Transcendence and healing

W Glannon

J Med Ethics; Medical Humanities 2004;**30**:70–73. doi: 10.1136/jmh.2002.000145

Healing aims to restore the wholeness of persons by restoring the unity of mind and body disrupted by disease. Transcendence promotes healing by altering or cultivating beliefs that can modulate the body's response to pain or make sense of pain. This in turn can produce an emotional response that enables people to cope with chronic or terminal illness. I explain transcendence in terms of a monistic rather than dualistic conception of mind and body, which supports the idea of medicine as a healing art as well as a curative science.

brain, which regulates our awareness of the body. Transcendence may also be achieved by finding meaning for pain and suffering by relating them to a larger spiritual or religious framework. A patient's spiritual or religious beliefs can frame his interpretation of and response to his medical condition. The two forms of transcendence I have described are based on a monistic rather than dualistic conception of mind and body. Mental states and physical states of the body and brain are interdependent and mutually influential. I will present examples illustrating different ways in which beliefs can be reframed or cultivated to generate positive emotions in response to pain and terminal illness and thereby show how transcendence can promote healing.

There has been controversy in medicine over the question of whether or to what extent the mind can causally influence the body. Earlier studies suggesting that group psychotherapy could prolong survival in patients with cancer, for example, have been debunked by more recent studies.^{1–3} But this does not mean that the mind has no positive role in medicine and that it cannot benefit patients. The beliefs, emotions, and other states that constitute the mind can alleviate the suffering resulting from pain, loss of control, and hopelessness in chronic and terminal illnesses. Cultivating or altering certain beliefs can affect the body and brain and in turn generate an emotional response that enables patients to cope with these conditions. Although the mind may not cure their bodies of disease and extend their lives, it can heal persons by making them whole again. By generating a salutary effect on the subjective experience of pain and illness, healing restores the experience of mind and body as a unity. The experience of this unity is essential to being a person.

Healing can occur along different dimensions and in varying degrees. I will focus on the phenomenon of transcendence as one of these dimensions. Transcendence consists in shifting or relating our immediate experience of an event or state to a different type of experience that is beyond or otherwise distinct from that event or state. In life threatening diseases, transcendence may be achieved by generating beliefs that shift one's awareness away from the future as a source of fear to an awareness of the timeless present. The alteration of a person's conscious sense of time can alleviate pain and suffering by enabling the person to be less attentive to the features of the body that cause pain. This can come about through such techniques as hypnotic suggestion, meditation, or biofeedback. The alteration of beliefs through these techniques can reduce the sensation of and emotional reaction to pain by modulating the somatosensory system in the

MIND AND BODY

Substance dualism derives from Descartes and holds that mind and body are ontologically distinct substances.⁴ The criterion for the existence of the mind is independent of the criterion for the existence of the body. The mind is essentially an immaterial substance, while the body is essentially a material substance. Although mind and body can causally interact, the mind can exist and function independently of the body. But if the mind is conceptually independent of the body, then it is unclear how the two substances can causally interact. Substance dualism is therefore inadequate in explaining the relation between mind and body. Some might defend property dualism, which distinguishes between mental and physical properties. Yet this still leaves us with the problem of explaining how these two types of properties can causally interact if they are ontologically distinct.

Monism is a more plausible alternative to dualism. Monism says that mind and matter are essentially the same.⁵ There are different versions of monism, and arguably the most plausible is the version associated with Spinoza. This says that the mental and the physical are two modes or aspects of a single substance. The psychological events and states of the mind and the physical events and states of the body are not ontologically distinct but instead are two inseparable, interdependent aspects of a human being. The mind is a higher level set of psychological states and events emerging from lower level set of physical states and events in the body. The mind emerges from the brain and body as a means of representing the external environment to a human organism, which cannot be done by the organism's physical components alone. The main feature of mental representation is *intentionality*. Mental states such

Correspondence to:
W Glannon, Centre for
Applied Ethics, University
of British Columbia,
Vancouver, BC, Canada;
wglannon@ethics.ubc.ca;
wglannon@cw.bc.ca

