has been invalidated, the assumptions and meanings associated with racial distinctions linger on and still exercise a malign influence in many settings.

There is an important parallel here with the distinction between mental and physical illness. The scientific basis for that distinction has also been discredited, but the assumptions associated with it are still influential and damaging. Sykes, whose primary concern is to establish that CFS and other somatoform disorders are physical illnesses, would have us preserve the discredited distinction between physical and mental illnesses in order to achieve that end. Instead of arguing that the distinction must be preserved because it is still *meaningful* to many people, he would, in my view, do better to accept that it has become deeply *misleading* and help to hasten its demise. That would surely be in the long-term interests of the patients he is trying to help.

Although the arguments for abandoning the late-eighteenth-century distinction between physical and mental diseases owe little to the assortment of syndromes currently known as somatoform disorders, they illustrate very clearly the near impossibility of distinguishing between physical and mental. DSM–IV (American Psychiatric Association, 1994: p. 445) openly concedes that 'the grouping of these disorders in a single section is based on clinical utility ... rather than on assumptions regarding shared aetiology or mechanism' and ICD–10 (World Health Organization, 1992: p. 161) observes that 'the degree of understanding, either physical or psychological, that can be achieved about the cause of the symptoms is often disappointing and frustrating for both patient and doctor'.

Sykes's own attempt to convince us that CFS is a physical illness depends primarily on the bald assertion that it should be assumed to be physical unless there is convincing evidence in the individual patient of 'psychological causation'. This is despite the fact that if this criterion were to be applied to such prototypical mental disorders as schizophrenia, bipolar disorder and Alzheimer's disease, none would qualify. He then tries to buttress this patently inadequate criterion by asserting that 'psychological causation should not be imputed in difficult cases where there is no widespread agreement' and by misrepresenting as an *experience* of physical illness the *belief* of many of the patients who regard themselves as suffering from 'ME' that their illness is physical. One is left with the strong impression that any argument will do so long as it produces the desired conclusion.

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Commentary

K.W.M. Fulford

Richard Sykes has been a tireless campaigner for sufferers of chronic fatigue syndrome (CFS) (also called myalgic encephalomyelitis, ME). Unlike many campaigners, his approach has been both moderate and rigorous. Drawing on his academic background in philosophy, together with his wide professional experience as a social worker and 12 years as Director of Westcare UK, he has shown how

K.W.M. (Bill) Fulford is Professor of Philosophy and Mental Health at the University of Warwick (Department of Philosophy, University of Warwick, Coventry CV4 7AL, UK), where he runs a Masters, PhD and research programme in philosophy, ethics and mental health practice. He is also an honorary consultant psychiatrist in the Department of Psychiatry, University of Oxford, and a visiting professor at a number of UK institutions. He is the Founder Chair of the Philosophy Special Interest Group of the Royal College of Psychiatrists. He has published widely on philosophical and ethical aspects of mental health.

https://doi.org/10.1192/apt.8.5.359 Published online by Cambridge University Press

muddled thinking about CFS has, through flawed conceptual models of disease, led to plain bad practice (Sykes & Campion, 2001).

The nub of his paper (Sykes, 2002, this issue) is that, faced with what he argues is the regrettable but unavoidable contingency of subdividing medical disorders into mental and physical, CFS should be classified as a physical disorder.

Sykes makes a number of persuasive points but I will concentrate on the grounds he gives for his proposal. His argument is essentially as follows.

1. The distinction between mental disorders and physical disorders is in widespread use. In spite of problems with this distinction, we need to work with it as best we can.
2. Regrettably, the classification of mental illness can have many negative consequences. An illness should not, therefore, be classified as mental unless there are good grounds for so doing.
3. The main grounds given for classifying CFS as a mental illness come from the belief that it is due to psychological causes.
4. This concept of psychological causation is used in DSM (explicitly in DSM–III, implicitly in DSM–IV; American Psychiatric Association (APA), 1990, 1994) and ICD–10 (World Health Organization, 1992) in their sections on 'somatoform' disorders, etc., as a criterion to distinguish mental disorders from physical ones.
5. 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.
6. Therefore, there are no good grounds to support the main reason (psychological causation) given for classifying CFS as a mental illness.
7. CFS should not, therefore, be classified as a mental illness.
8. In general, CFS should be classified as a physical illness unless there is 'unequivocal specialist medical opinion that, in a particular case, the condition is psychological in origin'.

