

compos mentis

Beyond the Mind Body Problem: A Feminist Relational Model of Mental Illness and Identity

Sabine Bickford

Eastern Michigan University

ABSTRACT

The philosophical "mind body problem" has for centuries captured the time and attention of many disciplines. The apparent distinctions between, and similarities of, the mind and the body represent many of the assumptions we make about the idea of personhood. In many ways, mental illness can be used to represent some of the inherent contradictions of the prevailing theories about the mind body problem, but it ultimately also can provide the basis for a framework that moves beyond the problem and takes a more holistic approach to our minds, bodies, identities, and the medical/social models. In this paper I will explore the origin, context, and relevance of the mind body problem and the contradictions it presents using the works of René Descartes and Eve Browning Cole. I will then examine possible alternative approaches to our conceptions of mind and body through the work of Thomas Schramme, Gilbert Ryle, and Thomas Szasz; and finally will establish a feminist relational view of body, mind, and mental illness based on a framework presented by feminist disability scholar Alison Kafer.

KEYWORDS

Descartes, Schramme, Ryle, Kafer, Mental Illness, Identity, Mind Body Dualism, Relational Model, Feminism, Disability

I. THE PROBLEM WITH THE MIND BODY PROBLEM

René Descartes, in what is often considered to be the origin of the contemporary mind body problem, comes to the conclusion in his *Meditations on First Philosophy* that mind and body are essentially unrelated to each other. While Descartes feels confident in his own mind, he decides that he cannot fully trust his body. He cannot trust his own physical sense, nor can he trust that the body itself is even "real." He ultimately decides that the relationship between physical and mental states is unknowable and that the only thing that has relevance is his mind, which he defines by his capacity to think (Descartes [1641] 1967, 31).

In her book *Philosophy and Feminist Criticism: An Introduction*, Eve Browning Cole summarizes a feminist critique of Descartes' mind body dualism and the dualist ideologies that both followed and preceded it in three parts:

(1) The body's relationship to the mind... is one of... servitude; mind properly dominates its body and directs its actions while body properly obeys. (2) Mind's behavior and dispositions are, however described in terms more appropriate to masculine gender identity... while body's configurations tend toward the feminine... (3) Thus, while rationality becomes defined as a masculine project, an adorned and disciplined physicality becomes the feminine project... (Cole 1993, 67)

Essentially, by creating the Cartesian rhetoric of the mind's dominance over the body, the body's "holding back" of the mind, and the connection of the mind with the masculine and the body with the feminine, a framework has been created such that the continued perceptions of masculine dominance and feminine weakness/liability have been upheld. Non-white races are similarly viewed in terms of the body, with white women actually taking up the role of the "mind" in comparison to the implied physicality of people of color (Cole, 1993, 68). Though this dynamic somewhat complicates the original distinction, it also emphasizes the use of mind/body dualism rhetoric as a form of oppression.

Cole does not specifically mention disability, but looking at her criticism in terms of mental illness can provide further insight into the complicated framework of mind, body, and disability. If the body and mind were truly separate and unrelated entities, with the body acting as the "ghost" that controls the "machine," then mental illness would necessarily be a kind of unknown affliction of the mind,

separate and incomparable to the body. Yet we have moved toward a distinctly biological and somatic approach to mental illness in a way that we have not done with other aspects of the mind. Conditions like depression are often characterized with terms like "chemical imbalance," despite there being no known standard chemical or ratio of chemicals that cause it (Harvard Health 2009). Even our terminology of mental illness approaches it as a somatic condition. Words like "illness," "symptoms" and "treatment" indicate an approach that stems largely from a medical model. This seems indicative of our eagerness to somaticize aspects of marginalized groups such as the mentally ill, while continuing to actively uphold certain obscure notions of purity and separation for the dominant groups.

In addition to the somatic rhetoric, there is a popular notion of a kind of separation between one's mental illness and their core mind/identity/personality. Phrases like "I am not my depression" or "that's just the bipolar talking" reinforce the idea that there is some core part of us that is held back by the physical nature of mental illness. The idea of being a helpless victim of one's own biological limitations fits rather well with Descartes' original dualist perspective, but what does it mean that we are able to separate and pathologize mental illness while viewing the rest of the mind as infallible and existing above biology or medicine?

The ideas of educational accommodations, or a plea of "insanity" in court further show our willingness to separate ourselves from our mental illness in a distinctly biological/medical way. It is common to say that someone with "mental impairment" may be excused for their actions, but what about someone with a family history of/genetic disposition toward violence? It seems that, until such a predisposition has been medicalized, it not only does not count as a "valid" excuse, it also means that the moral burden falls directly on the mind of the person involved. There is also a distinct perception of agency that appears to be tied in. The underlying idea seems to be that one's agency is directly connected to the Cartesian "mind." If the mind is being "held back" by mental illness, then a person's agency, and perhaps their entire personhood is seen as flawed or altered. The lasting power of Cartesian dualism in upholding certain power dynamics is also seen in the ways in which people of color and women are often diagnosed with mental illness and institutionalized in large numbers. Of course white, upper class men are also diagnosed with mental illness (though I would argue this has more to do with access to high quality care) as well, but in general they are given considerably more agency. Where a wealthy white man may receive an official

diagnosis and treatment designed to help him individually through school or a job, a poor person of color is much more likely to receive their diagnosis and treatment through other, more systemic and dehumanizing means, such as expulsion from school, institutionalization, or conviction and imprisonment (Erevelles and Minear, 2010, 132).

