benefit" (266; 311). As Grant bluntly puts it, "[i]t allows [people] to exercise a choice to die" when those lives are perceived as worse than death (311), while eliding the social, economic, and political conditions that produce much of that suffering.

It is precisely this obscured terrain that Frazee insists must be made visible: in a 2023 panel on "Feminism, Ableism, and MAiD" Frazee emphasizes that "[s]uffering from isolation, demoralization, social and material deprivation, food and housing insecurity, [and] the feeling of being a burden—unpack every one of these recurring themes in the Track 2 victim profile, and you will find that all are actually preventable." Yet, she argues, the law effectively requires clinicians to treat the limits of state-funded care "as immutable as impairment itself," operating as a fiction of inevitability that renders suffering that arises from gaps in support "lawfully MAiD-able" ("Feminism, Ableism, and MAiD"). Supports that could prevent or relieve suffering, but are not made available, "factor nowhere in the determination of Track 2 eligibility," even as numerous MAiD applicants have referenced these very lack of supports as their reason for choosing MAiD.

This displacement of structurally produced suffering onto the individual—framed as choice, attitude, or preference—closely mirrors the discursive treatment of fibromyalgia patients

who are routinely framed as if they choose illness or fail to recover through individual attitude or behavior, rather than as subjects of a deliberate withdrawal of care that is justified as being "for their own good"—that is, as a benefit rather than a harm—while leaving intact the structural conditions that perpetuate their suffering. As emphasized in this same 2023 panel, these dynamics are deeply gendered: women are disproportionately impacted by chronic illness, are less likely to receive appropriate or timely medical treatment, and are overrepresented among low-income individuals and families—conditions that sharply constrain the range of livable alternatives available to them (Benedet). The personal accounts of choosing MAiD referenced above make this logic even more explicit: an individual's "choice" to die was inseparable from their inability to obtain essential supports to live. Their suffering was structured by poverty and unmet need—conditions that could have been mitigated through adequate state intervention.

By conflating suffering with disability rather than acknowledging the role of structural deprivation, freedom-of-choice discourse displaces responsibility from the state onto the individual. Where decisions are shaped by "inescapable poverty, social isolation, stigma, loneliness," or by perceiving oneself to be "a burden on others," it becomes deeply problematic to characterize "state-inflicted death" as an autonomous act at all—conditions Grant suggests may amount to "a form of coercion" (325). Moreover, in an article examining fibromyalgia and CFS patients' experiences of seeking MAiD, co-authored by prominent MAiD provider Ellen Wiebe, a central finding was that approval for MAiD "provided validation of their illness" and that participants felt "the interviewers truly listened to them" (Fruhstorfer et al. 2024). These observations underscore the significance of recognition and credibility for patients whose symptoms have long been dismissed. When validation, belief, and attentive listening are routinely denied in life but finally conferred through eligibility for death, the conditions under

which consent is formed are fundamentally distorted, raising serious questions about how voluntary such choices can be and how absent coercion truly is.

It is within this context that the medical model is mobilized to legitimate "choice in the abstract" while foreclosing scrutiny of the narrow and unequal field of survivable options available to disabled people (Grant 301). This distortion becomes especially stark when Track 2 MAiD is defended using language that frames assisted death as an "insurance policy," as the trial judge in *Carter* described it, or a comforting "escape route" from disability (Grant 311). For many, however, MAiD is experienced not as reassurance but as a persistent moral pressure—a "monkey on their back," as Grant phrases it, throughout their efforts to live with chronic illness and disability in a society that withholds support while continually offering death (311). As Grant notes, the availability of MAiD places individuals in the "position of re-evaluating whether their lives are worth living in a social context where the state is offering to end those lives" (311)—a burden that falls most heavily on those already marked as dependent, costly, or expendable, and whose lives are considered less worth living. Thus, those who have been failed by social supports and our healthcare system and are routinely framed as societal burdens may now "choose" MAiD.

7. Benevolent "Care"

While MAiD is frequently justified through the language of autonomy and choice, it is equally framed as an act of compassion—one that positions the state and medical professionals as caring responders to suffering. Just as I argued that the *Rheumatology* authors' medical discourse framed the denial of care to fibromyalgia patients as responsible and protective, MAiD policy similarly mobilizes compassionate language to present assisted death as end-of-life "care." Appeals to alleviating suffering are persuasive precisely because they appear morally

self-evident. Track 2 was effectively marketed in media as relieving the suffering of Canadians, a framing that is especially effective in securing public support for MAiD and draws on ableist logics of pity rather than justice. Dying with Dignity Canada—a lobby organization that campaigns for the expansion of MAiD eligibility—has explicitly leaned into this rhetoric by featuring first-person narratives in support of legislative reform. One profile of "Justine," a person living with fibromyalgia, describes considering suicide as the only available option after being denied access to MAiD prior to the passage of Bill C-7 because her death was not reasonably foreseeable (Dying with Dignity 2023). Their story is presented not to interrogate why suicide emerges as the remaining option in the context of unmet care needs, but to position expanded access to MAiD as the compassionate—and more dignified—alternative. The ethical force of their narrative derives from the desire to avert a more violent, isolating, or undignified death, allowing the expansion of assisted dying to be framed as benevolent care.

Within MAiD policy, benevolent framing is sustained through the authority of the medical model to define both suffering and its appropriate response. Courts have explicitly endorsed the view that "people who are suffering based on disability…must be given access to MAiD…'at any moment during their life,'" on the grounds that denial would be paternalistic and would "deny them the autonomy to make the choice that death was preferable to life with a disability" (Grant 281). Justine's narrative echoes this reasoning, positioning MAiD access as the ethical response to suffering and restrictions on access as an unjust imposition rather than a failure of rethinking care. As Grant notes, however, the court "did not elaborate on why other Canadians who suffer intolerably, for reasons unrelated to disability, can be denied access to MAiD," revealing how disability itself becomes the condition that makes death conceivable as care (281). Grant further emphasizes in the 2023 panel on MAiD, "if you call it medical

treatment, you can construct it as a benefit…whereas if you characterize it as suicide,[85] we can see more clearly that fundamentally we are denying disabled Canadians the protection of the criminal law that everyone else enjoys" ("Feminism, Ableism, and MAiD"). Framing assisted death as an act of mercy thus replays older narratives that cast disabled lives as inherently tragic, pitiable, and burdensome. What looks like empathy on the surface can disguise a deeper ableist logic in which disability and dependency are considered incompatible with a good life. Positioning assisted death under these conditions as a beneficent gift granted by a caring state is therefore not a rejection of paternalism but its re-articulation.

As in the case of fibromyalgia, this asymmetry is reinforced by the medical model's concentration of authority in clinicians who function as gatekeepers to both resources and death. As Grant observes, this grants doctors enormous power to determine inclusion and exclusion within categories tied to care and legal status, including "who is capable of making medical decisions, marrying, entering a contract, or consenting to sexual activity" (295). Yet, paradoxically, "when doctors are the gatekeepers, we tend to insist on fewer safeguards than when, for example, police or judges are making these profound decisions about life and death," because "the benevolence we implicitly attribute to doctors obscures the need for procedural safeguards" (296). By framing death as compassionate care for those whose lives are already understood as diminished by disability, MAiD policy reproduces a familiar logic of benevolent oppression. As I discuss throughout this dissertation, harm to disabled people is typically not enacted through overt cruelty but through appeals to care, expertise, and protection that foreclose

[85] In this same 2023 panel, Grant notes that women are more than two times as likely to be given a diagnosis of depression. In the Netherlands, depression is a leading reason for psychiatric MAiD and 70-77% of all psychiatric MAiD deaths are women. She importantly notes that men are more likely to complete suicide, but women more likely to attempt it. Disturbingly, they have found that "the numbers for psychiatric MAiD map, almost perfectly, onto the numbers of attempted suicide for women." She therefore cautions that psychiatric MAiD risks functioning as "a way to ensure that women's attempted suicides become completed."

alternative forms of support while framing their withdrawal of supports as ethically acceptable. Benevolent rhetoric here works to disguise power, allowing decisions about life and death to appear humane even as they are shaped by ableist assumptions about dependency, worth, and the limits of a livable life.

8. Erasing Eugenic History

History cautions that benevolent intentions are not a safeguard against harm. As Grant emphasizes, "even with the best of intentions, the altruism of the medical profession can be invoked to carry out the eugenic policies of the state" (334). A rhetoric of benevolence has long functioned as justificatory language through which eugenic practices have been framed as care. As Heidi Janz states bluntly, "Canada's current MAiD regime is, in fact, eugenics disguised as autonomy" (145). Frazee has similarly referred to Bill C-7 as "eugenic creep cloaked in the language of benevolence" (79). Disability scholars and activists emphasize that the continuity with eugenics lies not in identical policy form but in the recurring logic through which disability, suffering, and death are linked. As Ameil Joseph explains, Canada has a long record of treating disabled people as "burdensome and unworthy of adequate incomes and services," while permitting "a medicalized idea of suffering to persist in persons with disabilities by omitting the social contexts of suffering, erasing historical contexts, and turning our gaze away from the systemic racism and discrimination that we know is persistent and pervasive across systems and services" (2021). Joseph argues that the medicalization of disability and suffering is a tactic that advances ableist and eugenic policies, noting that the erasure of historical context that is so critical to MAiD discussions it not an "accident"; rather, it is "coherent with the historical trajectories of ableism and eugenics that attach ideas of compassion to institutionalization, eradication and exclusion" (qtd. in Grant 300). Speaking for Indigenous Disability Canada, Neil

Belanger further notes that lack of meaningful consultation with Indigenous communities on the impact of expanding MAiD is "the continuation of the destructive colonial systems and their paternalistic mindset of 'Trust us, we know what's best'" (qtd. in Frazee 131). His comments underscore how benevolence has historically functioned as a vehicle for state violence rather than protection.

