

# THE DIVIDED MIND

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THE EPIDEMIC OF MINDBODY DISORDERS

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THE DIVIDED

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# INTRODUCTION

Health care in America is in a state of crisis. Certain segments of American medicine have been transformed into a dysfunctional nightmare of irresponsible practices, dangerous procedures, bureaucratic regulations, and skyrocketing costs. Instead of healing people, the broken health care system is prolonging people's suffering in too many cases. Instead of preventing epidemics, it is generating them.

Does this judgment sound too harsh? Let's look at some statistics. Over six million Americans suffering from the mysterious and excruciatingly painful ailment called "fibromyalgia" are being treated by an army of self-minted specialists, not one of whom has a clue as to what causes the disorder. Millions more are suddenly being treated for gastric reflux, at an annual cost of billions of dollars. Who says heartburn can't be profitable? And millions more—many of them youngsters—are dependent on mind-altering drugs which, it now turns out, may actually be endangering their lives.

The circumstances are serious. I am not overstating the situation. That's why my colleagues and I have written this book.

*The Divided Mind* is about the principles and practice of psychosomatic medicine. It is not about alternative medicine, or some

trendy New Age regimen. It is about straightforward, clinically tested medicine, as practiced by licensed physicians for over thirty years, working with thousands of patients.

First, I want to clear up any confusion surrounding the word *psychosomatic*. You may think it refers to something vaguely fraudulent, such as imaginary diseases dreamed up by people for their own selfish or confused reasons. That's simply not true. But even medical practitioners, doctors who might be expected to have a more accurate understanding of the term, sometimes make the mistake of assuming it refers to how stress makes disease worse, or the stressful consequences of living with a disease. Those are legitimate concerns and have been addressed in the medical literature, but they are not psychosomatic. Psychosomatic medicine specifically refers to physical disorders of the mindbody, disorders that may appear to be purely physical, but which have their origin in unconscious emotions, a very different and extremely important medical matter. Note that we will use the terms *psychosomatic* and *mindbody* interchangeably throughout the book, so don't let it throw you.

There are literally hundreds of disorders and illnesses that have been identified as purely psychosomatic or having a psychosomatic component. We will explore many of them in the pages that follow. They can range from mildly bothersome back pain all the way to cancer, depending on the power and importance of unconscious emotional phenomena. Psychosomatic illnesses seem to be an inescapable part of the human condition. Yet amazingly, in spite of the nearly universal prevalence of such disorders, the practice of psychosomatic medicine is almost totally unknown within today's medical community, and plays virtually no part in contemporary medical study and research. Nowadays, when physicians and many psychiatrists are confronted with a psychosomatic disorder, they do not recognize it for what it is and almost invariably treat the symptom.

The enormity of this miscarriage of medical practice may be compared to what would exist if medicine refused to acknowledge the existence of bacteria and viruses. Perhaps the most heinous manifestation of this scientific medievalism has been the elimination of the term *psychosomatic* from recent editions of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), the official publication of the American Psychiatric Association. One might as well eliminate the word *infection* from medical dictionaries.

This astonishing state of affairs—scandalous really—did not occur overnight. For the first half of the twentieth century the study and treatment of psychosomatic disorders was recognized by many medical professionals as a promising and important new frontier of medicine. Then, about fifty years ago, the American medical community took a wrong turn and simply abandoned its interest in psychosomatic medicine. I shall speculate on why this happened, but for now the important thing to note is that as a direct result of turning its back on this vital branch of medicine, the medical profession has helped to spawn epidemics of pain and other common disorders affecting the lives of millions of Americans.

I came upon psychosomatic medicine well along in my professional career, when I began to see large numbers of people suffering from those common but sometimes mysterious conditions associated with bodily pain, primarily of the low back, neck, trunk, and limbs. I did not know these disorders were psychosomatic. I had not trained in psychiatry or psychology, and it was only through direct daily confrontation with the suffering of my patients that I eventually came to recognize the true nature of their distress, and could then begin to administer effective treatment. Over the last thirty-two exciting and fruitful years, my colleagues and I have learned much. I've published three books to describe our work, our discoveries, and our successes. Those dealt largely with what I called the tension myositis syndrome

(TMS), a painful psychosomatic disorder afflicting millions. *The Divided Mind* will deal with the full range of psychosomatic disorders, a far broader and more important subject. Psychosomatic disorders fall into two categories:

1. Those disorders that are *directly induced* by unconscious emotions, such as the pain problems (TMS) and common gastrointestinal conditions including reflux, ulcers, irritable bowel syndrome, skin disorders, allergies, and many others.
2. Those diseases in which unconscious emotions may play a role in causation, *but are not the only factor*. They include autoimmune disorders like rheumatoid arthritis, certain cardiovascular conditions, and cancer. No one, as far as I know, who is currently studying these disorders includes unconscious emotions as potential risk factors. To my mind, this borders on the criminal.

Psychosomatic processes begin in the unconscious, that dark, unmapped, and generally misunderstood part of our minds first identified by Sigmund Freud. Though it has yet to be appreciated by either physical or psychiatric medicine, unconscious emotions are a potent factor in virtually all physical, nontraumatic ills. I gave this book the title *The Divided Mind* because it is in the interaction of the unconscious and conscious minds that psychosomatic disorders originate. Those traits that reside in the unconscious that we consider the most troublesome, like childishness, dependency, or the capacity for savage behavior, are the products of an old, primitive part of the brain, anatomically deep, just above the brain stem. Evolution has added what is called the neocortex, the new brain, the brain of

reason, higher intelligence, communication, and morality. There appears to be an ongoing struggle between these two parts of the brain. Sometimes reason prevails, and at other times the more childish, bestial part of human nature is dominant. This duality is one reason for psychosomatic disorders, as will be demonstrated.

The conclusions found in this book are not based on armchair deductions. They are the result of many years of experience with thousands of patients, and are reinforced by the findings of highly trained psychotherapists. In addition, six pioneering physicians from around the United States who have incorporated psychosomatic principles in their practices and research have also contributed findings based on their own experiences. Our successful treatment of a remarkably high percentage of patients dynamically supports our findings.

*The Divided Mind* is intended primarily to explain the nature of the psychosomatic process, particularly the psychology that leads to clearly obvious physical symptoms. The book's secondary purpose is to draw attention to the blinkered attitudes of too many practitioners of contemporary medicine who fail not only to acknowledge the existence of psychosomatic disorders, but who actually contribute to their spread by their failure to do so.

I undoubtedly will be challenged by the guardians of perceived wisdom for the so-called "lack of scientific evidence" for my diagnostic theories. This is almost ludicrous since there is no scientific evidence for some of the most cherished conventional concepts of symptom causation. The most glaring example of this is the idea that an inflammatory process is responsible for many painful states, for which there is no scientific evidence. Another example: studies have never been done to validate the value of a variety of surgical procedures employed for pain disorders, like laminectomy for intervertebral disk abnormalities.



Studying psychosomatic disorders in the laboratory poses some great problems. How do you identify and measure unconscious emotions? If acceptance of the diagnosis by the patient is critical to successful treatment, how can you demonstrate the validity of the diagnosis and treatment if most of the population doesn't accept the diagnosis? After many years of experience it is our impression that not more than 10 to 15 percent of the population would be willing to accept a psychosomatic diagnosis. Our proof of validity is the remarkable success of our therapeutic program.

As Freud noted, the physiology of the process is far less important than accurate observations of the process itself. He didn't have any laboratory data either. So I must leave it to the laboratory experts to figure out the nuts and bolts of the process.