Innocent until proven guilty, then. The motivation behind Sykes' proposal is the abuses to which people with CFS are subject because their condition is classified as a mental disorder. These range from prejudicial benefits' arrangements through flawed diagnoses and treatments, to outright accusations of malingering.

Such abuses will come as no surprise to psychiatrists and their patients, for these are the direct counterparts of the abuses to which people with mental disorders are all too often subject. The standard response among psychiatrists to such abuses, therefore, has been to seek to translate mental disorders, by one means or another, into physical ones. For psychiatrists, the favoured mechanism is to attribute presumed bodily, as opposed to psychological, causes. Although widely misunderstood (Arens, 1996), the great 19th-century physician, Wilhelm Griesinger, set the trend here with his claim that mental disorders are brain diseases; and much of the appeal of modern 'biological' psychiatry lies in its promise of translating mental disorders into the brain diseases that Griesinger envisaged.

The approach taken by Sykes has much in common with that of these psychiatrists, for he tries to show that CFS should properly be classified as a physical rather than a mental illness. Unlike Griesinger, however, he does not attempt to argue that all mental disorders are brain diseases. His aim is the more limited one of trying to show that CFS is not properly classified as a mental illness.

I have argued elsewhere that the approach of Griesinger and his successors, reasonable as it may seem, sells psychiatry short (Fulford, 1989, 2000). The standard response, of translating mental disorders into physical disorders, assumes that psychiatry is, somehow, deficient compared with physical medicine. But the difficulties we face in psychiatry, as professionals and users alike, arise from the fact that mental disorders are considerably more complex – scientifically, clinically and conceptually – than physical disorders. Hence, retreating to the model of physical medicine, as the standard response requires, is like trying to use an abdominal retractor for brain surgery! Rather, we should be seeking to build the future of psychiatry on a model of empirical science capable of meeting the needs of our more complex area of practice.

I will consider each of these three aspects of the complexity of psychiatry in relation to the ICD / DSM classification of CFS as a mental illness on grounds of presumed mental causation and Sykes's arguments against this.

Science and CFS

Is it good science to classify disorders by their causes? Well, yes, provided that widely accepted causal theories are currently available. Causal laws are at the heart of the scientific paradigm; and in medicine, causal theories of disease are the royal road to good clinical care.

Correspondingly, though, it is bad science to classify disorders by their causes in the absence of a widely accepted causal theory. Consequently, Sykes

https://doi.org/10.1192/apt.8.5.359 Published online by Cambridge University Press

is right to criticise those who wish to classify CFS as a mental disorder on the grounds of presumed psychological causation, for there is no widely accepted causal theory to support this. He is wrong, though, to base his criticism on the absence (in most cases) of evidence of psychological causation, for this objection to causal attribution, like causal attribution itself, depends on the availability of a widely accepted causal theory.

The recent history of psychiatric classification provides a cautionary tale. It is well known that our current classifications of mental disorders, the DSM and ICD, are based primarily on symptoms rather than causes. This is no accident. It follows the recommendations of a report, commissioned by the World Health Organization (WHO) from the British psychiatrist Erwin Stengel (1959) in response to the very poor uptake around the world of the mental disorders section of WHO's first attempt at an international classification of diseases (chapter V of ICD–6, World Health Organization, 1948). Stengel was directly influenced by the American philosopher of science, Carl Hempel (1961). Hempel pointed out that all sciences go through a descriptive stage before developing causal theories. Correspondingly, Stengel's diagnosis of the failure of the mental disorders chapter of ICD–6 was that it was based on premature (particularly psychoanalytical) causal theories which had not gained general acceptance. What was needed, therefore, was a classification which properly reflected the descriptive stage of the development of scientific psychiatry, namely one based primarily on symptoms.

