Somatic diseases and mental disorders: should they be differentiated?

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The authors of DSM-III and DSM-IV, as well as some other renowned scholars (e.g., M. Roth, R.E. Kendell) argue that the terms *somatic (physical)* and *mental disorder* should be abandoned because "there is much that is physical in the so-called mental disorders, and much mental in the so-called physical disorders". The author of this paper challenges such a view. He points that differences between somatic diseases and mental disorders largely outweigh their similarities. That is why, no matter how much they implicate an outdated mind-body duality, the terms *somatic disease* and *mental disorder* should be preserved.

Key words: Somatic disease, Mental disorder, Differences

Introduction

Lay people make a distinction between somatic disease and mental disorder. None of them would call pneumonia a mental disorder, or schizophrenia a somatic disease. Doctors and other health professionals would not make such a mistake, either. The distinction between somatic disease and mental disorder is *tacit knowledge*, to use Polonyi's phrase (1).

Nevertheless, many renowned scholars (2, 3, 4, 5) argue that somatic disease and mental disorder are fundamentally one and the same phenomenon. Thus Roth and Kroll assert: "To be precise, even the term 'mental illness' is a misnomer; it is based upon an outdated distinction between body and mind that remains a philosophical, but not a biological, dilemma. All illnesses eventually interfere with functioning in psychological, social, economic and physical spheres, place the affected person at a biological disadvantage, bring suffering to self and others, are present at times without the ill person recognizing it, have acute and chronic forms, and are associated with increased mortality" (2). Kendell, one of the most vociferous advocates of the idea that mental versus physical disease is a false dichotomy, goes so far as to use the term "psychiatric disorders" instead of "mental disorders" in "Companion to Psychiatric Studies" (4). "We should talk of psychiatric illnesses and disorders rather

than of mental illnesses; and if we continue to refer to 'mental' and 'physical' illnesses we should preface both with 'so-called', to remind ourselves and our audience that these are archaic and deeply misleading terms"(5).

The authors of DSM-III and DSM-IV share Roth's and Kendell's view. They consider physical disease and mental disorder to be hard-to-distinguish phenomena. 'Although this volume is titled the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), the term *mental disorder* unfortunately implies a distinction between 'mental' disorders and 'physical' disorders that is a reductionist anachronism of mind/body dualism. A compelling literature documents that there is much 'physical' in 'mental' disorders and much 'mental' in 'physical' disorders. The problem raised by the term 'mental' disorders has been much clearer than its solution, and unfortunately, the term persists in the title of DSM-IV because we have not found an appropriate substitute' (6).

The other group of scholars (7, 8, 9, 10, 11, 12, 13) regards mental disorders as being quite different from somatic diseases. However, by strongly and strictly differentiating somatic diseases and mental disorders, they in various forms virtually negate the existence of mental disorders.

So Szasz (7, 8,) indicates that as long as 'mental patients' have no underlying physical abnormality they cannot be considered diseased. And when the underlying physical abnormality of a 'mental abnormality' has been determined, that sort of abnormality gets the status of a neurological or somatic disease. He writes: 'Disease means bodily disease. Gould's Medical Dictionary defines disease as a disturbance of an organ or a part of the *body*. The mind (whatever it is) is not an organ or part of the body. Hence, it cannot be diseased in the same sense as the body can. When we speak of mental illness, then, we speak, metaphorically. When a metaphor is mistaken for reality and used for social purposes, then we have the making of a myth. The concepts of mental health and mental illness are mythological concepts, used strategically to advance some social interests and to retard others (7).

The basic premise of Szasz's line of reasoning is flawed. The known pathological substrate is not a prerequisite for the existence of either somatic or mental disturbance. The fact that one hundred years ago we did not know the pathological underpinnings of a great number of somatic diseases did not make them less real or irrelevant for medicine. The same holds for mental disorders.

Eysenck, on his part, argued that the vaguely defined field of psychiatry should be divided into two parts: a small medical part 'dealing with the effects of tumors, lesions, infections and other physical conditions', and a much larger behavioral part 'dealing with disorders of behaviour acquired through the ordinary processes of learning'(9).

