some dialogue or coordination, especially as neurologists sometimes blame the stigma of brain disease on misunderstandings created by inappropriate application of the term 'mental'.

I do not, however, share the possibly unrealistic and impractical view that the term 'mental illness' should be abandoned. Brain/mind issues have been debated by professionals, philosophers, patients and the public for centuries, and this will continue for some time to come. It is reminiscent of proposals to abolish the word 'epilepsy' because this neurological condition is so stigmatised. Similar suggestions have been made in the past for the words 'cancer' and 'leprosy', which together with 'epilepsy' were three great unmentionables for much of the 20th century (Reynolds, 2000).

Stigma results from ignorance, misunderstanding, fear and prejudice, and the way to combat it is by education and raising public awareness. Rather than abandon the word 'epilepsy' the International League Against Epilepsy (professional), the International Bureau for Epilepsy (patients/public) and the World Health Organization (political) have jointly initiated a global campaign to bring epilepsy 'out of the shadows' (Reynolds, 2000).

Baker, M. & Menken, M. (2001) Time to abandon the term mental illness. *BMJ*, **322**, 937.

Kendell, R. E. (2001) The distinction between mental and physical illness. *British Journal of Psychiatry*, **178**, 490–493.

Reynolds, E. H. (1990) Structure and function in neurology and psychiatry. *British Journal of Psychiatry*, **157**, 481–490.

__ (2000) The ILAE/IBE/WHO Global Campaign against Epilepsy: bringing epilepsy "out of the shadows". *Epilepsy and Behaviour*, **1** (suppl.), S3–S8.

__ & Trimble, M. R. (eds) (1989) *The Bridge between Neurology and Psychiatry*. Edinburgh: Churchill Livingstone.

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Kendell (2001) begins his editorial on the distinction between mental and physical illness by quoting with approval Lady Mary Wortley Montagu's comment that "madness is as much a corporeal distemper as the gout or asthma". This suggests that he might be a physicalist, that is an advocate of the view that all facts about mind and mentality are physical facts, but at no point does he say this explicitly. He is critical of Cartesian dualism – without saying exactly why.

Kendell then makes a proposal of his own: "In reality, neither minds nor bodies develop illnesses. Only people (or, in a wider context, organisms) do so, and when they do both mind and body, psyche and soma, are usually involved". But he does not explain how the individual person, the mind and the body are supposed to be related to one another and how this would heal the Cartesian split, nor does he offer any arguments in favour of this suggestion. If illnesses can be attributed only to people and not to minds or bodies, then we might expect Kendell to want to talk only of illnesses in general, and not of two different types of illness, as he continues to do in this editorial. Astonishingly, in the very next sentence he appears to be endorsing Cartesian dualism, the view he has already rejected: "Pain, the most characteristic feature of so-called bodily illness, is a purely psychological phenomenon". If pain is a "purely psychological phenomenon", then it can have no physical component. So there is at least one purely psychological, non-physical phenomenon in the world – a fact that is incompatible with physicalism. But, apparently oblivious of this, Kendell again dismisses Cartesian dualism when he observes that "the differences between mental and physical illnesses . . . are quantitative rather than qualitative", a remark that suggests physicalism again. Just how could differences between mental and physical illnesses by quantified? How can phenomenal consciousness or 'raw feelings' (i.e. what it is like to have certain mental experiences, such as pain or pleasure, visual hallucinations or paranoid delusions) differ only quantitatively and not qualitatively from physical phenomena?

Kendell seems to teeter between Cartesian dualism and physicalism and he presents no arguments for an alternative to dualism that might lend support to his proposed changes in terminology.

Kendell, R. E. (2001) The distinction between mental and physical illness. *British Journal of Psychiatry*, **178**, 490–493.

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Kendell's (2001) editorial made two mistakes in its reasoning, which led to an unhelpful conclusion. One cannot say that mental and physical illness should be conflated because, irrespective of the balance, mental and physical symptoms are expressed in both. This is insisting that differences in degree are not differences at all. There are indeed many disorders that have both mental and physical expressions. However, to claim that anxiety-related chest pain and myocardial infarction are both physical disorders is to conflate precisely what we wish to distinguish, even if anxiety can cause both. We contrast the terms 'mental' and 'physical' because the contrast says what we mean, and we have good reason for meaning it. As Kendell himself points out, no alternative has been found.

Proposing that disturbances in bodily function are necessary for psychiatric disorder does not imply that psychiatric disorders are physical disorders. Consider a computer virus. It may exist as a series of electrical states in a computer, a set of statements in a computer language, even a series of thoughts in someone's head, so its existence is not dependent on any physical object. None the less, it may disrupt a computer's function despite there being no physical fault in the machine. It is generally accepted that such arguments show that mental states might themselves be functions (Heil, 1998), and so purely functional psychiatric disorders are quite possible.

These mistakes lead Kendell to suggest that stigma might be reduced if all psychiatric disorders were to be regarded as physical. This makes mental illness literally unspeakable. But not speaking of something true implies an attitude towards it of denial, shame and horror, not acceptance. The concept of mental health and its promotion is currently competing successfully with 'madness' in popular culture. By falsely declaring 'mental' to be meaningless, the editorial threatens this progress. It may also consign those of our patients who are not sufficiently biological in their pathology to that therapeutic underclass, the 'worried well'.

Heil, J. (1998) *Philosophy of Mind: A Contemporary Introduction*. New York: Routledge.

Kendell, R. E. (2001) The distinction between mental and physical illness. *British Journal of Psychiatry*, **178**, 490–493.