Accepted for publication
8 December 2003

as beliefs are intentional in the sense that they are *directed toward* events and states of affairs external to our bodies. Although it is related to intentionality, the capacity to construct meaning for the events we perceive is of a higher order than intentionality as such. Finding meaning in an event often involves attributing an existential or spiritual significance to it, relating the event to something larger than what we simply apprehend with the mind's eye. Physical states of the body and brain cannot refer to anything beyond themselves and therefore cannot account for intentionality or meaning. Moreover, the mental states involved in the construction of meaning have a first person qualitative aspect that cannot be completely explained in physical terms either. Yet because the mind is generated and sustained by the body and brain, it cannot be separated from them. The mind does not become independent of the body once it emerges from it. Indeed, the inseparability of and interaction between mind and body is what makes possible the two types of transcendence I have described. In both cases, the ability to move beyond the immediate experience of pain by shifting our conscious awareness away from it is possible only because of the causal interaction between mind and body. This suggests that the conception of mind that best explains this phenomenon is monistic rather than dualistic.

In the first type of transcendence, beliefs can alleviate pain sensation and pain affect because they can modulate the somatosensory system in the brain. This is possible because beliefs and other cognitive states are grounded in and sustained by the brain's prefrontal cortex, which interacts with the regions of the somatosensory system. If beliefs were independent of these brain systems, then there would be no way of explaining how the mind could causally influence, and be influenced by, the brain. In the second type of transcendence, the ability to construct meaning for one's pain and suffering by framing them within one's spiritual or religious beliefs cannot be separated from the body and brain either. Meaning involves intentionality, which involves mental states over and above physical brain states. But this does not imply a separation of the mental and the physical. The capacity to find or construct meaning requires the normal functioning of systems in the brain regulating the formation, storage, and retrieval of memories. Without the connection between the formation of new memories and the retrieval of stored memories in the hippocampus and neocortex, a person would not be able to construct a meaningful narrative out of painful events in her life. She would not be able to make sense of these events by relating them to other events in a coherent framework of beliefs.

Transcendence involves mutually influencing mind/body interactions. It affirms rather than rejects the unity of mind and body. Altering beliefs about the body, or situating these beliefs within a religious or spiritual framework, can modulate one's perception and experience of pain. This can transform negative emotions such as fear and hopelessness into positive emotions such as hope, which enable people to cope with painful and terminal medical conditions.

CURING AND HEALING

Most diseases, and many treatments for them, can cause patients to experience pain and suffering. Cancer and chemotherapy are obvious examples. Pain is a perceptual and affective experience caused by bodily damage involving the sensory nerves.⁶ Suffering is related to but distinct from pain. Eric Cassell defines suffering as "the state of severe distress associated with events that threaten the intactness of the person".⁷ Unlike pain, suffering does not have a somatic location in the body. Although suffering usually accompanies pain, a person can suffer without experiencing pain. Someone who knows or believes that he will develop a late

onset genetic disease such as Huntington's disease can suffer before symptoms appear. He may suffer from the negative perception of what awaits him in the future. In many cases, though, pain and suffering are closely related in that both consist of cognitive and affective dimensions. In fact, pain is not only a somatic condition. In addition to involving the sensory nerves of the body, pain is a complex cognitive and affective experience involving beliefs and emotions influenced by one's history and one's present state of mind, which can also be influenced by one's physical and social environment. Moreover, the duration and intensity of pain are strongly influenced by the perception or fear in peoples' expectation of pain. Because the expectation of pain can influence one's experience of it, and because the expectation and experience of pain can cause one to suffer, pain and suffering are intimately related. Pain becomes suffering when the emotions or feelings associated with pain are negative, inclining the patient to perceive or feel his body as a source of distress and alien to him. He feels the disruption of the integrity of himself as a whole person, losing the unity of mind and body that grounded his self. Mind and body come to be perceived as separate, mutually antagonistic entities.

