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Dissolving Dualism in Medicine: Reuniting the Body and Mind through Patient Narratives

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Abstract

This paper looks at how the practice of health care tends to follow a dualistic system of thought, seeing the mind and body as distinct. Approaching patients in this way leads to a failure to understand them in a unified and holistic way, often leaving patients feeling less than “healed” and often facing “crises” that go beyond their physiological illness or ailment. This paper critiques this dualistic trend in medicine and looks at some of the ways in which this divide might be bridged through the inclusion of practices being developed by the emerging field of Medical Humanities.

The practice of health care has overwhelmingly followed in the tradition of treating the body and mind as distinct and isolated entities, dividing up the responsibilities of treating problems of the body and mind to the distinct fields of medicine and psychiatry respectively. While there have certainly been advantages to this tradition of abstracting the body and mind from each other, such as more restricted, specialized focus and experimentation on one or the other that has brought about great technological and pharmacological advancements, it also seems that something significant has been lost. Despite the usefulness of abstracting out isolated parts of the whole in terms of research, when it comes to the practice of treating patients who are suffering from illness, patients would benefit from a more holistic health care that treats them as unified persons, understanding the complex connections between the physical and mental processes that occur during illness. This paper will explore the historical tradition of mind-body dualism, and how this tradition has manifested in health care. Then, suggestions will be made for ways that health care can bridge the divide between body and mind, and come to see the patient as a unified person, providing them with health care that recognizes and accounts for their individual lived experiences.

I. The Tradition of Mind-Body Dualism: History and Current Practice

The tradition that sees the body and mind as distinct and separate entities is far from new. The most significant contributions to the development of mind-body dualism were made by René Descartes in the 1600s. Descartes (1596-1650) was a mathematician, scientist, and metaphysician. He sought to explain the natural world through mathematics, which contributed to his formulation of the modern formulation of the mind-body problem (Hatfield, 2008). As laid out in his work *Discourse on the Method* (1637) and expanded in *Meditations on the First Philosophy* (1641), Descartes argued that body and mind are composed of distinct and separate substances, a conclusion that he drew based on his ability to doubt the existence of material things, but his inability to doubt the existence of his capacity to think of himself as a thinking being. He reasoned, then, that his thoughts must have belonged to a non-spatial substance that was distinct from matter (Descartes, 1637). He expanded his justifications for this argument in *Meditations* (1641), in which he argued that matter is spatially extended, and spatially extended things cannot think. The essence of the mind is that it is not spatially extended, and has the ability to think (Hatfield, 2008). This reformulation of his argument for the distinction of mind and body was based on positive distinctions between mind and body and their characteristic essences, instead of being based on his ability to doubt one or the other. In addition to his conception of the mind and body as characteristically distinct, Descartes also was a major contributor to the development of the “New Science”, which sought to mathematize the natural world and explain the natural world in terms of mathematic principles. This new way of approaching the natural world took a mechanistic approach to nature, and sought to replace the Aristotelian system that had been dominant. Part of this mechanization of the natural world included Descartes’ attempt to describe the processes of the human body in a way that was purely mechanical, without appealing to a soul or “vital principle” (Hatfield, 2008). Despite the mechanized processes of the mind, he held that human beings also had a soul (which he equated with “mind”) that is responsible for intellection and volition, including conscious experiences and perceptions. The mechanized body and its physiological processes do not require intervention or guidance from the mind; rather they are dictated by natural processes of cause and effect which can be expressed in mathematical terms. In other words, Descartes felt that “many of the behaviors of human beings are actually carried out without intervention from the mind” (Hatfield, 2008). This view led to the increasingly isolated understandings of mind and body, and their respective roles in personhood and personal activity. Viewing the body and the mind as metaphysically distinct substances with separate roles and functions in the body became a predominant way of thinking, as reflected in the developing traditions of biology and psychology. The mind and body were studied separately and treated separately, without much attention paid to the ways in which they interact with and influence each other.

