PAINFUL QUESTIONS. . .

- Do you have constant pain in your neck, back, or shoulders that won't go away?

- Have you tried conventional and alternative treatments like herbs and acupuncture, but your problems still persist?

- Do you suffer from new, sometimes disabling conditions, such as carpal tunnel syndrome, fibromyalgia, and post-polio syndrome—all part of tension myositis syndrome—and wonder if they can be treated?

- Do your efforts to cure your chronic pain or illness seem like a Sisyphean endeavor?

- Are you fearful or suspicious of expensive medical procedures involving drugs and surgery that might fail to alleviate your condition?

- Do you want to understand how your mind and body can interact to solve your pain problems?

If your answers are "yes," don't despair. Fighting pain is not a losing cause. Pioneering physician Dr. John E. Sarno, who has helped thousands of relieved patients, introduces your most powerful weapon in the war on pain and disability. . .

THE MINDBODY PRESCRIPTION

"Dr. Sarno has had great success in treating TMS simply by explaining to patients the true nature of their pain. I'm convinced that Dr. Sarno is right and that all chronic back pain should be considered TMS until proved otherwise."

—Dr. Andrew Weil, author of
8 Weeks to Optimum Health

"For fifteen years, my life revolved around my back. I took time off from work, conducted meetings lying on the floor, and slept with ice bags. Could this be psychogenic? I had considered Dr. Sarno's idea preposterous, but ten years ago I was talked into seeing him. I haven't had back problems since. If Dr. Sarno is right about other psychogenic pain, America is wasting billions of dollars. What a tragedy."

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"Dr. Sarno describes in clearly written and understandable language how emotions influence and cause illness . . . . He has cured thousands with debilitating chronic back pain and now offers curative approaches to other painful conditions . . . . I recommend this book highly."

—Benjamin J. Sadock, M.D., professor and vice chairman, Department of Psychiatry, NYU Medical Center

"If you're suffering from an ailment that is difficult to diagnose or not responding to conventional or even alternative cures, read Dr. Sarno's book."

—Green Living

The Mindbody Prescription

Healing the Body, Healing the Pain

John E. Sarno, M.D.

WARNER BOOKS

NEW YORK BOSTON

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Contents

Preface

Pain, disability, misinformation, fear—that quartet has plagued the Western world for decades and the plague shows no sign of abating. Back, neck and limb pain are rampant, and statistics indicate that the epidemic is spreading. Disability in American industry from low back pain continues to increase year by year.

Industries that employ large numbers of people working at computers are experiencing great disability and health insurance problems because of a new pain disorder known as *repetitive stress injury* (RSI). Millions of Americans, mostly women, suffer from a painful malady of unknown cause called fibromyalgia. While gigantic medical industries have arisen to diagnose and treat these conditions, the plague continues.

This book is about that epidemic. It describes both a clinical experience that has identified the cause of the pain disorders and a method of treating them. Sadly, mainstream medicine rejects the diagnosis because it is based on the theory that the physical symptoms are initiated by emotional phenomena. Intelligent laymen in large numbers have embraced the concept, however, no doubt because they are not burdened by the bias imposed by a traditional medical education.

As if the pain epidemic were not of sufficient magnitude, a large group of physical disorders have been identified as *equivalents* of the pain syndrome, since they appear to stem from the same psychological process. These maladies have occurred commonly for years and, taken together with the widespread pain maladies, are universal in Western society. I refer to many of the headaches, gastrointestinal symptoms

and allergies, as well as respiratory, dermatologic, genitourinary and gynecologic conditions that are the stuff of everyday life.

If most of these are psychogenic—that is, they originate in the mind (and it is my goal to demonstrate that they are)—we have a public health problem of staggering proportions. The medical, humanitarian and economic implications are obvious and will be enumerated.

This book is about emotions, illness and wellness, how they are related and what one can do to enhance good health and combat certain physical conditions. The ideas are based on twenty-four years of successfully treating an emotionally induced physical disorder known as the Tension Myositis Syndrome (TMS). Although I will provide an up-to-date description of that condition, my major focus is the impact of the emotions on bodily function.

That connection came close to being accepted by Western medicine in the first half of the twentieth century and then fell into almost total disrepute. Repudiation of psychoanalytic theory, increased interest in laboratory research and the tendency of doctors to shy away from psychological matters (they see themselves as engineers to the human body) are the likely reasons for this historical trend. As the century draws to a close, few practitioners, either in physical or psychological medicine, believe that unconscious, repressed emotions initiate physical illness. Psychoanalysts are the only clinicians who have held to that concept, but their influence in the larger fields of psychiatry and general medicine is limited. In the physical medicine specialties virtually no one adheres to the idea.