If Eysenck's proposal had come into effect, the turf of psychiatry would have been occupied by neurologists and psychologists, with no place left for psychiatrists. Since mental disorder cannot be reduced either to the effects of 'tumors, lesions, infections and other physical conditions' on the psyche, or to learned behavior, Eysenck's 'reformist' idea in the last instance means that there is no such thing as mental disorder, or the greatest majority of mental disorders.

Laing's negation of mental disorder went along different lines (10, 11). With no reference to a possible cerebral pathology as part of mental disorders, first and foremost, of schizophrenia, Laing saw in schizophrenia a meaningful revolt against unbearable existential and social conditions, a way of coping with double-bind type of pressure placed on people by their family and society.

By conceptualizing schizophrenia as a 'revolutionary act' and in so far as the only route leading towards genuine mental sanity,

Laing, in fact, instrumentalized this mental disorder. The truth is that schizophrenia, as well as any other mental disorder, might in some instances be read as a reaction to a given social ambiance. However, if one claims that all mental disorders are but a way of coming to terms with a socially noxious environment, then they question the existence of mental disorders in those cases where such a way of looking at them is completely unfounded. And there are many such cases.

Sheff (12, 13) in his own way also denied the existence of mental disorder. When people have no answer to someone's weird behavior, argued Sheff, they label such behavior as the expression of mental disorder. What psychiatrists call mental disorder is in fact a way of adaptation to the shock of being labeled mentally disordered. Under the pressure of people's expectation to behave in tune with the label, those who are labeled as mentally disturbed sooner rather than later start behaving in accordance with the label. In Scheff's view, and the view of other protagonists of label theory, there is no mental disorder other than that created by the people and institutions that purport to treat it.

In my opinion, somatic disease and mental disorder should be differentiated, but in a way that does not put into question the existence of mental disorders. There are many differences between somatic diseases and mental disorders that fully justify their distinction without disputing the reality of mental disorders. The differences between somatic diseases and mental disorders, as I will show further down, far outweigh their similarities. Yet, none of the latter is so relevant to support the idea of their sameness.

The goal of this paper is to trace down in how many regards somatic diseases and mental disorders differ and, for that matter, to turn *tacit knowledge* about the difference between somatic diseases and mental disorders into *explicit knowledge*. To do so I will analyze dissimilarities of somatic diseases and mental disorders at several levels: etiology, clinical picture, diagnosis and social meaning of each one of these phenomena.

Etiology

As far as the etiology is concerned the same etiological factors take part in the genesis of both somatic diseases and mental disorders. There is such a huge body of data demonstrating the role played by biological, psychological and social variables in the engenderment and shaping of both somatic and mental disturbances, that it would be senseless to argue that somatic diseases are caused only by bio-physical agents and mental disorders only by psychological-social ones. There are few somatic diseases that, along with their biological causation, have not been to some degree conditioned, or at least triggered by psychological-social influences. On the other hand, the science of human genetics has recently made such remarkable progress that one cannot any longer turn a blind eye on hereditary factors in the formation of virtually any mental disorder. Furthermore, functional MRI is ever more providing insight into how the brain operates.

General assertion reads: the same group of agents (biological, psychological and social) gives rise to both somatic diseases and mental disorders. And that is where the similarities between somatic diseases and mental disorders begin and end.

If one takes a step further from this general statement, the differences between somatic diseases and mental disorders start to emerge. Even though, as stated earlier, biological, psychological, and social agents participate in the formation of both somatic diseases and mental disorders, physical-biological factors are more often responsible for the genesis of somatic diseases just as psychological-social factors are more relevant in the etiology of mental disorders. If that were not true, it would be hard to explain

why many mental disorders, in particular those which were called neurotic illnesses, can be efficiently managed by psychotherapy. On the other hand, psychotherapy is not a treatment of choice for virtually any somatic disease. The reasonable assumption is that the disturbances, conditioned to a greater extent by psychological-social factors, would better respond to psychotherapy. Similarly, the disturbances, in whose etiology biological-factors played a major role, would be more efficiently treated by physical-biological therapeutic techniques.