We are set for a new 'open season' of debates about causes *v.* symptoms in psychiatric classification with the launch in 2001, by WHO and the APA, of revision processes which will lead to new editions, respectively, of ICD and DSM. Currently, the basis of causal theories is likely to be biological rather than psychoanalytical. But the condition / cause distinction, implicit no less in modern debates about classification than at the time of Stengel and Hempel, is likely to remain a useful tool for clear thinking about disease classification. Certainly, it remains a useful tool for clear thinking about diagnosis in everyday clinical practice.

Clinical practice and CFS

In drawing on the experience of Westcare UK as a registered charity that provides professional psychological and other help to patients with CFS, Sykes reminds us of the extent to which such patients find themselves the butt of bad diagnostic practices. Psychological causes are attributed on the sole basis of an absence of identifiable bodily causes; causes and consequences are conflated (for example, in respect of the role of depression); and 'all in the mind' is used, not to access appropriate treatment, but as a label for naming and shaming.

Our response to bad diagnostic practices, however, should be good diagnostic practices based on good science. And in this instance, good diagnostic practice, to the extent that it is based on the good science of the Stengel / Hempel-inspired ICD and DSM, means keeping the condition distinct from its causes.

This distinction is reflected in the standard approach to diagnostic formulation. Here, the diagnostic possibilities (defined primarily by symptoms and signs) are listed separately from the possible aetiological factors (see Gelder *et al*, 1983). Keeping the condition and its causes distinct in this way thus allows us to consider, separately, the bodily and mental signs and symptoms, and the bodily and mental causes of those signs and symptoms, for each patient. In the present state of our knowledge, this remains important for clear thinking even in 'organic' psychiatry, i.e., in dealing with conditions, such as Alzheimer's disease, for which the underlying brain pathology is reasonably well understood (Lishman, 1978).

Sykes makes the interesting observation that if patients with CFS are told that their illness is physical rather than psychological, they are more, not less, willing to consider psychological factors in the aetiology of their condition.

I suspect that there may be some patients, if not with CFS then certainly with other conditions, for whom the reverse is true. In a study completed at Warwick University, UK, Tony Colombo (a social scientist) and his colleagues are finding that patients with schizophrenia are broadly divisible into those whose perspective is predominantly biological and those where it is predominantly psychosocial (Fulford, 2001; Colombo *et al*, 2002). The traditional diagnostic formulation, in separating the condition from its causes and considering biological, psychological and social components of each, thus allows us, as experts, to match our general knowledge appropriately to the particular perspectives of individual patients.

Conceptual models and CFS

The biopsychosocial model, as it is usually called, is sometimes thought to have made the body / mind distinction in medicine otiose, and with it the biological and psychosocial clinical perspectives

https://doi.org/10.1192/apt.8.5.359 Published online by Cambridge University Press

just discussed. As Sykes spells out, this is plainly nonsense. The 'biopsycho-' part of the model directly depends on the body / mind distinction. The '-social' part adds the social context, which has been relatively neglected by philosophers of mind.

Sykes, then, writing from the perspective of his background in philosophy, is right to remind us that we are stuck with the 'mental illness' / 'bodily illness' distinction, at any rate until someone comes up with a solution to that mother of all philosophical problems, the mind–body problem.

As already noted, there is no problem with adopting the causal distinction in principle. However, in practice, it is subject to all the difficulties we should expect, if we follow Hempel, in a science which is at a descriptive stage of development. Where there are competing causal theories, how should the 'medical specialist' (step 7 in Sykes's argument above) choose between mental and bodily theories? Similarly, in a multi-causation model, how should the medical specialist decide what is the 'predominant' cause, as Sykes points out would be necessary?

The 'predominant' cause, at the present stage of development of psychiatric science, tends to be interpreted according to the theoretical orientation of the person making the judgement in a particular case (Tyrer & Steinberg, 1993: chapter 5). Schizophrenia, for example, tends to be regarded as a brain disease by 'biological' psychiatrists, as a psychological disorder by psychologists, or as a product of adverse social factors by social scientists and anthropologists (as in cross-cultural psychiatry, for example). All three groups acknowledge the relevance of all three kinds of causal factor, but each group regards its 'own' factor as the most important. Nor is it likely that such differences of emphasis will be easily resolved. Even such relatively clear-cut causal attributions as the 'cause of death', are subject to widely differing interpretations (Lindahl & Johansson, 1994).