Joseph further cautions that contemporary MAiD debates proceed as though their rationales emerge in a vacuum when in fact they "arise out of a context of racism, ableism, and eugenics—that tie ideas of worth to heredity and ableism and racism" ("Death by Coercion"). He notes that policymakers "continue to pretend as though euthanasia and sterilization are not the real historical context with which health systems participated in the intentional destruction of people with disabilities" ("Death by Coercion"). In subsequent discussion, Joseph emphasizes the resulting mistrust among disability communities, observing that while policymakers invoke "compassion" and "dignity," they simultaneously refuse to acknowledge that "systemic racism [does] exist in access to services, income, employment, education, [and] healthcare" (Joseph). Without acknowledging these uneven conditions of access, MAiD is presented as ahistorical and benign, allowing a policy rooted in long-standing eugenic and ableist logics to masquerade as a neutral expansion of individual choice.

Legal scholars have noted that one reason these historical continuities are difficult to confront is that "the reference to the history of eugenics in the MAiD context has been largely considered taboo" (Lemmens "Death by Coercion"). Frazee emphasizes that eugenic formations in public health and public policy have long operated with mainstream legitimacy, a normalization that continues to shape how their contemporary iterations are recognized and named. Drawing explicit parallels to earlier eugenic projects, she notes that "eugenic innovations

in public health and public policy were sweeping and enjoyed widespread mainstream acceptance," endorsed by "leading progressive figures in politics, medicine, religion, philanthropy and the academy" (Frazee 6–7). In this sense, MAiD's presentation—"championed in public policy debates as progressive and humane" (Frazee 1)—is not an aberration from eugenic history but a recognizable feature of it. Eugenics rarely announced itself as violence; rather, it was most effective when framed as rational, compassionate, and socially responsible, particularly when elimination can be justified as a solution to suffering, dependency, or resource strain.

Trudo Lemmens, a professor of law and bioethics, further stresses that "the kind of language we see being used in this debate—language of suffering, compassion—was the basis of policies we have seen in the eugenics era" ("Death by coercion"). Lemmens clarifies that treating MAiD as a policy that is based on "informed consent" presents it as if "we are just creating an opportunity for rational being[s] who want to control the manner and timing of their death" (Death by coercion). This positions MAiD as "completely acontextualized" from its historical antecedents (Lemmens). Such a maneuver situates the government as acting with good intentions while concealing the social, economic, and historical forces that shape both suffering and the desire for death. So long as the preconditions for sustainable life are not provided and remain unmet, the combination of material deprivation, inadequate socio-medical supports, and access to MAiD operates as a form of systemic coercion for disabled people who are already among the most marginalized, and whose vulnerability is intensified at the intersections of other axes of oppression. It is in this sense that the policy is inherently and inescapably eugenic.

9. Conclusion

This dissertation began by examining how fibromyalgia and other contested illnesses are routinely hystericized within medical discourse, rendering patients' testimony suspect, their suffering exaggerated or feigned, and their need for care reframed as burdensome. By situating these representations within longer genealogies of hysteria, malingering, productivity, and dependency discourse, I argued that skepticism toward invisible illness is not merely a matter of epistemic misrecognition but a mechanism through which legitimacy, credibility, and worthiness of care are differentially assigned. This dissertation has demonstrated that skepticism toward fibromyalgia is not simply the result of scientific or diagnostic uncertainty but the expression of longstanding cultural and institutional logics that regulate whose suffering is recognized and whose lives are deemed worthy of care. By analyzing the rhetorical authority of influential rheumatologists and tracing the genealogies through which contested illness has been feminized, psychologized, and moralized, I have shown how medical discourse actively produces fibromyalgia patients as unreliable, burdensome, and undeserving of support. In doing so, these representational practices do not merely shape clinical perception, they help produce material conditions of abandonment by withholding legitimacy, care, and social recognition.

The coda has extended this analysis into a contemporary policy context, demonstrating that these same moral and epistemic logics do not remain confined to the clinic but reappear in MAiD policy with fatal effects for those whose lives are vulnerable to medical invalidation in life but not in death. In this way, the rhetorical construction of fibromyalgia emerges as a critical site through which broader cultural systems of ableism, productivity, and epistemic authority determine whose suffering matters—and whose lives are sustained. What emerges most starkly across this trajectory is the ethical significance of how worthiness of care is distributed unevenly:

the systematic denial of care, recognition, and material support produces conditions of isolation, deprivation, and internalized burdensomeness, within which assisted death comes to appear as a reasonable—compassionate—response.

Importantly, MAiD is not driven by malice or cruelty. As with earlier eugenic frameworks that were widely understood by the public as humane, progressive, and compassionate, MAiD operates within institutional and legal structures that frame assisted death as an ethical and benevolent response to suffering. This reflects the same justificatory logic I identified in the *Rheumatology* authors' withholding of medical legitimacy and care for fibromyalgia, which they framed as a responsible and ethical refusal undertaken for the good of the patient and society. What makes this continuity particularly striking is that the same logic used to justify withholding care from fibromyalgia patients on the grounds that recognition would perpetuate harm is now invoked to authorize assisted death as a compassionate response to suffering. In both cases, medical authority determines the ethical limits of care, regulating whose suffering warrants support and whose suffering warrants withdrawal or termination. Yet when assisted death is offered in a context where individuals are persistently denied medical validation, left waiting for care that never manifests, and made to feel that their continued existence constitutes a drain on others or on the system, the voluntariness of their "choice" to pursue MAiD cannot be ethically disentangled from these conditions.

In its current iteration, MAiD policy represents a culmination of these logic and demands a reckoning with what it means to respond to suffering in a society that continues to deny the material conditions necessary to live. Read alongside the analyses developed throughout this dissertation, this trajectory from medical invalidation toward MAiD reveals the limits of a rights-based medical framework that treats care as a conditional privilege rather than a shared

responsibility, and that mistakes the management of dependency for the protection of the public good. What is ultimately at stake are the lives of those whose survival depends on access to care. Whether medicine—and the broader social and policy contexts within which it operates—can move beyond guarding systems of exclusion that distribute care unevenly, sustaining some lives without question while denying others the supports needed to live, to instead recognize interdependence as a shared human condition remains this dissertation's urgent ethical question.

References

Abbi, B., and B.H. Natelson. 2013. “Is Chronic Fatigue Syndrome the Same Illness as Fibromyalgia: Evaluating the ‘Single Syndrome’ Hypothesis.” *QJM: An International Journal of Medicine* 106 (1): 3–9. https://doi.org/10.1093/qjmed/hcs156.

Allingham, Philip V. “The Victorian Sensation Novel, 1860-1880.” https://victorianweb.org/genre/sensation.html.

Altaf, Fatima and Peter Ochs. 2019. “Proposed Changes to Ontario Social Assistance–Missed Opportunity for Families in Poverty.” *Ontario Campaign 2000: End Child and Family Poverty*. Toronto.

American Psychiatric Association, ed. 1968. *Diagnostic and Statistical Manual of Mental Disorders: DSM-5*. 2nd ed. Washington, D.C.

American Psychiatric Association, ed. 1980. *Diagnostic and Statistical Manual of Mental Disorders: DSM-5*. 3rd ed. Washington, D.C.

American Psychiatric Association, ed. 1998. *Diagnostic and Statistical Manual of Mental Disorders: DSM-IV; Includes ICD-9-CM Codes Effective*. 4th ed. Washington, DC.

American Psychiatric Association, ed. 2013. *Diagnostic and Statistical Manual of Mental Disorders: DSM-5*. 5th ed. Washington, D.C.

Archimedes, Sondra. 2012. *Gendered Pathologies: The Female Body and Biomedical Discourse in the Nineteenth-Century English Novel*. 1st ed. Abingdon, Oxon: Routledge.

Atci, Aysel Gurcan. 2019. “Top 50 Cited Articles on Fibromyalgia: A Bibliometric Analysis.” *Romanian Journal of Rheumatology* 28 (2): 47–54. https://doi.org/10.37897/RJR.2019.2.1

Badowska, Eva. 2009. “On the Track of Things: Sensation and Modernity in Mary Elizabeth Braddon's Lady Audley's Secret." *Victorian Literature and Culture* 37 (1): 157–75. https://doi.org/10.1017/S106015030909010X

Barton, Ellen. 2002. “Inductive Discourse Analysis: Discovering Rich Features.” *Discourse Studies in Composition*. Ed. Ellen Barton and Gail Stygall. Cresskill, NJ: Hampton Press, 19–42.

Beard, George M. 1881. *American Nervousness: Its Causes and Consequences*. New York: Putnam. https://collections.nlm.nih.gov/catalog/nlm:nlmuid-66350900R-bk

Beard, George M. 1880. *A Practical Treatise on Nervous Exhaustion (Neurasthenia): Its Symptoms, Nature, Sequences, Treatment*. New York: Treat.

Beck. Julie. 2016. “Americanitis: The Disease of Living Too Fast.” *The Atlantic*. March 11, 2016.

Belenguer-Prieto R, Morales-Espinoza EM, Martín-González RM, Brito-Zerón P, Pastor-Oliver JF, Kostov B, Buss D, Gómez-Gálvez C, Salazar-Cifre A, Sisó-Almirall A, Ramos-Casals M. 2013. “Specificity and sensitivity of objective tests to detect possible malingering in fibromyalgia: a case-control study in 211 Spanish patients.” *Clin Exp Rheumatol*. 31 (6 Suppl 79): S86-93. PMID: 24373366.

Benjamin S, Morris S, McBeth J, et al. “The association between chronic widespread pain and mental disorder.” *Arthritis Rheum* 2000 (43): 561-7.

Berenson, Alex. 2008. “Drug Approved. Is Disease Real? Some Doctors Dispute a Pain Condition.” *The New York Times*. Jan 14, 2008.

Biss, Eula. 2007. “The Pain Scale.” *Creative Nonfiction* 1 (32): 65-84.

Bogousslavsky, Julien. 2007. “Marcel Proust’s Diseases and Doctors: The Neurological Story of a Life.” *Frontiers of Neurology and Neuroscience* 22: 89–104. https://doi.org/10.1159/000102874.