By sharing with you focused experiences in the diagnosis and treatment of large numbers of people who have suffered and are suffering from psychosomatic pain, my fellow doctors and I hope that our findings will have an important influence on medical practice, particularly in view of the millions who now suffer these disorders needlessly.

In conclusion I must express my deep gratitude to Mr. Al Zuckerman, who succeeded in finding a publisher for this rather controversial book.

ONE

# WHAT IS PSYCHOSOMATIC MEDICINE?

I remember the first time John R came into my clinic in 1996. He was a successful businessman in his early forties, well dressed and fit, radiating confidence. He seemed altogether at ease and self-assured—until he bent to sit down. Abruptly, his movements slowed and he became so cautious, so fragile, so tentative that he was suddenly a caricature of the driving, confident man who strode through my door only moments before. His body language made it clear that he was either experiencing excruciating pain or feared the pain would strike him if he made the slightest wrong move.

As a medical doctor, I could empathize with his suffering. My specialty is mindbody disorders, and I see cases like this every working day. I hoped I could help him, which meant helping him to help himself, because with mindbody disorders, a doctor cannot “cure” a

patient. It is the suffering patient who must come to understand his malady . . . and by understanding it, banish it.

As we went over John R's history, a picture began to emerge of an interesting and satisfying life. Married, three children. His own business, which probably took up too much of his time, but was doing well. I also heard a familiar litany of suffering and pain—a chronic bad back of mysterious origins, sometimes inducing such severe pain that he could not get out of bed in the morning. His long and unsuccessful search for relief—experiments with alternative medicine, prescription drugs, and finally, in desperation, surgery—immensely expensive and only temporarily successful. Then the sudden onset of brand-new ailments: sciatica, migraine headaches, acid reflux—the list of maladies went on and on.

As a physician, my heart went out to him. It was my job to help him. But I could only lead. Would John R follow? Would he understand the profound interconnectedness of mind and body? Would he grasp the awesome power of buried rage?

To the uninitiated, there is often something mysterious about mindbody medicine. In truth, the relationship of the mind to the body is no more mysterious than the relationship of the heart to the circulation of the blood, or that of any other organ to the workings of the human body. My first interview with John R indicated he would be open to the idea of mindbody medicine. Within a month of beginning treatment, his pains, which had tortured him for much of his adult life, simply disappeared, without the use of drugs or radical procedures. I still get an annual Christmas card from him. In his most recent one he reported that he continues playing tennis and skiing. Last summer he and his oldest boy walked the entire Appalachian Trail. The pain and the equally unexplained other disorders have not returned.

Many of my patients have an initial difficulty grasping the full

dynamics of the mindbody syndrome. It is one thing to accept the concept that the mind has great power over the body, but quite another to internalize that knowledge, and to understand it on a deeply personal basis. Even when my patients come to fully appreciate the central element of the equation—that it is their *mind* that contains the root cause of their physical distress—they may continue to stumble over the secondary details, unable to accept the reality of their own buried rage, and remain puzzled over the fact that their own mind can make decisions of which they are unaware.

Sometimes it helps my patients to understand the mindbody connection if they step back and look at it from a broader perspective. Psychosomatic disorders belong to a larger group of entities known as *psychogenic* disorders, which can be defined as any physical disorders induced or modified by the brain for psychological reasons.

Some of these manifestations are commonplace and familiar to all, such as the act of blushing, or the feeling of butterflies in the stomach, or perspiring when in the spotlight. But these are harmless and temporary phenomena, persisting only as long as the unusual stimulus remains.

A second group of psychogenic disorders includes those cases in which the *pain of a physical disorder is intensified* by anxieties and concerns not directly related to the unusual condition. An example would be someone recently involved in a serious automobile accident whose pain may be significantly worsened by concerns about his or her family, job, and so on, not about the injuries. While mainstream medicine tends to ignore almost all psychogenic manifestations, it generally acknowledges this type, recognizing that symptoms may worsen if the patient is anxious. Doctors may refer to this as *emotional overlay*. In my practice, patients have reported that their pain became much more severe when they were informed of the results of a magnetic resonance imaging (MRI) scan that described an ab-

normality, such as a herniated disk, particularly if surgery was suggested as a possible treatment.

The third psychogenic group is the exact opposite of the second: it covers cases in which there is a *reduction of physical symptoms* in an existing disorder. In one of the earliest studies of pain, Henry Beecher of Harvard reported that in a group of severely wounded soldiers in World War II, it was found that despite the severity of their injuries they often required little or no analgesic medication because their pain was substantially lessened by their becoming aware that they were still alive, being cared for and removed from the dangers of deprivation, hardship, and sudden death.

By far the most important psychogenic categories are the fourth and fifth groups, *hysterical disorders* and *psychosomatic disorders*. Hysterical disorders are mostly of historical interest, although the psychology of both is identical. My experience has been primarily with psychosomatic disorders.

The symptoms of hysterical disorders are often quite bizarre. The patient may experience a wide variety of highly debilitating maladies, including muscle weakness or paralysis, feelings of numbness or tingling, total absence of sensation, blindness, inability to use their vocal cords, and many others, all *without any physical abnormalities in the body to account for such symptoms*.

It is clear from the nature of hysterical symptoms that their origin is indeed "all in the head," to take a pejorative phrase commonly used to refer to psychosomatic symptoms. The absence of any physical change to the body indicates that the symptoms are generated by powerful emotions in the brain. Just where in the brain, no one can say for sure. One medical authority, Dr. Antonio R. Damasio, has suggested that these emotion-generating centers are located in the hypothalamus, amygdala, basal forebrain, and brain stem. The pa-

tients perceive symptoms as though they were originating in the body when the appropriate brain cells are stimulated. These symptoms often have a very strange and unreal quality about them. One of the nineteenth-century pioneers of psychiatry, Josef Breuer, likened them to hallucinations.

## PSYCHOSOMATIC DISORDERS

By contrast, in the fifth psychogenic group, psychosomatic disorders, the brain induces *actual physical changes* in the body. An example of this would be tension myositis syndrome (TMS), a painful disorder that we will examine at greater length. In this condition, the brain orders a reduction of blood flow to a specific part of the body, resulting in mild oxygen deprivation, which causes pain and other symptoms, depending on what tissues have been oxygen deprived.

One of the most intriguing aspects of both hysterical and psychosomatic disorders is that they tend to spread through the population in epidemic fashion, almost as if they were bacteriological in nature, which they are not. Edward Shorter, a medical historian, concluded from his study of the medical literature that the incidence of a psychogenic disorder grows to epidemic proportions when the disorder is in vogue. Strange as it may seem, people with an unconscious psychological need for symptoms tend to develop a disorder that is well known, like back pain, hay fever, or eczema. This is not a conscious decision.

A second cause of such epidemics often results when a psychosomatic disorder is misread by the medical profession and is attributed to a structural abnormality, such as a bone spur, herniated disc, etc.

A 1996 study in Norway suggests there is a third condition that fuels such epidemics: the simple fact that medical treatment may be

readily available. A paper published in the journal *Lancet* in 1996 described an epidemic in Norway of what is called “whiplash syndrome.” People involved in rear-end collisions, though not seriously injured, were developing pain in the neck and shoulders following the incident. Norwegian doctors were puzzled by the epidemic and decided to investigate. They went to Lithuania, a country with no medical insurance, and on the basis of a controlled study determined that the whiplash syndrome simply did not exist in that country. It turned out that the prevalence of whiplash in Norway had less to do with the severity of rear-end collisions than with the fact that it was in vogue; doctors couldn’t explain the epidemic and the ready availability of good medical insurance for treatment!

