

The mind/body problem in contemporary healthcare

Gillian Bendelow

Background

Health and illness are multi-faceted concepts which span a range of disciplines and have varied meanings in different societies (Helman 2002, Blaxter 2004). Since the nineteenth century we have witnessed dramatic advances in the understanding and cure of disease with, at least in Western countries, an unprecedented extension of both quality and length of life. Yet even as medical science has progressed, there has been a decline of faith in biomedicine and its dominance challenged by litigation, scandal, government regulation, lay expertise and social activism (Fox 2000, Scambler 2003). Social sciences associated with medicine, particularly medical sociology, philosophy/bioethics and health psychology, have shaped modern ideas about health and illness and over the course of the twentieth century formed a major challenge to the narrow philosophical grounding of biomedicine.

The combined impact of these factors has prompted critical developments in medical education, reflected in the UK in the rise of the 'new' medical schools and in radical changes in the medical curriculum including an unprecedented emphasis on the social sciences and ethics (Greenhalgh and Hurwitz 1998). Within medicine itself there are competing orientations of models of health (Wade and Halligan 2004), with general practice and new sub-disciplines such as liaison psychiatry and behavioural medicine gaining visibility. Moreover, the raised professional and academic status of allied professions including nursing, social work and occupational therapy, together with established social science disciplines such as medical sociology and health psychology, have contributed to make health and illness studies one of the most vibrant and important theoretical and empirical arenas in modern life. The contribution of the arts and medical humanities widens the agenda further. Health awareness has become a facet of everyday living, even some would say, a 'national obsession' (Scambler 2004) and lay perceptions and understandings (including collective enterprises such as politics and the media) play a vital role in defining concepts.

The critique of biomedicine, with its emphasis on high-technology, cure and 'body machines' has developed alongside the decline of the big killers of infectious diseases. In so-called 'developed' countries these have largely been replaced by 'lifestyle' and degenerative illnesses such as cancer, diabetes, vascular disease, obesity and dementia. Both biomedicine and social sciences have been challenged by a host of illnesses with multifactorial aetiologies and complex mind-body relationships which require traditional categories, formulations and management strategies to be re-evaluated.

Integrated Models of Health and Illness

The divide between physical and mental illness historically reinforces hierarchical divisions within medicine, since anything that is classified as a ‘mental’ or emotionally triggered illness is, and always has been, consistently stigmatised and marginalised (Cant and Sharma 1999). Nevertheless, epidemiological patterns reveal increasing prevalences and recent estimates claim that at least 25% of GP consultations in the UK are prompted by psychological symptoms and that 20% or more of UK adults have a recognisable medically defined *mental* disorder (Mental Health Foundation 2009). These mainly comprise of anxiety and depressive disorders, of which 80-90% are managed (or not) in primary care rather than by the mental health services. Moreover, behaviours which are now perceived as being major health risks, such as smoking, over-eating, alcohol and substance abuse, suicide, violence accidents and sexually transmitted diseases, inevitably have important emotional components.

Since the 1980’s the *biopsychosocial* model gained popularity amongst physicians as its multicausal definition allowed for the variety of perspectives to be taken into account in diagnosis and treatment, implying an inherently multi-disciplinary approach. However, this model has also been criticised for not fully addressing mind/body dualism as the patient can still be compartmentalised by the physician addressing biomedical symptoms and the psychologist/psychiatrist the psychosocial element. More recently, the combined shift towards both holism and interdisciplinarity in healthcare practice has resulted in *integrated models* becoming the preferred consensual term for both practitioners and theorists (Wade and Halligan 2004). Figure 1:3 charts the paradigm shift in models of health which renders the labels of physical and mental illnesses as outdated and redundant.

Figure 1 A Paradigm Shift in Models of Health and Illness

(from Bendelow 2009: 31)

Biomedical Model	Integrative Model
Mechanistic	Holistic
Body-mind dualism/reductionism	Interaction between body/mind
Single fundamental cause of illness	Multicausality
Isolated individual	Socially connected individual
Treatment = Curative ‘magic bullet’ approach Pharmaceutical/ technological interventions	Treatment= Appropriate interventions (may be biological/ psychosocial) Management Preventive- health maintenance
Focus on acute illness	Focus on long term health Allows for chronic illness

Thus, the critique of biomedicine, with its emphasis on high-technology, cure and 'body machines' (see Figure 1:3) has developed alongside the decline of infectious diseases, at least in the 'West'. Across North America, North and Western Europe, and Australasia, mortality and morbidity rates from infectious disease have largely been replaced by degenerative and 'lifestyle' illnesses, including cancer, diabetes, vascular disease, arthritis, and the dementias.