Bosomworth, Jodie, and Zahid Khan. n.d. “Analysis of Gender-Based Inequality in Cardiovascular Health: An Umbrella Review.” *Cureus* 15 (8): e43482. https://doi.org/10.7759/cureus.43482.

Braddon, Mary Elizabeth. 1862. *Lady Audley’s Secret*.

Breuer, Josef, and Sigmund Freud. 1895. *Studies on Hysteria*. Basic Books.

Byerly, Alison. *Are We There Yet? Virtual Travel and Victorian Realism*. Ann Arbor: University of Michigan Press, 2013.

CanadianPolling. 2023. “MAID should be available for those who can't find affordable housing.” X (formerly Twitter), September 27, 2023. https://x.com/CanadianPolling/status/1707470690834628734.

Chaney, Sarah. 2013. *Self-Mutilation and Psychiatry: Impulse, Identity and the Unconscious in British Explanations of Self-Inflicted Injury, c. 1864 – 1914*. PhD diss., University College London.

Cherney, James L. 2019. *Ableist Rhetoric: How We Know, Value, and See Disability*. The RSA Series in Transdisciplinary Rhetoric. The Pennsylvania State University Press.

Clauw, Daniel, Piercarlo Sarzi-Puttini, Greta Pellegrino, and Yehuda Shoenfeld. 2024. “Is Fibromyalgia an Autoimmune Disorder?” *Autoimmunity Reviews* 23 (1): 103424. https://doi.org/10.1016/j.autrev.2023.103424.

Cohen, Bruce M. Z. 2016. *Psychiatric Hegemony*. London: Palgrave Macmillan UK. https://doi.org/10.1057/978-1-137-46051-6.

Cohen, Milton L. 1996. “The Derailment of Railway Spine: A Timely Lesson for Post-Traumatic Fibromyalgia Syndrome.” Pain Reviews 3: 181-202.

Collin, Simon M., Inger J. Bakken, Irwin Nazareth, Esther Crawley, and Peter D. White. 2017. “Trends in the Incidence of Chronic Fatigue Syndrome and Fibromyalgia in the UK, 2001–2013: A Clinical Practice Research Datalink Study.” *Journal of the Royal Society of Medicine* 110 (6): 231–44. https://doi.org/10.1177/0141076817702530

Community Living Ontario. 2024. “For Immediate Release: Toronto, Ontario, November 28, 2024.” November 28, 2024. https://communitylivingontario.ca/for-immediate-release-toronto-ontario-november-28-2024/.

Daly, Nicholas. 2004. *Literature, Technology, and Modernity, 1860-2000*. Cambridge University Press.

Davis, Lennard J. 1995. *Enforcing Normalcy: Disability, Deafness, and the Body*. London ; New York: Verso.

De La L. Oulton, Carolyn W. 2021. “Railway Fiction or Seaside Sensation? Journeys to the Sea in Lady Audley’s Secret and No Name.” *Studies in the Novel* 53 (3): 232–49.

Dolmage, Jay. 2017. *Academic Ableism: Disability and Higher Education*. University of Michigan Press. https://doi.org/10.3998/mpub.9708722.

Dolmage, Jay. 2018. *Disabled Upon Arrival: Eugenics, Immigration, and the Construction of Race and Disability*. Ohio State University Press.

Disability Justice Network of Ontario. 2021. *Death by Coercion: A Panel on the Impacts of Changes to Medical Assistance in Dying (MAiD) on Black Indigenous Queer Sick & Poor Communities.* Moderated by Rowa Mohamed. Livestream panel, February 1, 2021. https://www.youtube.com/watch?v=AZYPLoWVRlQ.

Disability Rights UK. 2024. “Press Complaint to the Independent Press Standards Organisation.” https://www.disabilityrightsuk.org/news/press-complaint-independent-press-standards-organisation-disability-rights-uk.

Disabled Ontarian. 2022. “This will be my final post…” X (formerly Twitter), November 28, 2022. https://x.com/DisabledOntari1/status/1597388126888300546.

District Municipality of Muskoka. “Social Housing.” Accessed January 10, 2026. https://www.muskoka.on.ca/en/housing/social-housing.aspx.

Duncan, Grant. 2003. “Workers’ Compensation and the Governance of Pain.” *Economy and Society* 32 (3): 449–77. https://doi.org/10.1080/03085140303134.

Dusenbery, Maya. 2017. *Doing Harm: The Truth About How Bad Medicine and Lazy Science Leave Women Dismissed, Misdiagnosed, and Sick*. Harper Collins.

Dying with Dignity Canada. 2023. “Justine’s Story.” Accessed January 12, 2026. https://www.dyingwithdignity.ca/blog/justine_story/.

Ehrenreich, Barbara, and Deirdre English. 1978. *For Her Own Good: Two Centuries of the Experts’ Advice to Women.* Garden City, NY: Anchor Press.

Ehrlich, George E. 2003. “Pain Is Real; Fibromyalgia Isn’t.” *The Journal of Rheumatology* 30 (8): 1666–67.

Ehrlich, George E. 2003. “Fibromyalgia Is Not a Diagnosis: Comment on the Editorial by Crofford and Clauw.” *Arthritis & Rheumatism* 48 (1): 276–276. https://doi.org/10.1002/art.10636.

Ehrlich, George E. 2003. “Fibromyalgia, a Virtual Disease.” *Clinical Rheumatology* 22 (1): 8–11. https://doi.org/10.1007/s10067-002-0697-7.

Eikermann-Haerter, Katharina, and Susie Y. Huang. 2021. “White Matter Lesions in Migraine.” *The American Journal of Pathology* 191 (11): 1955–62. https://doi.org/10.1016/j.ajpath.2021.02.007.

Erichsen, Eric. 1866. *On Railway and Other Injuries of the Nervous System*. London: Walton and Maberly.

European Federation of IASP Chapters. EFIC's declaration on pain as a major health problem, a disease in its own right. www.efic.org/about_pain.htm#efic_declaration.

Fantina, Richard. 2010. “Sensation Fiction and the Emergence of the Victorian Literary Field.” In *Victorian Sensational Fiction: The Daring Work of Charles Reade*, edited by Richard Fantina. Palgrave Macmillan US. https://doi.org/10.1057/9780230102156_2.

Fairclough, Norman. 1993. *Discourse and Social Change*. Cambridge University Press.

Favaro, Avis. 2022. “Woman with Chemical Sensitivities Chose Medically Assisted Death After Failed Bid to Get Better Housing.” *CTV News*, April 13, 2022. https://www.ctvnews.ca/health/article/woman-with-chemical-sensitivities-chose-medically-assisted-death-after-failed-bid-to-get-better-housing/.

Ferrari R. 2010. “A Painful Train of Events: The Rebirth of Railway Spine.” *Clinical and Experimental Rheumatology* 28(6 Suppl 63): S134. https://pubmed.ncbi.nlm.nih.gov/21176435/

“Fibromyalgia.” 2009. Research Portfolio Online Reporting Tools (RePORT). *NIH*. https://report.nih.gov/funding/categorical-spending#/

Fitzcharles, M. A., Ste-Marie, P. A., Mailis, A., & Shir, Y. 2014. Adjudication of fibromyalgia syndrome: challenges in the medicolegal arena. *Pain research & management*, *19*(6), 287–292. https://doi.org/10.1155/2014/742830

Foucault, Michel. 1973. *The Birth of the Clinic: An Archaeology of Medical Perception*. Translated by A.M. Sheridan-Smith. London: Tavistock Publications.

Foucault, Michel. 1980. *Power/Knowledge: Selected Interviews and Other Writings, 1972–1977*. Edited by Colin Gordon. Translated by Colin Gordon, Leo Marshall, John Mepham, and Kate Soper. New York: Pantheon Books.

Ford C. V. 1997. “Somatization and Fashionable Diagnoses: Illness as a Way of Life.” *Scandinavian Journal of Work, Environment & Health* 23 Suppl 3: 7–16.

Frazee, Catherine. 2024. “MAID Resistance in Canada: Sounding the Five-Minute Entreaty.” *Canadian Journal of Disability Studies* 13 (2): 1–175. https://doi.org/10.15353/cjds.v13i2.1105.

Freud, Sigmund. 1892. “A Case of Successful Treatment by Hypnotism.” *The Standard Edition of the Complete Psychological Works of Sigmund Freud*, trans. James Strachey (London, 1966).

Freud, Sigmund. 1905. *Three Essays on the Theory of Sexuality*, trans. James Strachey. New York: Basic Books.

Fruhstorfer, Clark, Michaela Kelly, Laura Spiegel, Peter J. Baylis, Justine Dembo, and Ellen Wiebe. 2024. “Patient Experiences with Requests for Medical Assistance in Dying: Perspectives of Those with Complex Chronic Conditions.” *Canadian Family Physician* 70 (1): 41–47. https://doi.org/10.46747/cfp.700141.

Garland-Thomson, Rosemarie. 1997. *Extraordinary Bodies: Figuring Physical Disability in American Culture and Literature*. New York: Columbia University Press.

Garland-Thomson, Rosemarie. 2017. “Eugenic World Building and Disability: The Strange World of Kazuo Ishiguro’s Never Let Me Go.” *Journal of Medical Humanities* 38 (2): 133–45. https://doi.org/10.1007/s10912-015-9368-y.

Gervais, R. O., Russell, A. S., Green, P., Allen, L. M., Ferrari, R., & Pieschl, S. D. 2001. Effort testing in patients with fibromyalgia and disability incentives. The Journal of Rheumatology 28(8): 1892–1899.

Gilbert, Sandra and Susan Gubar. 1979. *The Madwoman in the Attic: The Woman Writer and the Nineteenth-Century Literary Imagination*. Yale University Press.

Giroux, Yves. 2020. *Cost Estimate for Bill C-7 "Medical Assistance in Dying."* Ottawa: Parliamentary Budget Officer. https://distribution-a617274656661637473.pbo-dpb.ca/241708b353e7782a9e5e713c2e281fc5ed932d3d07e9f5dd212e73604762bbc5.