The most important epidemics of psychosomatic disorders are those associated with pain. As will be discussed below, they have become the ailments du jour for millions of Americans. They are “popular” and most of them have been misdiagnosed as being the result of a variety of physical structural abnormalities, hence their spread in epidemic fashion.

What is the genesis of a psychosomatic disorder? As we shall see, the cause is to be found in the unconscious regions of the mind, and as we shall also see, its purpose is to deliberately distract the conscious mind.

The type of symptom and its location in the body is not important so long as it fulfills its purpose of diverting attention from what is transpiring in the unconscious. On occasion, however, the choice of symptom location may even contribute to the diversion process, something that is common with psychosomatic disorders. For example, a man who experiences the acute onset of pain in his arm while swinging a tennis racket will naturally assume that it was something

about the swing that hurt his arm. The reality is that his brain has decided that the time is ripe for a physical diversion and chooses that moment to initiate the pain, because the person will assume that it stems from an injury, not a brain-generated physical condition that caused the pain. How does the brain manage this trick? It simply renders a tendon in the arm slightly oxygen deprived, which results in pain. This is how “tennis elbow” got its name. If that sounds bizarre, diabolical, or self-destructive, you will see later that it is in reality a protective maneuver. My colleagues and I have observed it in thousands of patients.

But in time, such a symptom may lose its power to distract. Then the psyche has another trick up its sleeve. It will find another symptom to take its place, one that is viewed by both patient and doctor as “physical,” that is, not psychological in origin. For instance, if a treatment—let’s say surgery—neutralizes a particular psychogenic symptom, so that the symptom loses its power to distract, the brain will simply find another target and create another set of symptoms. I have called this the *symptom imperative* and it has enormous public health implications, because psychogenic symptoms are commonly misinterpreted and treated as physical disorders. All of a sudden, the “cured” patient has a brand-new disorder that demands medical attention. More distress. More time lost. More expense. This will be documented as we proceed.

Statistically, the most common psychosomatic disorder today is TMS, which I have described in its many forms in my previous books. I gave it that name because at the time of publication of the first book in 1984, it was thought that muscle (myo) was the only tissue involved. Since then, I have come to learn that nerve and tendon tissue may also be targeted by the brain; in fact, it now appears that



nerve involvement is more common than muscle. Accordingly, a more inclusive name, like *musculoskeletal mindbody syndrome*, might be more appropriate. However, because the term *TMS* is now so well known, I have been urged by my colleagues not to change it, so TMS it remains.

## **DISORDERS MEDIATED THROUGH THE AUTONOMIC-PEPTIDE SYSTEM**

How does the brain induce symptoms in the body? There are a number of ways, but by far the largest number of psychosomatic conditions are created through the activity of the *autonomic-peptide system*. The autonomic branch of the central nervous system controls the involuntary systems in the body, such as the circulatory, gastrointestinal, and genitourinary systems. It is active twenty-four hours a day and functions outside of our awareness. The word *peptides* has been added because peptides are molecules that participate in a system of intercommunication between the brain and the body and play an important part in these processes.

The most common disorders produced through this system are those of TMS, described above. These disorders afflict millions and cost the economy billions of dollars every year in medical expenses, lost work time, compensation payments, and the like.

Other conditions include:

- Gastroesophageal reflux
- Peptic ulcer (often aggravated by anti-inflammatory drugs)
- Esophagospasm
- Hiatus hernia
- Irritable bowel syndrome
- Spastic colitis

- Tension headache
- Migraine headache
- Frequent urination (when not related to medical conditions such as diabetes)
- Most cases of prostatitis and sexual dysfunction
- Tinnitus (ringing in the ears) or dizziness not related to neurological disease

The theories advanced here are based almost exclusively on work done with TMS, but there are many less common mindbody disorders (like reflux) whose symptoms are also created by the autonomic-peptide system. We refer to these as equivalents of TMS since they are the result of the same psychological conditions that are responsible for TMS. What put me onto the possibility that the pain I was seeing in the early 1970s was psychosomatic was the fact that so many of the pain patients had experienced these equivalent disorders, all of which I knew to be psychosomatic. That realization suggested that the pain disorder I was seeing was also psychosomatic.

## **WHY TMS IS PAINFUL**

As I stated earlier, the altered physiology in TMS appears to be a mild, localized reduction in blood flow to a small region or a specific body structure, such as a spinal nerve, resulting in a state of mild oxygen deprivation. The result is pain, the primary symptom of TMS. The tissues that may be targeted by the brain include the muscles of the neck, shoulders, back, or buttocks; any spinal or peripheral nerve; and any tendon. As a consequence, symptoms may occur virtually anywhere in the body. The nature of the pain varies depending on the tissues involved: muscle, nerve, or tendon. In addition to pain, nerve involvement brings with it the possibility of feel-

ings of numbness and tingling and/or actual muscle weakness. These reflect the function of nerves, which is to bring sensory information to the brain and carry movement messages to the body, either or both of which may be affected in TMS. The fact that patients recover rapidly when they are appropriately treated suggests that the tissues involved—nerve tissue being the most sensitive—are not in any way damaged but only rendered temporarily dysfunctional.

Because so few members of the medical profession recognize mindbody disorders for what they are, the pain of TMS is commonly attributed to a structural abnormality, such as the ones that often show up on x-rays, computed tomography (CT), or MRI scans. Following is a list of the most common ones:

**Abnormalities of the intervertebral disc due to wear and tear, aging, etc., including:**

- Narrowing of the disc space, indicating that the disc has lost substance
- Bulging of the disc, due to pressure from the material inside the disc (the nucleus pulposus)
- Herniation of disc material

**Abnormalities of other spinal bone elements, referred to as spondylosis (immobility and fusion of vertebral joints) including:**

- Bone spurs around spinal bone joints (“pinched nerve”)
- Enlargement of ligaments in the spinal canal
- Narrowing of the spinal canal due to the changes above (spinal stenosis)
- Spondylolisthesis (malalignment of spinal bones)

- Scoliosis (an abnormal side-to-side curvature of the spine)
- Abnormalities of tendons of rotator cuff muscles in the shoulder
- Tears of the knee cartilage (meniscus)
- Normal aging changes in the knee, called arthritis
- Changes in the hip caused by aging changes (arthritis)
- Bone spurs in the heel of the foot
- Many others less common conditions

In my experience, the majority of these abnormalities are not responsible for the pain. The cause of the pain is TMS, plain and simple. Nevertheless, despite the absence of proof that the abnormalities are the cause of the pain, the medical profession routinely treats those with surgery—in many cases, exorbitantly expensive surgery—as will be detailed.

