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GABOR MATÉ, M.D.

When the
BODY
SAYS NO

The Cost of
HIDDEN
STRESS

Vermilion
LONDON

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A Note to the Reader

PEOPLE HAVE ALWAYS UNDERSTOOD INTUITIVELY that mind and body are not separable. Modernity has brought with it an unfortunate dissociation, a split between what we know with our whole being and what our thinking mind accepts as truth. Of these two kinds of knowledge the latter, narrower, kind most often wins out, to our loss.

It is a pleasure and a privilege, therefore, to bring in front of the reader the findings of modern science that reaffirm the intuitions of age-old wisdom. That was my primary goal in writing this book. My other purpose was to hold up a mirror to our stress-driven society so that we may recognize how, in myriad unconscious ways, we help generate the illnesses that plague us.

This is not a book of prescriptions, but I do hope it will serve its readers as a catalyst for personal transformation. Prescriptions come from the outside, transformation occurs within. There are many books of simple prescriptions of one sort or another—physical, emotional, spiritual—that appear each year. It was not my intention to write yet one more. Prescriptions assume that something needs to be fixed; transformation brings forth the healing—the coming to integrity, to wholeness—of what is already there. While advice and prescriptions may be useful, even more valuable to us is insight into ourselves and the workings of our minds and bodies. Insight, when inspired by the quest for truth, can promote transformation. For those seeking a healing message here, that message begins on page one with the very first case study. As the great physiologist Walter Cannon suggested, there is

a wisdom in our bodies. I hope *When the Body Says No* will help people align with the inner wisdom we all possess.

Some of the case examples in this book are derived from published biographies or autobiographies of well-known persons. The majority are taken from my clinical experience or from taped discussions with people who agreed to be interviewed and quoted regarding their medical and personal histories. For privacy reasons, names (and, in some instances, other circumstances) have been changed.

To avoid making this work prohibitively academic for the lay reader, notes have been used only sparingly. References are provided for each chapter at the end of the book.

Italics, unless otherwise noted, are mine.

I welcome comments at my e-mail address: gmate@telus.net.

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The Bermuda Triangle

MARY WAS A NATIVE WOMAN in her early forties, slight of stature, gentle and deferential in manner. She had been my patient for eight years, along with her husband and three children. There was a shyness in her smile, a touch of self-deprecation. She laughed easily. When her ever-youthful face brightened, it was impossible not to respond in kind. My heart still warms—and constricts with sorrow—when I think of Mary.

Mary and I had never talked much until the illness that was to take her life gave its first signals. The beginning seemed innocent enough: a sewing-needle puncture wound on a fingertip failed over several months to heal. The problem was traced to Raynaud's phenomenon, in which the small arteries supplying the fingers are narrowed, depriving the tissues of oxygen. Gangrene can set in, and unfortunately this was the case for Mary. Despite several hospitalizations and surgical procedures, she was within a year begging for an amputation to rid her of the throbbing ache in her finger. By the time she got her wish the disease was rampant, and powerful narcotics were inadequate in the face of her constant pain.

Raynaud's can occur independently or in the wake of other disorders. Smokers are at greater risk, and Mary had been a heavy smoker since her teenage years. I hoped that if she quit, normal blood flow might return to her fingers. After many relapses she finally succeeded. Unfortunately, the Raynaud's proved to be the harbinger of something far worse: Mary was diagnosed with scleroderma, one of the autoimmune diseases, which include rheumatoid arthritis, ulcerative colitis, systemic lupus erythematosus (SLE) and many other conditions

that are not always recognized to be autoimmune in origin, such as diabetes, multiple sclerosis and possibly even Alzheimer's disease. Common to them all is an attack by one's own immune system against the body, causing damage to joints, connective tissue or to almost any organ, whether it be the eyes, the nerves, the skin, the intestines, the liver or the brain. In scleroderma (from the Greek word meaning "hardened skin"), the immune system's suicidal assault results in a stiffening of the skin, esophagus, heart and tissues in the lungs and elsewhere.

What creates this civil war inside the body?

Medical textbooks take an exclusively biological view. In a few isolated cases, toxins are mentioned as causative factors, but for the most part a genetic predisposition is assumed to be largely responsible. Medical practice reflects this narrowly physical mindset. Neither the specialists nor I as her family doctor had ever thought to consider what in Mary's particular experiences might also have contributed to her illness. None of us expressed curiosity about her psychological state before the onset of the disease, or how this influenced its course and final outcome. We simply treated each of her physical symptoms as they presented themselves: medications for inflammation and pain, operations to remove gangrenous tissue and to improve blood supply, physiotherapy to restore mobility.

