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.

L. J. KOTKAS.

1279 Third Avenue South,
Lethbridge,
Alberta,
Canada.

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.

CHRISTOPHER BAGLEY.

Department of Sociology,
University of Surrey,
Guildford, Surrey.

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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-

relevant physical pathology. It may be the case that for some accepted diseases the nature of the pathology is still obscure, and for others a physical concomitant is mistakenly believed to have aetiological relevance. There is still no certainty about the underlying pathology of schizophrenia, depression, anxiety, addictions, or any other 'functional' psychiatric disorder. That is not to say that such pathologies will not eventually be brought to light, but that until such a time the argument for any of these conditions being a disease in the medical sense is tentative, to say the least. Moreover, to claim that psychological processes, such as envisaged by the learning theories, ultimately have a physical basis is of course true. However, the nature of the physical explanation of psychological phenomena remains to be elucidated, and would not seem to be consistent with the specific disease pathologies—inflammation, neoplasia, degeneration, etc.—that currently exist.

Finally, I differ from Professor Roth's view that since we cannot as yet hope to reduce the prevalence of the 'functional' disorders by recommending social change there is no harm in continuing to provide medical care. I think it has to be faced that while society sees one of its most respected and trusted institutions—the medical profession—accepting responsibility for certain behaviours it will assume the 'experts' know best, and, with its conscience eased, expend proportionately less energy in looking at its own structure, patterns and processes. By and large the medical profession carries out its functions with humanity, sensitivity and dedication; it is possible that these very qualities so welcome in the short term, may defeat our aspirations for the long term.

H. Hershon.

Institute of Psychiatry,
Addiction Research Unit,
101 Denmark Hill,
London, SE5 8AF.

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DOCTORS' ATTITUDES TO HOMOSEXUALITY

Dear Sir,

Dr. Philip Morris's short investigation into homosexuality (*Journal*, April 1973, pp. 435–6), is important because of the profound depression, often suicidal in degree, which results from a broken relationship. As a psychotherapist, I have had to deal with a few cases, both male and female, where the depression was most distressing. If we could pinpoint the cause, we should have done a great service, at least to some of these unfortunates.

With regard to 2(a) in the investigation, in 4 of my male cases the patient had been abandoned by the mother in infancy and had been brought up by the grandmother. There were various reasons for this, as illegitimacy, separation by war, mother out at work, the whole family out all day except grandmother who ran the home.

The impression I got was that grandmothers tend to fondle their grandchildren overmuch. The infant is a bundle of erotic zones, some more vulnerable sexually than others. This is not important in the case of the female child but is devastating in the case of the male child, whose instinctual maleness is, albeit unconsciously, affronted. One man described it as being 'smothered among breasts' but the bathing etc. may be injudiciously carried out so that the male is unconsciously but surely set against the female sex.

An investigation into the infantile upbringing of homosexuals could, perhaps, be useful, and if the cause lies in the area of overpetting of the male by the female this might be dealt with satisfactorily by proper teaching regarding eroticism in infancy and the care needed in regard to it.

J. H. Thompson.

Newcastle & District Counselling Centre,
6 West Avenue,
Gosforth,
Newcastle upon Tyne, NE3 4ES.

SERVICES IN THE COMMUNITY FOR THE MENTALLY ILL

Dear Sir,

Is the College going to do anything towards reversing the deterioration of the personal services in the community for the mentally ill which has been going on since the implementation of the Social Services Act? One realizes that many areas had services which were only capable of improvement, but in other areas a corps of experienced workers with a vocation has been disbanded, diluted or even 'frittered away' and replaced by figures on paper representing personnel with no knowledge of, or enthusiasm for, the work. This is to the great detriment of the patient and his family, not to mention the hospital service and its staff. No one seems to recognize publicly that psychiatrists need workers in the community who can form a close personal relationship within their work, with both mental patients and psychiatrists, similar to that formed by ward sisters and junior colleagues. This is not possible for