
Physical or mental? A perspective on chronic fatigue syndrome

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This paper examines the question of whether chronic fatigue syndrome (CFS), often known as myalgic encephalomyelitis (ME), should be classified as a physical or mental illness.

The distinction made between physical and mental illness has far-reaching effects. Within medicine there are lists of illnesses considered to be mental disorders which are distinguished from those known as physical disorders. These lists appear in official classifications such as the ICD and the DSM. They are reflected in textbooks which only deal with illnesses considered to be mental ones. Although there is much dispute over some illnesses, there is also a large measure of agreement within medicine about which are to be called mental illnesses and which are not.

This demarcation is reflected in many other ways within medicine. There is a medical speciality which deals with mental illnesses (psychiatry), there is a branch of the National Health Service which deals with mental illnesses (the Mental Health Services), there are specially trained personnel (such as psychiatrists) who deal with people who have mental illnesses and there are special medications (e.g. antidepressants) and other treatments which are considered appropriate for those with mental illnesses.

In the wider world, the distinction between mental and physical illness is also widely used, with similar far-reaching effects. Regrettably, many of these are negative for people whose illnesses are classed as mental. In employment, those with a mental illness label may find themselves at a disadvantage; in financial matters, penalties may be imposed by insurance companies, pensions agencies or the state Benefits Agency; in society generally, there may be stigma.

A financial penalty

A clear example of the financial penalty attached to a diagnosis of mental illness comes from the current regulations relating to the mobility component of the disability living allowance.

The mobility component is paid at two rates. One of the qualifying conditions for the higher rate is that the person must be 'suffering from physical disablement'. If the disablement is judged to be psychological in origin, rather than physical, the person will only be entitled to the lower allowance. There is a substantial difference between the two rates, currently amounting to £24 per week (£1488 per year). The quality of life of people on a very low income, as those with chronic illnesses frequently are, can be substantially affected through being barred from receiving the higher allowance.

Criticisms of the distinction

Despite its widespread use, the distinction between mental and physical illness is currently the subject of much criticism (Box 1; Kendell, 2001). This can largely be summarised under five headings.

1. Criticisms of the term 'mental'

A frequent criticism is that this suggests an independently existing (Cartesian) mind (White, 1990; Ware, 1993). As DSM-IV puts it:

'The term *mental disorder* unfortunately implies a distinction between 'mental' disorders and 'physical' dis-

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Box 1 Criticisms of the distinction between physical and mental illness

The word 'mental' suggests a Cartesian mind
There are many common misconceptions associated with mental illness:

- that mental and physical illnesses are polar opposites
- that mental illnesses are not real or are of less importance
- that people with mental illnesses are responsible for their condition

Stigma is associated with mental illness

There are boundary problems (particularly with neurological illnesses and somatoform disorders)

There are no satisfactory definition or common features of mental illness

orders that is a reductionistic anachronism of mind/ body dualism' (American Psychiatric Association, 1994: p. xxi).

2. Misconceptions associated with mental illness

Mental and physical illness are polar opposites. Mental illnesses have only mental symptoms and only mental causes, and only mental treatments are appropriate; physical illnesses have only physical symptoms and only physical causes, and only physical treatments are appropriate.

Mental illnesses are not real, or are less important than physical illnesses.

Individuals with a mental illness are responsible for their condition; they could, if they made an effort of will, pull themselves out of it.

3. The association of stigma with mental illness

Critics argue that if the distinction between mental and physical illness were abolished, or the difference between the two were minimised, this would abolish or reduce the stigma attached to mental illness.

4. Boundary problems in connection with particular illnesses

It is pointed out that the distinction between neurological illnesses and some mental illnesses appears to be arbitrary and is essentially due to historical accident. There are also difficulties in drawing the boundaries of somatoform and similar disorders.

5. Lack of features distinguishing mental from physical illness

The absence of any features of mental illness by which it can be clearly distinguished from physical

illness also leads to the lack of any satisfactory definition of the former. Both mental and physical illnesses have mental and physical symptoms, mental and physical causes and can be treated appropriately by mental or physical treatments.

Further responses needed

Such criticisms are important and valuable. However, I suggest (Box 2) that four further responses are needed.