Despite the lack of interest of mainstream medicine, much has been written on the "mind-body connection." Careful studies have been conducted that relate psychological factors to pathological conditions such as coronary artery disease and hypertension. I know of only one investigator outside the field of psychoanalysis who has identified unconscious emotions as the cause of a physical illness. One reads of stress, anger, anxiety, loneliness, depression, but they are discussed as conscious, perceived emotions. In many instances these feelings are thought to aggravate underlying structural pathological processes, such as herniated discs, fibromyalgia or repetitive stress injury.

In view of the widespread Freud-bashing of recent years I may be courting disapproval to state that my concepts descend from Freud's clinical observations and theories. But I know this only in retrospect, for I did not set out to prove Freud right. My developing ideas were the consequence of clinical observations; they were not based on preconceived notions about the mindbody connection. As with Freud's patients, I found that my patients' physical symptoms were the direct result of strong feelings repressed in the unconscious. In addition, I have drawn on the concepts of three other psychoanalysts: Franz Alexander, founder of the Chicago Institute for Psychoanalysis, did pioneer work in mindbody medicine in this century; Heinz Kohut conceptualized what is known as Self Psychology and pointed out the importance of narcissistic rage; Stanley Coen suggested the crucial idea that the mindbody disorder I was studying (TMS) was a defense, an avoidance strategy designed to turn attention away from frightening repressed feelings.

This book addresses physical disorders that are caused by repressed, unconscious feelings. Because these disorders are very specific, they can be accurately diagnosed and successfully treated.

The Tension Myositis Syndrome is currently the most common emotionally induced disorder in the United States, and probably in the Western world. Since the publication of *Healing Back Pain*, other painful conditions of significant

public health importance have emerged. They, too, are manifestations of TMS.

The book is laid out in three parts. Part I is a discussion of the psychology that induces these physical maladies, and it includes a chapter that might be called a bridge, for it describes the psychoneurophysiology of psychogenic processes: in other words, how emotions stimulate the brain to produce physical symptoms. After traversing this bridge (which sounds more formidable than it is), Part II takes up the various emotionally induced physical maladies, beginning with TMS, the disorder that introduced me to the world of mindbody medicine, and including such ailments as the common disturbances of the gastrointestinal tract, headaches, allergies and skin disorders.

Part III discusses treatment for these disorders.

For those who are interested, an appendix covers the more academic aspects of the mindbody (psychosomatic) process.

A word of caution to the reader: What follows is a description of my clinical experience and the theories derived from my work. No one should assume that his or her symptoms are psychologically caused until a physician has ruled out the possibility of serious disease.

Introduction: A Historical Perspective

Like a wildly growing cancer, the problem of pain of all kinds has become, since my graduation from medical school, a major epidemic in most of the industrialized countries of the Western world. The diagnosis and treatment of these disorders in the United States is now a gargantuan industry. The back pain problem alone costs the nation upward of seventy billion dollars a year, and if we add all the modern pain epidemics, such as carpal tunnel syndrome, the figure is probably twice that. One does not hear these medical problems described as epidemics, probably because they are not usually life-threatening, nor is the public fully aware of their financial, social and emotional ravages. That they do not threaten life is the only positive thing that can be said about them, since they can be more physically and emotionally disabling than many seemingly catastrophic disorders. A well-rehabilitated person with paralysis of both legs can lead an essentially normal life, while someone with severe chronic pain may be almost totally disabled, unable to work and capable of very little physical activity.

The immediate and inevitable question is, Why and how did this happen? After millions of years of evolution, have we suddenly become incapable of functioning normally? Are there architectural inadequacies in our bodies that have only become apparent in the last forty years? If these pain disorders are not caused by structural abnormalities, how else can these epidemics be explained?

My early work in the diagnosis and treatment of back, neck and shoulder pain syndromes was decidedly unpleasant and frustrating. The conventional diagnoses and conservative (nonsurgical) treatment methods yielded disappointing

and inconsistent results. Even as I explained the rationales for diagnosis and treatment to patients, I was uncomfortable, for the explanations seemed to lack physiologic and anatomic logic. As far back as 1904 doctors had described a painful disorder of the muscles—variously called fibromyalgia, myofasciitis, fibrositis, fibromyositis—but no one had been able to identify the exact pathology or cause of the condition. Eventually I began to approach patients as though nothing were known about the cause of back pain. I soon realized the primary tissue involved was muscle. Something was happening to the muscles of the neck, shoulders, back and buttocks.

