correct the problem. Maybe it is simply the fresh air and oxygen?

Some people with attacks of phobic anxiety, panic, globus hystericus, hyperventilation etc. respond to heavy exercise (vigorous pushups or weight lifting). In any case, it diverts their preoccupation with themselves.

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SUICIDE PREVENTION: A MYTH OR A MANDATE?

DEAR SIR,

It is possible that Dr. Malleson (1) is right in assuming that the suicide rate in Britain is falling because of the reduction of toxicity in the gas supply. Yet to show the similarity of two curves on a graph is not to demonstrate a causal trend. These data are open to some alternative interpretations.

Dr. Malleson does, however, suggest that 'our thanks for Britain's falling suicide rate should probably go to Gas Boards and not to suicide prevention programmes'.

If Dr. Malleson's thesis is correct, we would expect —in the first half of the 1960s at least—an increase in those failing to complete suicide by gas poisoning. It is crucial to show such an increase if the hypothesis is to be sustained that there is an increase in 'failed suicides by gas' as a concomitant of the falling suicide rate. I am able to throw some light on this point through an examination of cases of attempted suicide admitted to a casualty department in a hospital in the South of England between 1960 and 1970.

The following are the proportions of such cases using gas as a method admitted in the years which I examined:

1960	1962	1964	1966	1968	1970
12·1%	11·6%	8·7%	7·9%	5·3%	4·8%

This continuous fall in the proportions using gas as a method for parasuicide is not consistent with Malleson's hypothesis. If the falling suicide rate were due to the decreasing toxicity of the gas supply, there should actually have been a slight increase in gas as a method of parasuicide, at least until 1966. I suggest that the use of gas as a method of self-injury has declined in *both* completed and attempted suicide, and that the fall in the rate of completed suicide has been due largely to factors other than detoxification of gas.

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PSYCHIATRY AND DISEASE

DEAR SIR,

I would like to comment on Professor Sir Martin Roth's recent paper, 'Psychiatry and its Critics' (*Journal*, 1973, **123**, 373–8), especially as some of the points he raises are relevant to the debate about alcoholism being a disease, a subject with which I have recently been concerned.

It is generally acknowledged that one of the fundamental aspects of the medical model is the patient's inability to control the disease directly by willpower so that he cannot be held responsible for it. Clearly, this is different from the person being held accountable for any behaviour which might have brought about the acquisition of the disease, or by his failure to seek medical advice, thereby prolonging his suffering. Psychiatric disorders such as obsessive-compulsive behaviour, addictions, etc., as Professor Roth points out, are now increasingly perceived as socially determined and therefore beyond the personal control of the afflicted individual. If this is accepted then the notion that such conditions are illnesses may be entertained. However, the point at issue is somewhat more complex, for whilst the alcoholic, for example, will have more difficulty in controlling his drinking behaviour than the social drinker, he never loses the power altogether; for periods he can and does abstain and in favourable circumstances can probably moderate his intake as well. The alcoholic is different from the non-alcoholic in having *relatively* less control over his drinking behaviour, whereas a person with pneumonia or cancer has *absolutely* no control over his disease.

There is however, another criterion of disease, against which claimants to that status can be tested —the demonstration of an underlying aetiologically-