One day, almost on a whim, in response to a whisper of intuition that she needed to be heard, I invited Mary to make an hour-long appointment so that she would have the opportunity to tell me something about herself and her life. When she began to talk, it was a revelation. Beneath her meek and diffident manner was a vast store of repressed emotion. Mary had been abused as a child, abandoned and shuttled from one foster home to another. She recalled huddling in the attic at the age of seven, cradling her younger sisters in her arms, while her drunken foster parents fought and yelled below. "I was so scared all the time," she said, "but as a seven-year-old I had to protect my sisters. And no one protected me." She had never revealed these traumas before, not even to her husband of twenty years. She had learned not to express her feelings about anything to anyone, including herself. To be self-expressive, vulnerable and questioning in her childhood would have put her at risk. Her security lay in considering other people's feelings, never

her own. She was trapped in the role forced on her as a child, unaware that she herself had the right to be taken care of, to be listened to, to be thought worthy of attention.

Mary described herself as being incapable of saying no, compulsively taking responsibility for the needs of others. Her major concern continued to be her husband and her nearly adult children, even as her illness became more grave. Was the scleroderma her body's way of finally rejecting this all-encompassing dutifulness?

Perhaps her body was doing what her mind could not: throwing off the relentless expectation that had been first imposed on the child and now was self-imposed in the adult—placing others above herself. I suggested as much when I wrote about Mary in my very first article as medical columnist for *The Globe and Mail* in 1993. "When we have been prevented from learning how to say no," I wrote, "our bodies may end up saying it for us." I cited some of the medical literature discussing the negative effects of stress on the immune system.

The idea that people's emotional coping style can be a factor in scleroderma or other chronic conditions is anathema to some physicians. A rheumatic diseases specialist at a major Canadian hospital submitted a scathing letter to the editor denouncing both my article and the newspaper for printing it. I was inexperienced, she charged, and had done no research.

That a specialist would dismiss the link between body and mind was not astonishing. Dualism—cleaving into two that which is one—colours all our beliefs on health and illness. We attempt to understand the body in isolation from the mind. We want to describe human beings—healthy or otherwise—as though they function in isolation from the environment in which they develop, live, work, play, love and die. These are the built-in, hidden biases of the medical orthodoxy that most physicians absorb during their training and carry into their practice.

Unlike many other disciplines, medicine has yet to assimilate an important lesson of Einstein's theory of relativity: that the position of an observer will influence the phenomenon being observed and affect the results of the observation. The unexamined assumptions of the scientist both determine and limit what he or she will discover, as the pioneering Czech-Canadian stress researcher Hans Selye pointed out. "Most people do not fully realize to what extent the spirit of scientific

research and the lessons learned from it depend upon the personal viewpoints of the discoverers," he wrote in *The Stress of Life*. "In an age so largely dependent upon science and scientists, this fundamental point deserves special attention." In that honest and self-revealing assessment Selye, himself a physician, expressed a truth that even now, a quarter century later, few people grasp.

The more specialized doctors become, the more they know about a body part or organ and the less they tend to understand the human being in whom that part or organ resides. The people I interviewed for this book reported nearly unanimously that neither their specialists nor their family doctors had ever invited them to explore the personal, subjective content of their lives. If anything, they felt that such a dialogue was discouraged in most of their contacts with the medical profession. In talking with my specialist colleagues about these very same patients, I found that even after many years of treating a person, a doctor could remain quite in the dark about the patient's life and experience outside the narrow boundaries of illness.

In this volume I set out to write about the effects of stress on health, particularly of the hidden stresses we all generate from our early programming, a pattern so deep and so subtle that it feels like a part of our real selves. Although I have presented as much of the available scientific evidence as seemed reasonable in a work for the lay public, the heart of the book—for me, at least—is formed by the individual histories I have been able to share with the readers. It so happens that those histories will also be seen as the least persuasive to those who regard such evidence as "anecdotal."

Only an intellectual Luddite would deny the enormous benefits that have accrued to humankind from the scrupulous application of scientific methods. But not all essential information can be confirmed in the laboratory or by statistical analysis. Not all aspects of illness can be reduced to facts verified by double-blind studies and by the strictest scientific techniques. "Medicine tells us as much about the meaningful performance of healing, suffering and dying as chemical analysis tells us about the aesthetic value of pottery," Ivan Ilyich wrote in *Limits to Medicine*. We confine ourselves to a narrow realm indeed if we exclude from accepted knowledge the contributions of human experience and insight.