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Author's reply: I agree with much of what Dr Reynolds says and with Baker &

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Menken's view, to which he refers. I also, like him, look forward to the time when psychiatrists and neurologists speak the same language. Both will need to change a good deal for this to be possible, but increasing understanding of the cerebral substrate of emotions and cognition will eventually provide a powerful stimulus to both specialities. I was not, though, suggesting that we should talk of psychiatric illnesses instead of mental illnesses because I prefer Greek to Latin derivations. The term 'mental illness' implies a disorder of the mind. By substituting 'psychiatric illness' I wished to imply simply that these are disorders which, if they come to specialist attention, are normally treated by psychiatrists. I should emphasise, too, that my objections to the term 'physical illness' are almost as great as to 'mental illness'. Both encourage doctors and patients alike to make inappropriate and damaging assumptions and to ignore the role of psychological and social influences across the whole spectrum of illness. That is why I do not think it is appropriate simply to combine mental and neurological disorders as 'brain disorders'.

In reply to Dr Crichton, I did not quote Lady Mary Wortley Montagu with either approval or disapproval, but simply to illustrate the fact that in the mid-18th century it was still the accepted view that madness was no different from other diseases. More importantly, Dr Crichton is confusing the difference between mental and physical events and what are misleadingly called mental and physical illnesses. There are indeed still many mysteries about the relationship between mental and physical (cerebral) events and no unanimity among either philosophers or neuroscientists about the nature of that relationship (although Descartes' original 'substance dualism' has passed into history). But this, although important, is irrelevant to my argument that there is no fundamental or qualitative difference between the heterogeneous collections of illnesses we currently distinguish as physical and mental. Both physical and mental phenomena are conspicuous in both – as aetiological factors, as features of the illness itself and as influences on outcome. And pain is indeed a purely subjective phenomenon, even though there are good reasons for assuming that it usually, perhaps always, has physical (cerebral) concomitants.

In reply to Dr Foreman I can only say that he should have read my editorial rather more carefully. I did not argue that psychiatric disorders *are* physical disorders. Rather, I drew attention to the extensive evidence of somatic abnormalities in almost all common mental disorders and to the lack of any characteristic features of either the symptomatology or the aetiology of so-called mental illnesses that reliably distinguished them from physical illnesses (and vice versa). Nor did I declare "mental to be meaningless", or argue that there are no important differences between mental and physical illnesses. My argument was that "the differences between mental and physical illnesses, striking though some of them are, are quantitative rather than qualitative, differences of emphasis rather than fundamental differences, and no more profound than the differences between diseases of the circulatory system and those of the digestive system, or between kidney diseases and skin diseases". And far from wanting mental illnesses to be regarded *as* physical illnesses, I argued that both terms are misleading. Finally, I did not say that "no alternative has been found" for the term mental illness. On the contrary, I suggested that "we should talk of psychiatric illnesses or disorders" instead. Nor was this merely a suggestion. The most recent edition of the *Companion to Psychiatric Studies*, which I co-edited (Kendell & Zealley, 1993), deliberately refers to psychiatric illnesses or disorders rather than to mental disorders throughout its 950 pages, and explains the reasons for doing so.

Kendell, R. E. & Zealley, A. K. (eds) (1993) *Companion to Psychiatric Studies* (5th edn). Edinburgh: Churchill Livingstone.

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General psychiatry and suicide prevention

I am grateful to Eagles *et al* (2001) for their recent editorial on the role of psychiatrists in the prediction and prevention of suicide. I am a member of the Royal Australian and New Zealand College of Psychiatrists' working group on suicide, and we are currently deliberating how to vote on a proposal to disband our group and hand responsibilities back to the College – after all, suicide is part of mental health.

Eagles *et al* start with how traumatic it is for psychiatrists when their patients commit suicide. Is this not a bit self-indulgent? Our surgical colleagues dealing in trauma frequently contend with the death of ordinary people in the operating theatre. More importantly, the authors do not even mention the suffering of family members affected by suicide.

In their conclusions Eagles *et al* focus on four points: first, they advocate less epidemiology and more multi-centre treatment trials with suicidal people; second, they advocate more support for traumatised psychiatrists; third, they make a plea to politicians and health service planners to realise what a difficult task suicide prevention is for us; fourth, they note that prediction is a very limited art (I entirely agree), but claim that "all of our patients are at increased risk of suicide". Taking their first and last points together, perhaps if they were more aware of epidemiological data they would realise Blair-West *et al*'s (1999) calculations have refuted the suggestion that 15% of people with depression eventually kill themselves: for this to be true, the annual number of suicides would have to be several times greater than it currently is. They recalculated the lifetime risk of suicide in people with depression as 3.4% with a lifetime risk of 7% for males and 1% for females.

As regards traumatised psychiatrists, I would simply say that all traumatised workers deserve support and that support should be in proportion to their trauma. I suspect that psychiatrists would rank well down the list, below fire, ambulance and police officers and many other medical workers – not to mention contemporary farmers in the UK!

The point relating to re-educating politicians and health planners about our limitations in influencing suicide rates has some validity. However, prevention is much more than that which might result from prediction. Nowhere in the editorial did I find any mention of basic public health concepts such as primary, secondary and tertiary prevention (Silverman & Maris, 1995). If general psychiatrists have not woken up to the fact that this is the basis of national suicide prevention strategies, I think I will have to vote in favour of retaining our local specialist-interest suicide prevention group.

Blair-West, G. W., Cantor, C. H., Mellsop, G. W. *et al* (1999) Lifetime suicide risk in major depression:

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