Goebel, Andreas, Camilla I. Svensson, David A. Andersson. 2021. "Passive transfer of fibromyalgia symptoms from patients to mice." *J Clin Invest*. 131 (13): e144201. https://doi.org/10.1172/JCI144201.

Goetz, C. G. 2016. "Charcot, Hysteria, and Simulated Disorders." *Handbook of Clinical Neurology* 139: 11–23. https://doi.org/10.1016/B978-0-12-801772-2.00002-3.

Goodley, Dan. 2018. The dis/ability complex. DiGeSt. *Journal of Diversity and Gender Studies*, 5 (1): 5-22.

Gordon, Duncan A. 1997. "Fibromyalgia: Out of Control." *The Journal of Rheumatology* 24 (7): 1247.

Gordon, Duncan A. 2003. "Fibromyalgia--Real or Imagined?" *The Journal of Rheumatology* 30 (8): 1665–1665.

Gordon, Duncan A. 2003. "Fibromyalgia Syndrome." The Workplace Safety and Insurance Appeals Tribunal.

Grant, Isabel. 2024. "Legislated Ableism: Bill C-7 and the Rapid Expansion of Medical Assistance in Dying in Canada." *McGill Journal of Law & Health* 15 (2): 259–335.

Gregory, Andrew. "What is ME and why is the NHS approach to it being criticised?" *The Guardian*. Aug. 9, 2024.

Greve, Kevin W., Jonathan S. Ord, Kevin J. Bianchini PhD, Kelly L. Curtis. 2009. "Prevalence of Malingering in Patients With Chronic Pain Referred for Psychologic Evaluation in a Medico-Legal Context." *Archives of Physical Medicine and Rehabilitation, Elsevier* 90 (7): 1117-1126. https://doi.org/10.1016/j.apmr.2009.01.018.

Grover, Chris, and Karen Soldatic. 2013. "Neoliberal Restructuring, Disabled People and Social (in)Security in Australia and Britain." *Scandinavian Journal of Disability Research* 15 (3). https://sjdr.se/articles/10.1080/15017419.2012.724446.

Hadler, Nortin M. 1996. “The Disabled, the Disallowed, the Disaffected and the Disavowed.” *Journal of Occupational and Environmental Medicine* 38 (3): 247–51.

Hadler, Nortin M. 1997. “Fibromyalgia: La Maladie est Morte. Vive le Malade!” *The Journal of Rheumatology* 24 (7): 1250–51.

Hadler, Nortin M. 2003. “‘Fibromyalgia’ and the Medicalization of Misery.” *The Journal of Rheumatology* 30 (8): 1668–70.

Hadler, Nortin M., and George E. Ehrlich. 2003. “Fibromyalgia and the Conundrum of Disability Determination:” *Journal of Occupational and Environmental Medicine* 45 (10): 1030–33. https://doi.org/10.1097/01.jom.0000088879.70638.14.

Hadler, Nortin M., and Susan Greenhalgh. 2005. “Labeling Woefulness: The Social Construction of Fibromyalgia” *Spine* 30 (1): 1–4. https://doi.org/10.1097/01.brs.0000149092.94171.9c.

Hadler, Nortin M. 2004. *The Last Well Person: How to Stay Well Despite the Health-care System.* MQUP.

Hadler, Nortin M., 2008. *Worried Sick: A Prescription for Health in an Overtreated America*. H. Eugene and Lillian Youngs Lehman Series. University of North Carolina Press.

Hadler, Nortin M. 2009. Stabbed in the Back: *Confronting Back Pain in an Overtreated Society.* University of North Carolina Press.

Hadler, Nortin M. n.d. “Nortin M Hadler, MD, MACP, MACR, FACOEM – Division of Rheumatology, Allergy, and Immunology.” UNC School of Medicine. https://www.med.unc.edu/medicine/rheumatology-allergy-immunology/people/nortin-m-hadler/

Hall, Kim Q. 2011. *Feminist Disability Studies*. Indiana University Press.

Hall, Kim Q. 2015. “New Conversations in Feminist Disability Studies: Feminism, Philosophy, and Borders.” *Hypatia* 30 (1): 1–12. https://doi.org/10.1111/hypa.12136.

Hammond, William A. 1870. *Spinal Irritation*. New York: D. Appleton and Company.

Hammond, William A. 1871. *A Treatise on Diseases of the Nervous System*. New York: D. Appleton and Company.

Harrington, Ralph. 1996. “The ‘Railway Spine’ Diagnosis and Victorian Responses to PTSD.” *Journal of Psychosomatic Research* 40 (1): 11–14. https://doi.org/10.1016/0022-3999(95)00514-5.

Harvey, David. 2005. *A Brief History of Neoliberalism*. Oxford: Oxford University Press.

Health Canada. 2024. *Fifth Annual Report on Medical Assistance in Dying in Canada, 2023*. Ottawa: Government of Canada.

Hodgkinson, N. 1988. "'Yuppie Flu' Is All in the Mind, Say Doctors." *Sunday Times*, July 17.

Hoffmann, Diane E., and Anita J. Tarzian. 2001. "The Girl Who Cried Pain: A Bias Against Women in the Treatment of Pain." *Journal of Law, Medicine & Ethics* 29 (1): 13–27.

Hoffman, K. M., Trawalter, S., Axt, J. R., & Oliver, M. N. 2016. "Racial bias in pain assessment and treatment recommendations, and false beliefs about biological differences between blacks and whites." *Proceedings of the National Academy of Sciences of the United States of America* 113 (16): 4296–4301. https://doi.org/10.1073/pnas.1516047113

Hoye, Bryce. 2022. "Winnipeg woman who chose to die with medical assistance said struggle for home care help led to decision." *CBC News*, October 4, 2022. perma.cc/YN5D-LSGJ

Hsu, Jo V. 2023. "Framing the Activists: Gender, Race, and Rhetorical Disability in Contested Illnesses." *Quarterly Journal of Speech*, December 26, 1–23. https://doi.org/10.1080/00335630.2023.2291895.

IASP Announces Revised Definition of Pain. IASP. July 16, 2020. https://www.iasp-pain.org/PublicationsNews/NewsDetail.aspx?

Illich, Ivan. 1976. *Medical Nemesis: The Expropriation of Health*. New York: Random House.

Income Security Advocacy Centre. 2002. "Background on Ontario's Zero Tolerance Policy: Lifetime Ban for Welfare Fraud." Toronto. https://incomesecurity.org/wp-content/uploads/2020/04/Rogers_Inquest_-_Statistical_Fact_Sheet_on_Lifetime_Ban_for_Welfare_Fraud_-_2002.doc

Income Security Advocacy Centre. 2018. "10 Myths and 10 Realities of Social Assistance in Ontario." Toronto. https://incomesecurity.org/wp-content/uploads/2020/04/Myths-and-Realities-of-Social-Assistance-in-Ontario-Sept-2018.docx

Income Security Advocacy Centre. 2023. "OW & ODSP Rates and the Cost of Living." Toronto: ISAC.

IOM (Institute of Medicine). 2011. *Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education, and Research*. Washington, DC: The National Academies Press.

Jahan F, Nanji K, Qidwai W, Qasim R. 2012. "Fibromyalgia Syndrome: An Overview of Pathophysiology, Diagnosis and Management." *Oman Med J* 27 (3): 192-195.

Jamil, Uzair, and Joshua M. Pearce. 2025. "Government Economics of Expanding Canada's Medical Assistance in Dying to Vulnerable Populations and the Ethical Implications of

Allowing the State to Control Death." *OMEGA – Journal of Death and Dying*, February 28, 2025. https://doi.org/10.1177/00302228251323299.

Jason LA, Richman JA, Rademaker AW, et al. 1999. "A Community-Based Study of Chronic Fatigue Syndrome." *Arch Intern Med*. 159 (18): 2129–2137. doi:10.1001/archinte.159.18.2129

Johnson, Melissa N.P., and Ethan McLean. 2020. "Discourse Analysis." In *International Encyclopedia of Human Geography*. Elsevier. https://doi.org/10.1016/B978-0-08-102295-5.10814-5.

Johnson, Walter. 1849. *An Essay on the Diseases of Young Women*. London: Simpkin, Marshall & Co.

Joseph, Ameil J. 2021. "Expanding MAiD Could Worsen Discrimination Against People with Disabilities." *QUOI Media*, February 22. https://perma.cc/TB6Z-FU4E

Kafer, Alison. 2013. *Feminist, Queer, Crip*. Indiana University Press.

Kassam, Ashifa. 2025. "Welfare Cuts Have Fuelled Rise of Far Right and Populism, Top UN Expert Says." *The Guardian*, October 21, 2025. https://www.theguardian.com/world/2025/oct/21/welfare-cuts-have-fuelled-rise-of-far-right-and-populism-top-un-expert-says

Khostanteen, I., Tunks, E. R., Goldsmith, C. H., & Ennis, J. 2000. "Fibromyalgia: can one distinguish it from simulation? An observer-blind controlled study." *The Journal of Rheumatology* 27(11): 2671–2676.

Kim, Jina B. 2016. *Anatomy of the City: Race, Infrastructure, and U.S. Fictions of Dependency*. PhD Diss. University of Michigan.

Kittay, Eva Feder. 2002. "When Caring Is Just and Justice Is Caring." In *The Subject of Care: Feminist Perspectives on Dependency*, edited by Eva Feder Kittay and Ellen K. Feder, 257–276. Lanham, MD: Rowman & Littlefield.

Laframboise, Kalina. 2024. "Woman with 'unmanageable' pain from Lyme disease chooses to die. She wasn't always believed." *Global News*, May 13, 2024. https://globalnews.ca/news/10529000/lyme-disease-assisted-death-canada/.

