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-
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 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

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 Melzach & 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 disability, 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


* denotes items of particular interest.

### Multiple choice questions

1. To qualify for the higher rate of the mobility component of the disability living allowance:
   a. it does not matter whether the claimant’s disablement is physical or psychological in origin
   b. the claimant must suffer from a physical disablement
   c. the claimant must go to an appeal tribunal
   d. the claimant need not be on low income
   e. the claimant must be unemployed.

2. The difference between the higher and lower rate of the mobility component of the disability living allowance is currently:
   a. £208 per year
   b. £624 per year
   c. £832 per year
   d. £1040 per year
   e. £1488 per year.

3. The distinction between physical and mental illness:
   a. is in widespread use and has far-reaching effects
   b. implies Cartesian dualism
   c. is meaningless
   d. is not relevant to patients
   e. has no satisfactory definition.

4. The absence of a known physical cause for a condition:
   a. shows that there is no actual physical cause
   b. shows that there must be some predominant psychological cause
   c. is not sufficient to show that there is no actual physical cause
   d. means that the illness is ‘all in the mind’
   e. 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.

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

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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.

References


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
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’ 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
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 of 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.

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.

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.

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.
just discussed. As Sykes spells out, this is plainly nonsense. The ‘biopsychosocial’ 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.

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**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.
References


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?

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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 neuro-physiological systems (Searle, 2000). In other words, it is impossible to have an emotion or thought without a physical process occurring in the brain.
This still allows psychological and social factors to influence health, but the influence is mediated through physical changes within the brain. This is why it is possible to reverse the neurophysiological abnormalities that occur in depressive illness by both ‘psychological’ (psychotherapy) and ‘physical’ (antidepressant) treatments. Psychiatric disorders, at one level, are simply physical disorders of the brain.

Sykes reviews the criticisms of dualism very well. Unfortunately for his argument, he needs dualism to make his point, thus having to defend an indefensible position. The weakness of his argument is demonstrated by his need to call as witnesses both the Benefits Agency and insurance companies, suggesting that their rules are justification for assuming the mind–body split. Incidentally, the Benefits Agency determines payment of the higher rate of mobility component of the disability living allowance if the claimant is ‘suffering from physical disablement’ [my italics] such that he is unable or virtually unable to walk’ (Social Security Contributions and Benefit Act 1992, Para 73(1)(a)). Advice is clear that this disablement can occur as a result of CFS.

Sykes’s argument is at its strongest in criticising somatoform disorders for their inherent assumption of a psychological causation. He quite rightly points out that the presence of premorbid ‘psychological factors’ does not imply causation. As Samuel Johnson once said, ‘It is incident to physicians, I am afraid, beyond all other men, to mistake subsequence for consequence’ (Johnson, 1734). Sykes also correctly points out the difficulty in deciding the primary cause of anything that has multiple causes. But, rather than challenge this woolly dualistic thinking, as others would do, Sykes accepts it and suggests that psychiatrists work with it. I believe that the whole section on somatoform disorders needs a radical rethink for ICD–11 and DSM–V. Such disorders are neither ‘mental’ nor ‘physical’, but have characteristics of both. A categorical and dualistic classification serves no purpose and merely confuses.

Assuming, for the sake of the argument, that dualistic thinking is alive and well, is CFS primarily physical?

Sykes is correct in pointing out that many of the symptoms of CFS are somatic. These include a sensation of physical fatigue or exhaustion, weakness, heaviness in the limbs, muscle and joint pain, headache and even transient sore throat and tender lymph nodes (Fukuda et al, 1994; Wessely et al, 1998). However, a conversion disorder can similarly cause entirely physical sensations and the corollary is that a frontal brain tumour can present with wholly ‘psychological’ symptoms and signs.

So, the presence of physical symptoms proves nothing.

We then turn to aetiology. Certain viruses have been shown to trigger CFS (White et al, 2001), but there is no replicated evidence of a persistent viral infection (Wessely et al, 1998). Immunological findings are inconsistent and have no established relationship with clinical findings (Peakman et al, 1997). A down-regulated hypothalamic–pituitary–adrenal axis is found in most studies (Cleare et al, 2001), but this could be the consequence of prolonged inactivity, rather than a primary event (White, 2000). The same finding is also evident in several psychiatric disorders (Wessely et al, 1998). Physical deconditioning is a reasonably reliable finding (Fulcher & White, 2000; White et al, 2001), but it would be expected to be due to the inactivity associated with CFS (White, 2000).

The most consistent findings regarding the aetiology of CFS are ‘psychosocial’ (Wessely et al, 1998). These include higher prevalence rates of both current and past mood disorders, compared with other chronic medical disorders (Wessely et al, 1998). Somatic illness perceptions and consequent avoidant behaviour are equally established findings (Deale et al, 1998; Vercoulen et al, 1998). ‘Psychosocial’ factors predict slower recovery and are associated with greater disability (Wessely et al, 1998). The quotation marks around the word ‘psychosocial’ are an important reminder of the need for a deeper understanding of how biological factors are determined by, and themselves determine, psychosocial phenomena. Sykes’s suggestion that either a psychiatric diagnosis or a psychological problem can be considered as an additional diagnosis to CFS misses this point and bypasses the possibility that such factors may be central to fatigue.

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**Would regarding CFS as ‘physical’ improve the management of patients?**

It is hard to make this argument. No ‘physical’ treatments for CFS or ME were supported by two recent systematic reviews of the management of both conditions (Whiting et al, 2001). Only two treatments showed promise, recording positive results compared with control treatments in high-quality replicated studies. These two treatments were cognitive–behavioural therapy and graded exercise therapy, developed and tested by clinicians espousing the biopsychosocial model of CFS.
Although neither treatment is based on the understanding that CFS is psychological, both treatments were developed and tested on a biopsychosocial understanding of the illness, with their common principle being a gradual return to avoided activities. Even the physical (or biological) treatments often used in psychiatry, such as antidepressants, do not help CFS.

**Conclusion**

The classification of illnesses as either mental or physical is meaningless on most levels of understanding. Sykes is right to criticise our current classification systems for doing so, especially when applied to somatoform disorders. Even if we accepted our current classification system, aetiological studies of CFS demonstrate the importance of both physical and psychosocial factors, not either one or the other. The most effective treatments of CFS are based on an integrated, biopsychosocial understanding of the illness. To regard CFS as a physical disease would be as great an error as to regard it as a psychological illness.

**References**


## Commentary

Peter D. White

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