Despite the apparent moral distinction, in actual practice it seems that the line between “personality” and “side effect” becomes much less clear. Someone with a cycling condition like depression may have periods of time where they are able to live without it, and view these periods of being as their true/unaffected selves. People with bipolar I disorder can be in a manic or depressive state for months, or even years and those who know them often claim that they seem like entirely different people when the switch is made, but what about someone who has something like ADHD or Autism their entire life? Is it fair to say such a person is “quirky,” or distractible, or are these merely symptoms unrelated to the core/pure mind underneath?

Psychiatric medications, in many ways, have been heralded as a way to “save” people with mental illness and uncover their true selves, in a rhetoric that is distinctly reflective of the way that the medical model treats physical illness. Those on psychiatric medications however, often report personality changes as “side effects” and make claims of not feeling “themselves,” again giving the impression that there is true self, and it is distinct from (or even obscured by) the pathology/biology of mental illness and medication.

II. LOOKING OUTSIDE OF THE PROBLEM

All of the examples I have provided thus far would seem to imply a contradiction somewhere down the line. If Cartesian dualism is correct, and the body and mind are two distinctly separate entities, then how can we view mental illness as a biological affliction of the mind? If dualism is incorrect and the mind is entirely biological/somatic, then why do we view certain traits such as morality, agency or core personality as legitimate; and why does our rhetoric for mental illness include language indicative of some sort of true self outside of such illness? These are all questions Thomas Schramme attempts to address in his paper *On the Autonomy of the Concept of Disease in Psychiatry*. Schramme begins with a look into the work of another philosopher, Thomas Szasz, who in 1974 made the impactful skeptical claim that mental illness does not exist (Szasz [1974] 2013,,

4). Szasz, by using the work of Gilbert Ryle (the inventor of the phrase "ghost in the machine"), claims that Descartes makes a fundamental category mistake in his original argument for dualism. By assuming that the people have both a mind and body, and emphasizing that they are two separate things, Descartes has put the two into the same logical category, a mistake in both Ryle's and Szasz's views. Ryle gives the example of a logical categorization error through the example of a student going on a tour of the buildings of a university. The student then asks to see "the" university, failing to realize that the university is not one of the buildings, but a more conceptual category that the buildings are a part of (Ryle, 2009, 6). Szasz argues that, just as a building and a school are entirely different categorizations of "thing," so are the body and mind. He continues that, since body and mind are not actually in the same logical category, it is impossible for mental illness to exist given his conception that illness is a concept only applicable to the type of thing that a body is.

This argument against mental illness however, is not particularly different from one against the reality of mental illness based on Cartesian dualism. Though Szasz's point is that mental illness could only be applicable as the same type of "illness" that bodies contract if the mind and body were of the same logical category, Schramme points out that there is no real indication that the concept of "illness" can only be applied to a certain logical category (for example, one could describe a university as "old" while also describing a specific building at that university as old). This conception is not any more likely than a Cartesian view that "illness" is categorically part of the body itself, and a way of actually distinguishing the body from the mind within the same logical category.

Schramme goes on from this dismissal to formulate his own theory on mental illness and psychiatry, advocating that they "should be neither "mindless" nor "brainless," (Schramme, 2013, 3). While Schramme denies that Szasz's conception of the "myth of mental illness" is correct, he agrees with both Szasz and Ryle's rejections of Cartesian dualism as erroneously presenting mind and body as existing within the same logical category. He further rejects the eliminative viewpoint that our "folk-psychology" conception of the mind and all of its desires/beliefs/wants does not exist in any meaningful way, and the reductive viewpoint that all of our mental states can simply be reduced fully down to purely biological/physiological states, for similar reasons to the contradictions that I have previously explored. Schramme argues "the rejection of these accounts leads to the possibility of an

independent conceptualization of mental illness," (Schramme, 2013, 8). Meaning that mental illness does not necessarily have to fall into one of the categories that have created our original dilemma in the first place. Schramme does not discuss in detail what this independent conception of mental illness might look like, if it were not bound to reductionist, eliminative, Cartesian, or Szaszian ideals, but we can look to feminist scholar Alison Kafer for an idea of what this new model for mental illness could be.