Medically Unexplained Symptoms

Medically unexplained symptoms or MUS, an acronym in popular usage in the medical and social science literature is perhaps more neutral and less stigmatising than 'psychosomatic symptoms', but still identify illnesses or syndromes which cannot be defined in terms of organic pathology and are thus seen as abnormal and low in 'illness hierarchy' (Nettleton et al 2004). The term 'contested conditions' is used to signify illnesses of controversial scientific status (e.g., ME, CFS, RSI, chronic low back pain) in which the patient experiences distressing physical symptoms such as impaired mobility or coordination, intermittent paralysis, fitting, pain, fatigue, or visual disturbance, but there is usually an absence of physical signs, clinical explanation or medical diagnosis, and estimates vary that between 25-50% of GP consultations in the UK are prompted by emotional or psychological issues.

Traditionally biomedicine has been unable to deal effectively with people who present in this way, creating a 'diagnostic limbo...which widens the gap between clinical reductions and lost metaphysics' (Williams 1984) but may be more accessible by integrative, holistic approaches. As we have seen, physical complaints do often point to physical disorders, but pain and fatigue can also be clues to psychological disturbance which manifest in distressing symptoms which also require help or intervention.

The acute/ chronic distinction within the biomedical model can also potentially place limitations on understanding the illness experience. A primary role of medicine is often perceived as treating or alleviating pain, but what actually constitutes pain is subjective, value laden, and difficult to define objectively and empirically, relying as it does on expressivity of both bodily signs and language which are culturally embedded, subject to multiple interpretation, and the phenomena of chronic pain in particular provides us with one of the clearest examples of the need to adopt integrative models of healthcare which understand the relationship, not only between mind and body, but mind/body/society .

Chronic pain

Medical theories of pain have traditionally concentrated upon its neurophysiological aspects, both in diagnosis and treatment and

scientific medicine reduces the experience of pain to an elaborate broadcasting system of signals, rather than seeing it as moulded and shaped both by the individual and their particular socio-cultural context. A major impediment to a more adequate conceptualisation of pain is due to the manner in which it has been 'medicalised', resulting in the inevitable Cartesian split between body and mind. Consequently, the dominant conceptualisation of pain has focused upon **sensation**, with the subsequent inference that it is able to be rationally and objectively measured. Medical practice has concentrated on the nociceptive or sensory aspects of pain, employing the acute/chronic differentiation which does not necessarily take emotional aspects of pain into account. It is universally acknowledged that one of the most complex and difficult types of pain to treat is *idiopathic* pain - that is, pain for which there is no established physical pathology (Melzack and Wall 1988) - often termed *chronic pain syndrome*.

Yet as well as being a medical 'problem', pain is an everyday experience, and not the sole creation of our anatomy and physiology. Rather, as Morris suggests, it emerges only at 'the intersection of bodies, minds and cultures' (1991:1). Moreover, defining pain is a semantic problem; in any language there may be wide variations in interpretation and meanings. For example, according to the Oxford Reference Dictionary (1996) pain refers to any or all of the following:

PAIN [from the Latin *poena*, meaning penalty or punishment]

1. An unpleasant feeling caused by injury or disease of the body.
2. Mental suffering.
3. [old use] punishment e.g. on pain of death.

In Greek, the word used most often for physical pain is (*algos*), which derives from roots indicating neglect of love. Another Greek word is (*akos*) meaning 'psychic pain' from which we derive the English 'ache' (Procacci & Maresca 1985:201). Implicit in these meanings is a broader definition of pain than the narrowly defined Cartesian proposition which inevitably acts to divorce mental from physical states and tends to attribute single symptoms to single causes.