First, care should be taken not to overstate the difficulties associated with the current distinction. Sometimes it is said that the distinction implies Cartesian dualism, but this overstates the problem. The distinction does not *imply* Cartesian dualism, although it may *suggest* it to some people. Talking of mental illness does not imply the existence of some independent entity, the mind, any more than to talk about psychological illness implies the existence of some independent entity, the psychology of the person involved. In a similar way we can talk about the side view or the frontal view of a mountain or a person, without implying that the side view and the frontal view exist independently. The fact that two things can be conceptually distinguished (conceptual dualism) does not imply that they have some kind of separate independent existence (ontological or Cartesian dualism).

Second, the distinction between mental and physical illness is sometimes said to be meaningless. This view has been attributed to the authors of DSM-IV (Kendell, 2001). However, to say that a patient has a mental illness is certainly not meaningless. There is a difference between the definition and the meaning of the term. Just because we cannot precisely define mental illness, it does not follow that the term has no meaning. There are lists of illnesses which are considered to be mental illnesses (see ICD-10 and DSM-IV); to say that a patient has

Box 2 Further responses to the distinction between physical and mental illness

The difficulties of the distinction should not be overstated

The distinction does not *imply* a Cartesian mind
The distinction is not meaningless

The need for some kind of distinction should be recognised

Substantial efforts need to be devoted to finding and introducing a better distinction

While the distinction remains, clinicians must work with it in the best interests of patients

a mental illness at least involves saying that he or she has one of the listed disorders or something very similar. Further, as has already been pointed out, to classify an illness as mental rather than physical, can have far-reaching effects for the patient both in the medical treatment provided and in society generally. When patients claim that their illness is a physical one, their claims cannot be brushed off on the grounds that they are meaningless.

Third, the need for some kind of distinction should be recognised. Some kinds of mental illness are very different from some kinds of physical illness and we need a way of marking the difference. Schizophrenia and gout, for example, are very different.

Fourth, there needs to be greater recognition of the importance of finding and introducing a better distinction and taking appropriate action. The current distinction causes difficulties which present a significant impediment to good communication among doctors and between doctors and patients, with unhappy results for both parties. Significant resources need to be devoted to improving the way in which the distinction is drawn, for this apparently theoretical task has important practical implications.

Very importantly, while the distinction is in widespread use, clinicians, including psychiatrists, need to be willing to work with it and use it intelligently in the best interests of their patients.

Why clinicians need to work with the distinction

The reason why clinicians, including psychiatrists, need to work with the distinction is simple, although its importance is often overlooked. If clinicians do not place their patient's illness in one category or the other, they can be sure that other colleagues will do so. Within medicine, the patient's illness will be categorised by medical researchers, administrators and nosologists. Outside medicine, administrators in employment and financial agencies will do the same. However, the decision made by others may not be appropriate or fair, or in the best interests of the patient. Many of the financial agencies have vested interests and their decision may reflect those interests rather than the true state of affairs.

The classification of CFS

Medically unexplained somatic syndromes are difficult to classify as either physical or mental illnesses. I will take CFS as an example (for a recent

review of CFS see Pinching, 2000). The problem is that many patients experience CFS as a physical illness – they often say that they had something like bad influenza or a viral attack from which they have never properly recovered. Komaroff (2000) reviews the biology of CFS, citing evidence of biological abnormalities of the central nervous system and the immune system. However, medical scientists have not yet been able to establish an undisputed physical basis for the continuing symptoms and some people therefore conclude that the illness must be a mental one, caused by mental or psychological problems and hence it should be classified as a mental illness.

I will argue that, even taking a sympathetic stance on psychological causation, there are no good grounds for saying that CFS is generally due to psychological problems. It should therefore not be classified as a mental illness.

Psychological causation in DSM and ICD

The notion of psychological causation in DSM and ICD in connection with somatoform disorders is of particular relevance to discussions of CFS.

When DSM-III was published (American Psychiatric Association, 1980), it abandoned the concept of neurosis and, consequently, disorders previously regarded as neuroses had to be redefined and reclassified. One result of this reorganisation was the introduction of the new category of 'somatoform' disorders. Two reasons are given (p. 241) why these newly named disorders should be regarded as mental rather than physical. The first is that 'there are no demonstrable organic findings or known physiological mechanisms' and that 'the specific pathophysiological processes involved are not demonstrable or understandable by existing laboratory procedures'. The second is that, although the symptoms are physical, they are 'linked to psychological factors or conflicts' and are 'conceptualised most clearly using psychological constructs'.

The second reason makes it clear that psychological causation was being used in DSM-III as a criterion of mental illness for certain conditions, namely conditions whose essential features are physical symptoms that suggest a physical disorder but for which there are no known physical causes. If the condition has psychological causes, then it counts as a mental illness (a somatoform disorder). If there is no known psychological causation, then it should be classified as a physical illness.