Lagu, Tara, Carol Haywood, Kimberly Reimold, Christene DeJong, Robin Walker Sterling, and Lisa I. Iezzoni. 2022. "'I Am Not The Doctor For You': Physicians' Attitudes About Caring For People With Disabilities: Study Examines Physician Attitudes about Caring for People with Disabilities." *Health Affairs* 41 (10): 1387–95. https://doi.org/10.1377/hlthaff.2022.00475.

Lamp, Sharon and Carol Cleigh. 2011. “A Heritage of Ableist Rhetoric in American Feminism from the Eugenics Period.” In *Feminist Disability Studies*, edited by Kim Q. Hall, 175—189. Indiana University Press.

Le Page, Judy Ann. 2005. “Contested credibility of fibromyalgia within medical, legal, and insurance contexts (T).” University of British Columbia. Retrieved from https://open.library.ubc.ca/collections/ubctheses/831/items/1.0076904

Ledger, Sally. 1995. “The New Woman and the Crisis of Victorianism.” In *Cultural Politics at the Fin de Siècle*, edited by Sally Ledger and Scott McCracken. 2009. Cambridge University Press. https://doi.org/10.1017/CBO9780511553707.003.

Ledger, Sally. 1997. *The New Woman: Fiction and Feminism at the Fin de Siècle*. Manchester: Manchester University Press.

Lewis, Talila A. 2022. “Working Definition of Ableism – January 2022 Update.” *Talila A. Lewis Blog*, January 1, 2022. https://www.talilalewis.com/blog/working-definition-of-ableism-january-2022-update

Liggins, Emma. 2006. "George Gissing, the Working Woman, and Urban Culture." Ashgate.

Linden, Stefanie C., Edgar Jones, and Andrew J. Lees. 2013. “Shell Shock at Queen Square: Lewis Yealland 100 Years On.” *Brain* 136 (6): 1976–88. https://doi.org/10.1093/brain/aws331.

Linton, Megan. 2021. “Disability, Death, and the Fight for Justice.” *Disability Visibility Project*, June 8, 2021. https://disabilityvisibilityproject.com/2021/06/08/disability-death-the-fight-for-justice/.

Logan, Peter. 1997. *Nerves and Narratives: A Cultural History of Hysteria in 19th-Century British Prose.* University of California Press.

Lombardo, Paul A. 2008. *Three Generations, No Imbeciles: Eugenics, the Supreme Court, and Buck v. Bell*. Baltimore: Johns Hopkins University Press.

Love, Heather A., and Jerika Sanderson. 2023. “‘Modern Neurotic Women’ and the Pains of Childbirth: Staging Medicalized Maternity in Sophie Treadwell’s Machinal.” *Feminist Modernist Studies* 6 (3): 173–90. https://doi.org/10.1080/24692921.2022.2154558.

Lutz, Tom. 1991. *American Nervousness, 1903: An Anecdotal History*. Ithaca: Cornell University Press.

Mailis AH, Furlong W, Taylor A. “Chronic pain in a family of 6 in the context of litigation.” *J Rheumatol* 2000, 27(5): 1315-17.

Maitzen, Rohan. 2015. “Second Glance: Fatal Beauty.” *Open Letters Monthly*, May 31. https://www.openlettersmonthlyarchive.com/second-glance/second-glance-fatal-beauty.

Major, Darren. 2025. “Carney Says Canada Should Prepare for ‘Sacrifices’ as He Outlines Plan for Budget.” *CBC News*, October 23, 2025. https://www.cbc.ca/news/politics/politics-carney-address-budget-9.6948685

Manivannan, Vyshali. 2017. “What We See When We Digitize Pain: The Risk of Valorizing Image-Based Representations of Fibromyalgia over Body and Bodily Experience.” *Digital Health* 3 (January). https://doi.org/10.1177/2055207617708860.

Manivannan, Vyshali. “Hollow Me, Hollow Me, Until Only You Remain.” *Spark: A 4C4Equality Journal* Vol. 4. https://sparkactivism.com/hollow-me/

Martin, Daniel. 2008. “Railway Fatigue and the Coming-of-Age Narrative in ‘Lady Audley’s Secret.’” *Victorian Review* 34 (1): 131–53.

Masson, Jeffrey Moussaieft, ed. and trans. 1985. *The Complete Letters of Sigmund Freud to Wilhelm Fliess, 1887-1904*. Cambridge: The Belknap Press-of Harvard University Press.

McLaren, Angus. 1990. *Our Own Master Race: Eugenics in Canada, 1885–1945*. Canadian Social History Series. Toronto: McClelland & Stewart.

McDermott, Barbara E & Marc D Feldman. 2007. “Malingering in the Medical Setting.” Psychiatric Clinics of North America. 30 (4): 645-62. https://doi:10.1016/j.psc.2007.07.007.

McGuire, Coreen. 2020. *Measuring Difference, Numbering Normal: Setting the Standards for Disability in the Interwar Period*. Disability History. Manchester University Press.

McLean, S. A., Williams, D. A., & Clauw, D. J. 2005. “Fibromyalgia after motor vehicle collision: evidence and implications.” *Traffic injury prevention* 6(2): 97–104. https://doi.org/10.1080/15389580580590931545

Meeus, Mira, and Jo Nijs. 2007. “Central Sensitization: A Biopsychosocial Explanation for Chronic Widespread Pain in Patients with Fibromyalgia and Chronic Fatigue Syndrome.” Clinical Rheumatology 26 (4): 465–73. https://doi.org/10.1007/s10067-006-0433-

Micale, Mark S. 2008. *Hysterical Men: The Hidden History of Male Nervous Illness*. Harvard University Press.

Mikuls TR, Johnson SR, Fraenkel L, Arasaratnam RJ, Baden LR, Bermas BL, et al. 2021. American College of Rheumatology Guidance for the Management of Rheumatic Disease in Adult Patients During the COVID-19 Pandemic: Version 3. *Arthritis Rhematol* 73: e1-e12. doi: https://onlinelibrary.wiley.com/doi/10.1002/art.41596.

Mingus, Mia. “Ableism.” *Leaving Evidence* (blog), November 3, 2018. https://leavingevidence.wordpress.com/tag/ableism/

Mingus, Mia. “Access Intimacy, Interdependence, and Disability Justice.” Leaving Evidence (blog), April 12, 2017. https://leavingevidence.wordpress.com/2017/04/12/access-intimacy-interdependence-and-disability-justice/

Mingus, Mia. “Medical Industrial Complex Visual.” *Leaving Evidence* (blog), Feb. 6, 2015. https://leavingevidence.wordpress.com/2015/02/06/medical-industrial-complex-visual/

Mingus, Mia. 2013. “Mia Mingus on Disability Justice (interview).” Interview by Greg Macdougall. Posted Nov. 30, 2013. YouTube. https://www.youtube.com/watch?v=3cJkUazW-jw. Recorded in Ottawa.

Mitchell, S. Weir. 1884. *Fat and Blood: An Essay on the Treatment of Certain Forms of Neurasthenia and Hysteria.* Philadelphia: J. B. Lippincott.

Mollow, Anna. 2014. “Criphystemologies: What Disability Theory Needs to Know about Hysteria.” *Journal of Literary & Cultural Disability Studies* 8 (2): 185–201. https://doi.org/10.3828/jlcds.2014.15.

Morris, Edwin. 1868. *A Practical Treatise on Shock After Surgical Operations and Injuries*. Philadelphia: J.B. Lippincott.

Moynihan, Ray, Iona Heath, and David Henry. 2002. “Selling Sickness: The Pharmaceutical Industry and Disease Mongering.” *BMJ* (Clinical research ed.) 324 (7342): 886–91. https://doi.org/10.1136/bmj.324.7342.886.

Newsweek Staff. 1990. "Chronic Fatigue Syndrome." *Newsweek*, Nov. 11, 1990.

Noonan, Joanna L. and Wagner, Shannon L. 2005. “Chronic Pain Compensation in Canada.” *International Journal of Disability, Community & Rehabilitation* 4 (1). https://www.ucalgary.ca/uofc/Others/ijdcr/VOL04_01_CAN/articles/wagner.shtml

Onofrj, M., A. Digiovanni, P. Ajdinaj, M. Russo, C. Carrarini, M. Di Giannantonio, G. Martinotti, & S.L. Sensi. 2021.“The factitious/malingering continuum and its burden on public health costs: a review and experience in an Italian neurology setting.” *Neurol Sci*. 42 (10): 4073–4083. doi:10.1007/s10072-021-05422-9. https://pmc.ncbi.nlm.nih.gov/articles/PMC8443469/

Ontario Provincial Auditor. 2002. *Annual Report of the Provincial Auditor of Ontario, 2002*. Toronto: Queen’s Printer for Ontario.

Pay the Rent and Feed the Kids. 2003. *Welfare: Myth and Reality*. Toronto.

Peter A. Allard School of Law. 2023. *Feminism, Ableism, and Medical Assistance in Dying.* Panel with Janine Benedet, Catherine Frazee, Isabel Grant, and Elizabeth Sheehy. Symposium recording, March 13, 2023. https://biopoliticalphilosophy.com/2023/03/20/video-and-audio-recording-of-feminism-ableism-and-maid-peter-a-allard-school-of-law-ubc-mar-13-2023/.

Piepzna-Samarasinha, Leah Lakshmi. 2018. *Care Work: Dreaming Disability Justice*. Vancouver: Arsenal Pulp Press.

Price, Margaret. 2011. *Mad at School: Rhetorics of Mental Disability and Academic Life*. Corporealities. The University of Michigan Press.

Price, Margaret. 2015. "The Bodymind Problem and the Possibilities of Pain." *Hypatia* 30 (1): 268–84. https://doi.org/10.1111/hypa.12127.

Pulrang, Andrew. 2023. "3 Forms of Gaslighting Disabled People Experience Most Often." *Forbes*, August 28, 2023. https://www.forbes.com/sites/andrewpulrang/2023/08/28/3-forms-of-gaslighting-disabled-people-experience-most-often

Pykett, Lyn. 1992. *The "improper" Feminine: The Women's Sensation Novel and the New Woman Writing*. Routledge.