III. A FEMINIST RELATIONAL MODEL OF BODY AND MIND

In the first chapter of her book *Feminist, Queer, Crip*, Alison Kafer critically examines both the "social" and the "medical" models of disability, in an exploration that parallels that of the mind body problem. She finds that the medical model, like the reductive or eliminative viewpoints on mental illness, takes an inflexible stance and does not account for the genuine lived experiences and day-to-day lives of people with disabilities, or for the idea of disability as identity. The social model accounts for these factors in a more comprehensive way, as a Cartesian view, or Szasz's view might, but Kafer notes that it also "erases the lived realities of impairment... overlooks the often-disabling effects of our bodies... social and structural change will do little to make one's joints stop aching" (Kafer 2013, , 7). Similarly, certain mental illnesses like depression have very real and very painful effects on one's day-to-day life, and simply claiming that depression is not real, or cannot be defined, will not alleviate its very real harm in the way that a more medical approach like medication (or other treatments) may be able to for some.

Instead, Kafer—just as Schramme does—implies that the oppositional distinction between the medical/body and the social/mind frameworks is a categorical error, and instead advocates for a more flexible and relational approach. Disability (and mental illness specifically, in Schramme's case/the case of this paper) need not be placed in a false and limiting dilemma between the biological/medical/somatic (body) and the social/unknowable/other (mind). Instead, Kafer proposes what she calls the relational (or political/relational) model of disability. The relational model acknowledges the limits of the medical model and acknowledges that built, political, and social environments have much to do with disability as it is both perceived and experienced. This relates directly to my earlier discussion of the institutionalization and criminalization of certain groups with mental illness, and more largely to the idea of somatization and medicalization as continued forms

of oppression and perceived inequality of marginalized groups like women and people of color. The political/relational model also takes a very important stance by establishing disability as a non-concrete category. Kafer wishes to see disability not as a separate, concrete condition, but as a condition that exists in a political/social context, and in relation to others. This is a similar feminist perspective to that provided by Cole, as an alternative to the more Cartesian method of associating individuality and seclusion with a type of "pure" rationality. This contextualizing of disability is crucial to the idea of mental illness, and is able to eliminate many of the original apparent contradictions of the mind body problem and mental illness, such as the flexible distinctions between personality and mental illness. Using the relational model, we can acknowledge that apparent contradictions like the emergence of both somatic and personality-based aspects of mental illness can exist alongside each other. In part because of the categorical error that puts body and mind in opposition, but also because of the inclusion of social/political factors that can account for seemingly oppressive aspects of both the social and medical models of mental illness. This model can then also account for an acceptance of mental illness as an aspect (but not the entirety of) identity, rather than placing it in opposition to one's "true" personality. Such an understanding can then lead to the idea of personality and identity being shaped by, but not limited to disability, in the same way that they are shaped by other aspects such as gender, race, or sexuality. Instead of saying "I am not my depression," someone under Kafer's feminist relational model may say something like "my depression is a part of me, but it is only one of many aspects of my identity." Similarly, someone who commits a violent crime could be viewed in court as being influenced by their genetic history, but not automatically excused or entirely culpable, and a suitable sentence could be determined based upon this framework (as has happened in the past with certain mental illnesses, but not in such a broad context).

Overall, when looking at mental illness and philosophical concepts like the mind body problem, it can become very easy to fall into the rhetorical framework of apparently necessary dichotomies. But these dichotomies, like Descartes's own conception of dualism, are not necessarily the only choices, and may fall into category errors of their own. By examining mental illness in more relational, political, and independent terms such as those espoused by feminist theorists, as well as by the acknowledging some of the negative conditions of living with it, we can begin to develop a conception of it that avoids falling into faulty categories

and instead focuses on a more holistic approach toward the nuanced interactions among disability, identity, mind, and body.

REFERENCES

- Cole, Eve Browning. 1993. *Philosophy and Feminist Criticism: An Introduction*. New York: Paragon House.
- Descartes, René. (1641) 1967. *The Philosophical Works of Descartes*. Translated by Elizabeth Sanderson Haldane. London: Cambridge U.P. Internet Encyclopedia of Philosophy.
- Erevelles, Nirmala, and Andrea Minear. 2010. "Unspeakable Offenses: Untangling Race and Disability in Discourses of Intersectionality." *Journal of Literary & Cultural Disability Studies* 4 (2): 127-45.
- Kafer, Alison. 2013. *Feminist, Queer, Crip*. Bloomington: Indiana University Press.
- Ryle, Gilbert. 2009. *The Concept of the Mind*. New York: Routledge.
- Schramme, Thomas. 2013. "On the Autonomy of the Concept of Disease in Psychiatry." *Frontiers in Psychology* 4: 1-9.
- Szasz, Thomas S. (1974) 2013. "The Myth of Mental Illness." In *Perspectives in Abnormal Behavior*, edited by Richard Morris, 4-11. Amsterdam: Elsevier.
- "What Causes Depression?" *Harvard Health*. Last modified June 09, 2009. <http://www.health.harvard.edu/mind-and-mood/what-causes-depression>.