We have lost something. In 1892 the Canadian William Osler, one of the greatest physicians of all time, suspected rheumatoid arthritis—a condition related to scleroderma—to be a stress-related disorder. Today rheumatology all but ignores that wisdom, despite the supporting scientific evidence accumulated in the 110 years since Osler first published his text. That is where the narrow scientific approach has brought the practice of medicine. In elevating modern science to be the final arbiter of our sufferings, we have been too eager to discard the insights of previous ages.

As the American psychologist Ross Buck has pointed out, until the advent of modern medical technology and of scientific pharmacology, physicians traditionally had to rely on "placebo" effects. They had to inspire in each patient a confidence in his, the patient's, inner ability to heal. To be effective, a doctor had to listen to the patient, to develop a relationship with him, and he had also to trust his own intuitions. Those are the qualities doctors seem to have lost as we have come to rely almost exclusively on "objective" measures, technology-based diagnostic methods and "scientific" cures.

Thus the rebuke from the rheumatologist was not a surprise. More of a jolt was another letter to the editor, a few days later—this time a supportive one—from Noel B. Hershfield, clinical professor of medicine at the University of Calgary: "The new discipline of psychoneuroimmunology has now matured to the point where there is compelling evidence, advanced by scientists from many fields, that an intimate relationship exists between the brain and the immune system. . . . An individual's emotional makeup, and the response to continued stress, may indeed be causative in the many diseases that medicine treats but whose [origin] is not yet known—diseases such as scleroderma, and the vast majority of rheumatic disorders, the inflammatory bowel disorders, diabetes, multiple sclerosis, and legions of other conditions which are represented in each medical subspecialty. . . ."

The surprising revelation in this letter was the existence of a new field of medicine. What is *psychoneuroimmunology*? As I learned, it is no less than the science of the interactions of mind and body, the indissoluble unity of emotions and physiology in human development and throughout life in health and illness. That dauntingly complicated word means simply that this discipline studies the ways that the psyche—the

mind and its content of emotions—profoundly interacts with the body's nervous system and how both of them, in turn, form an essential link with our immune defences. Some have called this new field *psychoneuroimmunoendocrinology* to indicate that the endocrine, or hormonal, apparatus is also a part of our system of whole-body response. Innovative research is uncovering just how these links function all the way down to the cellular level. We are discovering the scientific basis of what we have known before and have forgotten, to our great loss.

Many doctors over the centuries came to understand that emotions are deeply implicated in the causation of illness or in the restoration of health. They did research, wrote books and challenged the reigning medical ideology, but repeatedly their ideas, explorations and insights vanished in a sort of medical Bermuda Triangle. The understanding of the mind-body connection achieved by previous generations of doctors and scientists disappeared without a trace, as if it had never seen daylight.

A 1985 editorial in the august *New England Journal of Medicine* could declare with magisterial self-assurance that “it is time to acknowledge that our belief in disease as a direct reflection of mental state is largely folklore.”²

Such dismissals are no longer tenable. Psychoneuroimmunology, the new science Dr. Hershfield mentioned in his letter to the *The Globe and Mail*, has come into its own, even if its insights have yet to penetrate the world of medical practice.

A cursory visit to medical libraries or to online sites is enough to show the advancing tide of research papers, journal articles and textbooks discussing the new knowledge. Information has filtered down to many people in popular books and magazines. The lay public, ahead of the professionals in many ways and less shackled to old orthodoxies, finds it less threatening to accept that we cannot be divided up so easily and that the whole wondrous human organism is more than simply the sum of its parts.

Our immune system does not exist in isolation from daily experience. For example, the immune defences that normally function in healthy young people have been shown to be suppressed in medical students under the pressure of final examinations. Of even greater implication for their future health and well-being, the loneliest students suffered the greatest negative impact on their immune systems. Loneliness has been

similarly associated with diminished immune activity in a group of psychiatric inpatients. Even if no further research evidence existed—though there is plenty—one would have to consider the long-term effects of chronic stress. The pressure of examinations is obvious and short term, but many people unwittingly spend their entire lives as if under the gaze of a powerful and judgmental examiner whom they must please at all costs. Many of us live, if not alone, then in emotionally inadequate relationships that do not recognize or honour our deepest needs. Isolation and stress affect many who may believe their lives are quite satisfactory.