Quadagno, Jill S. 1984. "From Poor Laws to Pensions: The Evolution of Economic Support for the Aged in England and America." *The Milbank Memorial Fund Quarterly. Health and Society* 62 (3): 417. https://doi.org/10.2307/3349859.

Quintner, John L, and Milton L Cohen. 1999. "Fibromyalgia Falls Foul of a Fallacy." *The Lancet* 353 (9158): 1092–94. https://doi.org/10.1016/S0140-6736(98)06468-X.

Rabinbach, Anson. 1990. *The Human Motor: Energy, Fatigue, and the Origins of Modernity*. New York: Basic Books.

Rehfeld, E., A. Schröder & P. Fink. 2009. "Specialised Treatment for Severe Bodily Distress Syndromes (STreSS)." *The Research Clinic for Functional Disorders and Psychosomatics*, Aarhus University Hospital.

Region of Peel. "While on the Housing Wait List." Accessed January 10, 2026. https://peelregion.ca/housing-social-support/housing-subsidy/while-on-housing-wait-list.

Reid, Fiona. 2019. "War Psychiatry and Shell Shock." *International Encyclopedia of the First World War*. https://encyclopedia.1914-1918-online.net/article/war-psychiatry-and-shell-shock-2-0/.

Rembis, Michael. 2010. "Disability and the History of Eugenics". Chapter 5 in *The Oxford Handbook of Disability History* (Oxford Handbooks). Oxford University Press.

Ribatti, Raffaella Maria, Thomas Merten, Tiziana Lanciano, and Antonietta Curci. 2025. "Detecting Simulated Symptoms in Chronic Pain and Fibromyalgia: A Two-Study Evaluation of the Italian Version of the Self-Report Symptom Inventory." *Applied Neuropsychology: Adult*, 1–9. doi:10.1080/23279095.2025.2475951.

Rodgers, Linda. 2019. "9 Diseases That Can Mimic Fibromyalgia (and Delay Your Diagnosis)." *CreakyJoints*, September 2, 2019. https://creakyjoints.org/about-arthritis/fibromyalgia/fibromyalgia-overview/fibromyalgia-misdiagnosis/

Rogers, Richard, and Joshua W. Payne. 2006. "Damages and Rewards: Assessment of Malingered Disorders in Compensation Cases." *Behavioral Sciences & the Law* 24 (5): 645–58. https://doi.org/10.1002/bsl.687.

Romano, Thomas J. Letter to the editor. "Fibromyalgia and the law." *J Rheumatol* 2001 28(3): 674. https://www.jrheum.org/content/28/3/676

Rose, Sarah F. 2017. *No Right to Be Idle: The Invention of Disability, 1840s-1930s*. Chapel Hill: University of North Carolina Press.

Russell, Marta. 2019. *Capitalism and Disability: Selected Writings by Marta Russell*. Edited by Keith Rosenthal. Chicago: Haymarket Books.

Samuels, Ellen. 2011. "Critical Divides: Judith Butler's Body Theory and the Question of Disability." In *Feminist Disability Studies*, edited by Kim Q. Hall, 48—66. Indiana University Press.

Samuels, Ellen Jean. 2014. *Fantasies of Identification: Disability, Gender, Race*. New York: New York University Press.

Samuels, Ellen. 2017. "Six Ways of Looking at Crip Time." *Disability Studies Quarterly* 37 (3).

Sawar, K., Sawar, L., Reddy, V., Sahyouni, A., & Sawar, A. 2024. "Screening a Suspected Malingerer Using the Symptom Checklist-90-Revised and Visual Analogue Pain Scale Questionnaires." *Cureus*, 16 (6): e62904. https://doi.org/10.7759/cureus.62904.

Sheppard, Emma. 2022. "The Case of Chronic Pain." In *The Disability Bioethics Reader*. Routledge.

Schroeder, Nicole. 2025. "Dying a Good Death: Disability and the Assisted Suicide Debate." *Disability Visibility Project*, January 1, 2025. https://disabilityvisibilityproject.com/2025/01/01/dying-a-good-death-disability-and-the-assisted-suicide-debate/.

Schuster, David G. 2003. "Neurasthenia and a Modernizing America." *JAMA* 290 (17): 2327–28. https://doi.org/10.1001/jama.290.17.2327

Schweiger, V, G Del Balzo, D Raniero, et al. 2017. “Current Trends in Disability Claims Due to Fibromyalgia Syndrome.” *Clinical and Experimental Rheumatology*.

Scull, Andrew. 2009. *Hysteria: A Disturbing History*. London: Oxford UP.

Shorter, Edward. 1993. *From Paralysis to Fatigue*. Simon and Schuster.

Showalter, Elaine. 1985. *The Female Malady: Women, Madness, and English Culture, 1830s-1980*. NY: Pantheon.

Showalter, Elaine. 1997. *Hystories: Hysterical Epidemics and Modern Culture*. Columbia University Press.

Showalter, Elaine. (@ecshowalter), Twitter, March 31, 2018.

Siebers, Tobin. 2008. *Disability Theory*. Corporealities. University of Michigan Press.

Sins Invalid. 2015. *“10 Principles of Disability Justice.”* https://sinsinvalid.org/10-principles-of-disability-justice/

Smythe H. 2000. “Fibromyalgia: can one distinguish it from malingering? More work needed; more tools supplied.” *The Journal of Rheumatology* 27 (11): 2536-40.

Soldatic, K. 2011. Appointment Time: Disability and Neoliberal Workfare Temporalities. *Critical Sociology* 39 (3): 405-419. https://doi-org.proxy.lib.uwaterloo.ca/10.1177/0896920511430168.

Statistics Canada. 2006. “Fibromyalgia.” *Musculoskeletal Diseases*. April 4, 2006. https://www150.statcan.gc.ca/n1/pub/82-619-m/2006003/4144159-eng.htm

Stone, Deborah A. 1984. *The Disabled State*. Health, Society, and Policy. Philadelphia: Temple University Press.

St. Petersburg Times. 1990. “Test Devised for ‘Yuppie Flu.’” November 19, 1990.

Tatu, Laurent, and Julien Bogousslavsky. 2016. “Neuropsychiatric Disturbances, Self-Mutilation and Malingering in the French Armies during World War I: War Strain or Cowardice?” *Frontiers of Neurology and Neuroscience* 38: 143–54. https://doi.org/10.1159/000442653.

Taylor, Jenny Bourne. Introduction. *Lady Audley's Secret*. By Mary Elizabeth Braddon. London: Penguin, 1998. vii–xli.

Teive, H. A. G., F. M. B. Germiniani, and R. P. Munhoz. 2015. “Overlap between Fibromyalgia Tender Points and Charcot’s Hysterical Zones: A Historical Curiosity.” *Neurology* 84 (20): 2096–97. https://doi.org/10.1212/WNL.0000000000001592.

The Guardian. 2025. "MPs Vote to Reject Amendment on 'Being a Burden.'" June 20, 2025.

Torres, Xavier, Eva Bailles, Antonio Collado, Joan Taberner, Fernando Gutierrez, Josep-Maria Peri, Anna Arias, Miquel-Angel Fullana, Manuel Valdes. 2010. "The Symptom Checklist-Revised (SCL-90-R) is able to discriminate between simulation and fibromyalgia." J Clinical Psychology. 66 (7): 774-90. https://doi:10.1002/jclp.20698.

Trotter, Thomas. 1808. *A View of the Nervous Temperament*. New York: Wright, Goodenow, & Stockwell.

UK Parliament. 2025. *Terminally Ill Adults (End of Life) Bill: Amendment Paper, Report Stage (New Clause 16).* June 20, 2025. https://publications.parliament.uk/pa/bills/cbill/59-01/0212/amend/terminally_ill_adults_day_rep_0620.pdf.

United Way Waterloo Region Communities. 2024. "Make It Liveable." February 15, 2024. https://www.uwaywrc.ca/make-it-liveable/.

Ussher, Jane. 2005. *The Madness of Women: Myth and Experience*. New York: Routledge.

Ussher, Jane. 1991. *Women's Madness: Misogyny or Mental Illness?* Manchester.

Vidali, Amy. 2013. "Hysterical Again: The Gastrointestinal Woman in Medical Discourse." *Journal of Medical Humanities* 34 (1): 33–57. https://doi.org/10.1007/s10912-012-9196-2.

War Office Committee of Enquiry into "Shell-Shock." *Report of the War Office Committee of Enquiry into "Shell-Shock" (Cmd. 1734).* London: His Majesty's Stationery Office, 1922. https://www.nationalarchives.gov.uk/education/resources/medicine-on-the-western-front-part-two/war-office-report-on-shell-shock/

Welke, Barbara Young. 2010. *Law and the Borders of Belonging in the Long Nineteenth Century United States*. Cambridge University Press. https://doi.org/10.1017/CBO9780511778704.

Wendell, Susan. 1996. *The Rejected Body: Feminist Philosophical Reflections on Disability*. Routledge. https://doi.org/10.4324/9780203724149.

Wendell, Susan. 2001. "Unhealthy Disabled: Treating Chronic Illnesses as Disabilities." *Hypatia*, 16 (4): 17—33.

Wessely, Simon. 1990. "Old Wine in New Bottles: Neurasthenia and 'ME.'" *Psychological Medicine* 20 (1): 35–53. https://doi.org/10.1017/S0033291700013210.

Wessely Simon. 2006. "The Life and Death of Private Harry Farr." *Journal of the Royal Society of Medicine*, 99 (9): 440–443. https://doi.org/10.1177/014107680609900913

White, Kevin P., and John Thompson. 2003. “Fibromyalgia Syndrome in an Amish Community: A Controlled Study to Determine Disease and Symptom Prevalence.” *The Journal of Rheumatology* 30 (8): 1835–40.

Wildman, Stuart. 2022. *The English Workhouse at Night, 1834-1914*. *The UKAHN Bulletin* 10 (1). https://bulletin.ukahn.org/the-english-workhouse-at-night-1834-1914/.