This historical view of mind-body dualism that was developed by Descartes in the 1600s is still pervasive in our current systems of health care. The medical field has generally taken on the responsibility of answering questions about the physiological processes of the body, which can be seen as having organic causes and can be expressed using the laws of science and mathematics. Psychology, on the other hand, deals with processes of the mind, which are often seen as representing a different type of reality, one that does not have organic causes that can not be explained in terms of mathematical concepts. When organic causes are found to explain seemingly mental phenomena, they often become questions for specialties of the medical field, such as neuroscience or neurobiology. In general, medicine has limited itself to dealing with physiological issues exclusively, and has generally ignored the experiential aspects of illness, leaving these to be addressed by psychology. However, despite the separation of these fields into a seemingly clean-cut division, altered mental states and processes often accompany physical and physiological illnesses and symptoms, and are often closely tied to the physiological illness that the medical field is seeking to remedy. Ignoring these mental aspects of illness, as the medical field often does, misses a lot of what is central to how the patient experiences their illness. The medical field has a tendency not to take these individual experiences seriously, brushing them off as too “subjective”, and instead limiting its focus to the objective or that which can be generalized across a wider population of people than just the subject at hand.

Despite the fact that mind-body dualism is generally taken for granted and accepted as fact within the scope of health care practice, this dualism tends to be in contrast with the lived experiences of human beings. Although it is possible to consider our bodies and minds as distinctly separate in the abstract, this does not coincide with the way we experience ourselves. In general, human beings experience themselves as unified beings, with integrated minds and bodies. Particularly, during experiences of illness, humans have a clear sense of the connection between their minds and bodies. Illness often brings out experiences that directly involve the bodily or physiological experiences of the illness, but also involve the mental processes or emotions that go along with the illness experience, and are equally important to the experiencer of the illness. Medicine’s attempt to treat only the objective, physiological parts of the illness in a generalized way largely ignores the complex and individuated aspects of illness. Moving forward, a more effective health care practice would be one that takes seriously the individual mental experiences of patients that coincide with the physiological aspects of illness. This project is one that has been undertaken by the emerging field of Medical Humanities, which takes seriously the task of understanding how we can best serve patients by accounting for their individual, subjective experiences, and aims to get away from the limiting, generalized trends of current health care practice.

II. Criticisms of the Dualistic System

In strictly limiting its focus to the organic causes and physiological effects of illness, medicine has largely overlooked the personal, individualized experiences of illness and has lost sight of the person *with* the illness. Oliver Sacks addresses this trend, stating that medicine has shifted its focus to getting to know and treat a disease instead of getting to know and treat the person with the disease (Sacks, 1985, p. 17). Sacks thinks that in order for medicine to serve its purpose in treating the patient in their entirety, it has to learn how to listen to the patient, understand the complexities of their individual experiences of illness, and treat the mental and physical aspects of the illness simultaneously. Sacks states that the goal of medicine should be more than just stopping illness, but restoring the patient's identity or sense of self that gets lost or fragmented during illness. Sacks takes seriously the ways in which a physiological illness or ailment can have significant impacts on the patient in terms of their mental states, or even their identity- elements of illness that are not often considered within the medical practice. In his book, *A Leg to Stand on* (1984), Sacks examines the ways in which physical changes to the body can have large impacts on the mind, giving a personal story of the mental impacts and complex emotions that resulted from his experience with a breaking his leg. Upon analysis of his own experience, Sacks reflects on the ways in which bodily alterations or loss of function can lead to experiences of "alienation, derealization, anxiety, and horror", as well as alteration of identity or selfhood, in ways that the medical field can not currently describe or account for. Despite knowing that other patients have similar "existential crises" when going through illnesses, Sacks realizes that the objectively-focused sciences leave little space for discussing these issues, seeing them as problems to be dealt with by the psychologist or the philosopher, but not the objective-minded practitioners of medicine. Sacks traces this disconnect back to Descartes and offers a critique of the system of Cartesian dualism, arguing that this system of dividing the physical and mental misses out on a critical third realm, the one in which an organic, physical change in the body leads to altered mental states or experiences (Sacks, 1984, p.197).

Arguably the most clear depiction of the types of identity crises that can occur during illness is articulated by Kathy Charmaz in her 1983 article "Loss of Self: A Fundamental Form of Suffering in the Chronically Ill." In this piece, Charmaz details the ways in which the most profound form of suffering in illness, which she calls the "loss of sense of self", is completely neglected by medical practice, which limits its focus to physical discomfort or ailment exclusively. She outlines four main effects of illness that lead to this profound "loss of self", which are: 1) restricted lives, 2) social isolation, 3) being discredited, and 4) burdening others. She argues that each of these experiences are central to those who are suffering chronic illness, and they end up contributing to a loss of sense of self that has drastic impacts on the patient. However, despite the significance of these losses for the patient, they are generally ignored by

medical practice, which only focuses on one form of patient suffering: the bodily or physical. Limiting the focus to the physical aspects of chronic illness, Charmaz argues, misses out on the most fundamental forms of suffering that a chronically ill patient has to deal with- those which affect the sense of self.