Some preliminary points need clarification. In the first place, psychological causation was *not* being suggested in DSM-III as a criterion for mental illness

in general, since many mental illnesses have a known physical cause. Second, DSM-III does not actually use the phrase 'psychological causation', but it is used in ICD-10 in the following description: 'neurotic, stress-related and somatoform disorders have been brought together in one large overall group because of the historical association with the concept of neurosis and the association of a substantial (though uncertain) proportion of these disorders with psychological causation' (World Health Organization, 1992: p. 134). A third point is that the characterisation of somatoform disorders in DSM-IV omits any reference to psychological factors. However, in so doing, it fails to provide any justification for classifying such disorders as mental rather than physical.

Problems with psychological causation

There have also been many criticisms of the distinction between physical and psychological causation (White, 1990), of which I will mention three. The first is that of establishing which psychological factors are genuinely involved. A second is establishing which of the psychological factors involved has a causal role rather than being a consequence of the illness or merely being associated with it. (It may well be this problem that led the authors of DSM-III to posit linkages rather than causes.) A third problem arises from multiple causation, for there appear to be both physical and mental causes in many, if not all, cases.

Despite these difficulties, the distinction between psychological and physical causation is used frequently and appears to be appropriate in many practical situations. For example, the cause of pain that follows a blow by a hammer seems to be of a very different kind from the cause of the fear felt by someone with a dog phobia when in the presence of large dogs. The distinction may be difficult and imprecise, but it can be useful.

Exploring the concept of psychological causation

A major deficiency in the use of psychological causation as a criterion by DSM and ICD is the failure to give an account of the concept: what counts as psychological causation and under what conditions it can be imputed (Box 3)? This failure makes the criterion ambiguous and liable to varying interpretations.

To make up for this deficiency, I will explore the concept of psychological causation. The guidelines that I set out seem to be reasonable, but I make no great claims for them. The point is to show that, even if you take a sympathetic view of the concept of psychological causation, there are no sufficient grounds for saying that, in general, CFS is due to psychological factors. Consequently, there are no good grounds for saying that, in general, CFS should be classified as a mental illness.

The reason for considering this in some detail is not that I particularly wish to defend the concept of psychological causation, but simply to do as much justice to it as I can. As already mentioned, the argument from psychological causation is the main basis for classifying CFS as a mental illness.

To give some substance to the concept of psychological causation, the following guidelines are provisionally suggested. First, the grounds for imputing particular psychological problems to a patient should be strong. Weak grounds are not sufficient. Regrettably, this principle is frequently ignored and often patients find that psychological problems are imputed to them on very little evidence.

Second, there need to be good grounds for inferring that the psychological factors which are present do, in fact, have a causal influence.

Third, the absence of any *known* physical cause is not sufficient in itself to establish that there is no *actual* physical cause and hence that there must be some psychological cause. Our knowledge of the causes of pain, fatigue and other symptoms central to CFS is very limited and it is quite possible that there is some actual physical cause which we have not yet discovered. As medical science progresses, more and more physical causes are found for conditions that previously were not fully explained. The recent discovery of *Helicobacter pylori* as a significant cause of peptic ulcer is a case in point.

Box 3 Guidelines for imputing psychological causation

There must be good grounds for imputing psychological problems

There must be good grounds for thinking that particular psychological factors have a causal influence

The absence of a known physical cause is not good grounds for imputing psychological causation

The presence of some psychological causal factors is not sufficient

Psychological factors should be the predominant causes

When a symptom or condition has no known physical cause, there is a strand of medical thinking which makes the assumption that it must have a psychological cause. This assumption has had a long and troublesome past in the history of medicine, but it is time that it is finally declared unacceptable.

Fourth, the presence of some psychological causal factors is not, in itself, sufficient grounds for classifying an illness as a mental one. Many physical illnesses, for example heart attacks, also have psychological causal factors.

Fifth, in view of the previous point, the psychological causal factors involved should generally be agreed to be the *predominant* causes. The judgement as to whether this is the case or not will be difficult in some instances, but less so in others. Adopting a conservative strategy, psychological causation should not be imputed in difficult cases where there is no widespread agreement. This approach is justified on the principle that mental illness should not be imputed without good grounds, as classifying a condition as a mental illness can have negative consequences and may result in major difficulties in doctor–patient communication.