How may stress be transmuted into illness? Stress is a complicated cascade of physical and biochemical responses to powerful emotional stimuli. Physiologically, emotions are themselves electrical, chemical and hormonal discharges of the human nervous system. Emotions influence—and are influenced by—the functioning of our major organs, the integrity of our immune defences and the workings of the many circulating biological substances that help govern the body's physical states. When emotions are repressed, as Mary had to do in her childhood search for security, this inhibition disarms the body's defences against illness. Repression—dissociating emotions from awareness and relegating them to the unconscious realm—disorganizes and confuses our physiological defences so that in some people these defences go awry, becoming the destroyers of health rather than its protectors.

During the seven years I was medical coordinator of the Palliative Care Unit at Vancouver Hospital, I saw many patients with chronic illness whose emotional histories resembled Mary's. Similar dynamics and ways of coping were present in the people who came to us for palliation with cancers or degenerative neurological processes like amyotrophic lateral sclerosis (ALS, also known in North America as Lou Gehrig's disease, after the great American baseball player who succumbed to it, and in Britain as motor neuron disease.) In my private family practice, I observed these same patterns in people I treated for multiple sclerosis, inflammatory ailments of the bowel such as ulcerative colitis and Crohn's disease, chronic fatigue syndrome, autoimmune disorders, fibromyalgia, migraine, skin disorders, endometriosis and many other conditions. In important areas of their lives, almost none of my patients with serious disease had ever learned to say no. If some people's

personalities and circumstances appeared very different from Mary's on the surface, the underlying emotional repression was an ever-present factor.

One of the terminally ill patients under my care was a middle-aged man, chief executive of a company that marketed shark cartilage as a treatment for cancer. By the time he was admitted to our unit, his own recently diagnosed cancer had spread throughout his body. He continued to eat shark cartilage almost to the day of his death, but not because he any longer believed in its value. It smelled foul—the offensive stench was noticeable even some distance away—and I could only imagine what it tasted like. “I hate it,” he told me, “but my business partner would be so disappointed if I stopped.” I convinced him that he had every right to live his last days without feeling responsible for someone else's disappointment.

It is a sensitive matter to raise the possibility that the way people have been conditioned to live their lives may contribute to their illness. The connections between behaviour and subsequent disease are obvious in the case of, say, smoking and lung cancer—except perhaps to tobacco-industry executives. But such links are harder to prove when it comes to emotions and the emergence of multiple sclerosis or cancer of the breast or arthritis. In addition to being stricken with disease, the patient feels blamed for being the very person she is. “Why are you writing this book?” said a fifty-two-year-old university professor who has been treated for breast cancer. In a voice edged with anger she told me, “I got cancer because of my genes, not because of anything I did.”

“The view of sickness and death as a personal failure is a particularly unfortunate form of blaming the victim,” charged the 1985 editorial in the *New England Journal of Medicine*. “At a time when patients are already burdened by disease, they should not be further burdened by having to accept responsibility for the outcome.”

We will return to this vexing question of assumed blame. Here I will only remark that blame and failure are not the issue. Such terms only cloud the picture. As we shall see, blaming the sufferer—apart from being morally obtuse—is completely unfounded from a scientific point of view.

The *NEJM* editorial confused blame and responsibility. While all of us dread being *blamed*, we all would wish to be more *responsible*—that is, to have the ability to *respond* with awareness to the circumstances of our

lives rather than just reacting. We want to be the authoritative person in our own lives: in charge, able to make the authentic decisions that affect us. There is no true responsibility without awareness. One of the weaknesses of the Western medical approach is that we have made the physician the only authority, with the patient too often a mere recipient of the treatment or cure. People are deprived of the opportunity to become truly responsible. None of us are to be blamed if we succumb to illness and death. Any one of us might succumb at any time, but the more we can learn about ourselves, the less prone we are to become passive victims.

Mind and body links have to be seen not only for our understanding of illness but also for our understanding of health. Dr. Robert Maunder, on the psychiatric faculty of the University of Toronto, has written about the mind-body interface in disease. “Trying to identify and to answer the question of stress,” he said to me in an interview, “is more likely to lead to health than ignoring the question.” In healing, every bit of information, every piece of the truth, may be crucial. If a link exists between emotions and physiology, *not* to inform people of it will deprive them of a powerful tool.

And here we confront the inadequacy of language. Even to speak about links between mind and body is to imply that two discrete entities are somehow connected to each other. Yet in life there is no such separation; there is no body that is not mind, no mind that is not body. The word *mindbody* has been suggested to convey the real state of things.

