Mind body Dualism: an historical perspective and its prevalence within contemporary medical discourse

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ABSTRACT

This paper sets out to describe the origins of mind-body dualism within Western society. The historical basis of this dichotomy is discussed, and then the idea of how medical discourse is used to maintain this dualism is explored. However, for medicine this dualist construction has become an entrenched position. The medical discourse describing chronic pain is provided as an example of this phenomenon.

HISTORICAL CONTEXT - THE ORIGINS OF MIND-BODY DUALISM

'The body is the tomb of the soul' ***Plato*** *(Synnott, 1993 p7)*

The ancient Greeks celebrated the human body, this being demonstrated by their art and literature and by their organisation of the Olympic Games. However, as the founders of Western philosophy they also began the intellectualising of the mind-body split. Plato, in the quote at the top of this page, sees the body as a captivating force, an armoured carapace locking in the soul. Also, in one of his dialogues, Phraedus (Hutchins, 1952) he describes body and mind as fighting against each other in a constant struggle.

This image of the body is echoed in Roman times when Stoicism was a dominant philosophy by Seneca (d.65BC) who said: `Nature has summoned our soul with the body as its cloak'. (Synnott, 1993 p10). Again, we see the body acting as some kind of concealer, an object to prevent seeing, a definite entity in its own right. Indeed, Seneca goes on: `a high minded and sensible man divorces soul from body' (Synnott, 1993 p10). Although `soul' here does not necessarily mean `mind', these quotes do emphasise that the body per se is somehow separate, somehow distanced. The early Christians seemed to have a hard time reconciling their bodies as part of themselves: `Your body is the temple of the Holy Spirit'. St Paul (Synnott, 1993 p7); `We must hate our bodies with (their) vices and sins' Francis of Assisi (Synnott, 1993 p16).

There is thus a confusing message that the body is something to be worshipped as it contains the holy spirit, but at the same time it is full of evil as demonstrated by desire. The body as a beautiful object was rediscovered in the renaissance of the fourteenth century. Artists such as Botticelli, da Vinci and Michelangelo produced images glorifying the body, emphasising its curves, liberating libido onto canvas or through sculpture. The body was something to be admired, adorned and enjoyed. However, as civility and refinement increased, so basic bodily instinctual behaviour was frowned upon. The body became distant, as Synnott puts it: `New notions of civility began to privatize the body' (1993, p19). Throughout, the mind is considered as higher, of greater worth, the body as a vehicle for the mind. This was given credence by the work of Rene Descartes (1596-1650), `the patriarch of Western philosophy' (Boyne, 1990, p1) and by his famous quote, `cogito ergo sum'. The view of body as machine was given a philosophical meaning and, combined with the monumental work of Isaac Newton, the prevailing Cartesian attitude was that `the rules of mechanisms are the rules of nature' (Synnott, 1993, p23). It was believed that everything could be reduced to its constituent parts, analysed and, therefore, understood. Modernity was born, a fundamental belief that man could at last, with his scientific tools and reductionist philosophy, understand the universe; this, of course, included the mind and that irritating encumbrance, the body. The increase in scientific knowledge gained ground in the 18th and 19th centuries, and a neurotic scientific discourse was founded, believing the universe could be understood by examining its constituent components. This largely remains today with the entrenched belief that mind is separate from body. Sanitary science in the 1870s put the body in its place. An acknowledgement of the scientific dangers of human waste led to phobias of the diseases from without, affecting the body. Although the advances in sanitary disposal undoubtedly helped in the improvement of people's health at large, it established `a new anatomical space' (Armstrong, 1993).

In the eyes of public health administration the body became political. However, during the 19th century certain cracks started to appear in this dualistic paradigm. Charles Darwin demonstrated that our bodies are still evolving, thus implying that `mind was dependant on body' (Synnott, 1993). Karl Marx suggested that, if a body can be viewed as a machine, it can become a disposable asset (Fox, 1993; Synnott, 1993), therefore pointing out that body as machine can be used as a manipulative tool, and that power is knowledge. If that knowledge comes from a philosophical base of reductionism, then workers are units, units are machines, and machines are expendable.

He therefore exposed a cruel extrapolation of Cartesian thought. Later, in 1895, Freud's studies on hysteria led him to see that psychological phenomena converted into physical symptoms (Freud, 1977). He, in effect, founded psychosomatic medicine. With the dawn of the 20th century came further scientifically-generated technologies. Science, however, became stuck. The two great theories of physics, relativity and quantum mechanics, became irreconcilable. The Cartesian dream of reducing the universe to its constituent parts was not possible (Briggs and Peat, 1984). Although the debate continues with metaphysical explanations abounding on the behaviour of subatomic particles

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(Capra, 1975; 1982), those in control of our bodies remain entrenched in the dualist world. Medicine has taken control of our bodies and our minds. `The magic bullets work better and quicker than prayer' (Synnott, 1993, p28). Bodies in pain can be cured. The propaganda of medicine was that science provides cures and treatment for all ailments. The doctor has now become a scientist; as an art form, medicine is dead. Now, our bodies are diagnosed via machines; technology can read our symptoms and provide a cure. The intense technology-laden images here are of a body as machine, the body as parts to be serviced. This is all very well for the body, but what of the other side to the dualism, the mind? This aspect of life is also considered in pieces. The medical concept of madness implies there is some biochemical problem which only needs to be corrected (Murray, 1991; Frankl, 1994), or there is a blueprint problem in the genetic code (Crow, 1991; Hill, 1991). Again, the implication here is that if the cells of the brain, the interconnections of the neurones can be understood, then so can the mind.