Others have also given accounts of the significant ways in which physical illness leads to profound identity alterations and crises. In his book *The Wounded Storyteller* (1995), Arthur Frank describes how the onset and development of illness can radically alter how a person perceives and relates to their world. He says that ill patients often need a “new destination and a new map” (Frank, 1995, p.1), but modern medicine does little to address these issues and help patients restore or reconstruct their identities. Frank, similar to Sacks, contributes this trend back to the tradition of Cartesian dualism. Frank critiques this mind-body dualism, arguing that despite its pervasiveness, it is not how patients truly experience their illnesses, and that it cannot account for the full picture of illness. Frank states, “The general principle is clear: the mind does not rest above the body but is diffused throughout it” (Frank, 1995, p. 2). By offering this critique of mind-body dualism and suggesting instead that the mind and body are inherently integrated, Frank is suggesting that medicine ought to pay more attention to the interconnectedness of mind and body as patients experience it, and deal with healing the entire person and their holistic experiences of illness. In *Intoxicated by My Illness* (1992), Anatole Broyard offers another brilliant depiction of the ways in which experiences of illness go way beyond the physical realm, and how physicians currently have little understanding of these complex and difficult experiences. Broyard states, “To the typical physician, my illness is a routine incident in his rounds. To me, it’s the crisis of my life” (Broyard, 1992, p. 43). Broyard wrote about how he wasn’t necessarily looking for the medical field and his physicians to be able to deal with or remedy this life crisis, but simply to acknowledge its significance and recognize how profoundly it was affecting him. Broyard called what he was seeking from his physicians “empathetic witnessing” (p. 144), which is a good way to articulate what he (and many other patients) are searching for. He was not looking for his physicians to be able to deal with this crisis or even heal him from it per say, he was simply seeking recognition and for them to be present and engaged with him as he dealt with it. This call for “witnessing” is also made by Christina Middlebrook in her book, *Seeing the Crab: A Memoir of Dying* (1996). Middlebrook describes the difficult identity changes that she underwent while dealing with cancer and undergoing a bone marrow transplant and subsequent chemotherapy, and how she became unable to recognize and identify with her new and unfamiliar self. She wrote about this identity fragmentation, and how it was central to have witnesses there to remind her of who she was and how she has changed, and to “tell the parts of the story that she can’t tell” (Middlebrook, 1996, p. 60). Middlebrook felt that the witnessing of others was an important way to hold onto the pieces of herself and start to bring herself back together. Patricia Stanley (2004) also encourages those around the ill patient to engage in empathy and witnessing, and

to make an attempt to reconnect and restore community with those who are isolated by illness. For scholars and patients who are writing these narratives and describing these difficult identity crises, witnessing on behalf of those around them seems to be an indispensable part of reconstructing a sense of self that has been damaged by illness, as well as a sense of community between healthy and ill persons.

III. Hearing Patients' Voices

If we are convinced by the arguments of Sacks, Franks, Broyard, Middlebrook, Stanley and so many others that it is crucial that the medical practice learn how to engage in empathetic witnessing and account for the individual lived experiences of patients, the question then arises about how to achieve those ends. This has been one of the central tasks of the medical humanities. Medical humanities seeks to find ways to bridge the communication gaps that often arise between patients and physicians, and to find new ways for patients to express their complex experiences of illness that doctors can receive and respond to. Methods that are emerging in the medical humanities set the stage for the type of witnessing and fostering of community that many of the scholars referenced above argue are essential for the patients who are experiencing the drastic effects of illness (isolation, loss of sense of self, loss of life's map, loss of sense of being in the world, and other such existential crises that have been described). Those within the relatively new field of the medical humanities hope to see the medical practice start to use these new methods more widely, to develop a more holistic and understanding practice of health care.

