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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.

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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.

Would regarding CFS as 'physical' improve the anagement 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.

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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.

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