To further complicate the problem, there are a number of soft tissue disorders that are also blamed for the pain of TMS. These misdiagnoses include:

- Myofascial pain, usually in the back (actual cause unknown)
- The postpolio syndrome (pain in parts of the body previously afflicted by polio). Such pain is routinely attributed to the polio, but there is no proof that this is the cause. There is a Latin phrase commonly quoted in scientific circles that refers to this particular kind of misdiagnosis: “post hoc ergo propter hoc.” It means “after this [i.e., polio] therefore because of this,” a classic error in logic leading to a dangerous and unscientific conclusion.
- Strained back or neck muscles

- Pain in the buttock attributed to compression of the sciatic nerve by the piriformis muscle—a rather frivolous concept with no evidence of validity
- Pain and other dental abnormalities (temporomandibular joint disorder [TMS]) that are most likely due to TMS in jaw muscles
- Tendon pain in various locations around the elbow attributed to overuse (tennis elbow)
- Wear or tear of rotator cuff tendons
- Pain in the front of the sole of the foot (metatarsalgia)
- Pain in the middle of the sole of the foot (plantar fasciitis)
- Pain in the heel of the foot (bone spur)
- Pain attributed to a benign tumor in the sole of the foot (metatarsal neuroma)
- Carpal tunnel syndrome (repetitive stress injury)
- Fibromyalgia: see what follows
- Other less common soft tissue disorders

In the last thirty-five years, three of the above conditions have been so often misdiagnosed that their incidence has reached epidemic proportions. They are:

1. Chronic pain from back, neck, shoulder, and limbs
2. Fibromyalgia
3. Carpal tunnel syndrome

Each has a different story to tell.

## THREE MINDBODY EPIDEMICS

### 1. Chronic Pain Syndromes: A Modern Plague

The so-called black plague of European and Asian history—bubonic plague—killed millions. It was caused by a bacterium carried by rats and transmitted by fleas. The authorities of the day had the means to control the spread of the plague, but because bacteriology and epidemiology were unknown sciences at that time, they did not understand the need to do so. In other words, the plague flourished because of their ignorance. An epidemic of chronic pain exists today because of a similar lack of knowledge. Modern medicine knows neither the cause of chronic pain nor the means of its spread. This has led directly to an epidemic that has been going on since the late 1960s. It reached its peak in the 1990s and is still devastating the lives of millions. It is why pain clinics have proliferated in recent years.

The reason for this epidemic is the stubborn resistance of the medical profession to even consider the likelihood of mindbody disorders. Most people with chronic pain are suffering from one of the many manifestations of TMS just described, but the majority of practitioners called upon to treat them are unaware of that diagnosis. Those few who know about it often choose not to acknowledge it. Instead, they attribute the pain to one of the many disorders just listed. The persistence of the pain—the fact that it often lasts for months or even years—is explained by an ingenious idea conceived by behavioral psychologists many years ago. According to their theory, the pain continues because it serves the purpose of what is called *secondary gain*, that is, an unconscious desire on the part of the sufferer for some kind of benefit from the symptom, such as sympathy, support, release from responsibility or from arduous la-

bor, monetary gain, and so on. This clever explanation was readily embraced by medical practitioners since it absolved them of responsibility for their failure to help their patients. It was, after all, the patient's own fault. One cannot imagine a more devastatingly wrong explanation, from both the scientific perspective and that of the suffering patient.

As we shall see, the true cause of the pain, TMS, serves the purpose of *primary gain*, that is, to prevent the conscious brain from becoming aware of unconscious feelings like rage or emotional pain. There is rarely secondary gain. We shall elaborate on this in the chapter on the psychology of these disorders.

As noted above, mindbody disorders tend to spread in epidemic fashion:

- a. if they are in vogue;
- b. if they are misdiagnosed, that is, if the pain is falsely attributed to some purely "physical" phenomenon, like a herniated disc or bacteria in the stomach; and
- c. if treatment is readily available and funded by medical insurance.

Chronic pain fits these criteria admirably, which explains the persistent inability of medicine to make any inroads on the problem. The medical profession bears a heavy responsibility for this and for the other epidemics. On the simplest level, it has violated one of its most fundamental medical admonitions: *do no harm*.

In truth, American medicine has done enormous harm. It has misdiagnosed the cause of the pain, guaranteeing that even if the patient experiences pain relief due to a placebo reaction, the pain will return to the same or some other location or, following the principle

of the symptom imperative, another physical disorder will take its place. In no way has the patient been healed.

In its blindness, modern medicine has enhanced the tendency of the pain syndromes to spread in epidemic fashion. It has introduced a variety of ineffective treatments, some of them extremely expensive, placing great burdens on the government and private insurance.

The enormity of the problem is illustrated by an article that appeared in the business section of the *New York Times* on December 31, 2003. It described how one such expensive treatment, spinal fusion, is being widely performed *despite the lack of evidence that it has any value whatsoever*. The article went on to point out that the doctors, hospitals, and manufacturers of the hardware used in these procedures all have a financial stake in the performance of this operation. The national bill for its *hardware alone* has soared to \$2.5 billion a year. What the cost of treatment must be staggers the imagination. My medical school professors would be shocked and horrified at what has happened to medical practice. The marketplace and economic factors have taken over.

In my experience, the many structural abnormalities that are claimed to be the basis for the surgery described above are usually not responsible for the pain so that neither surgical nor even conservative physical treatment of any kind is appropriate. I have taken to advising my patients that the worst indication for musculoskeletal surgery is pain attributed to some structural abnormality.

## 2. Fibromyalgia

*Fibromyalgia* is a medical term that has been around for a long time. For some reason it was adopted by the rheumatology community in



the early 1980s and applied to patients suffering pain in many locations in the trunk, arms, and legs. In fact, it is a severe form of TMS. Significantly, fibromyalgia patients commonly suffer from other mindbody disorders as well, like headache and irritable bowel syndrome, as well as emotional symptoms including anxiety, depression, and sleep disorders. When rheumatologists first became interested in people with these symptoms, they were not able to explain what caused the disorder, but they created diagnostic criteria to define it. That became a kind of medical kiss of death. The American College of Rheumatology decreed that the diagnosis could be made if the person under examination exhibited pain in eleven of a potential eighteen locations. Since that time, hundreds, if not thousands, of papers have been published describing studies that try, still unsuccessfully, to explain the disorder. Two of these published studies of people with fibromyalgia found that the oxygen level in their muscles was reduced, confirming the hypothesis that fibromyalgia is a manifestation of TMS, which as we've seen is caused by mild oxygen deprivation. But the rheumatology community did not accept the idea of mild oxygen deprivation as the cause of fibromyalgia, and the epidemic continued. By the year 2000 the enormous increase in the number of people with this diagnosis prompted an article in *The New Yorker* magazine by Jerome Groopman, a professor of medicine at Harvard, in which he noted that there were *six million* Americans (mostly women) with this disorder of unknown cause and that it appeared to be analogous to the nineteenth-century epidemic of neurasthenia.

The fibromyalgia story is another tragic example of the epidemic proclivity of psychosomatic disorders when they are misdiagnosed and, therefore, inevitably mismanaged. Another major epidemic began around the same time, and for the same reason.

### 3. Carpal Tunnel Syndrome

Carpal tunnel syndrome (CTS) became fashionable in the 1980s. It is another TMS manifestation that has been widely misread by medicine, with predictable results. Patients experience a variety of symptoms in their hands that are the result of dysfunction of the median nerve at the wrist. The dysfunction can be documented by electrical tests, so there is no doubt about the reason for the symptoms. What is in doubt (although the medical community does not admit to any doubt) is what is troubling the nerve. The generally accepted diagnosis is that the nerve is compressed as it passes under a ligament at the wrist, and the recommended treatment is to inject a steroid under the ligament, or cut it, which sometimes produces symptomatic relief. However, a paper published in the journal *Muscle and Nerve* suggests that nerve function returns too rapidly after the ligament has been cut to blame compression for the disorder, and that it is more likely that local ischemia (reduced blood flow) is responsible for the symptoms. Because ischemia is what causes the symptoms of TMS, the finding supports the idea that carpal tunnel syndrome is a manifestation of TMS.