There are two major points in any discussion about the etiology of mental disorders. The first is the biological (material) foundation of all mental phenomena, and related to it is the biological basis of mental disorders; the second is the nature of the relation between cerebral and mental occurrences in general, and cerebral and mental pathology in particular.

The brain is the locus of the origin of psyche. That is a general statement very few psychiatrists, regardless of their general conceptual orientation, would be keen to dismiss nowadays.. So far, however, this general assertion has not proved to be of much help in tracing down the origin of a majority of mental disorders. Joseph Glenmullen, clinical instructor in psychiatry at Harvard Medical School, wrote: 'In medicine, strict criteria exist for calling a condition a disease. In addition to a predictable cluster of symptoms, the cause of the symptoms or some understanding of their physiology must be established…Psychiatry is unique among medical specialties in that… we do not yet have proof either of the cause or the physiology for any psychiatric diagnosis…In recent decades, we have had no shortage of alleged biochemical imbalances for psychiatric conditions. Diligent though these attempts have been, not one has been proved. It has just been opposite. (14). This view has been shared by many scholars (15, 16,17).

Interestingly enough, when the underlying somatic pathology of some disorders that about one hundred years ago were considered to be functional in a sense of mental, like, for example, epilepsy, Parkinson's disease, and Huntington's disease was discovered, they started to be considered as neurological diseases rather than psychiatric disorders.

Unlike in psychiatry, the somatic pathology of a majority of somatic diseases is now being found. (This does not imply that the appropriate cure has also been found.)

As stated earlier, a second major point in discussion of the etiology of both somatic and mental disorders is the nature of relations between physical and mental occurrences. The question is as follows: how does it happen that neuro-electrical, biochemical, and other processes produce feelings, thoughts, memory, cognition? How does the subjective experience arise from neural computation? How do the two substantially different phenomena: the material (neurotransmitters, neural associations, etc.) and mental (thoughts, affection, memories, etc.) relate to one another? How does the former get transformed into the latter?

Psychiatrists may say that it is a philosophical question, and that it is not up to them to deal with it. However, no matter how much they ignore the fundamental question of the nature of the relationship between the material and the mental and, for that matter, between the brain and the mind, it is a question which, as long as it remains unanswered, casts a long shadow on an increasing biological knowledge base for understanding the somatic origins of mental disorders. The question relates to the fundamental discontinuity in the hierarchical sequence of psychiatric explanation that makes the relationship between such issues as metabolism and misunderstanding obscure (18).

The idea of the transformation of the material into the mental is at the heart of the ac-

knowledgment that the brain is the place of birth of psyche, and of the notion that biological disorders underpin mental disorders; and still, such transformation is beyond our comprehension. To be aware of that question means to be cognizant of hard-to-surmount hurdles psychiatrists have to face up to in their day-to-day practice. 'As contemporary philosophers have stressed, the irreducible subjectivity of consciousness defies description in non-mental terms…Hence the language of psychology and the language of biology involve two different levels of discourse when working with a patient'(19).

Things are quite different when the etiology of somatic diseases is in question. Nobody is at pains to understand how physical pathology produces the signs of, for example, bacterial pneumonia, or uremia, or diabetes mellitus. Physical occurrences have physical effects. There is no need to resort to philosophical interpretation. Things seem to be self-evident.

There is one more point of difference between somatic diseases and mental disorders in regard to their etiology. There are as many etiologies of mental disorders as there are conceptions about the nature of mental disorders. The truth is that some conceptions are more applicable to some sorts of mental disorders. However, the advocates of each single conception argue that their conception is sufficient and binding for all mental pathology. Furthermore, the epistemological premises of various general concepts about the nature, causes and treatments of mental disorders are incompatible with one another. They tend to be more than mere differences in regard to perspectives; each is an encompassing view, resting on certain assumptions of legitimacy and importance, and each develops, in part, in opposition to the other (20).

I will mention just a few conceptual models in psychiatry. *Disease model* regards mental malfunction as a consequence of physical and chemical changes primarily in the brain; sometimes in other parts of the body, as well. *Psychodynamic model* proposes that how we feel, what we perceive and what we do is influenced by competing forces which are largely unconscious. According to the *social model* mental illness is related to social factors. This model is based on general theories of groups, communities and cultures.

