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The mind-body dichotomy

ABSTRACT: The mind-body problem has been pondered by philosophers and physicians since antiquity, yet remains unsolved despite frequent appeals for a holistic approach. The perpetuation of Cartesian dualism[1] has been attributed to many factors ranging from the limitations of Indo-European languages[2] to the founding of scientific medicine on Newtonian physics instead of the more modern quantum and relativity theories.[3,4] Liaison psychiatry is described as the latest attempt to eradicate mind-body dualism and to treat the patient and his illness as one.

The theoretical underpinnings of liaison psychiatry can be found in contemporary psychosomatic medicine which "proposes that human health and disease result from an interaction of biological, psychological and social factors."[5] It therefore parallels the aim of the psychosomatic movement of the 1930's which began with a reformer's proselytizing zeal to humanize medicine by emphasizing the whole-person approach.[6] The early phase of this movement was strongly influenced by psychoanalytic theory but, as Lipowski[7] pointed out, when the hoped-for efficacy of therapy based on psychoanalytic hypotheses failed, a widespread disenchantment with psychosomatic medicine followed.

The fruitful findings of many investigators who turned their attention to the patient's external environment paved the way for the reemergence of a holistic approach to illness. To Lipsitt[8] "the clinical psychosomaticians of the 30's and 40's became the liaison psychiatrists of the 50's and 60's." In the 70's, consultation-liaison departments continue to expand inside general hospitals but, according to Strain,[9] their ultimate success can be measured only by a decline in demand for their services, as other physicians ultimately assume responsibility for treating the whole patient.

Balint,[10,11] a pioneer in liaison psychiatry, identified many of the mind-body splits in his analysis of the doctor-patient relationship, drawing attention to the "mutual agreement" struck between the two participants. This agreement is based on the patient's offering and the doctor's response. Patients generally offer symptoms related to parts of the body such as "pain in the stomach"; doctors respond with investigation, diagnosis, and treatment of the pathologically changed somatic part function. If the diagnosis is beyond his grasp, the doctor calls in a specialist for consultation. The patient's feelings and emotions may also be considered as a separate part function and these, too, are turned over to a specialist—the psychiatrist. This is the traditional medical approach yielding traditional diagnosis and treatment. As Balint[12] wrote, however, "more often than scientific medicine cares to admit, it is not with the part but with the whole man that something has gone wrong." For Balint, an *overall diagnosis* that comprehends the whole patient with all of his

problems is the essence of the psychosomatic approach.

How collusion occurs

Yet an organic diagnosis remains the preference of most non-psychiatrists and whenever possible, doctors and their patients collude to camouflage the real distress. The physician's failure to make an *overall diagnosis* perpetuates the patient's split between mind and body not only between emotions and physical symptoms, but also between awareness of life stresses and their connection with the onset of illness. Doctors not familiar with the psychosomatic approach may show a similar division in their own attitudes which further enhance this collusion. Winnicott[13] indicated how the patient exploits these divisions within the medical profession. The maintenance of this mind-body split and the failure to make an overall diagnosis contribute to what Balint called a "collusion of anonymity" in which nobody really wants to take responsibility for the management or mismanagement of a case. Vital decisions may be made without anyone's openly accepting the full responsibility and, frequently, the patient is a willing accomplice. Referring to this phenomenon, Winnicott[14] used the phrase "scatter of responsible agents." In certain cases the cause of this scatter is the patient's mind-body separation: in others it occurs because of the doctor or the medical setting.

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The liaison psychiatrist seeks to overcome this deficiency in medical care by functioning both as consultant and mediator between patients and those taking care of them. Employing a psychosomatic approach and equipped with observational skills derived partially from psychoanalysis, the liaison psychiatrist frequently identifies mind-body splits that have important diagnostic and therapeutic implications. When attempting to translate these to doctor or patient, however, considerable resistance is often encountered, and this frequently results in failure to achieve integrated psychosomatic care.

Mind-body duality: patient, doctor, and hospital

The following examples illustrate the problems and attempts by a liaison psychiatrist at resolution.

Case 1

A 55-year-old professional man developed pain in his lower legs shortly after taking up jogging. The pains increased, radiating to his thighs even when he discontinued the exercise program. After consultations with his family doctor, whose diagnoses and recommendations failed, he was referred to a succession of specialists including two orthopedic surgeons, a cardiovascular surgeon, a physiatrist, and a rheumatologist. Multiple and expensive investigations were carried out and a variety of medical treatments prescribed without any relief of the problem.

In frustration, the rheumatologist advised a neurological or psychiatric consultation. The patient chose the former but, fortunately, the neurologist detected depression and requested a psychiatric opinion. During their first interview the patient told the liaison psychiatrist that he had intended seeking psychiatric help eventually because of marital and other personal problems but had decided to get his physical health in order first. He had successfully separated his problems into physical and psychological categories and discussed only the physical with his doctors. Unwittingly they had colluded with the patient by responding with excessive investigations of the somatic symptoms he offered. As each doctor failed, he referred the patient to another specialist trained to investigate that part of the body. By confronting the split, taking a complete personal and marital history, and recognizing the symbolic communication in the patient's symptoms, it was not difficult for the liaison psychiatrist to make sense out of what appeared to be a medical enigma. After individual and marital therapy, the patient's symptoms subsided.