It is highly significant that the rapid spread of carpal tunnel syndrome coincided with the spectacular growth of the computer industry. What fueled the spread of CTS was the belief that the problem was caused by working at computer keyboards, and that CTS was one of a number of “repetitive stress injuries.” Since those early days, armies of office workers and those employed in other occupations requiring a variety of repetitive tasks have developed CTS, so that now, like chronic pain and so-called fibromyalgia, it is a major public health problem. People with CTS are particularly resistant to the idea that it is a *mindbody disorder* even when that more benign term is used rather than the word *psychosomatic*.

It is quite remarkable that I have been unable to find a single mention in the medical literature questioning the reason for these epidemics. And one never gets a reasonable answer when one asks, *Why is it that the millions of men and women who pounded typewriters since the beginning of the twentieth century never developed CTS?* Again, medicine bears the responsibility for these epidemics on two counts: first, by failing to make the correct diagnosis, and then by attributing the epidemics to structural and other specious causes, thereby contributing to the severity and long-term nature of symptoms. This is important because it supports the mind's strategy, which is to distract attention from what is going on in the unconscious mind and focus it on a body symptom. By so doing it perpetuates the process. The sad reality is that most of the people suffering from conditions like chronic pain, fibromyalgia, and CTS will not accept a psychosomatic diagnosis.

## **OTHER DISORDERS MEDIATED THROUGH THE AUTONOMIC-PEPTIDE SYSTEM**

In addition to the three conditions just discussed, there are numerous other disorders that are brought about by the same body-mind system, the autonomic-peptide system. Like the first three, they have the same genesis and serve the same psychological purpose. They include:

### **Gastrointestinal Mindbody Syndromes**

Upper and lower gastrointestinal symptoms continue to be common psychosomatic manifestations. They are treated with a variety of medications, often with success which, as has been noted, is a

Pyrrhic victory since the brain will simply find another place to create psychosomatic symptoms.

Many physicians, including psychiatrists, now refuse to believe that ulcers are psychosomatic, because of the discovery of a bacterium in the stomachs of people with peptic ulcers. It is claimed that patients are cured with antibiotics. This is one of the many examples of medicine's inability to confront the reality of psychosomatosis. The presence of bacteria in the stomachs of some patients in our view is merely part of the process.

Similarly, a paper in the *American Journal of Gastroenterology* attributed irritable bowel syndrome to the presence of bacteria in the colon. Such a conclusion would be ludicrous if it were not tragic, for if this idea gains acceptance among physicians and their patients, this is another psychosomatic disorder whose true cause will be ignored in favor of treating the symptom.

## Tension Headache and Migraine Headache

There is no laboratory proof that tension headaches and migraine headaches are psychosomatic, but the clinical experience of treating them as such is impressive. As early as the 1930s and 1940s leading medical authorities published numerous papers on the *psychological* basis for migraine, and all noted that migraines were related to repressed rage. In *Psychosomatic Medicine* (1950), Franz Alexander noted, "The most striking observation is the sudden termination of the attack almost from one minute to another after the patient becomes conscious of his hitherto repressed rage and gives expression to it in abusive words." Note Alexander's reference to *rage*. As will be seen, rage in the unconscious mind is central to understanding virtually all psychosomatic reactions.

The groundbreaking work of Alexander and his colleagues (see chapter 2) has been forgotten. The patients who come into our clinic report that the treatment they have previously received for their migraine or tension headaches is invariably with medications, another example of the regression of contemporary medicine.

### Genitourinary Mindbody Syndromes

The perceived need for frequent urination is psychosomatic except when it is related to diabetes; renal, cardiac, or adrenal disease; bladder infection; or an enlarged prostate. It is very common. A careful history will reveal that in many cases the habit of getting up frequently during the night to urinate is not brought on by a full bladder but by a mild form of insomnia. The person is programmed by the unconscious to awaken and then programmed to have the urge to urinate.

It has been documented in the medical literature that prostatitis in young men is commonly related to stress when not due to an obvious infection.

Most sexual dysfunction is psychologically based at any age. Though it is well known that libido decreases with age, emotional factors may still be responsible for sexual difficulties in the elderly.

### Tinnitus and Vertigo

Both of these conditions may be signs of disorders of the nerves or the ears, but they are most commonly benign and psychosomatic. I once experienced vertigo that lasted only a few hours. It ended when I was able to identify the psychological basis for it.

## DISORDERS ATTRIBUTED TO ACTIVITY OF THE IMMUNE-PEPTIDE SYSTEM

The disorders described up to this point are the most common of a very large group, all of them activated by the autonomic-peptide system. A second group of ailments is associated with the body's *immune system*. (Again, we include the peptide communication system because of the role it plays in the interaction between brain and body.) It is not known what determines the unconscious mind's choice of which system or symptom to employ, but it makes no difference since the purpose of all symptoms is the same—to distract the conscious mind.

With the immune-peptide system, the disorder may be induced by either overactive or underactive immune function. Overactive immune activity leads to:

- Allergic phenomena (e.g., allergic rhinitis, conjunctivitis, sinusitis, asthma)
- A large number of skin problems (e.g., eczema, hives, angioedema, acne, psoriasis)

The question invariably arises, “Aren't allergic reactions caused by allergens, like grass pollens?” The answer is yes, but such allergens are merely *triggers*. They are foreign substances, and the immune system is designed to repel foreign invaders. However, not everyone reacts to grass pollens. If your unconscious mind causes your immune system to overreact, the system is said to be *hyperactive* or *hypersensitive*. Both terms denote an allergic reaction. This excessive sensitivity of your immune system is not to protect you from foreign substances, but to keep your conscious attention focused on the body.

Conversely, the unconscious mind may do the opposite to de-

flect attention from itself. It may *decrease* the efficiency of the immune system and render the person susceptible to infection. Recurrent infections of any kind are usually an indication of this process. The infections must be treated “medically,” but they will continue to recur if they are not treated psychologically as well. It is highly significant that many of the people suffering from the pain of TMS who have participated in our therapeutic program have reported the disappearance of allergies or frequent infections simultaneously with the cessation of pain.

Most people with TMS have a history of one or more of these autonomic or immune system conditions. Indeed, it would be most unusual to find someone who has never experienced one or more mindbody symptoms. One is forced to the conclusion that psychosomatic reactions and, therefore, the emotions that cause them, are universal. It is important to recognize that they are not illnesses; *they are a part of life, part of the human condition*. This should become clear when the psychology of mindbody disorders is described in detail in chapter 3.

## **DISORDERS PRODUCED BY THE NEUROENDOCRINE-PEPTIDE SYSTEM**

There is still a third medium for transferring mindbody disorders from the mind to the body. It is the neuroendocrine-peptide system, which governs the body’s hormonal distribution. The disorders associated with it are a small but distinct group of conditions that seem to fall somewhere between the physical and psychological in their manifestations:

- Bulimia
- Anorexia nervosa
- Neurasthenia (known today as chronic fatigue)

The desire to overeat or the inability to eat at all seems to point to some strong emotional factor, though it would not be surprising in today's medical atmosphere for someone to come forward with a purely physical explanation for them. Bulimia and anorexia nervosa are generally treated psychiatrically.

As for neurasthenia, a group of physicians representing three of Britain's royal colleges studied the problem and issued a report in 1996 suggesting that psychological factors were primary in the disorder and that a therapeutic program consisting of physical activity and psychotherapy was the most effective of those tried. There is anecdotal evidence based on numerous letters I have received from readers that exposure to my book, *Healing Back Pain*, has relieved many people with neurasthenia. This is logical since the underlying psychology for this is the same as for TMS.