Given the multitude of conceptual approaches in psychiatry it is small wonder that psychiatrists, depending on their conceptual orientation, find relevant etiological agents of a particular mental disorder either in somatic pathology, or in unconscious forces, or in social influences.

That is not the case with health professionals in fields other than psychiatry. In most instances they share the same conceptual approach. When one has, for example, pneumonia or uremia, none of specialists in internal medicine they seek help from will say that the etiology of their somatic disturbance is in their unresolved mental conflicts, or in an anomic social environment they have lived in.

That is not the case with psychiatrists. If you approach a psychiatrist asking for the origin of your mental difficulties, the answer you will be given depends on the psychiatrist's conceptual orientation. 'It matters a great deal how a psychiatrist is taught to look at mental illness, because the 'how' cannot be clearly separated from the 'what' of the disease. To understand the psychiatric ways of seeing, we have to proceed knowing that what counts as 'fact' is a tinted window onto the world you cannot step outside to see' (21).

Bodkin, Klitzman and Pope (22) carried out a study among psychiatrists that proves that most of them are conceptually biased. The authors of the study sent a questionnaire to 435 academic psychiatrists to assess whether they were primarily biologically or primarily psycho-dynamically oriented, or whether they demonstrated evidence of

mixing both approaches. Even though most clinicians claimed to be open to both approaches and to mix them, the researchers found that they could classify 27 percent of practitioners as biological and 37 percent as psychotherapeutic. These practitioners spent more than three-fourths of their time solely working in tune with their approach. Ghaemi, on his part, indicates that in his experience most psychiatrists claim to be bio-psycho-social eclectics. 'Yet in practice, only one-third is in fact eclectics. Most clinicians are eclectics only in theory; they are dogmatists in practice' (23).

As the *bio-psycho-social* model is usually opposed to the above mentioned individual models, it requires a comment in the context of this paper. The bio-psycho-social model has been spelt out most clearly by Engel (24, 25). This model is not just one of many competing possibilities within the contested field of mental illness and psychiatry. By assigning equal weight to the entire gamut of different interpretative positions the bio-psycho-social model is conceived of as an alternative to the reductive explanatory models that dominate psychiatry. However, the problem with this model in psychiatry is that it does not provide a clue as to how the data from the individual conceptual models could be mutually related and ordered into a new coherent model. The bio-psycho-social model is praiseworthy in so far as it strives to conceptually integrate all levels of human existence. However, the theory or, more accurately, the general orientation of this model does not have its (psychiatric) practice because the theory of the bio-psycho-social model, apart from advocating conceptual high ground of the position that equally respects all dimensions of human existence, does not teach us how to explain or understand and treat individual mental disorders. The bio-psycho-social model itself, as Weiner (26) noted, is easier to define in a negative way (i.e. in terms of what it is not), than in a positive manner that does not at the same time appear trite.

Those clinicians who do not want to be aligned with any particular model, and who insist on the advantages of an all-encompassing approach in fact combine elements of the existing different conceptual models in their everyday clinical work. They intentionally 'underplay differences' and 'homogenize complexities' in clinical explanation (27). One cannot ignore data from individual models for by doing so, they would ignore psychiatric knowledge. The bio-psycho-social model has not superseded other individual models within psychiatry. It has argued a holistic position and repudiated all sorts of undimensional explanations, but it has failed to produce substantially new psychiatric knowledge.On the other hand, each model captures important facets of clinical reality, yet disregards or even denies others (28). Today, the bio-psycho-social approach, combined with eclectism, has frequently come to mean simply avoiding a discussion of methods and assumptions in one's psychiatric work (23).