Because they are easily identified on X ray, most practitioners attributed the pain to a variety of structural abnormalities of the spine, such as normal aging changes, congenital abnormalities or malalignment. Others believed that the muscles were painful because they were weak, sprained or strained. Furthermore, back, neck or shoulder pain was often accompanied by pain and other neurological symptoms in an arm or leg. If, therefore, a structural abnormality was found in the vicinity of a spinal nerve whose destination was an arm or leg, the clinician would be strongly inclined to attribute the symptoms to that abnormality without concern for the rigors of a scientific diagnosis. However, a careful history and physical examination often revealed that the presumed culprit was innocent, that the bone or disc distortion could not account for the findings. Nevertheless, pain was still blamed on the spine.

An unlikely alliance arose among disparate disciplines. Chiropractors, for years roundly criticized by physicians as unscientific, slowly came to be fully accepted into the fraternity of diagnosers and treaters of the back. They had always maintained that structural abnormalities of the spine were the cause of back pain. Since doctors believed the same thing, it was inevitable that chiropractors would become members

of the back therapy community. Other members of this therapeutic community are osteopaths, physiatrists (specialists in physical medicine and rehabilitation), orthopedists, neurologists, neurosurgeons, physical therapists, acupuncturists, kinesiologists and a host of others who use special regimens of exercise or massage. What they have in common is the idea that the spine and/or its surrounding musculature is deficient, easily injured and in need of some kind of physical intervention. Surgery is the most drastic and one of the most common.

Because some sort of structurally induced inflammation, *whose nature has never been elucidated*, is said to be responsible for much of the pain, large numbers of nonsteroidal and steroidal medications are prescribed.

In view of the many diagnostic and therapeutic programs now used in the management of these pain syndromes, any significant disruption in the application of existing therapies would create financial havoc, for the diagnosis and treatment of chronic pain is now a gigantic industry in the United States. But accurate diagnosis and treatment would save enormous amounts of money.

In the early 1970s, in the midst of this burgeoning epidemic, I began to doubt the validity of the conventional diagnoses, and therefore treatment, of the syndromes of neck, shoulder and back pain. A closer look had suggested that back muscles, from the back of the head to the buttocks, were the primary tissues involved. This confirmed the work of all those through the years who described what they called fibromyalgia, fibrositis or myofascial pain. My study of the literature and growing experience with patients suggested that those maladies were part of a pain disorder I call the Tension Myositis Syndrome (TMS). (*Myositis* means physiologic alteration of muscles.) TMS is a painful but harmless change of state in muscles.

But what of the neurological signs and symptoms in the legs and arms? For a while I thought they must be caused by structural compression in the spine or that mysterious "inflammation" so often cited by other practitioners. As the number of inconsistencies mounted, however, I was forced to the conclusion that the process causing the muscle pain was responsible for the nerve symptoms as well. But what was that process?

When physicians take a patient's history they routinely inquire about past or current medical disorders or symptoms. I found that 88 percent of my pain patients had a history of minor gastrointestinal maladies such as heartburn, pre-ulcer symptoms, hiatus hernia, colitis, spastic colon, irritable bowel syndrome and other tension-induced reactions like tension headache, migraine headache, eczema and frequent urination. Although not all practitioners agree that these disorders are related to psychological or emotional phenomena, my clinical experience as a family physician and my own personal medical history made me quite comfortable with that conclusion. For example, for a number of years I had experienced regular migraine headaches, complete with typical visual "lights" prior to the onset of headache. Someone suggested that repressed anger might be the basis for them. The next time I had the "lights"—harbinger of a headache—I sat down and tried to think of what anger I might be repressing. I failed to find an answer, *but for the first time in my life I didn't get a headache.* It was powerful evidence that migraine headache was caused by emotional phenomena.

It was, therefore, logical to hypothesize that these back muscle pains might fall into the same group of emotionally induced physical disorders. When I put the idea to the test, by telling patients that I thought their pain was the result of "tension," I was astonished to observe that those who accepted the diagnosis got better. Those who rejected it remained unchanged.