Indeed, the notion of pain having a substantial emotional component, literally the obverse of pleasure is much older than that of pain being a physiological sensation and can be traced back to Plato's (429-347 BC) deliberations of extremes and opposites in the World of Forms. He declares pleasure and pain to be the twin passions of the soul, the results of the interactions between earth, air, fire and water. Aristotle (384-322 BC) developed the pain/pleasure principles further, describing them as basic moral drives guiding human action, and believed the pain experience to be negative passion which had to be conquered by reason. He believed that pain was conveyed by the blood to the heart, yet excluded it from his classification of the five senses, instead preferring to describe it as 'a quale¹ of the soul; a state of feeling and the epitome

¹ meaning 'emotional quality'.

of unpleasantness'(quoted in Bendelow 2000: 34). Literature, theology and philosophy abound with considerations of the nature and purpose of pain (amongst many others, see Systematic Theology vols. 1-3 1950-63, by Tillich; or Works of Love 1847 by Kierkegaard) and the pleasure/pain dichotomy is constantly evoked and reinforced, for example:

Our well being is only freedom from pain, That is why the philosophical school which has given the greatest importance to pleasure has also reduced it to mere absence of pain. Not to suffer is the greatest good man can hope for... (de Montaigne 1959,1592 In Defense of Raymond Sebend: 44 quoted in Bendelow 2000:35)

Treatment of chronic pain

The critique of the limitations of biomedicine has developed within medicine, by those working in the area of pain, most notably in the pioneering work of Melzack and Wall (1965, 1984) and Bonica (1953). Developments such as the widespread acceptance of Melzack and Wall's Gate-control theory of pain and the influence of the hospice movement have shifted the pain paradigm, increasing the emphasis upon cultural and psychological components and the need for a multi-disciplinary approach. Social science, in particular the sociological literature on chronic illness offers a framework for understanding the experience of chronic pain by focusing on the *person* rather than the pain. Here, concepts such as biographical disruption, narrative reconstruction and illness adjustment (Williams 1984 Bury 1991 Greenhalgh and Hurwitz 1998) have been particularly valuable. In relation to adjustment to chronic pain, Kotarba (1983) charted the process of becoming a 'pain-afflicted' person, in order to trace the continuity of personal identity. Using pain biographies he identified three stages in this process. First, there is the 'onset' stage, which is perceived to be transitory, and able to be dealt with by diagnosis and treatment. Here, pain is diagnosed as 'real' by physicians, having a physiological basis. The second stage concerns what Kotarba terms the 'emergence of doubt'. At this stage, treatment may not work, there is an increase in specialist consultations but patients still feel in control in seeking the best care available. Finally, the third stage concerns what Kotarba terms the 'chronic pain experience'. Following the shortcomings of treatment, the patient, at this stage, may return to the lay frame of reference, and seek help within the 'chronic pain subculture' (Kotarba 1983:27)

Using a focus on the person, rather than measuring so-called objective symptoms, allows us to encompass more easily the notion of *total* pain, which includes psychological, spiritual, interpersonal and even financial aspects of chronic pain, as well as its physical aspects, as was advocated by Dame Cicely Saunders (1976), one of the founders of the hospice movement. Additionally, beliefs about pain have been shown to have an important effect on compliance with

physical therapy interventions (Williams and Thorn 1989). However, whilst at a theoretical level, medicine may acknowledge the holistic, multi-faceted nature of pain, it is nonetheless debatable how much the attempt to transcend the mind/body dualism extends to treatments or therapy.

Pain clinics or pain centres are institutions which have been developed specifically for the treatment of chronic pain conditions (pain with no demonstrable cause was rarely treated before the 1970's) The concept of having special institutions for treating pain originated with John Bonica, an anaesthetist in the US, who recommended in *The Management of Pain* (1953) that the treatment and understanding of pain would be best achieved through the co-operation of different disciplines. The first pain clinic was set up in the USA in 1961 with specialists from thirteen different disciplines, aiming to collaborate in a non-hierarchical manner. The subsequent developments of pain centres throughout North America and Europe vary in provision and resources, but are characterised by diversity in the organisation of work, medical specialities, working principles and therapies. They can be private organizations, or affiliated to medical schools, university departments or hospitals, and may incorporate a variety of treatment methods, or adopt one approach. A cross-sectional survey of 25 pain centres in a single urban community in the U.S. (Csordas and Clark 1992) found that there were wide variations in the treatment modalities offered, the types of pain conditions treated, the populations served, the patient selection criteria and the diagnostic and aetiologic frames of reference. The research also examined pain centres and clinics across the whole of the U.S. and identified three different types. First, they found multidisciplinary, comprehensive pain centres, which are dedicated to all kinds of pain problems and offer a wide range of treatment modalities. Secondly, there were syndrome-orientated centres, which only treat one kind of pain problem (e.g. headache or back pain). Finally, there were modality-orientated treatment centres, which offered only one type of treatment modality (e.g. analgesic nerve blocks) (Csordas & Clark 1992: 385).

