the aid of psychotherapy, leading to subsequent success with behaviour therapy. Because of the lack of theoretic application to many of a patient's problems, the need is for a combined approach to ascertain the relevant factors involved and to specify goals for treatment. The present trend is for the two disciplines to move closer together. Many psychotherapists are acquiring skills in behaviour therapy; many clinical psychologists are recognizing the role of covert factors and are inclining towards psychotherapy. Far from the psychiatrist interfering in treatment in which the psychologist is expert (Eysenck, p 18), there is little reason why a flexible collaboration cannot be created.

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THE CONCEPT OF DISEASE

DEAR SIR,

Professor Kendell (*Journal*, October 1975, **127**, 305–15) has argued the most interesting thesis that disease should be defined as that which decreases fertility and increases mortality, but excludes 'purely cultural factors determining who lives and dies'. Since man is biologically a cultural animal—his culture being a major determinant in individual and species survival—this is a curious position. Kendell is forced to the arbitrary exclusion of cultural factors because he has confused two questions. These are the scientist's question and the practitioner's question.

The scientist, the passive outsider, may ask, 'What factors reduce fertility and increase mortality?' His answer will clearly encompass cultural factors, including the efforts of doctors. The practitioner, the active insider, may ask, 'Whom should doctors treat?' The answer will depend upon doctors' competence and optimism and their given role in a community. The group treated will continually change as doctors' competence and the community change. Their role is subject to continual negotiation, as is the role of, say, psychologists, social workers and so on. The answer to the second question is specific to time, place and culture.

The answers to the two questions will *not* be the same. We may use the term 'illness' in one or other answer, or neither, just as we wish, but we may not, as Kendell does, confound the two and use a partial answer to the scientist's question to try to answer the practitioner's question. Logically it is wrong, practically it could be disastrous.

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DEAR SIR,

Professor Kendell's address (*Journal*, October 1975, **127**, 305) encourages us to rethink our concepts of disease. Briefly, he finds it difficult to define disease and advocates in its place the concept of 'biological defect'. While appreciative of his thoughtful contribution, I am more in agreement with the customary definitions of disease and the morbid process than with his position; the customary definitions are rarely challenged by their critics, they are simply ignored.

Disease stands for 'absence of ease' (Oxford English Dictionary)—the patient's subjective awareness that there is something wrong, covered by the clinician with the term 'symptom'. The lack of ease, or symptom, is the discerned result of the underlying morbid process. The patient is usually, but not always, aware of his disease; discernment is increased by screening devices. The symptom must not be confused with the underlying morbid process.

The morbid process of disease is well defined in most adequate medical dictionaries (e.g. Butterworths). It results essentially from one or more noxious agents acting on a structure, setting up dysfunction in it, and releasing coping devices to restrict and repair the damage, which, if they fail, cannot be prevented. The power of the coping devices varies with individuals and populations. The noxious agent can be psychic or somatic; the structure can be the psyche or the soma; the morbid process can be psychic or somatic. Indeed psychic trauma can lead to somatic

pathology, and physical trauma can lead to psychopathology. Usually, the two processes occur together. Knowledge steadily reduces the number of unknown morbid processes that are not understood.

The period from the seventeenth to the nineteenth century is the most confused one-twentieth of the recorded span of medical history, a period when psychopathology was almost ignored. A brief excursion into history will show that this neglect did not always obtain. From Hippocrates to Galen and Timothy Bright, the physician's concern was with psychic as well as organic pathology. Indeed the humoral theory, found not only in ancient Greek and Roman medicine but also in the medical systems of India, China and Egypt, is an attempt, within the limits of knowledge available to those civilizations, to explain the interchange between psyche and soma, this being, then as now, a matter of prime concern to the physician. Unhappily for psychiatry, the seventeenth century saw an upsurge in physiology and organic (physical) medicine; psychic pathology tended to be overlooked in the new enthusiasm. Today we see a move within medicine to redress the balance. The dynamically orientated psychiatrists were an active group in founding the Royal College, independent of the physicians but still within the corpus of Medicine.

It is now possible to understand the mistake made by Szasz. He states (Szasz, 1974), 'illness means there is something wrong with the *body* of the person said to be ill' (my italics). Wrongly, by ignoring psychic pathology, he limits the definition of disease and the function of medicine. The same misunderstanding is seen in the statements by critics of the 'medical model'.

The patient being ill-at-ease psychically, somatically, or both, seeks the help of a healer, and this constitutes the reason for the intervention of the medical practitioner. This clinician is ready to help with, for example, an ulcer—the end product of anxiety, or with, for example, depression—the end product of physical injury. Where special knowledge of a system is required, the medical practitioner becomes a specialist. In the case of the psychic system the specialist is the psychiatrist, a term meaning 'healer of the psyche', originally defined and described by J. C. Reil in a book (Reil, 1803) devoted to treatment by psychic methods. Thus disorders of the psyche is the true field of the psychiatrist. If insanity is a matter of psychopathology, that too is a part of this field. But should insanity be a matter of somatic defect, as is likely, then it becomes the field of the neurologist or neuro-psychiatrist.

A concept of 'biological defect' based on statistics, confuses anomaly with morbid process and gives an unclear guide to aetiology, diagnosis, pathology, and treatment. The concept does not face up to the finding that the norm may be unhealthy. It is particularly unfortunate to equate disease with low fertility; history amply demonstrates the high fertility of those suffering from an undoubted disease, for instance, in the early stages of GPI or in a state of severe neurosis, as in a problem family.

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SPEECH IN SCHIZOPHRENIC PATIENTS

DEAR SIR,

I was interested to read the comments made by Silverman and Marcus (*Journal*, October 1975, **127**, 415) on the paper by myself, Wishnei and Callaghan (*Journal*, June 1975, **126**, 571). Because the sampling constraints necessarily imposed by our design may have led to the selection on unrepresentative speech passages (a point, which, of course, we acknowledged in the paper), we have recently conducted two follow-up studies. In the first, 200-word passages from ten schizophrenic speakers and ten normal speakers were 'Clozed' by normal raters under fourth-word deletion, and no difference was found between the two types of passage. In the second, passages from twenty-five schizophrenic speakers were rated by normals under both fourth- and fifth-word deletion, and the two deletion conditions produced identical scores. The findings of both studies are, I think, quite different from what Silverman would predict.

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