In those early days all my patients had physical therapy administered by therapists whom I had briefed to inform patients that the therapy was designed to provide temporary relief from symptoms, but that real recovery depended on recognizing the nature of the process. Those who improved agreed with the diagnosis. This was similar to my experience with migraine: Acknowledgment of an emotional role in the genesis of symptoms somehow banished those symptoms. Many years would pass before I understood the reason for this fascinating, mysterious phenomenon.

At the time, telling patients that I thought their pain was caused by "tension" was difficult. Any physician would scoff at this idea; the average person would be insulted if you suggested that some physical symptom was "in the head." That was a phrase I avoided assiduously because of its pejorative connotation, although the patient often introduced it. Sometimes I was able to explain the connection between tension and pain satisfactorily, but I was quite handicapped because of my own poor understanding of the psychodynamics involved. Instead I talked about certain personality characteristics that appeared to be common in people with TMS and how these characteristics might lead to tension and anxiety. I suggested that the symptoms were a physical rather than emotional expression of anxiety and that people who were hardworking, conscientious, responsible, compulsive and perfectionistic were prone to TMS. I could not provide a clinical definition of the word *tension* but it was a word with which people could identify. *Psychological* and *emotional* were bad words that implied there was something strange about you; I avoided the word *psychosomatic* because to most people it meant the pain was phony or imaginary. Nevertheless, I continued to make the diagnosis, and my rate of suc-

cess in treatment began to rise substantially. I now felt I understood the nature of the disorder and could predict with some accuracy who would get better and who wouldn't.

On physical examination almost every patient was found to have tenderness on palpation of (pressing on) certain muscles regardless of where in the neck or back they felt pain. For example, someone might have pain only in the right lower back but on examination felt pain when I pressed on the top of both shoulders (upper trapezius muscles), the small of the back on both sides (lumbar paraspinal muscles), and the outer part of both buttocks (gluteal muscles). This consistent finding strongly suggested that the syndrome originated in the central nervous system (brain) rather than in a local structural abnormality.

By the mid-1970s I had concluded that the majority of neck, shoulder and back pain syndromes, along with the associated pain often seen in the legs and arms, was the result of a psychologically induced process, which made it a classical psychosomatic condition. That is, emotional factors were setting off a reaction in certain tissues in the body that resulted in pain and other neurologic symptoms.

What was the nature of this reaction? The physical therapy treatment consisted of deep heat (delivered as high-frequency sound waves), deep massage and active exercise of the involved muscles. Most patients reported at least temporary relief. Since I knew that these treatment modalities increased the local circulation of blood, it was logical to conclude that the cause of the symptoms was a reduction in blood flow to the involved tissues. The circulation of blood is under the control of a subsystem of the central nervous system known as the autonomic nervous system. Many of the other mindbody disorders (peptic ulcer, colitis, migraine and tension headache) are also mediated through the autonomic system. Nothing could be simpler: Something in the brain

decides to initiate this process; autonomic centers are activated, and within milliseconds the circulation to the involved areas is reduced. This means that these tissues are now deprived of their full complement of oxygen, which is almost certainly the reason for the symptoms. This correlated with the finding of two German investigators in 1975 that there was evidence of mild oxygen deprivation in the nuclei of muscle cells of patients with back pain, as well as with studies reported in the medical literature by a team of Swedish rheumatologists in the 1980s.

Since it provided a logical explanation for the symptoms, I proceeded on the premise that oxygen deprivation causes pain. Further, even if the cause of the pain should prove to be some other brain-induced process, it was still apparent that definitive treatment had to be directed at the brain, not the local tissues.

I told my patients there was really nothing wrong with their backs. I explained that they had a harmless condition that must be treated through the mind, not the body. Awareness, insight, knowledge and information were the magic medicines that would cure this disorder—and nothing else could do it.

In 1979 I instituted the practice of bringing patients together and lecturing them on the physical and psychological details of TMS. The logic was clear: If information was the cure, I ought to be doing a better job of providing it. These lectures now represent the cornerstone of the therapeutic program and appear to be all that is necessary for 80 to 90 percent of those who go on to complete recovery.