All the said differences between somatic diseases and mental disorders in regard to their etiology come from the fact that, unlike physical pathology, which can be reduced to biological-physical data, mental pathology is at the same time a physical and a mental-spiritual phenomenon. Mental pathology is mid-way between the physical and the mental-spiritual. The physical part of mental pathology is the object of investigation of the natural sciences (*Naturwissenschaften*). They look for observable influence of one occurrence on another that could be tested objectively and repeatedly. In order to assess the nature of the relation between two or more objects in an empirically verifiable form the natural sciences break down the external world into its elements. By doing so, they strive to formulate some general principles or rules governing the way in which ob-

jects, physical-biological data under defined circumstances relate to one another. On the other hand, the 'mental' of mental disorder can be properly dealt with by human sciences (*Geisteswissenschaften*). The *cause* is the key category of natural sciences, whereas the *meaning* is the key category of human sciences. The goal of natural sciences is to explain (*erklären)* natural phenomena. The human sciences aim at making us understand the meaning of people's intentions and actions. Unlike the natural sciences that, as stated, break down the whole into its parts, the human sciences are focused on the whole.

Jaspers, German psychiatrist turned philosopher, who laid down the foundations of psychopathology, largely elaborated this distinction in his seminal work 'General Psychopathology'. There is no better way to grasp what this distinction is all about than to cite Jaspers himself. 'In natural sciences, we find only causal connections but in psychology our bent for knowledge is satisfied with the comprehension of quite a different sort of connection. Psychic events 'emerge' out of each other in a way which we understand. Attacked people become angry and spring to the defense, cheated persons grow suspicious.' And Jaspers adds: 'The evidence for genetic understanding is something ultimate. When Nietzsche shows how an awareness of one's weakness, wretchedness and suffering gives rise to moral demands and religions of redemption, because in its roundabout way the psyche can gratify its will to power in spite of its weakness, we experience the force of his argument and are convinced… Such conviction is gained on the occasion of confronting human personality; it is not acquired through repetition of experience (29).

Clinical picture

In relation to the clinical picture the major difference between somatic diseases and mental disorders is that somatic diseases manifest themselves through primarily physical signs whereas mental disorders through predominantly mental symptoms. That is, after all, how laymen and health professionals alike usually differentiate somatic from mental disturbances.

One more subtle although no less important difference between somatic diseases and mental disorders is created by the role played by the personality in shaping the manifestations of both somatic diseases and mental disorders. The truth is that the personality affects various aspects of both somatic diseases and mental disorders; for example, one's perception of either somatic disease or mental disorder is heavily influenced by one's personal vulnerability, early conditioning, socioeconomic status, environmental stress and emotional arousal. In addition to that, the psychological make-up of an individual may affect to a significant degree the extent of the disability produced by the somatic disease or mental disorder, may color their manifestations and may even, in some instances, affect their course (30, 31).

However, the personality plays a far more important role not only in the engenderment, but also in shaping the clinical picture of mental disorders than of somatic diseases. Since somatic diseases are manifested mainly with physical signs, the influence of the individual's psyche on the transformation of structural-functional changes of some organ(s) (e.g., inflammation; degeneration; hyper- or hypofunction of particular hormones; impact of external force on the organism) into physical signs (e.g., edema, cough, high body temperature, the change of urine's color, tremor, intense sweating, difficulty in swallowing), that is, into the clinical picture of somatic diseases is inappreciable or none. That does not hold for mental disorders.

The personality of the patient is involved in the process of creation of the clinical picture even before the appearance of the first

symptoms of the disorder. A good number of mental disturbances originate in the particular psychological make-up of the individual. Furthermore, it is personality which struggles to counter the menacing mental imbalance at the very beginning of mental illness. Since mental defensive mechanisms are an integral part of the personality, it is personality which tries to find a sort of co-existence of the individual and the disturbing mental symptoms. By doing so, the personality abundantly tailors the clinical picture of any mental disorder. Hence the symptoms a mental patient presents with are an amalgam of putative somatic pathology and coping mechanisms of that particular individual.

The patient's reaction to their mental disturbance is a part of that particular mental disorder. So much so that in many cases it is hard to tell what are genuine symptoms of the disorder and what is the individual's reaction to the symptoms; so closely they are interwoven. However, whenever psychiatrists can differentiate these two kinds of phenomena they mention each of them in their description of the patient's clinical presentation. In a patient's reaction to their symptoms is mirrored their personality, and that is, among other things, why psychiatrists are expected to pay due attention to it.