One important method that has been suggested by many who are doing work in the medical humanities is to develop a system of medical narratives, and to implement the use of medical narratives into the practice of health care. At the forefront of this notion is Rita Charon, who has written extensively on the ways in which a system which she has termed "narrative medicine" can be integrated into the practice of health care. Charon argues that implementing a system of narrative medicine is essential for increasing competence about illness experiences, bridging communication guides between physicians and patients, and establishing and developing empathy, reflection, professionalism, and trustworthiness in physicians (Charon, 2001). Charon offers a very systematic way of implementing narrative medicine into health care practice, and views it not only as an important improvement, but an essential change. Others have advanced similar ideas about the use of narratives of illness to build connections and lead to a better understanding of unique patient stories. Oliver Sacks has suggested this process, though he refers to the stories as "Clinical Tales", which are often constructed by the health care professional in an attempt to better understand the experiences of the patient (Sacks, 1985). A.R. Lauria has also suggested this narrative phenomenon, using the term "Clinical Biography" to describe it (Hunsaker Hawkins, 1986). Anne Hunsaker

Hawkins has written about the same process, but has referred to the resulting narratives as “pathographies”, or autobiographies of the illness experience (Hunsaker Hawkins, 1994). Regardless of the term that these authors choose to use, they are all suggesting similar methods for changing the structure of the medical field and the doctor-patient interaction. They are calling for a new method that uses the narrative approach to allow patients to share their stories, and for the medical professionals to be able to witness and engage with those stories, allowing for an understanding of a person and not merely a disease.

This narrative process has many important implications for the patient, the physician, and those around the patient. The process of constructing the narrative is often therapeutic for the patient, in that it allows for them to put a sense of cohesion back into a life that has been deconstructed or fragmented by illness. Arthur Frank (1995) describes the process of creating the narrative as an important way of allowing the patient to restore their voice, by giving them the capacity to tell their own story. He also talks about how this is a way of becoming familiar with a new self that results from illness, and a way of structuring a “new life map” after the old one is destroyed by illness. In addition to the creation of illness narratives being important for the patient themselves, they are also important for the physician. Arthur Kleinman (1988) describes how the process of sharing personal stories establishes trust between the storyteller and the listener, which creates a unique learning experience for the physician as they try to truly listen to and understand the complexities of the story the patient is sharing. Rita Charon (2001) talks about how narrative medicine is an indispensable approach for the physician, because it often leads to the revelation of smaller details that would otherwise go unnoticed. When the physician is able to get the trust of the storytelling patient, and get the full story with all of its details, the physician is able to get a better understanding of the patient as a whole, and can thus treat them more effectively. Charon lists the following important consequences of the implementation of narrative medicine: access to otherwise unreachable or undisclosed knowledge, positive influences on the doctor-patient relationship, and a closer clinical teamwork that allows the doctor and patient to work together to solve difficult problems. Charon and others agree that medical practice has lost the personal touch, and argue that methods such as narrative medicine can help restore it.

Another important feature of narrative stories of illness is that they allow for a reformation of community around the person with illness. Often, illness strips the ill person of the community around them, causing them to feel isolated and cut off from those around them. Narratives of illness are one way that community can be fostered and restored, by allowing the patient to share the details of their experience and for others to engage with the ill person in new and unique ways as they develop a deeper understanding of the what the ill person is going through. Patricia Stanley (2004) describes the tendency of ill persons to navigate the illness experience alone, and to feel

isolated from those around them, including health persons and loved ones. Stanley points out how damaging this isolation can be for the person experiencing the illness, and recommends narrative approaches to help give voice to the patient, minimize their sense of isolation, and restore and rebuild community in spite of illness.

As shown above, illness narratives can take many forms, and can be productive in many ways. They are important for the ill person as a means of restructuring and reordering their life after illness. They are also important for allowing the physician to gain better insight into the lived experiences of the patient. Lastly, they are important for fostering community and minimizing isolation of the ill person, by allowing for community between the storyteller and those who choose to listen to and engage with the stories. In these ways, illness narratives could greatly improve the quality of life for those who are dealing with illness, and could also improve the effectiveness of the practice of health care. Illness narratives allow for a more complete picture- one that rejects the classic Cartesian dualism mindset and chooses to see and understand a complete person and their lived, embodied experiences.