My view of the problem in the early 1980s is best illustrated by a letter I wrote to *New York Times* columnist Russell Baker, whose August 16, 1981, column was titled "Where Have All the Ulcers Gone?" Since I suspected it would be of

interest to him, on September 23, 1981, I sent the following letter:

Dear Mr. Baker:

Because you are a well-informed man, I thought you would be interested in knowing the real reason for the decline in the incidence of ulcers, about which you wrote awhile back. Gastric and duodenal ulcers are members of a family of physical disorders which, as you correctly reported, reflect the presence of large quantities of tension. Other members of this villainous family are colitis, spastic colon, tension headache and garden variety allergies, to name some of the most prominent. There is another one, however, which has escaped the notice of the medical community, or rather survived in the guise of being something else, and it is a very important one for it has assumed the role of the previously ubiquitous ulcer. Why this switch should have occurred is a very interesting story, to which I shall return in a moment. This other disorder is none other than the common backache (or neck or shoulder ache). For years it has been assumed that back pain is due to some deficiency of the spine and related structures, but this is merely a diagnostic smoke screen which has successfully obfuscated doctors and other practitioners. In fact, back pain is due to hyperactivity in that same branch of the nervous system which causes ulcers, the stimulus for which is the same old bugaboo, tension.

I am very serious in this assertion and have published my views in the medical literature. However, a certain degree of light-heartedness is appropriate since even the most painful and disabling of these is still reflective of a very benign process—much more so than ulcers which can bleed or perforate and become rather messy. All of

these disorders are members of the same family and represent variants of a similar underlying process, i.e., tension producing physical manifestations, the definition of a psychosomatic disorder. Heart attacks are manifestations of a more serious kind of psychosomatic process and not equatable with peptic ulcer.

Now to the question of why the switch. This is not comprehensible unless one realizes that the purpose of a physical manifestation of tension is to deceive. Our brains have decided that *feeling tense*, which is the appropriate response to *being tense*, is too unpleasant to bear and is not as socially acceptable as having something "physically" wrong. And so the brain makes a few adjustments in circuitry and instead of looking and acting like a nervous wreck, presto—a bellyache or a backache. The reason why the ulcer had to go was that everybody began to realize that it was a phony, that it really meant tension, and that's not socially acceptable.

The old backache has always been what it is now, a tension equivalent, but nobody paid much attention to it until the advent of modern medicine. Here, said the brain, is a natural. Everybody thinks backaches are the last word in a "physical" disorder and so it's a perfect substitute for tension. The ulcer has lost its value—up the backache as the new but thoroughly hidden standard bearer for the army of the tense.

And so it is that practically everyone you talk to has a backache story to tell. The incidence of all kinds of pain syndromes involving the backside of western *Homo sapiens* has risen dramatically in the last twenty years or so, while the discredited ulcer is fading into obscurity.

Isn't that a fascinating story?

A few days later I received the following note, reprinted with Mr. Baker's kind permission:

> Dear Dr. Sarno:
>
> That's a fascinating story indeed and casts some light on my own "backache." This affliction comes over me after four or five hours at the typewriter when I am performing, as it were, for an audience. It is often particularly bad when I am aware the writing is going badly.
>
> Last week I had occasion to help my son move and warned him that I'd probably have to drop out after a few hours on account of my back. The moving, in fact, was rather enjoyable, at least in the sense that it was mindless labor, fetching, lifting and hauling, performed in a pleasant rustic atmosphere with my mind thoroughly relaxed. After a ten-hour day at it, I remembered my back for the first time since morning, and then only to remark that it hadn't bothered me all day.
>
> Yrs,
> Russell Baker

In 1981, I believed that physical manifestations were a substitute for anxiety. Later, a change in concept led me to a much better understanding of the problem and, accordingly, greater effectiveness in treating it. The subtle but important shift was that unconscious emotional phenomena *necessitated* physical symptoms.

And, of course, ulcers have not faded into obscurity; they are now being attributed to the presence of a bacterium in the stomach. It is my opinion that they are still stress-induced and that the bacterium is merely part of the process. They are not as common as they used to be and do not occur as frequently as the pain disorders.

In 1982 I conducted the first follow-up survey of my patients. One hundred and seventy-seven patients whose charts were drawn randomly from those who had been treated between 1978 and 1981 were interviewed about their level of pain and their functional ability. Seventy-six percent were leading normal lives and were essentially free of pain. Fourteen patients were somewhat improved and twenty-eight (16 percent) were considered treatment failures.

Two important facts about this group of patients should be noted: Before coming to see me most of them had long histories of back pain and had received multiple treatments, including surgery for some, yet they still continued to have severe symptoms; also, I had not screened any of them before they made an appointment. Since 1987 I have interviewed patients calling for an appointment to determine whether they are appropriate for our program. Most of the large population of people with these pain syndromes reject the idea of an emotionally induced process and would, therefore, derive no benefit from our therapeutic program, since acceptance of the diagnosis is essential to a successful outcome. Currently I accept about 50 percent of those who call. When I am criticized for this selectivity I remind my critics that, like a surgeon who will not operate on a poor surgical risk, I am exercising my prerogative to work only with patients who have a reasonable chance for success. This selectivity is not only to my advantage; it spares the potential patient unnecessary expense and aggravation.