A paper published in *The New England Journal of Medicine* in 1993 entitled "Neuroendocrine-Immune Interactions" concluded with this statement: "Central nervous system influences on the immune system are well documented and provide a mechanism by which emotional states could influence the course of diseases involving immune function. Whether emotional factors can influence the course of autoimmune disease, cancer and infections in humans is a subject of intense research that has not been satisfactorily resolved at this time."

This paper addressed the influence of the neuroendocrine network on the immune system and so has relevance to the allergic and infectious processes referred to above as well as the broad fields of autoimmune disease and cancer. It is introduced here because it is likely that the neuroendocrine network is also responsible for bulimia, anorexia nervosa, and neurasthenia. Once again, the peptide network provides the mechanism by which emotional states are able to induce physical ones.



Bulimia, anorexia nervosa, and neurasthenia are quasi-physical equivalents of TMS. Experience strongly suggests that *anxiety, depression, and obsessive-compulsive disorder (OCD)*, all purely emotional conditions, are equivalents as well.

Recalling the symptom imperative mentioned earlier, I have observed that some patients, upon being relieved of the pain of TMS by some chemical therapy or a placebo, become anxious or depressed rather than developing another physical symptom. But then when their emotional symptoms were relieved by a tranquilizing or antidepressant medication, their body pains returned! Others who were suffering the symptoms of TMS and OCD simultaneously had relief of both while participating in the TMS therapeutic program.

The conclusion is inescapable that the psychology behind both the physical and affective (emotional) disorders is the same and that people whose pain is replaced by anxiety or depression are also experiencing the symptom imperative. This is a daring statement, for it presumes to express an opinion about the origin of anxiety and depression, disorders in the domain of psychology and psychiatry. Nevertheless, it is being suggested that like psychosomatic symptoms, affective states are also reactions to powerful emotions in the unconscious mind that are threatening to become conscious, and it follows that good medicine requires first acknowledging those unconscious emotions and then dealing with them. Treating anxiety or depression with medications without in-depth psychotherapy is poor medicine, and may even be dangerous if the symptom imperative leads to a serious disorder like one of the many autoimmune maladies or cancers. These are not fanciful conclusions based on conjecture; they derive from irrefutable clinical experience.

A word about the peptide network: the scientist who has contributed most to an understanding of this crucially important system, who has, in fact, written about “the biochemistry of emotions,”

is Dr. Candace Pert. She has described her work in her book, *Molecules of Emotions*, which should be read by all professionals interested in the mechanics of how emotions induce physical symptoms. The peptide network explains the physical part of the psychosomatic process, but it also explains the placebo effect, namely, how blind faith can lead to the amelioration of symptoms. It has been stated already that the placebo effect may be dangerous because of the symptom imperative, but treating the symptom rather than the cause is poor medicine in any event because it is almost invariably temporary, whether or not it leads to a substitute symptom. Placebos take many forms: surgery, a variety of other physical treatments, and pharmaceuticals. If the celestial architect were to suddenly abolish the placebo effect in humans, there would be economic chaos, particularly in the United States, for much medical treatment today owes its success, such as it is, to the placebo phenomenon.

## **THE CURRENT STATUS OF MINDBODY MEDICINE**

In view of our success in the treatment of pain disorders, my colleagues and I are often asked why more patients and physicians don't subscribe to these theories. It's a good question, and not easy to answer. The reasons are many and some of them subtle.

## **WHY MOST PEOPLE CANNOT ACCEPT THE IDEA OF MINDBODY DISORDERS**

Experience suggests that in the United States only 10 to 20 percent of people with a psychosomatic disorder are able to accept the fact that their symptoms are emotional in origin. Many are downright hostile to the idea. Though there are large numbers who seek psychotherapy or psychoanalysis, they represent only a small portion of

the entire population. For the majority there is a stigma attached to disorders relating to psychology. Negative words like *weird*, *crazy*, *kooky*, and *nuts* come to mind. Psychologists and psychiatrists are head shrinkers or “shrinks.” “It’s all in your mind” is almost insulting, implying there’s something strange or weak about you or that the symptoms are in your imagination. This is most unfortunate, since the symptoms are very real, the result of a very physical process.

Another factor negatively impacting mindbody medicine is that, as with the stigma attached unfairly to cancer and tuberculosis patients in the early twentieth century, there is shame associated with the idea that one may be suffering from psychologically induced symptoms. This persists in many quarters despite the fact that today’s young, educated people are more accepting of the need for psychological help than were earlier generations.

Stress is another matter. Most people will accept the idea of stress, finding it less threatening because they think of stress as stemming from things “out there” that are doing something to you, so it does not imply some personal defect. Much of the research in psychology today has to do with the effects of stress in both health and illness. For example, how does stress make a medical condition like diabetes worse? Or how does a medical condition like diabetes cause stress in one’s life? This is laudable research, but it doesn’t deal with that crucial domain—the unconscious, which is where mindbody disorders begin.

Much of the skepticism of psychosomatic therapy demonstrated by patients is strongly reinforced by the medical profession, including much of the psychiatry community. People much prefer a diagnosis that suggests they can get better with a “quick fix”: an injection, a medication, a manipulation, even surgery. Many patients come to see me only after they have tried all of the above.

## WHY THE MEDICAL PROFESSION IGNORES MINDBODY CONCEPTS

Since the mid-twentieth century the physical specialties of medicine have moved increasingly farther away from the idea that the brain can bring about physical alterations in the body and that psychosomatic disorders exist. Some specialties, such as orthopedics, neurosurgery, neurology, and psychiatry, are particularly opposed to the idea, no doubt because it contradicts their belief that structural abnormalities account for all observed symptoms. Their diagnoses are based on the therapeutic methods they employ. They are, therefore, understandably loath to consider another diagnosis, particularly one that is psychosomatic. Primary care physicians, who generally do not consider themselves competent to deal with patients suffering from persistent pain or neurological symptoms, tend to refer them to “specialists”—the very orthopedists, neurologists, and the like, who have already rejected the validity of psychosomatic diagnoses. Those same primary care physicians might well choose to treat the disorders themselves, if they understood that they were psychosomatic.

Psychosomatic symptoms involving other systems (e.g., gastrointestinal, genitourinary, dermatologic) are usually treated with medication, diet, and so on. Doctors of all kinds now appear to be constitutionally incapable of attributing physical symptoms to emotions. This is a dramatic change from medical attitudes and practices in the first half of the twentieth century. The legendary Sir William Osler once remarked that one was more likely to learn about the course of tuberculosis by looking into the patient’s head than in his chest. What has happened?

First, a sad paradox. Medical research has become more laboratory oriented in the last fifty years. To be sure, this shift has produced

some impressive results. But at the same time, human biology is not exclusively mechanical, and there are limits to what the laboratory can accurately study. The laboratory study of infectious diseases has been magnificent—it is very straightforward. But its very success has deflected attention from the influence of emotions. As a result, medical research has failed abysmally in many areas. The evidence is everywhere you look. Pain problems have become epidemic. Gastrointestinal, dermatologic, and allergic conditions are increasingly widespread, all because laboratory identification of the physics and chemistry of these conditions does not, contrary to popular medical belief, identify their cause. And paradoxically, wonderful new diagnostic tools, like the MRI, often contribute to misdiagnoses when doctors misinterpret the significance of findings. The methods of the laboratory may be impeccable but are wasted if the interpretation of their findings is faulty.

