

Contribution of John E. Sarno, M. D., Professor of Rehabilitation Medicine, New York University School of Medicine for presentation at the Senate hearing entitled "Pain in America: Exploring Challenges to Relief." February 14, 2012

Pain syndromes can be broadly grouped into two categories: Those resulting from injury, surgery, or associated with severe infection, as seen in patients in an acute hospital setting, and those with pain in the back, neck, shoulders and limbs of a psychophysical origin. The high incidence of the latter group has evolved into a public health problem of great magnitude over the past forty years. It has been estimated that 80 percent of the population have a history of one of these painful conditions which has led to the performance of a great deal of unnecessary surgery and the widespread use of pain medication.

Contemporary medicine does not recognize the psychological basis for a segment of these common pain syndromes. The biases that common pain must be the result of structural abnormalities of the spine, or chemical or mechanically induced deficiencies of muscle, coupled with the belief that emotions do not induce physiological change, have contributed to the exponential increase in the incidence of these now common pain disorders.

I first became aware of the high incidence of pain involving the back, neck, shoulders, buttocks, and limbs when I joined the staff of the Rusk Institute of Rehabilitation Medicine, as Director of Outpatient Services in 1965. Conventional medical training had taught me that these pains were primarily due to a variety of structural abnormalities of the spine most commonly arthritic and disc disorders, or to a vague group of muscle conditions attributed to poor posture, underexercise, overexertion and the like. Pain in the legs or arms was presumed due to compression

(pinching of nerves). However, it was not at all clear how these abnormalities actually produced the pain.

The experience of treating these patients was frustrating and depressing; one could never predict the outcome. Further, it was troubling to realize that the pattern of pain and physical examination findings often did not correlate with the presumed reason for the pain. For example, pain might be attributed to degenerative arthritic changes at the lower end of the spine but the patient might have pain in places that had nothing to do with the bones in that area. Or someone might have a lumbar disc that was herniated to the left and have pain in the right leg.

Along with doubt about the accuracy of conventional diagnoses there came the realization that the primary tissues involved were nerve and muscle, specifically of the neck, shoulders, back and buttocks. But even more important was the observation that 88 percent of the people seen had histories of such things as tension or migraine headache, heartburn, hiatus hernia, stomach ulcer, colitis, spastic colon, irritable bowel syndrome, hay fever, asthma, eczema and a variety of other disorders, all of which were strongly suspected by physicians of being emotionally based. This pain syndrome is referred to as the Tension Myoneural Syndrome (TMS).

When that theory was put to the test and patients were treated accordingly, there was an improvement in treatment results. In fact, it was then possible to predict with some accuracy which patients would do well and which would probably fail. Simple awareness of the diagnosis can be therapeutic and eliminate pain. On occasion it is necessary for the patient to work with a psychologist to get at the psychological root of the problem. Although back pain may disappear spontaneously, in many patients it becomes a lifelong problem.

What are the emotions that stimulate the psychological reaction? They are legion. Everyday life pressures are obvious. Not so obvious, but of greater importance, are the self-imposed pressures of the need to be perfect and good, stimulated by the predominant culture of our time.

There is no logic to the traditional physical treatment. Instead, experience has shown that the only successful and permanent way to treat the problem is by teaching patients to understand what they have. The notion of treating the “whole person” was not new to my thinking since I was specialized in physical medicine and rehabilitation where this concept is fundamental.

Though the cause of this common pain disorder is emotional, the diagnosis must be made on physical rather than psychological grounds, in the tradition of clinical medicine. Psychologists may suspect that patients’ symptoms are psychologically induced but, not trained in physical diagnosis, cannot say with certainty that they have TMS. A physician, because he recognizes both physical and psychological dimensions of the condition, must make the diagnosis. It goes without saying that pain syndromes must always be properly studied to rule out serious disorders such as cancer, tumors, bone disease and many other conditions. The presence of persistent pain anywhere requires comprehensive examination and tests. Though TMS is the result of an emotional phenomenon, it is a physical disorder. It is not “in the patient’s head.”

Judging by the reactions of doctors in my immediate environment, most either ignore or reject the diagnosis. A few physicians in my own specialty say that they see the validity of the diagnosis but find it difficult to treat such patients. One hopes that the younger generation of physicians will be more open to this diagnosis.

There is a need to raise consciousness both inside and outside the field of medicine to help change people’s perception of the cause of the common pain syndromes which represent a major public health problem. Science requires that all new ideas be validated by experience and replication. It is essential that these ideas be subjected to research study in the future.