The idea of pain as a disruptive force has a rich ancestry. Aristotle, for example, emphasised that pain upsets and disrupts the nature of the person who feels it.⁸ Yet, to a certain extent, the capacity to feel pain is essential to one's sense of self. The sensory nerves that enable one to feel pain are what connect one's body to one's mind. All of our sensory experience of the external world is mediated through the body. Nerve blocks and other forms of anaesthesia that desensitise the arms or legs can create the feeling of dislocation, as though the affected body parts did not belong to us. Furthermore, the capacity to feel pain protects by making us averse to burns and other deforming injuries. Pain as such is not harmful to us but is essential to our survival. Pain causes suffering and disrupts our selves when its intensity and duration reach a point where we feel that our conscious beliefs and emotions are prisoners of a body that feels alien to us. Healing aims to restore the self by reintegrating the mind and body and thus the integrity of the whole person.

"Cure" derives from the Latin *curare*, "to care for". "Heal" is from the Old English *haelen*, "to become whole or sound". Cicero used *curare* to mean "to cure an invalid" or "to cure a disease".⁹ Curing, then, plausibly pertains to psychological as well as physiological conditions. On this broad sense of the term, curing seems equivalent to healing. Unfortunately, the modern use of "cure" has become narrower and is usually limited to stopping a disease process, with little or no consideration for the patient's psychology. It suggests a dualism that separates persons from their bodies. "Healing" has retained its broader meaning, which includes both physiological and psychological conditions. It thus preserves the monistic idea of the person as a unity of body and mind. In the modern, narrow sense of curing, a person can be cured without being healed. Conversely, a person can be healed without being cured. This can occur in chronic and terminal diseases, where healing involves gaining a measure of psychological control over a disease despite losing physiological control over its progression.

Howard Spiro claims that "healing has more to do with spirit than with body".¹⁰ But this suggests a duality of mind and body as distinct entities. If persons are beings with both spiritual (mental) and bodily dimensions, and healing makes a person whole again, then healing involves both spirit and body. Spiro's further claim that "doctors sometimes cure diseases, whereas healers help illness" also suggests that doctors are obligated only to cure disease, not also to address the non-physiological dimensions of patients' needs (Spiro,¹⁰

p 136). On this view, when there is no longer any hope of curing or controlling disease, presumably a doctor's duty to a patient ends. But the duties of non-maleficence and beneficence to patients should be more broadly construed. Healing patients by alleviating their pain and suffering can benefit them, even when their diseases cannot be cured or controlled. The benefit is qualitative rather than quantitative. It pertains not to extending the patient's life, but to improving the quality of his life despite disease.

TWO TYPES OF TRANSCENDENCE

An expectation is a cognitive state of belief that some event will occur. The belief that one will experience pain at some future time generates the affective state of fearing pain. This can negatively influence one's perception of the future and generate suffering. Altering a patient's perception of time, by shifting her conscious awareness away from the future and past to the immediacy of the present, can reduce or eliminate fear, reduce suffering, and facilitate healing. Hypnosis can be especially effective in reframing one's cognitive states about time. This mental technique can reduce anxiety and fear of the future for patients with a grave prognosis, or those who have to undergo painful treatment. It is one way of achieving the first type of transcendence.

Cassell describes the case of a woman with stomach cancer which illustrates the salutary effect of hypnosis in altering the patient's temporal awareness. After completing one course in chemotherapy, she fearfully anticipated the next treatment. Hypnosis was able to reduce her memory and anticipation of pain: "Her chemotherapy was likened to watching telephone poles from the window of a train. They [the treatments] are not there until they suddenly 'arrive' and then they quickly disappear. Although weakness, some nausea, and poor appetite lasted for a brief period post-chemotherapy, the problem had greatly lessened, as had the anticipation of the next treatment" (Cassell,⁷ pp 239–40).

Hypnosis enabled the woman to reframe her mental states and thereby make herself less attentive to the sequence of events affecting her body and more attentive to the immediacy of the present moment. She was able to reduce her pain and suffering by regulating "mind time", which is how one experiences the passage of time and how one organises chronology. This altered her perception of the events affecting her in "body time". Although the woman eventually died from the cancer, the hypnosis enabled her to control her responses to pain and be in command of her feelings and emotions until the end of her life.