As John B Watson, the founder of Behaviourism, said in 1966: `the human body . . . is not a treasure house of mystery but a very common-sense kind of organic machine' (Synnott, 1993, p28). In response to the area of mind, medicine has created a monolith: psychiatry. This is like Plato's tomb, only the mind is now entombed in psychiatry with its whims and far-reaching powers (Thomas Szasz; 1987). It is not until the post-modern era that we see a real movement towards breaking down these dualist beliefs. The philosophy of existentialism provides some relief, as Sartre said `I live my body . . . the body is what I immediately am . . . I am my body to the extent that I am', (Synnott, 1993, p32). This is a monist view and therefore put forward against the hard-nosed scientific dogmatic dualism. However, due to the tremendous propaganda which leads to the lay person's belief of `body as machine', there is a large resistance to the acknowledgement of mind-body unity. Our culture demands `to know' and belittles `to feel'.

This `to know' is to be real, to have proof; `to feel' is unknowing, unscientific and weak. No wonder mind and body must be separate since, to acknowledge our feelings is to demonstrate scientifically unproven weakness.A way of highlighting this dichotomy is to examine medical discourse with respect to pain. Pain is an intensely personal bodily experience, yet in order for medicine to understand it, the pain must somehow be objectified. The first part of this process is to deny or devalue any psychological components to the pain, in effect to actively seek out a mind-body split in order to isolate the body. For, after all, medical discourse is based on the premise that we are built like machines, thus the part to be serviced must first be isolated. At some later date, it will be reintroduced back to the grateful patient.

Medicine, pain and discourse

The basic premise of medical discourse became hegemonic. Thus knowledge is power. *DiGiacomo (1992)*

Within contemporary society symptoms represent a sort of calling card, a raison d'etre for visiting a doctor. It is now well documented that, in many patients who present to their GPs complaining of symptoms, no active disease process can be found (Ford, 1986; Fisch, 1987; Lipowski, 1977 and 1988; Coen and Sarno, 1989; Craig and Boardman, 1990; Craig et al, 1993). These people are termed somatisers. The symptom, therefore, gives the patient permission to visit the doctor (Mechanic, 1972). If the symptom is considered to be `real' by the doctor, then further investigations may ensue. However, the `. . . presentation of somatic complaints often masks an underlying emotional problem, that is frequently the major reason the patient has sought help' (Mechanic, 1972). Indeed, such is the prevalence of such occurrences that Hannay (1980) has observed `. . . many doctors complain about being bothered about what they perceive as unnecessary trivia'. This is not surprising bearing in mind that medicine firmly believes in the separateness of mind and body; as Taylor (1992) suggests: `advances in biological sciences strengthened physicians' allegiance to the traditional biomedical model of disease'. As a technophilic society, subjective perceptions are devalued when looking at symptoms (Hannay, 1980). Also, any psychosocial reasons for a possible link with symptoms seem to be undervalued (Mechanic, 1972; Hannay, 1980; Thompson et al, 1983).

There is a vast area to be covered in looking at medical discourse in relation to links between bodily symptoms and psychosocial distress. One or two abstractions may help to illustrate the point that the mind-body dichotomy actively operates within medicine, and that this is a powerful controlling force.Taylor (1992), a psychiatrist, suggests a synthesis between psychoanalysis and psychosomatics. He suggests that the classical psychosomatic diseases may be `reconceptualised as disorders of regulation'. Whilst I have no particular argument with this, he goes on to suggest the reason people become emotionally disturbed is because they `. . . have failed to achieve the usual and proper level of self-regulation'. These words, common within medical discourse, see the patient as failing to respond. The onus is on the patient to succeed with a treatment or methodology imposed by another, in this case medical, person. The implication is that if proper self-regulation can be achieved, then all will be well.

This is a frequent excuse for the administration of treatment. It is, within the psychiatric world, a way of life; the brain is what they treat, it is a biomechanical machine which somehow does not function properly. The magic bullet is required to set it right, to restore correct and proper regulation. DiGiacomo (1992) observed a similar discourse in operation within cancer treatment `. . . the rare active verb signals unsuccessful treatment, not by an omission, but by a reversal of agency: the patient `fails' chemotherapy'. She goes on to point out that `. . . a patient who fails radiotherapy may be salvaged with chemotherapy'. The whole area of medical jargon is thick with impenetrable dialogue. A patient who fails to respond is acting like a machine which will not work properly. What if the patient is a person? If that person does not want to respond, does he/she have a right to do so?