Yet, in describing the clinical picture of a somatic disease physicians mostly ignore people's reaction to the signs they display. In somatic medicine the signs matter rather than the subjective interpretation of them. When, for example, an oncologist gives their assessment of the clinical picture of someone suffering from a particular kind of cancer, they very rarely, if at all, include the patient's reaction to the signs, least of all, the patient's reaction to the diagnosis of cancer.

Eventually, there are some other features that also differentiate somatic diseases from mental illnesses. Mental disorders express themselves primarily through cognitive, affective and behavioral symptoms, and it is cognition, emotions and behavior that make us what we are as individuals. Consequently, the afflicted individuals are in their own eyes and in the other people's perception identified with the illness (32). The terms such as 'a schizophrenic' or 'a neurotic' are widely used by laymen and health workers, alike. They designate that someone suffers from schizophrenia or neurosis. That is not the case with somatic diseases. Nobody is identified with, for example, renal calculosis, or inflamed gall bladder. There are no terms that would be used as identifiers of persons suffering from a particular somatic disease.

Diagnosis

Nowadays physicians, apart from anamnesis and the observation of signs, diagnose somatic diseases more and more on the basis of laboratory tests and imaging techniques. The etiology of a good number of somatic diseases has been unveiled, and structural and functional standards of what is normal and what is pathological have been established. Such a diagnostic approach, that is in fact etiological, has increased the reliability of diagnoses in somatic medicine.

As the etiology of mental disorders in most cases is unknown psychiatric diagnoses cannot be etiological. In diagnosing mental disorders psychiatrists have to rely on what patients tell them about how they feel, what they think, how they experience themselves and the surrounding world, as well as on patients' behavior. This kind of diagnosing has a great many imperfections. For example, patients are not always keen to talk about how they feel or what they think. Or they deliberately distort their feelings, or what they really think about someone or something. Or psychiatrists succumb to counter-transference feelings and misinterpret patients' attitudes, their assertiveness, and way-of-being. Besides, inexperienced

psychiatrists are not able to pose the right questions to patients. Or they cannot differentiate those patients' symptoms and ways of behaving that are more important in diagnostic terms from the symptoms and behavioral manifestations that are less important. Psychiatrists also have a great deal of difficulty to agree upon how a particular symptom should be interpreted, that is, what its meaning is within the whole clinical picture. Moreover, there is a disagreement among psychiatrists as to the cluster of symptoms which is sufficient and necessary for the diagnosis of a particular mental disorder.

The low reliability of psychiatric diagnosis is a result of all these contingencies of psychiatric diagnosis. That is why a set of measures has been taken in order to improve the reliability of psychiatric diagnosis: structured interviews, standardized meaning of psychopathological notions, operational definitions of mental disorders.

There is another reason why the reliability of psychiatric diagnosis has to be enhanced. There is no validity of a particular diagnosis without its high reliability. And it is the validity of a diagnosis that matters. If a diagnosis is valid in a sense of being well-founded, it cannot be put in question. The validity of a diagnosis makes that diagnosis real.

There is a substantial difference between somatic diseases and mental disorders as far as their validity is concerned. The diagnosis tests the hypothesis that particular signs and symptoms, which are commonly found together, belong to a particular class. 'In medical nosology (nosology of non-psychiatric disorders), class membership can often predict aspects of aetiology, pathogenesis, therapy, and prognosis, but this is not the case in psychiatry where diagnostic labels usually provide information only on correlation between symptoms' (33).

So far, various and numerous validators such as family aggregation or a characteristic course and outcome have been used in psychiatry to demonstrate clinical stability and provide indirect clues about mechanisms (34). In most cases there have been no convincing results. One might assert that a descriptive diagnosis – and the greatest majority of psychiatric diagnoses are descriptive – by definition cannot be valid, and hence, it is hardly surprising that all attempts at validating psychiatric diagnoses by examining their relationship to external measures, be it mechanisms or etiology, have failed.

Kendel and Jablensky (35) have recently questioned the opinion that the established etiology is a guarantor of the validity of a psychiatric diagnosis. In their view, the weakness of the validity criteria is that those criteria implicitly assume psychiatric disorders to be discrete entities; in other words, that there exists a natural boundary between one entity and the other. But there is no such a boundary between entities. They cite several studies the authors of which have attempted to demonstrate natural boundaries between related syndromes or between a common syndrome such as depression and normality, either by locating a 'zone of rarity' between them or by demonstrating a nonlinear relationship between the symptoms' profiles and a validating variable such as outcome or heritability. 'Most of such attempts have ended in failure (35).'