IV. Conclusions

Despite the fact that physical illness is often accompanied by profound psychological, emotional, or existential changes and crises, the current practice of health care has failed to account for and deal with these issues that fall outside of the scope of the objective, physiological spectrum of what medicine currently deals with. Many people have written substantial critiques about the ways in which the pervasiveness of mind-body dualism, tracing back to Descartes in the 1600s, has robbed patients of a more encompassing and productive medical experience, that teats their unique individual experiences and all aspects of their bodies and minds during illness. Currently, individuals within the emerging field of Medical Humanities have undertaken the difficult project of finding ways to change the current practice of health care to bring it closer to reflecting the ways patients actually experience illness. One important method that works towards reaching this end is the use of patient narratives, in which the patient is able to construct and share their individual story, which allows them to piece together their fragmented identity, and also help convey their experience to others. The use of medical narratives is one way to open the door for health care professionals to be able to have a wider understanding of complex patient experience, but surely there are other outlets in addition to the narrative form that can help patients express their subjective experiences (artwork, music, poetry, and so on). The field of health care needs to open itself up and be willing to hear these voices, understand the complex forms of suffering that arise in different patients, and respond to them in a way that is empathetic and understanding. As Broyard says in *Intoxicated by My Illness*, “for each man is ill in his own way” (Broyard, 1992, p.44), and the medical field needs to

recognize that. The practice of health care needs to start moving away from the over-generalized standards of care that treat all patients with a certain illness in identical ways, which ignores the fact that they likely experience that illness in completely different ways.

It is important to understand that if the current goals of medical practice are upheld, there will never be room for the incorporation of medical humanities. The current goals of medical science are to 1) repair injury or heal the patient when possible, and 2) improve function and reduce suffering when healing or repairing is not possible. These current goals of medicine clearly show that the current practice of medicine is one that views the body as a machine, with the goal of medicine being to repair a physical “cog in the machine.” When viewed in this way, it seems difficult to understand why the medical humanities are necessary for meeting those goals. Instead of trying to bring the medical humanities into this old view of the goals of medicine, medical humanities can work with the medical field to construct new, more encompassing goals that reflect the goal of medicine as one that is to heal the patient in all ways that the patient needs to be healed, and to restore their physical and mental health, as well as their sense of self. In this way, medical humanities can help create a system of health care that gets away from dualistic notions of strict separation of body and mind, and move towards a more complete and encompassing health care practice.

References

Broyard, Anatole. *Intoxicated by My Illness: And Other Writings on Life and Death*. New York: C. Potter, 1992. Print.

Charmaz, Kathy. “Loss of Self: A Fundamental Form of Suffering in the Chronically Ill.” *Sociology of Health and Illness* 5.2 (1983): 168-95. Web.
<http://dx.doi.org/10.1111/1467-9566.ep10491512>

Charon, R. “Narrative Medicine: A Model for Empathy, Reflection, Profession, and Trust.” *JAMA: The Journal of the American Medical Association* 286.15 (2001): 1897-902. Web. <http://dx.doi.org/10.1001/jama.286.15.1897>

Charon, Rita. “Narrative Medicine: Form, Function, and Ethics.” *Annals of Internal Medicine* 134.1 (2001): 83. Web.

Descartes, René, David Weissman, and William Theodore Bluhm. *Discourse on the Method; And, Meditations on First Philosophy*. New Haven: Yale UP, 1996. Print.

Frank, Arthur W. *The Wounded Storyteller: Body, Illness, and Ethics*. Chicago: U of Chicago, 1995. Print. <http://dx.doi.org/10.7208/chicago/9780226260037.001.0001>

Hatfield, Gary. "René Descartes." *Stanford University*. Stanford University, 03 Dec. 2008. Web. 05 Dec. 2014

Hunsaker Hawkins, Anne. "A.R. Lauria and the Art of Clinical Biography." *Literature and Medicine* 5 (p.1-15). 1986 <http://dx.doi.org/10.1353/lm.2011.0296>

Hunsaker Hawkins, Anne. "Reconstructing Illness: Studies in Pathography." *Choice Reviews Online* 31.06 (1994): 31-3262. Web.

Kleinman, Arthur. *The Illness Narratives: Suffering, Healing, and the Human Condition*. New York: Basic, 1988. Print.

Middlebrook, Christina. *Seeing the Crab: A Memoir of Dying*. New York: Basic, 1996. Print.

Sacks, Oliver W. *A Leg to Stand on*. New York: Summit, 1984. Print.

Sacks, Oliver W. *The Man Who Mistook His Wife for a Hat and Other Clinical Tales*. New York: Summit, 1985. Print.

Stanley, Patricia. "The Patient's Voice: A Cry in Solitude or a Call for Community." *Literature and Medicine* 23.2 (2004): 346-63. Web. <http://dx.doi.org/10.1353/lm.2005.0016>