Despite this lack of selectivity prior to 1987, a second follow-up survey in 1987 revealed an increase in the effectiveness of the program since 1982. This time we made it more difficult for ourselves and limited the population surveyed to people with CT-scanned documented herniated discs. This abnormality is responsible for most back surgery, yet our experience shows that it is rarely responsible for the pain. One hundred and nine of these randomly selected pa-

tients were interviewed. One to three years after treatment, ninety-six (88 percent) were free of pain and leading normal lives, eleven people were somewhat better and only two were unchanged—a considerable improvement over the 1982 survey.

What was responsible for this significant improvement in our results? I had become more proficient at teaching the nature of TMS and was, therefore, more successful in stimulating confidence in the diagnosis; moreover, in 1985 I discontinued prescribing physical therapy. Although all the therapists were fully aware of the nature of the process they were treating and faithfully reinforced the concept that psychological and not physical factors were responsible for the pain, it became apparent that some patients would focus on the physical treatments, pay lip service to the ideas I was teaching, and have a placebo cure, if any (*placebo cure*—a cure based on blind faith and usually temporary). More subtly, by requiring physical treatment two or three times a week, we were focusing patients' attention on their bodies, whereas success in treatment depended on shifting concern from the physical to the emotional. The possible benefit of the physical therapy was heavily outweighed by its negative potential. I believe this played an important role in the improved statistics.

Although a third follow-up survey has not been done, I believe that our results are now even better than they were in 1987. I attribute this to the selectivity process as well as to a major leap in my understanding of the psychology of TMS.

While I was collaborating on a medical paper with a psychoanalyst colleague, Stanley Coen, he suggested that the physical symptoms were probably not a physical expression of anxiety, which had been my working hypothesis for many years, but were the result of what psychoanalysts call a defense mechanism, a term I find somewhat misleading in view

of what it does. The purpose of a defense mechanism (in this case physical symptoms) is to divert people's attention to the body, so that they can *avoid* the awareness of or confrontation with certain unconscious (repressed) feelings. This new understanding of the role of repression was a major landmark in the journey upon which I had embarked roughly fifteen years before. Not only did this idea fit perfectly with the diagnosis, but for the first time I had an explanation of why people got better when they learned about and accepted what was going on. Now it was clear why someone in Peoria, Illinois, might read either of my books on TMS and make a complete recovery without ever having talked to or been examined by me. The mystery was solved. Once accepted by the patient, the knowledge of what was going on destroyed the brain's strategy. Although we had always known that TMS was a brain-induced process, we didn't know why the brain was doing it. Now it was clear that the symptoms were meant to draw the person's attention away from hidden emotions, and that by exposing the undercover operation and thereby ending it, the pain would disappear, as indeed it did.

While these ideas on the mindbody link represent the culmination of a twenty-four-year-long clinical experience, they are, in fact, the starting point for the body of this book. Though they developed out of my experience with the diagnosis and treatment of pain, I believe they have relevance to many medical conditions. Indeed, I believe that everyone has mindbody physical symptoms. Few people, if any, go through life without one or more such manifestations, for they reflect the evolutionary contemporary organization of the human psyche. Most importantly, these manifestations demonstrate that there is no separation between mind and body; that the two are inextricably intertwined. One cannot study the pathology of human disease without factoring in the role of the psyche. My experience with the common pain

syndromes has demonstrated the folly of neglecting the emotional component of human illness. In some cases the emotions will play a participatory role; in others they are primary. To neglect this dimension of illness pathology is as great an omission as to ignore the role of microorganisms in human illness.

What emotions could be so terrible as to induce the brain to subject someone to severe physical pain and frightening neurological symptoms? The answer to this question is basic not only to the understanding of these pain syndromes but to the whole range of psychosomatic disorders.

Conflicts rage constantly in the unconscious, born of the various elements that represent the mosaic of the human psyche. These conflicts result in the development of emotions that cannot be tolerated and, therefore, must be repressed. Because these undesirable feelings appear to strive for recognition, the mind must do something to prevent them from coming to consciousness. Hence, the mindbody symptom. This book explores the nature and content of these undesirable feelings and explains why the mind chooses to mask emotional turmoil with physical pain.

The Mindbody Prescription