Thus, in the view of Kendel and Jablensky, it would be foolish to search for the etiology of a psychiatric syndrome whose existence at the level of the defining characteristics (symptoms) is doubtful. After all – the question arises – the etiology of which syndrome would be explored if 'our existing syndromal concepts do not reflect genuine discontinuities in the variation of symptoms'. Hence the question should be posed: what will happen if all future attempts at detecting discontinuities in symptoms do not bear fruit? If that happens, the prognosis is quite gloomy. 'Our existing typology will be abandoned and replaced by a dimensional classification (35).'

And will a dimensional classification pave the way for making the diagnosis of mental disorders more valid? I do not believe it would. Quite the inverse is more likely to happen.

Sartorius, writing about the revision of the classifications of mental disorders, maintains that current categorial classification might be replaced by a dimensional one, or by the use of both - dimensions and categories. Such an option is likely to make the validation of psychiatric diagnoses even more difficult. Moreover, 'the problem with a dimensional classification is that the making of a diagnosis – i.e. the profile of a patient on a fixed number of dimensions – might take a long time and would require the application of a number of instruments which the psychiatrists and other medical staff are unlikely to use (36).'

Due to all these conceptual difficulties in diagnosing mental disorders we seem to be a long way off from establishing the validity of psychiatric diagnoses. On the other hand, as stated, the problems involved in establishing the validity of the diagnosis of somatic diseases are much less intractable.

Social meaning of somatic disease and mental disorder

Social meaning of physical disease and mental disorder is quite different, too. The discrepancy in social meaning of somatic diseases and mental disorders is the result of their various social effects.

Both somatic diseases and mental disorders are a serious nuisance to humans and society, yet in a rather different way. Generally speaking, somatic diseases threaten the biological existence of individuals, and thereby, of human species. Even though the mortality rate of mental patients is higher than that of physically healthy people (37), mental disorders are significantly less threatening to humans than somatic diseases. Yet they do endanger them - socially. Mental disorders, primarily the psychotic ones, in short, include the disturbance of relations between Ego, as the representative of social reality, and both the irrational part of the personality (Id) and Super-Ego.

The respect of the common code makes communication possible in any community. The communication code consists of a huge number of rules and symbols of communication, both verbal (written) and nonverbal. The code is stable, even though not fixed once for all. In time people slightly change it. The point is that a system of signals and rules is commonly used by the whole community. People practice it without thinking about it; it is the key part, the key dimension of their social existence. Those people who make use of the existing communication code in meeting their needs and exercising their rights, in exhibiting their sorrows and their joyfulness, re-affirm it. They stay within the borders of the real and symbolic order established in community as a whole.. They are honored as members of the community. And those who show disrespect for the code by disrupting or violating it, are labeled as either outsiders or deviants.

There are many sorts of deviants. Mentally ill people are one of them.

There are two main differences between mentally ill people and the rest of deviants. Unlike other deviants, mentally ill people do not ignore the code intentionally. They do it under the pressure of their disturbed mental condition. They merely cannot do otherwise. And second, the repressive measures that are usually used to constrain people's deviant drives have proved unsuccessful in subduing socially disruptive behavior of those who are mentally disordered (38).

Mentally ill people are regarded as outsiders and estranged individuals sitting on the other side of the fence, not only because they do not respect the incumbent communicative code and symbols, but also because

they cannot be forced through the punishment and reward system to become social order abiding citizens.

The result of such a state of affairs regarding the deviant nature of mentally ill people is that they are always and everywhere perceived as alienated from the dominant social values, that is, from the social values which are cherished most in a given society or epoch. For example, in those societies in which religious beliefs and practice are a top priority, mentally ill people are labeled as devils, anti-Christ, demons. In societies wherein rationality is praised as the highest value, mentally ill people are considered to be irrational, deprived of the faculty to explain the world in rational terms. Where work, productivity, efficacy and pragmatism are the chief criterion of people's soundness, mentally ill people are viewed as lazy, unproductive, and good-for-nothing individuals.

