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Correspondence

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THE PSYCHIATRIST IN SEARCH OF A SCIENCE

DEAR SIR,

May I be permitted to make two comments on the admirable paper by Dr. Eliot Slater? (*Journal* (1972), **121**, 591–8).

(a) Summarizing Frederick Golla's reply to Mapother's address, though critical of its conclusions, Dr. Slater states that 'no amount of scientific data could help us ultimately to know a personality . . .'. It was Jaspers in particular who had, in his *Allgemeine Psychopathologie* drawn attention to the fact that 'it is a mistake when investigating the individual to act as if all our knowledge of him lay at one level, as if we had him before us as an object, a single thing which we could know as a whole in its causes and effects'. Following Kantian lines of thought, Jaspers argued that 'if there were an empirical finality of human existence and it could be classed wholly as a form of Being which we could explore, there would be no freedom'. The definiteness of this conclusion arises out of the assertion which it seems to involve that 'the attempt to grasp the individual finally and entirely as a whole is bound to fail'.

In this context one may well refer to the work of Scheler (man is not a thing but rather 'a direction of movement of the universe itself'), and especially Husserl's famous Crisis lecture in which he criticised the ideal of modern science, namely that of *mathematization of nature*. Husserl expressed such a position when he noted that the possibility of achieving an objective science of the world might suggest to us 'the idea of a nature which is constructively determinable in the same manner in all its *other aspects*'. It is precisely this mathematization or objectification of the subject that, according to Husserl, constitutes the crisis of European humanity.

(b) Dr. Slater's statement that 'for a fundamental and enduring advance, the empiricist has to explain the phenomena of a higher level as implied by the simpler and more secure laws of a lower level' seems to get support from N. Hartmann's law of categorical stratification. The idea of a stratified world gives, according to Hartmann, rise to different levels or strata of Being, which correspond to the distinction between corporeal things, organic bodies, physical life, etc. What we are entitled to assert in this hierarchy of forms is that the 'higher' levels rest upon the 'lower' ones, and that, according to Hartmann's law of recurrence, the lower categories are retained in the higher ones as their elements, but not vice-versa. The most important point, therefore, of Dr. Slater's exposition of his problem in this part of his paper seems to be confirmed by Hartmann's conclusion that 'where a higher stratum rears itself above a thoroughly determined lower one, it brings its own determination with it without suspending that of the lower stratum'.

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REFERENCES

HARTMANN, N. *New Ways of Ontology*, translated 1953 by R. C. Kuhn, p. 128. Chicago: Regenery Company.

HUSSERL, —. *The Crisis of European Sciences*, translated 1970 by D. Carr, p. 33 ff. Evanston: Northwestern University Press.

JASPERS, K. *General Psychopathology*, translated 1963 by J. Hoenig and Marian W. Hamilton. Manchester University Press.

'THE RUNNING TREATMENT'

DEAR SIR,

Referring to Dr. Orwin's article in the February number of the *Journal* (**122**, 175–9), I should like to suggest that another possible mechanism for the relief of anxiety by vigorous exercise may be the mobilization of liver glycogen and correction of low blood sugar. Many mild cases of hypoglycaemia have typical phobic anxiety symptoms.

There may be other mechanisms as well that would repay study. I remember how, when I couldn't concentrate on the necessary cramming for exams in medical school, running around the block a few times, or reading while walking vigorously, would

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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REFERENCES

1. MALLESON, A. (1973). 'Suicide prevention: a myth or a mandate?' *British Journal of Psychiatry*, **122**, 238–9.
2. BAGLEY, C. (1968). 'The evaluation of a suicide prevention scheme by an ecological method.' *Social Science and Medicine*, **3**, 1–14.
3. —— (1972). 'Doctors, Samaritans and suicide.' *British Journal of Psychiatry, News and Notes*, August 6–8.

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-