Not even in the West is mind-body thinking completely new. In one of Plato's dialogues, Socrates quotes a Thracian doctor's criticism of his Greek colleagues: “This is the reason why the cure of so many diseases is unknown to the physicians of Hellas; they are ignorant of the whole. For this is the great error of our day in the treatment of the human body, that physicians separate the mind from the body.” You cannot split mind from body, said Socrates—nearly two and a half millennia before the advent of psychoneuroimmunoendocrinology!

Writing *When the Body Says No* has done more than simply confirm some of the insights I first articulated in my article about Mary's scleroderma. I have learned a great deal and have come to appreciate deeply the work of hundreds of physicians, scientists, psychologists and researchers who have charted the previously unmapped terrain of

mind-body. Work on this book has also been an inner exploration of the ways I have repressed my own emotions. I was prompted to make this personal journey in response to a question from a counsellor at the British Columbia Cancer Agency, where I had gone to investigate the role of emotional repression in cancer. In many people with malignancy, there seemed to be an automatic denial of psychic or physical pain and of uncomfortable emotions like anger, sadness or rejection. "Just what is your personal connection to the issue?" the counsellor asked me. "What draws you to this particular topic?"

The question brought to mind an incident from seven years ago. One evening I arrived to see my seventy-six-year-old mother at the nursing home where she was a resident. She had progressive muscular dystrophy, an inherited muscle-wasting disease that runs in our family. Unable to even sit up without assistance, she could no longer live at home. Her three sons and their families visited her regularly until her death, which occurred just as I began to write this book.

I had a slight limp as I walked down the nursing home corridor. That morning I had undergone surgery for a torn cartilage in my knee, a consequence of ignoring what my body had been telling me in the language of pain that occurred each time I jogged on cement. As I opened the door to my mother's room, I automatically walked with a nonchalant, normal gait to her bed to greet her. The impulse to hide the limp was not conscious, and the act was done before I was aware of it. Only later did I wonder what exactly had prompted such an unnecessary measure—unnecessary because my mother would have calmly accepted that her fifty-one-year-old son would have a gimpy knee twelve hours post-surgery.

So what had happened? My automatic impulse to protect my mother from my pain, even in such an innocuous situation, was a deeply programmed reflex that had little to do with the present needs of either of us. That repression was a memory—a re-enactment of a dynamic that had been etched into my developing brain before I could possibly have been aware of it.

I am both a survivor and a child of the Nazi genocide, having lived most of my first year in Budapest under Nazi occupation. My maternal grandparents were killed in Auschwitz when I was five months old; my aunt had also been deported and was unheard from; and my father was

in a forced labour battalion in the service of the German and Hungarian armies. My mother and I barely survived our months in the Budapest ghetto. For a few weeks she had to part from me as the only way of saving me from sure death by starvation or disease. No great powers of imagination are required to understand that in her state of mind, and under the inhuman stresses she was facing daily, my mother was rarely up to the tender smiles and undivided attention a developing infant requires to imprint a sense of security and unconditional love in his mind. My mother, in fact, told me that on many days her despair was such that only the need to care for me motivated her to get up from bed. I learned early that I had to work for attention, to burden my mother as little as possible and that my anxiety and pain were best suppressed.

In healthy mother-infant interactions, the mother is able to nourish without the infant's having in any way to work for what he receives. My mother was unable to provide that unconditional nourishing for me—and since she was neither saintly nor perfect, quite likely she would not have completely succeeded in doing so, even without the horrors that beset our family.

It was under these circumstances that I became my mother's protector—protecting her in the first instance against awareness of my own pain. What began as the automatic defensive coping of the infant soon hardened into a fixed personality pattern that, fifty-one years later, still caused me to hide even my slightest physical discomfort in front of my mother.

I had not thought about the *When the Body Says No* project in those terms. This was to be an intellectual quest, to explore an interesting theory that would help explain human health and illness. It was a path others had trod before me, but there was always more to be discovered. The counsellor's challenge made me confront the issue of emotional repression in my own life. My hidden limp, I realized, was only one small example.

Thus, in writing this book, I describe not only what I have learned from others or from professional journals but also what I have observed in myself. The dynamics of repression operate in all of us. We are all self-deniers and self-betrayers to one extent or another, most often in ways we are no more aware of than I was conscious of while "deciding" to disguise my limp. When it comes to health or illness, it is only a matter