Withers, A. J. 2024. *Disability Politics and Theory*. Revised and expanded ed. Halifax: Fernwood Publishing.

Wolf, Jacqueline H. 2009. *Deliver Me from Pain: Anesthesia and Birth in America*. Baltimore: Johns Hopkins University Press.

Wolfe, Frederick, Hugh A. Smythe, Muhammad B. Yunus, Robert M. Bennett, Claire Bombardier, Don L. Goldenberg, Peter Tugwell, Stephen M. Campbell, et al. 1990. “The American College of Rheumatology 1990 Criteria for the Classification of Fibromyalgia: Report of the Multicenter Criteria Committee.” *Arthritis & Rheumatism* 33 (2): 160–172.

Wolfe, Frederick, and Joshua Potter. 1996. “Fibromyalgia and Work Disability: Is Fibromyalgia a Disabling Disorder?” *Rheumatic Disease Clinics of North America* 22 (2): 369–91. https://doi.org/10.1016/S0889-857X(05)70277-5.

Wolfe, Frederick. 1997. “The Fibromyalgia Problem.” *The Journal of Rheumatology* 24 (7): 1247–49.

Wolfe, Frederick. 2000. “For Example Is Not Evidence: Fibromyalgia and the Law.” *The Journal of Rheumatology* 27 (5): 1115–16.

Wolfe, Frederick. 2000. “Sayin' ‘stand and deliver, for you are a bold deceiver’: Faking Fibromyalgia.” *The Journal of Rheumatology* 27 (11): 2534-5.

Wolfe, Frederick. 2003. “Stop Using the American College of Rheumatology Criteria in the Clinic.” *The Journal of Rheumatology* 30 (8): 1671–72.

Wolfe, Frederick. 2009. “Fibromyalgia Wars.” *The Journal of Rheumatology* 36 (4): 671–78. https://doi.org/10.3899/jrheum.081180.

Wolfe, Frederick, Clauw, Daniel J., Fitzcharles, Mary-Ann, Goldenberg, Don L., Katz, Robert S., Mease, Philip, Russell, Anthony S., Russel, I. Jon, Winfield, John B. and Muhammad B. Yunus. 2010. “The American College of Rheumatology Preliminary Diagnostic Criteria for Fibromyalgia and Measurement of Symptom Severity.” *Arthritis Care & Research* 62 (5):600 – 610. https://doi.org/10.1002/acr.20140.

Wolfe, Frederick, and Brian Walitt. 2013. “Culture, Science and the Changing Nature of Fibromyalgia.” *Nature Reviews Rheumatology* 9 (12): 751–55. https://doi.org/10.1038/nrrheum.2013.96.

Wolfe, Frederick. 2018. “Fibromyalgia Syndrome: Aspects of the Social Construction of Organized Distress.” In *Fibromyalgia Syndrome and Widespread Pain: From Construction to Relevant Recognition*, edited by Winfried Häuser and Serge Perrot. IASP Press.

Wolfe, Frederick, and Johannes J Rasker. 2021. “The Evolution of Fibromyalgia, Its Concepts, and Criteria.” *Cureus*, 13 (11). https://doi.org/10.7759/cureus.20010.

Zhang, Lanlan et al. “Gender Biases in Estimation of Others’ Pain.” *The Journal of Pain* 22 (9): 1048 – 1059. https://www.jpain.org/article/S1526-5900(21)00035-3/fulltext

Appendices

Table 1. Additional Publications on Fibromyalgia

	Author	Year	Type	Publication	Title
1.	**George Ehrlich**	2003	Letter to the Editor	Arthritis & Rheumatology	Fibromyalgia Is Not a Diagnosis: Comment on the Editorial by Crofford and Clauw
2.	**George Ehrlich**	2003	Editorial	Clinical Rheumatology	Fibromyalgia; A Virtual Disease
3.	**Duncan Gordon**	1997	Comment	The Journal of Rheumatology	Fibromyalgia: Out of Control
4.	**Duncan Gordon**	2003	Discussion paper	The Ontario Workplace Safety and Insurance Appeals Tribunal (WSIAT)	Fibromyalgia Syndrome
5.	**Nortin Hadler**	1996	Editorial	Journal of Occupational and Environmental Medicine	The Disabled, the Disallowed, the Disaffected and the Disavowed
6.	**Nortin Hadler**	1996	Editorial	Spine	If You Have to Prove You Are Ill, You Can't Get Well. The Object Lesson of Fibromyalgia
7.	**Nortin Hadler**	1997	Editorial	The Journal of Rheumatology	Fibromyalgia: La Maladie est Morte. Vive le Malade!
.	**Nortin Hadler & George Ehrlich**	2003	Editorial	Journal of Occupational and Environmental Medicine	Fibromyalgia and the Conundrum of Disability Determination
9.	**Nortin Hadler & Susan Greenhalgh**	2005	Editorial	Spine	Labeling Woefulness: The Social Construction of Fibromyalgia
10.	**Nortin Hadler**	2013	Editorial	The Journal of Rheumatology	Workers' Compensation, Fibromyalgia, and Kafka
11.	**Frederick Wolfe and Joshua Potter**	1996	Article	Rheumatic Disease Clinics of	Fibromyalgia and Work Disability: Is Fibromyalgia a Disabling Disorder?

				North America	
12.	**Frederick Wolfe**	1997	Editorial	The Journal of Rheumatology	The Fibromyalgia Problem
13.	**Frederick Wolfe**	2000	Editorial	The Journal of Rheumatology	For Example Is Not Evidence: Fibromyalgia and the Law
14.	**Frederick Wolfe**	2000	Editorial (response to articles published in same issue: "Fibromyalgia: can one distinguish it from simulation" and "Fibromyalgia: can one distinguish it from malingering"	The Journal of Rheumatology	Sayin' 'Stand and Deliver, For You are a Bold Deceiver': Faking Fibromyalgia
15.	**Frederick Wolfe**	2009	Review	The Journal of Rheumatology	Fibromyalgia Wars
16.	**Frederick Wolfe & Brian Walitt**	2013	Opinion	Rheumatology	Culture, Science and The Changing Nature of Fibromyalgia
17.	**Frederick Wolfe & Johannes Rasker**	2021	Article	Cureus	The Evolution of Fibromyalgia, Its Concepts, and Criteria

Table 2. Disorders Listed in the DSM

Disorder	Intent	Symptoms	Motivation
Factitious Disorder (DSM-V)	***Conscious*** (intentional production of symptoms)	Fake or self-induced symptoms, but without external rewards	Desire to assume the "sick role" (internal incentives such as interpersonal or medical attention)
Malingering	***Conscious*** (intentional deception)	Exaggerated or fabricated symptoms	External incentives (e.g., financial gain, avoiding responsibility)

Somatization Disorder (DSM-III)	***Unconscious***	Multiple, recurring, medically unexplainable physical symptoms across different areas of body	Psychological distress manifests as persistent physical symptoms
Hysteria (Conversion Disorder) (DSM-III)	***Unconscious***	Neurological or physical symptoms with no medical cause	Psychological distress converted into physical symptoms
Neurasthenic Neurosis (DSM-II)	***Unconscious***	Chronic fatigue, weakness, headaches, difficulty concentrating	Emotional exhaustion due to stress; a depletion of nervous energy
Somatic Symptom and Related Disorders (DSM-V)	***Unconscious***	Distressing physical symptoms (may or may not be medically explained), plus excessive thoughts, feelings, or behaviors about symptoms	Psychological distress and health-related anxiety, leading to excessive symptom focus

Figure 1. DSM Classifications

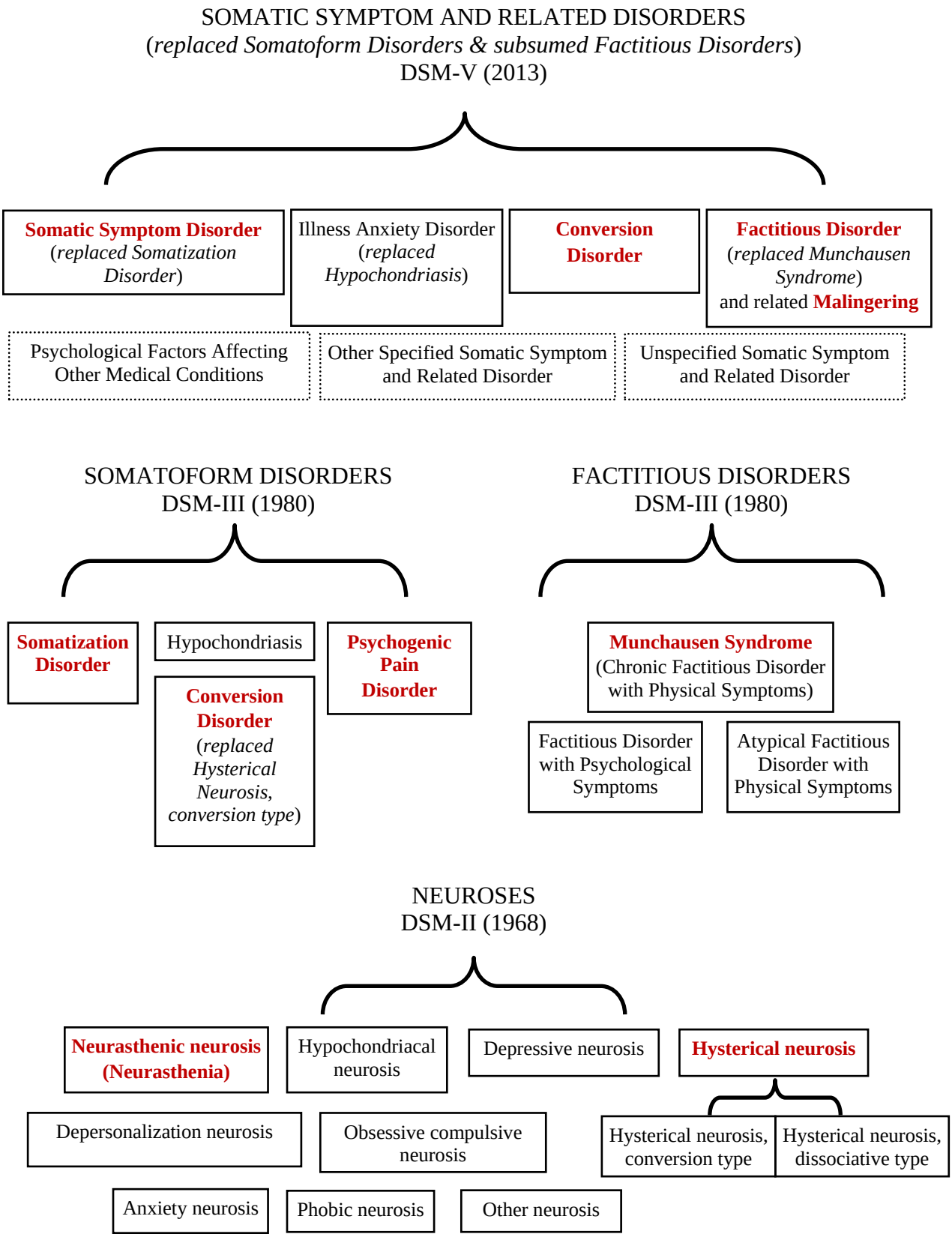


Figure 2. “Some People are Born to be a Burden on the Rest”