Case 2

A 49-year-old man was admitted to a medical ward for control of labile hypertension. He also complained of a condition that he called "lethargy" and became increasingly frustrated and agitated when his doctor failed to treat it. His blood pressure was unresponsive to propranolol, and he resented his physician's insistence on prescribing higher doses of the drug. The liaison psychiatrist inferred from the patient's use of the word "lethargy" that there were powerful aggressive underlying impulses. The deteriorating doctor-patient relationship was further aggravating the patient's emotional state and he threatened to leave the hospital. Although the patient declared a direct link between his hypertension and his "lethargy," such a link could not be found by his doctor, who stubbornly insisted on treating the patient's "medical illness" with higher doses of propranolol while directing the psychiatrist to treat the patient's "mental disorder." Regrettably the doctor remained unreceptive

to the liaison psychiatrist's many suggestions which were based on the psychosomatic approach and an awareness of the dynamics operating in the doctor-patient relationship. The patient quickly signed out of the hospital, a move necessary for him to re-establish emotional equilibrium, and the liaison psychiatrist made further treatment recommendations to the family doctor with whom the patient had good rapport. Although this patient's complaint of "lethargy" required decoding, he did offer an overall statement about himself. In the hospital, it was the doctor's insistence on mind-body duality that led to responses that jeopardized a favorable outcome.

Case 3

A 61-year-old woman was hospitalized for investigation of chronic fatigue and other physical complaints. She was taking neostigmine for myasthenia gravis, diagnosed 19 years earlier when she complained of weakness after her father's death. She had chosen her father's doctor to be her physician and continued to consult him even after his practice was relocated in a distant city. Three years prior to this hospitalization she was placed on a regimen of two-hour feedings after her doctor diagnosed hypoglycemia. She was also taking thyroid hormone for hypothyroidism (diagnosed when she was 23) and took an A.S.A. butalbital compound for frequent headaches.

Exhaustive medical tests in the hospital demonstrated conclusively that she had neither myasthenia gravis nor hypoglycemia and even the diagnosis of hypothyroidism was considered equivocal. Examination by the liaison psychiatrist revealed chronic depression and a history of increasingly intense depressive symptoms occurring each year around the anniversary of her father's death. Communication between the patient and her doctor had always been around physical symptoms, however, and the psychiatrist's diagnosis of depression was met with considerable resistance by both the patient and her doctor. Over the years they had colluded in a relationship based on their mutual belief in the separation of mind and body. Despite much frustration in the relationship they were even more threatened by any suggestions that might have modified it or brought about any change in the patient's symptoms. The doctor informed the patient that he had "cured" her hypoglycemia and myasthenia gravis, and she was discharged from the hospital presumably to try a variety of other physical treatments for her multiple and chronic complaints.

Case 4

A 63-year-old man was admitted to the medical ward in a state of extreme inanition and dehydration. He was crippled from ankylosing spondylitis, blind from secondary uveitis, and had serious dental caries from neglect. He was severely depressed, refused food and fluids, and evoked considerable negative feelings among the nursing staff by his passive-aggressiveness. Although attempts were made to treat his depression medically, it became increasingly clear that he required transfer to the psychiatric ward for ECT. However, his physical state overwhelmed the psychiatric nursing staff who insisted that he was primarily a "medical problem" and should be treated on the medical ward. The medical staff continued to press for his transfer, claiming that he was really a "psychiatric patient." The mind-body split evinced by both staff groups resulted in the patient's being disowned. Nobody was willing to assume responsibility for providing him with integrated psychosomatic care.

Because of the administrative structure of the department of psychiatry, the liaison psychiatrist was not free to transfer the patient to the psychiatric unit nor could he treat the patient with ECT on the medical floor. He therefore spent considerable time and energy mediating between the various staff members, negotiating with them about their resistance to adopting a holistic approach. Eventually the patient was accepted on the psychiatric ward where he responded extremely well to a short course of ECT. His medical and dental problems were treated concurrently, and after successful rehabilitation he returned home in a cheerful mood and with a hearty appetite.

Conclusion

While the dominant model of disease remains dualistic and reductionistic,[1] various mind-body splits may arise in the patient, the doctor, or among members of the hospital staff resulting in poor quality medical care. Liaison psychiatrists with a psychosomatic approach have responded to the need for reducing mind-body dualism but largely by default, and their efforts show varying degrees of success. While Lipowski[7] optimistically considers the current revival of psychosomatic medicine to "mark the twilight of the golden age of reductionism," Schuffel and Schoneeke[15] proclaim a complete failure in teaching our medical colleagues. Clearly major changes in education of medical students and residents will prove more effective in promoting holistic medicine than liaison services which, coming after the fact, attempt to change the attitudes and resistance of contemporary physicians.

Innovative primary care training programs that include liaison psychiatry, as described by Lazarus,[16] are encouraging the reduction of mind-body dualism. But until many more psychosomatically-oriented physicians are trained, liaison psychiatrists will have to bridge the gap. Like the hyphen that Winnicott[13] retained in the

word "psycho-somatic," liaison psychiatry not only links mind and body—psyche-care and soma-care—but also draws attention to the marked separation between the two in medical practice. □

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