The increasing emphasis on interdisciplinarity in understanding pain has influenced the development of pain clinics. Vrancken(1989) reviewed the theory and practice of pain in eight academic pain centres in the Netherlands, and identified five broad approaches to both theoretical and practical aspects of pain.

1. the **Somatico-Technical** approach,[adopts a neurophysiological model. Here, pain is viewed as organic, with much emphasis on classification, and time is the only distinction made between acute and chronic. Treatment consists mainly of surgical procedures to eradicate, block or ease pain, long-term use of narcotics and the development of

secondary psychological complications are seen as second-rate. Patients are cured when objective signs disappear.

2. the **Dualistic Body-Orientated** approach sees pain as a result of organic, psychological and social factors. In this model, there is supposedly no distinction between the body and the mind in theory. However, in practice, although other factors affect the final expression, the nociceptive (i.e. the purely sensory) aspect is the major factor, therefore there tends to be methodological dualism. Again, the patient is cured when the pain is gone.
3. The **Behaviourist** approach is used where pain is seen to be chronic, intractable, consisting of overt actions which constitute 'pain behaviour', completely separate from acute pain which is mainly nociceptive and treated by physicians. The patient is deemed to have recovered when the pain behaviour is replaced by effective 'well behaviour'.
4. The **Phenomenological** approach sees pain as a complex of reactions and behaviours, triggered as a physiological self-defence under harmful conditions but in its course independent of the initial event - the 'pain function'. Chronic pain is the result of an interrupted healing process, so that the pain sufferer is unable to find a place in the world, and is thus unable to remain an integrated person due to ongoing pain experiences. Pain patients, according to this approach, have a deficient organic life and remain in existential need, are angry and distanced from their pain. Therapy therefore aims to return the person to human life by (re)awakening through human encounters. The patient in this approach is seen to have recovered when they emerge through the encounter as a 'whole' person again and does not need doctors to remain healthy.
5. The **Consciousness** approach provides a further move away from a dualistic framework as 'the part of the body which is in pain has become part of here-and-now awareness and has been hurt to the core of existence...pain is incorporated into the meaning of being human' (Vrancken 1989:440). Pain patients in principle are anyone complaining of pain and therapy is not specific, the main prerequisite is the possibility of establishing an interpersonal relationship. This may be any form of treatment but preferably not invasive surgery, and the patient is seen to have recovered either by pain disappearing or by gaining enough insight to accept and manage it (from Vrancken 1989:436-440).

Thus, illness narratives and phenomenological accounts have become intrinsic components of pain treatment in many pain clinics, which have been at the forefront in challenging the mind/body divide. Nevertheless it remains the case that many chronic pain sufferers struggle to and a study by Glenton (2003) maintains that the acknowledgement of pain as 'real' by a physician is still the most important aspect in both understanding and 'treating' chronic pain.

Conclusion

Integrated models of health and illness are increasingly permeating contemporary healthcare, and are gaining popularity and credibility within the mainstream medical literature and research, as the limits of biomedicine become increasingly evident in contemporary times (Wade and Halligan 2005). Integrated models also challenge traditional sociological assumptions that doctors are only concerned with biological (disease) and that the social (illness) is of concern outside medicine as 'in everyday clinical practice doctors constantly faced with issues relating to social causes of ill-health and the social contexts of ill-health and lifestyle provide doctors with a framework to talk about the social' (Hansen and Easthope 2006). Certainly, the concept of *balance*, which is intrinsically holistic and based on the Hippocratic view of the body as a microcosm of Nature is crucial to the process of intellectual and conceptual thinking, as it is in understanding and constructing models of health care which encapsulate the social in a meaningful way. The dissolution of the artificial divides between mental and physical health is an essential part of this *rapprochement*, and an understanding the role of emotions in health and illness is crucial to developing a mind/body/society perspective, as well as enlightened mental/ emotional healthcare.

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