Neurologist Antonio Damasio and colleagues have reported a similar effect of this technique.¹¹ In experiments designed to manage chronic and intractable pain, hypnotic suggestions were given to a group of patients. The suggestions reduced both their sensation of pain and their emotional reaction to pain. Positron emission tomography (PET) scans showed that the hypnosis that altered the patients' perception of pain caused changes in the primary somatosensory cortex and the cingulate cortex of the brain. These changes in turn reduced pain sensation and pain affect. The process went from an altered belief state to an altered brain state, which then resulted in a positive emotional state. The effect of hypnosis in these cases should not be characterised as "mind over matter", but instead as mind and matter interacting with each other. Altering one's perception and feeling of pain through hypnotic suggestion is made possible by the fact that beliefs are generated and sustained by certain regions of the brain and can influence these regions.

The second type of transcendence consists in the capacity to see ourselves as belonging to and participating in something larger than our own bodies and minds. This enables us to find meaning and purpose in pain and suffering by relating

them to a larger framework. Theologian John Hick calls this capacity the "fifth dimension" of our human nature, the dimension of our being that is "either continuous with, or akin to and in tune with the ultimate reality that underlies, interpenetrates and transcends the physical universe".¹² Our bodies are part of this physical universe. Transcending, or overcoming, the feeling of one's self being broken by a diseased body does not, however, imply a rejection of the body. Rather, transcendence enables a patient to achieve atonement with her body, to be at one with it and thus restore the unity of mind and body and the integrity of the whole person. This can be realised by the person seeing herself as part of a universal human community larger and more enduring than her life alone.

Cassell writes: "the quality of being greater and more lasting than an individual life gives this aspect of the person its timeless dimension" (Cassell,⁷ p 14). Universality and timelessness, the experience of the eternal present, are the two defining features of the second type of transcendence. Significantly, unlike the curative model, healing through transcendence shifts the focus of care away from the physician to the patient. The physician's role is more of a facilitator than an agent. The outcome of the recent studies on group psychotherapy for women with metastatic breast cancer is a good example of this. Although these interventions did not prolong patients' lives, they improved the quality of the remainder of those lives. The patients did not live longer, but they experienced less distress and pain than patients who did not receive group therapy. They benefited from it even though their disease was neither cured nor controlled. In other words, the therapy healed them. The benefit likely came from each patient identifying with the larger group, which could be taken as a microcosm of humanity. Moreover, their reduced pain and distress could be attributed to the effect of the therapy on their temporal awareness, shifting their attention from the future to the present.

Anne Harrington's account of a remark from a woman in a similar group of patients with metastatic breast cancer further illustrates the importance of patients' attitudes toward time when afflicted with a terminal disease. Asked whether she believed she would live longer when so many other members of her psychotherapy group were dying, the woman responded: "'I guess if you could eliminate the concept of time, you could say that we live longer'".¹³ She did not literally mean that she would live longer. Instead, she meant that, by shifting her attention from the horizontal dimension of life extension to the vertical dimension of her connections with others in the here and now, her life was enriched and its meaning deepened. She transcended the distress and hopelessness of her terminal illness by seeing herself as an integral part of a timeless interpersonal dimension and thereby healed herself.

In some cases, transcendence consists in focusing on and accepting one's pain. Pain and suffering themselves are essential to the meaning one finds in one's life and death. This is critical to the concept of redemptive suffering. One redeems and achieves atonement with oneself and with a higher authority by transcending the ego through wilful acceptance of pain and suffering. This may involve refusing all medication and other interventions to relieve pain. Patients who practise this may model their lives on the example of the Crucifixion. Consider the case of a woman with breast cancer, with lesions over much of her body, who was admitted to an inpatient hospice care unit of a hospital. The constant dressing changes were extremely painful. When asked by her doctors whether they could do anything to make her more comfortable, she responded: "What would we think of Christ on the Cross if he had been given your

medicines?'.¹⁴ For this patient, the suffering she bore during her life had value for her because of what it meant for the life to come. She identified with Christ's suffering and its implications for her belief in her own personal redemption.