As DiGiacomo (1992) points out 'The patient's first difficulty . . . is getting the doctor to recognise that the patient has, in fact, a point of view at all'. Within our current medical set-up, this appears not to be of any relevance. The medical gurus will use their knowledge, their science on your body. This is an imposition of will or, as Leder (1984) put it: `. . . there is an ironical fulfilment of Cartesian dualism - a mind (namely that of the doctor) runs a passive extrinsic body (that of the patient)'. It seems that much medical discourse is embedded in the Cartesian mould. In the paper by Taylor (1992) the suggestion is put forward that psychological disorder in psychosomatic patients will be able to be medically understood. Once this understanding has occurred this will lead to the ability to `cognitively process emotions'. This implies that the mind has a sort of computer-like ability to process emotions and that all that is required is finding the right program. However, the computer is, after all, merely a machine. This idea of

programming was highlighted by Taylor et al (1991) with a suggestion of the term 'alexithymi'' opening up a new paradigm in the understanding of people who suffer psychosomatic pain. Taylor et al (1991) see this so-called inability to express emotions as a deficit in cognitive programming `Psychosomatic patients show an apparent inability to verbalise feelings'. It could be that their feelings are, in fact, being very adequately expressed via their bodies. However, from the murky world of mind-body dichotomy, this apparent insight is overlooked. This may seem surprising, but for a psychiatrist to look to the body is unthinkable, apart from medical union rules of demarcation, there would be the possibility of getting their hands `dirty', feeling the pain, and having to acknowledge its existence.

It is far easier to remain aloof, intellectualise the pain as a biochemical problem, or a cognitive malfunction. Taylor et al (1991) explain how someone in pain who cannot verbalise their feelings may be approached `. . . the therapist might explain to alexithymia patients that they differ from other people in that they experience their emotions mainly as physiological reactions and bodily sensations rather than feelings'. Apart from the supreme arrogance of this statement, it devalues these alexithymia patients' feelings. Since, as humans, we do feel, surely to feel bodily pain is as valid as any other. However, to link this bodily pain with emotional pain would let the `patient' have his/her pain. This, within the medical model, is not allowed. The patient must deliver up their pain, and must accept the treatment which by now has become a judgement, a judgement that `we know what is best for you'. How on earth is the patient to fight against this? The will of another has taken over. No-one has asked the bearer of the pain what it means to them; they have become the passive imbiber of treatment, for their own good. Within the sphere of chronic pain, where the term somatisation abounds, a medical speciality has sprung up especially to deal with this problem. Although pain is a personal feeling, a personal experience, the reductionist medical approach is to assume it is either a somatic complaint or a psychological problem. Chronic pain has created a problem; it is a reality for the person concerned, but an example that medical methodology has failed (Bazanger, 1992).

The medical response is thus to create a speciality, and fine tune its discourse with concepts like alexithymia. Although the deeply personal experience of bodily pain cannot be reduced by objectification (Bazanger, 1992), the medical profession ends up by defining its increasing specialisation by the methods used to treat the pain (Bazanger, 1992). The result is typically a course of drugs and, if that fails, the use of electrical equipment, eg, TENS machine and, if that fails, some acupuncture or other complementary therapy. Finally, if all else fails, a short course of counselling is prescribed.

This latter `treatment' at least allows the patient to talk about their pain, but in reality involves a nursing specialist handing out advice and information packs. Thus there remains a problem in allowing pain to be heard. Our culture more or less expects doctors to be able to take pain away. Medicine encourages this belief by purporting a reductive discourse as or Foucault puts it: `The restraint of clinical discourse (its rejection of theory, its abandonment of systems, its lack of a philosophy; all so proudly proclaimed by doctors) reflects the non-verbal conditions on the basis of which it can speak' (1973, xix). It is the body which is able to speak, and eloquently at that. The postures and gestures we make are all taken for granted. It is, perhaps, not surprising then that our unconscious communication is also disregarded, unacknowledged. One aspect of this communication is pain, a personal experience, but one full of unconscious meaning. This meaning is suppressed, by not being understood. The body that creates the pain becomes a site of an immense power struggle. The individual's instinct is engulfed by a medical super-ego. As suggested by Fox (1993, p12): `. . . the body is a site for the exercise of power'. Medicine thus provides a means for exercising this power. Its discourse is not objective and purely scientific, but full of prejudice, disempowerment, and related to society's mores (Armstrong, 1989; Fox, 1993). Thus within our culture the body as a separate entity cannot be avoided. The reductionist medical discourse firmly separates mind from body.

CONCLUSION

Medicine is a part of our Western culture, and it is that culture that puts forward the `body as machine' metaphor. In effect, medicine reflects society's wishes. However, the mechanisms inherent within medical discourse result in a disempowerment of the patients who are treated. One such mechanism is the notion of mind-body dualism: we do not live solely in our minds or our bodies. Perhaps, then, it is time to acknowledge that we are an integrated whole.

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