Therefore, unless causal attributions are made, whether by medical specialists or others, on the basis of a well-established causal theory, they will remain highly subjective and hence vulnerable to just those stigmatising abuses against which Sykes has campaigned so vigorously.

Anyway, the required distinction between mental disorder and bodily disorder can be drawn relatively straightforwardly at the level of the condition itself, i.e. in terms of symptoms, rather than at the level of causes. Moreover, if drawn at the symptomatic level, the distinction is entirely consistent with Sykes's proposal for CFS. Thus, where physical medicine is concerned with symptoms involving bodily functions (bodily sensations, such as pain, nausea, paralysis and blindness), psychiatry is concerned with symptoms involving the 'higher' mental functions, such as emotion, desire, volition, belief and motivation (Fulford, 1989: chapter 5). Characterised as it is by physical exhaustion, bodily pain and so forth, CFS is, consistently with Sykes's proposal, at least as much bodily as mental at the symptomatic level.

Taking care with causes

In psychiatry, then, we have scientific, clinical and conceptual reasons for taking care with causes. I do not want to be misunderstood here. The point is not that we should be barred, in principle, from distinguishing mental from physical disorders on the basis of causes: we do, and we should (in the case of dissociative disorders, for example). Neither is it that distinguishing mental from physical disorders at the level of the conditions themselves (i.e. at the level of symptoms) will always be unproblematic – on the contrary, the 'appetitive' disorders, for example, provide teasing examples at the border between the mental and the physical (e.g. anorexia). Rather, the point is that at the present stage of our knowledge, following the Stengel / Hempel line, we should be chary of making causal attributions do all, or even much of the work of distinguishing between mental and physical disorders.

Those who classify CFS as a mental illness on grounds of presumed psychological causation do, I believe, try to make causal attributions do too much work. However, in making the absence of evidence for psychological causation the grounds of his objection to this, Sykes, too, tries to make psychological causation do too much work. For the proposal and objection both depend, in equal and opposite ways, on a widely accepted theory of psychological causation, and we lack this at the present stage of our knowledge.

Better, therefore, to stick with the Stengel / Hempel line: to define CFS descriptively, by its (mainly bodily) symptoms, and consider biological, psychological and social causal factors separately on a case-by-case basis. This is a more complicated approach, certainly, but it is true to the descriptive stage of the development of psychiatric science; it provides a framework for clear thinking clinically (as in the traditional diagnostic formulation); and it offers a robust conceptual model for countering the abuses to which CFS and psychiatric patients alike are subject, as Sykes has done so much to show.

https://doi.org/10.1192/apt.8.5.359 Published online by Cambridge University Press

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Commentary

Peter D. White

Richard Sykes is the founder and director of Westcare UK, a charity that has been at the forefront of organisations providing practical assistance for patients. It has also produced two recent reviews of management and specialist management centres in the UK (National Task Force, 1994, 1998). In his paper (2002, this issue), Sykes takes a further step in trying to improve the care of patients with chronic fatigue syndrome (CFS) by arguing that the condition should both be regarded and classified as a 'physical illness'. Is this a useful classification? If it is, is CFS a 'physical illness'? And if this is the case, would this perception improve the care of patients?

Is this a useful classification?

Kendell (2002, this issue) and Fulford (2002, this issue) argue convincingly that the distinction between mental and physical illnesses is not only meaningless but also harmful. I commend John Searle's solution to the mind–body problem: that conscious states are caused by neurophysiological processes and are realised in neurophysiological systems (Searle, 2000). In other words, it is impossible to have an emotion or thought without a physical process occurring in the brain.

Peter D. White is a senior lecturer in psychological medicine at Barts and the London, Queen Mary School of Medicine and Dentistry (University of London, St Bartholomew's Hospital, London EC1A 7BE, UK). He has run a chronic fatigue clinic for 13 years and has studied the epidemiology, physiology and treatment of chronic fatigue syndrome.

https://doi.org/10.1192/apt.8.5.359 Published online by Cambridge University Press