Disturbing social effects of the way mentally ill people behave, relate to themselves and others, their manner of talking and acting, put them, literally and metaphorically, on the margins of society. In order to ensure that mentally ill people stay there for good, the community stigmatizes them. Once stigmatized, the mentally disordered individuals are most likely to carry the label for the rest of their lives (39, 40, 41). It is the stigma of mental disorder which strengthens social isolation of mentally ill people. Initially, the isolation is caused by the mental disturbance itself which alienates people from community, but later it is reinforced by the fear of the community in relation to the socially disruptive potential of the mentally ill.

The story with the somatically diseased is quite different. The social role of the physically ill is temporary, with the exception of those who are crippled or seriously and permanently incapacitated by the effects of a particular disease. In cases when such patients are released from everyday obligations because of their disease, they are not regarded as people who, really and/or potentially, threaten the existing social order. In most cases somatically diseased people fully respect the prevailing social and cultural code, that is, they abide by the rules governing the behavior of those who perform a social role of the diseased person. Since the behavior of the physically diseased is deemed to be predictable unlike that of the mentally ill, other people are not prompted to protect themselves from it. There is no good reason for such a reaction. On the other hand, the mentally ill are considered to be unpredictable, and it is the unpredictability of the mentally ill people that stirs up fear of them. People, threatened by those who break social norms and whose actions are hard to predict, tend to keep a distance from them by stigmatizing them or putting them in asylums which are commonly built on the outskirts of cities.

The violation of social norms by the mentally disordered has one more effect. The social norms are treasured. If people respect them, social life goes smoothly. The more people respect the social norms, the more each and every individual knows what they can expect from other people, and thereby the safer they feel.

Because of being social norm breakers, the mentally ill people are negatively valued. A widespread belief is that the mentally ill are more responsible for their calamity than the somatically diseased, which, in turn, supplies additional reason for their negative valuation. Unlike the mentally disordered people, the somatically diseased do not disrupt the extant social order, their behavior is regarded as predictable, and in most cases they are not held responsible for their predicament. As a result, their social rating is much higher than that of the mentally ill people.

A comparison might be made between the negative attitude towards the mentally disordered and the social management of four somatic diseases: plague in the Middle Ages, tuberculosis in the nineteenth century,

and cancer and AIDS in the twentieth and twenty-first centuries, respectively. All these four diseases were at particular periods and some still are used as a figure of speech or metaphors, lurid, unsavory and distorting metaphors at that The above diseases, thought to be intractable and capricious, have been experienced as the epitome of evil, and 'perceived not just as lethal but as dehumanizing, literally so' (42).

However, the meaning of these four diseases and their metaphors in particular, is exceptional, with no pair among somatic diseases. Yet, the above description of the social meaning of mental disorders, primarily of psychoses, which are at the heart of psychiatry, is fairly common.

Conclusion

The community of mental health workers and the psychiatric community in particular consider DSM-III and DSM-IV to be the *Psychiatric Bible*. Spitzer (43), who was in charge of conceptualizing DSM-III, wrote that the Task Force planned to include in the Introduction to DSM-III a statement that mental disorders were a subset of medical disorders. Apparently, it became clear that the inclusion of such a statement would only fan the fires of professional rivalry and might be a real obstacle to the use of DSM-III by non-medical health professionals who had used DSM-I and DSM-II in their clinical and research work. Therefore, due to a trivial rather than substantial reason DSM-III contains no explicit reference to mental disorders being a subset of medical disorders, as initially planned

Frances (44), who directed the fourth revision of DSM, claims that *mental disorder* and *physical disease* are unfortunate terms, preserving as they do an outdated mind-body duality, and asks: can anyone suggest better terms for us?

Obviously, the authors of the *Psychiatric Bible* share the view that the distinction between somatic diseases and mental disorders should be abolished because 'there is much that is physical in the so-called mental disorders, and much mental in the so-called physical disorders'.

I have shown the differences between somatic diseases and mental disorders to be numerous and significant, outweighing by and large their similarities. That is why the terms *somatic disease* and *mental disorder* should be preserved.

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