Editorial

The mind-body Cartesian dualism and psychiatry

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Abstract

The French philosopher René Descartes (1596-1650) argued that the natures of mind and body are completely different from one another and that each could exist by itself. How can these two structures with different natures causally interact in order to give rise to a human being with voluntary bodily motions and sensations? Even today, the problem of mind-body causal interaction remains a matter of debate.

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The French philosopher René Descartes (1596-1650) argued that the natures of mind and body are completely different from one another and each could exist by itself.[1,2] A major question arises from this mind-body dualism theory: how can these two structures with different natures causally interact in order to give rise to a human being with voluntary bodily motions and sensations? Until today, the problem of mind-body causal interaction remains a matter of debate. This topic will be discussed by Berrios in this issue (p 5).

This Cartesian view introduced a problem of incommunicability, especially difficult to solve for psychiatry and psychology. In fact, mental disorders should have either physical or psychic roots. Psychosomatics, as well as a bio-psycho-social model in psychiatry, have tried to reconcile this dual approach (see Henningsen in this issue, p 23). The close relationships between body and mind will be reviewed in this issue with the examples of coronary heart disease, diabetes, oncology, infertility, and psychosomatic diseases (De Hert et al, p 31; Sartorius, p 47; Penninx and Lange, p 63; Lang-Rollin and Berberich, p 13; Rooney and Domar, p 41).

Descartes also raised the question of consciousness ("I think, therefore I am") and argued that you cannot deny the existence of your mind while using your mind to deny it. Notwithstanding, consciousness in near-death experiences or out-of-body experiences seems to occur when the brain cannot function properly. These experiences challenge the current model of mind-body interactions and may improve our knowledge of consciousness and its relationships with brain functioning. Near-death or out-of-body experiences, associated with respectively 9% and 2% of cardiac arrests with successful resuscitation,[3] and their potential long-term adverse psychological outcomes will be discussed in this issue (Naber and Bullinger, p 73).

For many years, the brain basis of many psychiatric disorders has been poorly understood and difficult to treat, and thus these disorders have been called "functional" as if they had no organic roots because they defied neurological interpretation. This perpetuated the Cartesian dualism. Moreover, a split between neurology and psychiatry occurred when psychoanalysis took over psychiatry in Europe and in the USA during the early 20th century. Gradually, psychiatry has become separated from the rest of the medical specialties. This isolation has seriously damaged psychiatry and caused important recruitment and funding problems, as well as diminished value of careful diagnosis, therefore reducing psychiatry to a nonspecific psychological support, which contributes to increasing the stigma.[4] Yet, recent advances in neuroscience make it more and more difficult to draw a precise line between neurological disorders (considered to be "structural brain disorders") and psychiatric disorders (considered to be "functional brain disorders"). Fibromyalgia, as did neurosis in the past, filled a gap left between neurology and psychiatry. Fibromyalgia will be discussed in this issue (Häuser and Fitzcharles, p 53). ❑

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