When it is clear that a patient's religious beliefs are an essential part of her worldview, a physician can benefit that patient by facilitating or at least respecting the expression of her beliefs. In these cases, spirituality and religion can play an important role in the patient's ability to cope with and make sense of her illness.¹⁵ This can be especially helpful when a patient's physical condition is not improving despite medical treatment. Religious beliefs can enable a patient with a chronic or terminal condition to regain control of her situation. They can give hope, purpose, and meaning to negative life circumstances and transform them into something positive. Significantly, spiritual and religious healing presupposes interaction between mind and body as two inseparable aspects of a person. The case that I have just presented involves a different temporal perspective from that of the psychotherapy group with cancer. Here the ability to make sense of an illness by situating it within a framework of religious beliefs consists in constructing a meaningful narrative from the present by linking actual events in one's past to possible events in one's future. This requires the normal working of the hippocampus, neocortex, and other structures in the brain that regulate the formation, storage, and retrieval of memory.

CONCLUSION

I have discussed two types of transcendence as ways to promote healing. While the first type promotes healing by altering one's perception of the body and of time, the second type promotes healing by making sense of illness within a framework of spiritual or religious beliefs. Both practices can reduce suffering by enabling patients to gain a measure of control over disease and pain and thus cope with these. Transcendence can promote healing most effectively in cases where patients are beyond the hope of cure in the final stage of their lives.

A monistic conception of the relation between mind and body offers a better explanation of transcendence and healing than a dualistic conception. People can reduce or make sense

of pain and suffering because beliefs can cause changes in the body and brain, and because these physical changes can in turn modulate the experiences of pain sensation and pain affect. The two types of transcendence I have described are examples of beneficial mind/body interactions in medicine. They can be a critical factor in healing, restoring the integrity of the whole person by restoring the unity of mind and body disrupted by disease. Healing can be especially beneficial to patients with terminal diseases, because it is often the fear, loss of control, and hopelessness caused by these diseases that cause patients to suffer. In this and other stages of patients' lives, medicine can and should be a healing art as much as a curative science.

REFERENCES

- 1 Spiegel D, Bloom J, Kraemer H, et al. Effects of psychosocial treatment on survival of patients with metastatic breast cancer. *Lancet* 1989;186:888-91.
- 2 Goodwin P, Leszcz M, Ennis M, et al. The effect of group psychosocial support on survival in metastatic breast cancer. *N Engl J Med* 2001;345:19-26.
- 3 Petticrew M, Bell R, Hunter D. Influence of psychological coping on survival and recurrence in people with cancer: systematic review. *BMJ* 2002;325:1066-9.
- 4 Descartes R. Meditations on first philosophy. In: Cottingham J, ed and trans. *Descartes, meditations on first philosophy with selections from the objections and replies*. [2nd ed]. Cambridge: Cambridge University Press, 1996.
- 5 Churchland PM. *The engine of reason, the seat of the soul*. Cambridge, MA: MIT Press, 1996.
- 6 Melzack R, Wall P. *Textbook of pain* [4th ed]. Edinburgh: Churchill Livingstone, 1999.
- 7 Cassell E. *The nature of suffering and the goals of medicine*. New York: Oxford University Press, 1991:35-6.
- 8 Aristotle. *Nicomachean ethics*. Book IV, 1119a23-24. In: Barnes J, ed and trans. *The complete works of Aristotle: volume II*. Princeton: Princeton University Press, 1984.
- 9 Cicero. *De finibus*, 1, 13. In: Adler MJ, Doren CV, eds. *Great treasury of western thought*. New York: RR Bowker, 1977:1147.
- 10 Spiro H. *The power of hope*. New Haven: Yale University Press, 1998:137.
- 11 Damasio A. *The feeling of what happens*. New York: Harcourt Brace, 1999:75-6.
- 12 Hick J. *The fifth dimension: an exploration of the spiritual realm*. Oxford: One World Press, 1999:2.
- 13 Harrington A. *Ideas: rethinking medicine: health and healing in the twenty first century*. Toronto: Canadian Broadcasting Corporation, 2000:65.
- 14 Lynn J. Travels in the valley of the shadow. In: Spiro H, Peschel E, Curnen M, et al, eds. *Empathy and the practice of medicine*. New Haven: Yale University Press, 1993:44.
- 15 Koenig HG, McCullough M, Larson D, et al. *Handbook of religion and health*. New York: Oxford University Press, 2001.