The failure of scientific medicine to stem the tide of chronic pain disorders is unfortunate enough, but it has failed as well in another even more crucial sphere. There is abundant anecdotal evidence in the medical literature that psychological factors influence more serious disorders like those of the autoimmune group, cardiovascular conditions, and cancer. Yet scientific medicine has paid scant attention to this evidence in its research, with the National Institutes of Health conspicuous in its indifference. Put bluntly, emotional factors should be studied as risk factors in these life-threatening disorders, and they are not.

Another trend in contemporary scientific medicine is its preoccupation with studying the anatomy, physiology, and chemistry of the brain, at the expense of studying its dynamic relationship to the body as a whole. Neuroscience can be enormously important and of consuming interest, but what is learned of the physical brain may be either detrimental or irrelevant to clinical medicine. An example of

the former is the almost universal tendency to treat the chemical aberrations associated with depression with drugs, as though the altered chemistry was the cause of the depression when, in fact, the reason for the depression is an unconscious psychological conflict and the chemical change is merely the mechanism that produces the symptom of depression. Treating the depression with drugs alone, without psychotherapy, is not only poor medicine, it is also dangerous. The symptom imperative tells us that taking away a symptom by the use of a placebo or an antidepressant will only give rise to another symptom, and the other symptom may be related to something serious, like cancer.

Then, too, the findings of neuroscience may be totally irrelevant to some areas of clinical medicine. For example, the fact that a positron-emission tomography (PET) scan can identify the areas of the brain that are activated when a person is manifesting anger is not helpful in determining the source of the anger, particularly if unconscious processes are involved. Such findings are extremely interesting but of little use if one is trying to help a patient deal with a behavioral problem. Such help can come only from the laborious process of psychological analysis conducted by someone appropriately trained. When I am working with a patient suffering from pain induced by buried rage, it does no good to know which brain nuclei are involved in the pain process. I must help the patient to understand the sources of the rage. Experience has demonstrated that such understanding will usually “cure” him. This very interesting and germane process will be explained in chapter 4.

Neuroscience is one of the contemporary glamour specialties of research medicine, thanks to some extent to the interest of people like Drs. Gerald M. Edelman and the late Francis Crick, both Nobelists in other fields. Their studies of the “neural correlates of consciousness” are of enormous interest, comparable to the fascinating

work being done by cosmologists and astrophysicists, but of little relevance to clinical medicine, particularly where emotions are involved.

An article in the May 2004 issue of *Natural History* illustrates beautifully the limitations of laboratory findings. The author, Robert M. Sapolsky, a professor of biological sciences and neurology, reported on what he identified as a landmark paper published in the journal *Science*. The investigators followed a population of over a thousand New Zealand children from age three into young adulthood, identifying the incidence of depression, and noting that a proportion of the group being studied also possessed a serotonin-regulating gene known as 5-HTT. The role of serotonin in depression is well known due to widely used drugs like Prozac. The investigators correlated the incidence of two variants of the 5-HTT gene and depression and found that inheriting the genes only increased the risk of depression in people. The “bad” gene did not produce depression in those who had not suffered major stresses. The author noted, “We all have a responsibility to create environments that interact benignly with our genes.”

Another aspect of this problem was enunciated by Stephen J. Gould, who wrote in *Natural History*, “An unfortunate but regrettable common stereotype about science divides the profession into two domains of different status. We have, on the one hand, the ‘hard’ or physical sciences that deal in numerical precision, prediction and experimentation. On the other hand, ‘soft’ sciences that treat the complex objects of history in all their richness must trade these virtues for ‘mere’ description without firm numbers in a confusing world where, at best, we can hope to explain what we cannot predict. The history of life embodies all the messiness of this second, and undervalued, style of science.”

As this book was being prepared for publication a very important medical paper appeared in the September 2005 issue of the

*Proceedings of the National Academy of Sciences.* A research team at the University of Wisconsin was able to relate activity in areas of the brain known to be involved with emotions to an inflammatory process that causes symptoms of asthma. Since we theorize that asthma is a mindbody disorder, and an equivalent of TMS, this is important evidence that emotions may be a crucial factor in the causation of mindbody disorders. I intend to initiate a similar study since it is highly likely that the brains of people suffering an episode of TMS will show the same kind of changes.

Neuroscience can play an important role in identifying how mindbody processes work. If unconscious emotions can be identified and measured objectively we would have so-called hard data to support our clinical observations.

The world of the unconscious mind, like the history of life, cannot be studied exclusively by hard science. How can one objectively identify and quantify the personality traits and emotions that reside, so to speak, in the unconscious? The idea that powerful unconscious emotions are responsible for mindbody disorders is based on medical history, knowledge of the psyche, physical examination, logical deduction, and trial-and-error therapeutic experimentation. Success in treatment validates the accuracy of diagnosis if one is assured that there is no placebo effect.

Instead of dealing with this messy reality, contemporary medical science has simply discarded the entire concept of mindbody medicine. It would rather deal with mechanical, measurable, chemical realities than the abstruse phenomena of psychology. It does not want to know that emotions drive the chemical and physical manifestations they have identified, and it has the dangerous idea that treating the chemistry will correct the disorder. Such treatment may indeed modify the symptoms, but that is not the same thing as curing the disorder.



One must additionally make a distinction between medical research and clinical medicine. They do not necessarily correlate. Medical research, whatever it chooses to study, plays by certain rules. Clinical medicine, on the other hand, tends to be less objective and often follows diagnostic and therapeutic trends despite the lack of evidence to support their validity.

Though physicians should lead the way to enlightenment by the exercise of good judgment and objectivity, they are frequently victims of the same prejudices held by laymen about things psychological and are equally uneducated about them. The degree of their psychological naiveté, including their inadequate knowledge of their own psyches, is astonishing, and more than a little scary.

The consequences of this medical failure have been catastrophic. It has spawned the major epidemics described earlier, and fostered numerous minor epidemics that once barely existed, like the whiplash syndrome, knee pain, foot pain, and shoulder pain. New and expensive therapeutic practices and whole new industries have been developed to treat these disorders, making it unlikely that enlightened change can be expected in the near future.

Let me emphasize that I know many physicians who are caring and do a wonderful job with their patients, surgeons among them. They are stars in the medical firmament. But because of the present climate in medicine, most of them cannot and will not make a psychosomatic diagnosis. Mindbody medicine is a world apart and has very few practitioners.

## **PSYCHIATRY AND PSYCHOSOMATIC MEDICINE**

As pointed out earlier, official psychiatry has not recognized psychosomatic medicine for years. Even the term has been banished from the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) and

been replaced by the term *somatoform*. It is informative how the DSM deals with this matter. The introductory paragraph defines somatoform as follows:

The essential features of this group of disorders are physical symptoms suggesting physical disorder (hence somatoform) for which there are no demonstrable organic findings or known physiologic mechanisms, and for which there is positive evidence, or a strong presumption, that the symptoms are linked to psychological factors or conflicts. Unlike Factitious Disorder or Malingering, the symptom production in Somatoform Disorders is not intentional, i.e., the person does not experience the sense of controlling the production of symptoms. Although the symptoms of Somatoform Disorders are “physical,” the specific pathophysiologic processes involved are not demonstrable or understandable by existing laboratory procedures and are conceptualized by psychological constructs. For that reason they are classified as mental disorders.