[Image Description: Some people are born to be a burden on the rest. This light flashes every 15 seconds [light bulb] Every 15 seconds $100 of your money goes for the care of persons with bad heredity such as the insane, feebleminded, criminals and other defectives. This light flashes every 16 seconds. [light bulb] Every 16 seconds, a person is born in the United States. This light flashes every 7 1/2 minutes [light bulb] Every 7 1/2 minutes a high grade person is born in the United States who will have ability to do creative work and be fit for leadership. About 4% of all Americans come within this class.]

Figure 3. The Three Graces

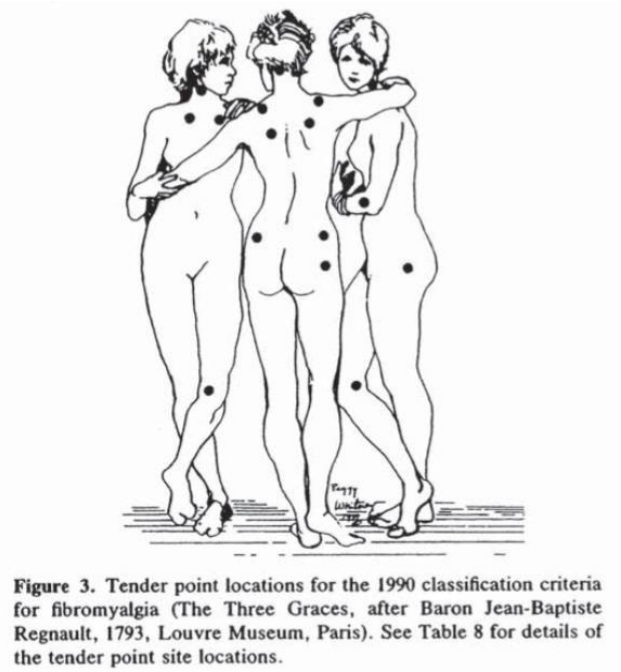


Figure 3. Tender point locations for the 1990 classification criteria for fibromyalgia (The Three Graces, after Baron Jean-Baptiste Regnault, 1793, Louvre Museum, Paris). See Table 8 for details of the tender point site locations.



Figure 4. Tender Points v. Hysterogenic Zones

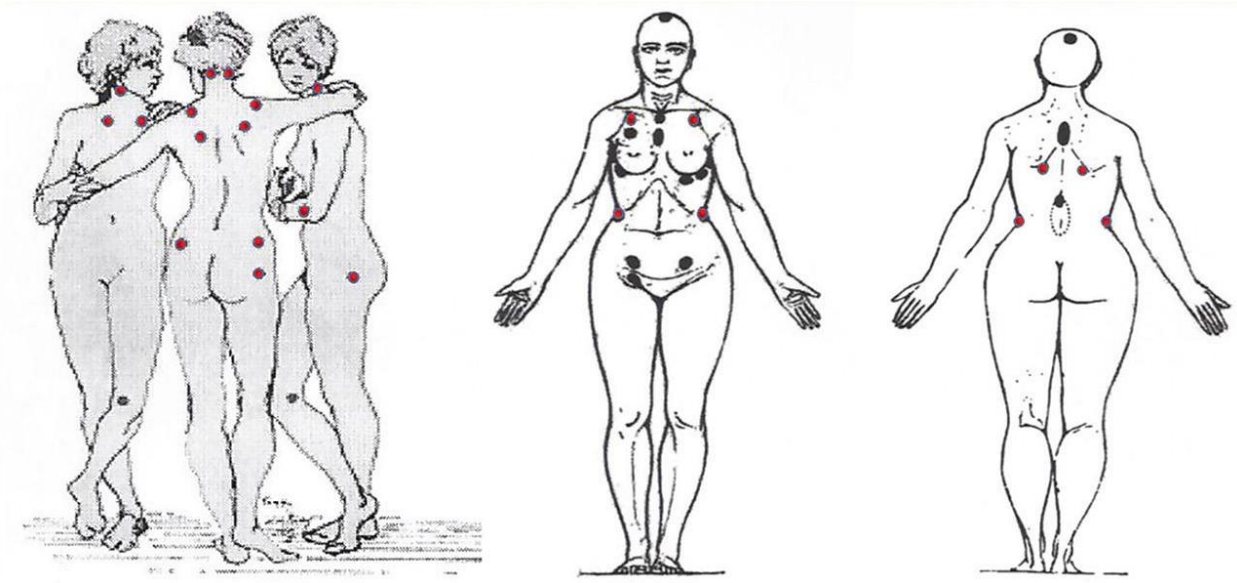


Figure 5. The McGill Pain Scale

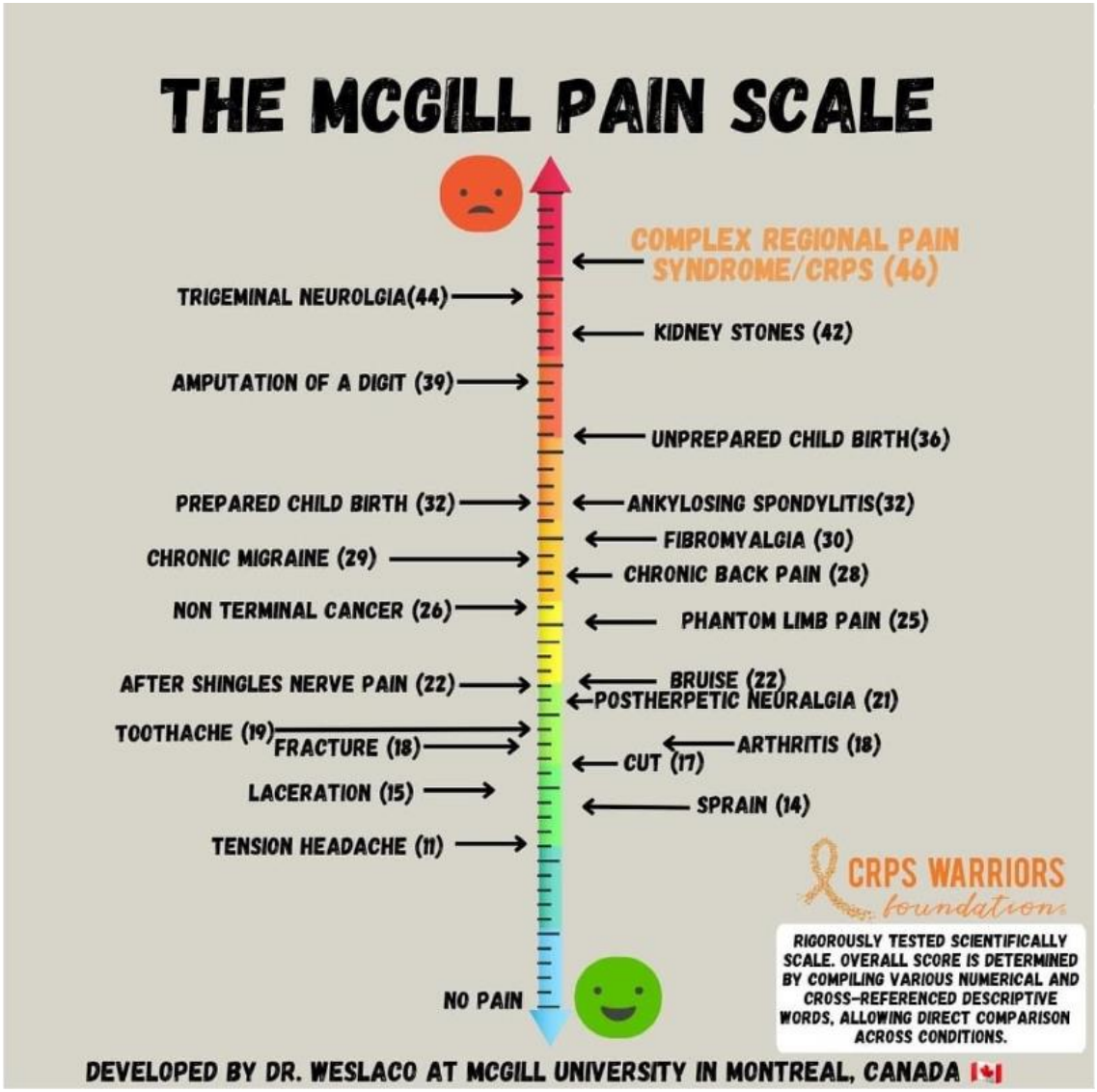


Figure 6. Wong-Baker Faces Pain Scale