CFS and the absence of predominant psychological causation

If this or a similar account of psychological causation is adopted, it is clear that there are no good grounds for imputing predominant psychological causation in many cases of CFS (Box 4).

Too frequently, a misperception has been that people with CFS/ME have problems coping with the world and that this in some way causes their illness. Yet very often there is simply no evidence for this allegation: indeed, the evidence suggests that, up to the time of their illness, they were coping very well.

It is often assumed, without argument, that since no physical causes for CFS have been clearly identified, there must be psychological ones. But this, as already indicated, is an unjustified inference. If psychological problems such as depression are involved, they may be part of the illness or a consequence of it.

Where psychological causal factors are correctly identified, they are often insufficiently significant either to be considered predominant or to rule out the possibility of some important physical factor which has not yet been identified. Many patients with CFS mention that they were under considerable stress at the time that they fell ill. But so are people who have heart attacks. The presence of stress leading up to a heart attack does not result in heart

attacks being classified as mental illnesses. Equally, the presence of stress leading up to CFS is not, on its own, a sufficient justification for considering it to be a mental illness.

CFS and the Benefits Agency

One condition for awarding the higher level of the disability living allowance mobility component is that the claimant should be 'suffering from a physical disablement'. This has posed considerable problems for people severely affected with CFS who have difficulty in walking even a very short distance. Doctors are unable to find a clear physical basis for these difficulties. Yet it is not irrational fear, depression or some other psychological problem that keeps such patients from walking. In their experience, it is quite the reverse. They desperately want to walk and are well motivated to do so, but they find that even a short walk makes them very ill and their efforts result in increased malaise, pain and other symptoms.

Confusion over whether this difficulty should be regarded as a physical disablement or not has meant that people with severe CFS have often had very stressful experiences when trying to claim the higher rate of the mobility component. They have frequently had their claim disallowed initially and then, on appeal, sometimes allowed and sometimes not. Not surprisingly, the stress involved has frequently led to a worsening of their condition.

Recognition of the nature of their difficulties has been slow in coming but official guidance (Disability Alliance, 2000) now advises decision-makers that

Box 4 Reasons for thinking that CFS does not generally have psychological causation

There are often no significant psychological problems

Where psychological problems are present, they are often part of the illness or consequences of it

The absence of a known physical cause does not imply psychological causation

Where psychological factors are present, they are often not the predominant cause

Patients report a flu-like illness from which they have never fully recovered

There is evidence of biological abnormalities of the central nervous and immune systems

The Department of Social Services regards patients' problems in walking as generally not of psychological origin

in the vast majority of claims, if a doctor says that the claimant has CFS, this can be taken as an opinion that they have a physical disablement, even if it cannot be identified. A lack of physical findings in the medical evidence is recognised as a general feature of CFS and should not be taken to mean that mobility limitations are mental in origin. The exception would be if there is unequivocal specialist medical opinion that, in a particular case, the condition is psychological in origin.

Of course, clinicians may say that the present regulations should be changed. Maybe they should. But the point is that, while the current regulations are in force, the classification of their disablement can make a considerable difference to patients.

This example is only one of many where the decision as to whether a disablement or its origin is physical or mental has serious consequences for the patient. For the clinician to stay aloof and merely say that the distinction cannot be made is to fail to come to grips with the reality of the situation for the patient.

CFS as a physical illness

Taking the approach adopted by the Benefits Agency – and the fact that it reflects the genuine experience of many patients with CFS is one good reason why we should – leads naturally to the view that this illness should generally be classed as physical, unless there is, in a particular case, unequivocal medical opinion to the contrary.

A major advantage of this proposal is that it would help to defend people with CFS from the unjustified attributions of psychological problems to which they have been vulnerable. It would not mean, of course, a denial of psychological problems or mental illness where they are present. It would, however, place the onus of proof on the clinician to establish that the patient does have a psychological problem rather than, as at present, on the patient that he or she does not. The current situation can easily lead to friction and misunderstanding between clinician and patient.

Some psychiatrists might worry that classing CFS as a physical illness will lead patients to ignore or discount the psychological aspects of their illness. In practice, the experience of Westcare UK and of other agencies has been quite the opposite. This classification can give patients increased confidence and trust that the health care practitioner really understands their illness. This can make them more willing to consider any possible psychological aspects of their illness. (See Sykes & Campion (2002) for a fuller discussion of the physical *v.* psychological issues.)