What is particularly disturbing about this statement is that it may well apply to hysterical symptoms, but it certainly does not apply to psychosomatic disorders. Two phrases in the definition are of special importance: “physical symptoms suggesting physical disorder (hence somatoform) *for which there are no demonstrable organic findings or known physiologic mechanisms*” and “the specific pathophysiologic processes involved *are not demonstrable or understandable by existing laboratory procedures*” (italics mine).

These two phrases bring us to the heart of the matter for they represent *a matter of opinion on the part of the psychiatric community*, not a scientific construct. Put bluntly, the opinions of general psychiatry on the existence or nonexistence of psychosomatic disorders are irrelevant. Psychiatrists lack expertise in the domain of physical dis-

orders, and therefore have no basis for an opinion as to whether a given set of symptoms represents a structurally induced or a psychosomatic condition. People with physical symptoms such as back pain or gastroesophageal reflux do not consult psychiatrists. One fails to see, then, how the writers of the DSM can have taken upon themselves the prerogative of deciding that psychosomatic disorders do not exist, as they have done in recent editions of that widely consulted reference work. It makes as little sense as it would for dermatologists to arbitrarily decide to render opinions on neurological disorders.

Regarding the manual's phrase "demonstrable organic findings," as long ago as 1888 Freud, working with patients with muscular rheumatism (known today as TMS), demonstrated the presence of pain on palpation (medical examination by touch), which is surely an organic finding. The disorder is clearly a mindbody process, with many demonstrable physical signs. The writers of the manual have been *unaware of*, or have *simply chosen to ignore* the evidence for the existence of psychosomatic disorders like TMS and the common gastrointestinal and allergic disorders described in this book.

Historically, there have been very few people qualified to judge whether a disorder is psychosomatic, and some of the best of them have been unaware of the most common of these conditions, the pain syndromes. As will be seen in chapter 2, Sigmund Freud described TMS but concluded it was "organic." Alfred Adler did not go into detail but stated that many physical symptoms were induced by the brain. Perhaps the best paper on the subject was "Psychogenic Regional Pain Alias Hysterical Pain," by Dr. Allan Walters, a highly respected Canadian neuropsychiatrist, published in the journal *Brain* in 1961. Walters described patients with pain that was clearly emotional in origin but who were not *hysterics*, as that term was used at the time. It is apparent that he was describing what we now call TMS.

It would appear that modern psychiatry has regressed back to the nineteenth century, when the predominant view of mental disorders was that they were either hereditary or due to brain disease. Freud had not yet introduced the idea that psychology, not physiology, was the important factor in mental disorders. So pervasive was the conventional view, however, that even Freud had trouble disavowing it. Now, despite evidence to the contrary, modern psychiatry suggests that the psyche does not induce emotional states like anxiety and depression and prefers to view them as chemically caused—back to the old nineteenth-century physiology again, albeit in a more sophisticated form. One cannot help but suspect that much of this is simply a repudiation of Freud, which can be dangerous and short sighted. It's true enough that Freud may have been in error about some details, but his basic ideas on the workings and importance of the unconscious are sound. Our experience with TMS makes that crystal clear.

In 1895, Josef Breuer and Sigmund Freud published *Studies on Hysteria*. It is a fitting bridge between this chapter and the next to mention two of the cases Freud described, for they recapitulate some issues just discussed, including Freud's description of what we now call TMS, his failure to recognize it as psychosomatic, the occurrence of a variety of psychogenic symptoms in one of the cases, and his and Breuer's pioneering concepts on the unconscious. The cases will then be examined in greater detail in chapter 2.

## **EMMY VON N AND ELISABETH VON R**

Frau Emmy von N was a woman in her early forties who illustrates a concept suggested earlier: that the same psychology may give rise to a variety of psychogenic symptoms. First of all, she had emotional symptoms including anxiety, phobias, compulsive behaviors, delu-

sions, and hallucinations. But she also had physical symptoms. Some were clearly hysterical in type; others were typical of what we see in patients with TMS, what was then called muscular rheumatism, a psychosomatic manifestation. So she had three of the psychogenic categories described earlier.

Fraulein Elisabeth von R was twenty-four when Freud first saw her. She had symptoms that were almost exclusively of the muscular rheumatism (TMS) type and a history typical of the cases I work with today. Here is what Freud said about muscular rheumatism:

It seems probable that in the first instance these pains were rheumatic; that is to say, to give a definite sense to that much misused term, they were a kind which resides principally in the muscles, involves a marked sensitiveness to pressure and modification of consistency in the muscles, is at its most severe after a considerable period of rest and immobilization of the extremity (i.e. in the morning) is improved by practicing the painful movement and can be dissipated by massage. These myogenic pains, which are universally common, acquire great importance in neuropaths. They themselves regard them as nervous and are encouraged by their physicians, who are not in the habit of examining muscles by digital pressure. Such pains provide the material of countless neuralgias and so-called sciaticas, etc.

This is a brief but remarkable description of one of the many pain patterns of people with TMS, of whom my colleagues and I have seen literally thousands. Freud was a peerless observer. It is interesting that though he attributed all of the symptoms to muscle, he mentions neuralgias and sciaticas in his descriptions, both of which are nerve manifestations of TMS. Those who have read my books describing TMS will recognize his description. The pity is that he

did not recognize that *the psyche initiated the process*. In this case he would have done well to heed the patients' family doctors, who said the symptoms were "nervous." He was fooled by the truly physical nature of the symptoms, the pain on digital pressure, which is one of the hallmarks of TMS.

Freud's view at the time was that the process was "organic"—that is, originating in the body, not the mind—because of the physical findings on examination. His view was entirely justified by the neuroscience of the time. He further believed that the psyche simply used the symptoms for a neurotic purpose. I think he would have discovered the truth had he continued to study physical manifestations, but he turned his attention to the neuroses and had very little to say about physical symptoms as his career developed.

The principle of emotional and physical equivalency plays out differently today than it did in Freud's time. Cases like Frau Emmy von N are unusual now, because hysterical signs or symptoms are rare, though I encountered one recently. The patient was a young woman in her twenties who described feeling as though her leg was sinking into the ground when she walked. One of the characteristics of a hysterical symptom is its bizarre, unreal quality, demonstrated classically in this young woman. Generally, people now tend to have either a physical or an affective symptom—either TMS (or one of its equivalents) or emotional manifestations like anxiety, depression, phobias, or obsessions. The medical profession recognizes the latter but not the former as psychological. The prevailing pattern depends on what is in vogue. Hysterical signs and symptoms are out of fashion; TMS is in, with all its variations like low back pain, "sciatica," neck and shoulder pain, "fibromyalgia," "carpal tunnel syndrome," knee pain, hip pain, and on and on. Gastrointestinal symptoms are also in vogue. Less commonly, a patient may have emotional and physical symptoms concurrently. I had such a patient recently. The

young man came with a history of quite severe back pain of two years' duration. He did well in the program and became pain free in about three weeks. Shortly thereafter, he began to feel anxious and began to have some of his old stomach trouble again. This was the symptom imperative at work. The occurrence of two simultaneous psychogenic manifestations clearly suggested the need for psychotherapy. Either the severity of a symptom, emotional or physical, or the existence of two or more at the same time is an indication of the power of the unconscious conflict within. To extend this further, more serious physical disorders like the autoimmune, cardiovascular, or neoplastic disorders suggest more deeply repressed phenomena.

In our view, all of Frau Emmy's and Fraulein Elisabeth's symptoms, affective or physical, hysterical or psychosomatic, served the same purpose, that is, as a defense against powerful emotions in the unconscious that were striving to come to consciousness, or were being repressed because of their emotionally painful nature.