An alternative proposal, which has the merits of simplicity and clarity, is that CFS *per se* be classified as a physical illness and, where mental illness or psychological problems are present, an additional diagnosis be given. A person with CFS who is depressed would be given a dual diagnosis. The patient would be diagnosed as having both CFS, a physical illness, and depression, a mental illness.

Other medically unexplained somatic symptoms

The approach suggested for CFS can be applied to other medically unexplained somatic symptoms and syndromes. Many problems facing people with CFS also face those with similarly unexplained conditions.

In dealing with these syndromes, the same fallacious inference is often made, that if there is no *known* physical cause, then there is no *actual* physical cause and the condition must therefore be psychological in origin. As Melzack & Wall (1988: p. 32) write in connection with unexplained pain:

‘The patients with the thick hospital charts are all too often prey to the physician’s innuendoes that they are neurotic and that their neuroses are the cause of the pain. While psychological processes contribute to pain, they are only part of the activity in a complex nervous system. All too often, the diagnosis of neurosis as the cause of pain hides our ignorance of many aspects of pain mechanisms.’

The proposal is that other medically unexplained somatic symptoms and syndromes, such as unexplained pain, should be classified as physical illnesses unless there is unequivocal medical opinion to the contrary. Alternatively, they should be classed as physical illnesses *per se* and where there are sufficient grounds for imputing a mental illness or a psychological problem, a dual diagnosis should be given.

This approach would help to defend a wide range of patients from being unjustifiably characterised as having psychological problems. It would not mean that the psychological aspects of their illness would be denied or ignored. It would be more likely to have the reverse effect, helping patients to be more willing to consider the possible psychological aspects of their illness.

Summary

In the current situation, all illnesses are classified either as mental illnesses or as physical illnesses.

Despite the real problems of the distinction, it cannot be ignored and clinicians, including psychiatrists, need to be able to work with it and apply it appropriately in the best interests of their patients.

Regrettably, there may be many negative consequences from classifying an illness as a mental one and this should not be done without good reason.

The main grounds given for classifying CFS as a mental illness come from the claim that it is caused by psychological factors. The concept of psychological causation is used in the DSM-III (American Psychiatric Association, 1990) and ICD-10 (World Health Organization, 1992) (in their discussion of 'somatoform' disorders, etc.) as a criterion to distinguish mental disorders from physical disorders. There are difficulties with the concept of psychological causation, but even if these are set on one side and a sympathetic account of the concept is given, there are no good grounds for saying that CFS, in general, is due to psychological causes. There are thus no good grounds for classifying CFS as a mental illness, and it should not therefore be so classified. In general, CFS should be classified as a physical illness.

Current guidance from the UK Benefits Agency is that walking difficulties experienced by people with severe CFS should, in the vast majority of cases, be classified as a physical disablement, unless there is unequivocal specialist medical opinion that, in a particular case, the condition is psychological in origin. This, in turn, suggests that CFS should generally be classed as a physical illness.

An alternative approach would be for CFS *per se* to be classified as a physical illness and for a dual diagnosis to be given if there are good grounds for imputing a mental illness or psychological problems.

This approach can be extended to other somatic symptoms and syndromes for which there is no medical explanation, such as pain. This would help to protect patients from the unjustified but frequent imputation of non-existent psychological problems and would remove a source of substantial but unnecessary friction between doctors and patients. It would not involve a denial of any genuine psychological problems. Indeed, somewhat paradoxically, in practice it has been found to increase patients' readiness to consider the possible psychological aspects of their illness rather than reduce it.

References

- American Psychiatric Association (1980) *Diagnostic and Statistical Manual of Mental Disorders* (3rd edn) (DSM-III). Washington, DC: APA.
- (1994) *Diagnostic and Statistical Manual of Mental Disorders* (4th edn) (DSM-IV). Washington, DC: APA.
- Disability Alliance (2000) *Disability Rights Bulletin* (summer).
- Kendell, R. E. (2001) The distinction between mental and physical illness. *British Journal of Psychiatry*, **178**, 490–493.

*Komaroff, A. L. (2000) The biology of chronic fatigue syndrome. *American Journal of Medicine*, **108**, 169–171.

Melzack, R. & Wall, P. D. (1988) *The Challenge of Pain* (2nd edn). Harmondsworth: Penguin.

*Pinching, A. J. (2000) Chronic fatigue syndrome. *Prescribers' Journal*, **40**, 99–106.

*Sykes, R. D. & Champion, P. (2002) *The Physical and the Mental in Chronic Fatigue Syndrome/ME. Principles of Psychological Help*. Bristol: Westcare UK.

Ware, N. C. (1993) Society, mind and body in chronic fatigue syndrome: an anthropological view. In *Chronic Fatigue Syndrome. Ciba Foundation Symposium 173* (eds G. Bock & J. Whelan), p. 69. Chichester: John Wiley & Sons.

White, P. (1990) Fatigue and chronic fatigue syndrome. In *Somatization: Physical Symptoms and Psychological Illness* (ed. C. Bass), p. 113. Oxford: Blackwell.

World Health Organization (1992) *The ICD-10 Classification of Mental and Behavioural Disorders. Clinical Descriptions and Diagnostic Guidelines*. Geneva: WHO.

* denotes items of particular interest.

Multiple choice questions

- To qualify for the higher rate of the mobility component of the disability living allowance:
 - it does not matter whether the claimant's disablement is physical or psychological in origin
 - the claimant must suffer from a physical disablement
 - the claimant must go to an appeal tribunal
 - the claimant need not be on low income
 - the claimant must be unemployed.
- The difference between the higher and lower rate of the mobility component of the disability living allowance is currently:
 - £208 per year
 - £624 per year
 - £832 per year
 - £1040 per year
 - £1488 per year.
- The distinction between physical and mental illness:
 - is in widespread use and has far-reaching effects
 - implies Cartesian dualism
 - is meaningless
 - is not relevant to patients
 - has no satisfactory definition.
- The absence of a known physical cause for a condition:
 - shows that there is no actual physical cause
 - shows that there must be some predominant psychological cause
 - is not sufficient to show that there is no actual physical cause
 - means that the illness is 'all in the mind'
 - does not mean that the illness is not serious.

5. The view of the Benefits Agency is that, in the vast majority of cases, the difficulty in walking experienced by claimants with CFS:
- a is psychological in origin
 - b is both physical and psychological in origin
 - c is a physical disablement
 - d should be regarded with great suspicion
 - e can satisfy one of the conditions for the award of the higher rate of the mobility component of the disability living allowance.

MCQ answers

1	2	3	4	5
a F	a F	a T	a F	a F
b T	b F	b F	b F	b F
c F	c F	c F	c T	c T
d T	d F	d F	d F	d F
e F	e T	e T	e T	e T

Commentary

R.E. Kendell

Richard Sykes (2002, this issue) wants to convince psychiatrists that chronic fatigue syndrome (CFS)/myalgic encephalomyelitis (ME) is a 'physical' illness, and also convince them that patients presenting with this syndrome should normally be regarded as suffering from a 'physical disablement', and thus be eligible for the full mobility component of the Benefits Agency's disability living allowance. In fact, there is no need to worry about the disability living allowance. This is a purely administrative issue which, as he says, has already been conceded by the Benefits Agency. But in order to convince psychiatrists that CSF is a physical disorder, he feels that he has to rebut the argument that the distinction between mental and physical is 'meaningless'.

I assume that I have been invited to comment on his article because I recently argued that the distinction between mental and physical illness is ill-founded and incompatible with contemporary understanding of disease, and that it is high time we abandoned it (Kendell, 2001).

Sykes is quite right to point out that the distinction between physical and mental illness is in widespread use and has far-reaching effects. (He is also right that some naïve doctors assume that a patient's symptoms must be psychogenic if they cannot find a physical cause for them.) It is true, therefore, that the distinction is still meaningful to the lay public

and to some doctors. The crucial issue, though, is not whether the distinction is meaningful to some people but whether it is soundly based or misleading.

As others have done, I have argued that the historical assumptions on which the distinction between mental and physical diseases was based have been discredited and that it is increasingly clear that there is no fundamental difference between them. Both somatic and psychological symptoms have a somatic substrate, psychological and social factors often contribute to aetiology and influence outcome in both physical and mental illnesses, and psychological and social therapies may have an important role in the treatment of both. As a result, the assumptions that are commonly made about so-called mental illnesses – that they are fundamentally different from all other kinds of illness, that they are due to a lack of self-control or will power, and therefore less deserving of treatment and sympathy – are unjustified and misleading.

Two generations ago, it was widely assumed that anthropologists and laymen could distinguish several different human races and that there were important physical, intellectual and moral differences between them. The scientific basis for those assumptions and beliefs has now been eroded, most recently and conclusively by the human genome project. But although the scientific basis of the concept of race