aspect of believing that gives to faith its essential characteristic. Without this personal response faith may degenerate and become assent, merely, to a convenient formula, or a sudden uprush of emotion unrelated to real life.

Faith implies growth, and personal maturation is an individual experience whose content must be given a personal interpretation. In order to understand such experience it is therefore of primary importance to give not only an objective account of the events themselves but also a description of their belief in their own words by those concerned. Indirect reporting is inevitably coloured by the observer's own attitudes and prejudices. Unless Dr. Sargant considers the totality of the situation of faith, giving each aspect of it the due seriousness he gives to the researches of Pavlov, his hypotheses regarding the gaining and losing of faith must of necessity have a very limited application to the realities of those situations he attempts to analyse.

My lack of conviction derives not from any antipathy to the use made of neurophysiology, which has a legitimate field of application, but to the use made of the concept of faith which by analogy must be regarded not as the Lowest Common Multiple but as the Highest Common Factor. For the approach to the life of another person in terms of his faith demands a sensitive awareness that will stretch our own ways of believing to the full so that our own faith cannot remain unaffected. To play safe, as it were, by fixing the result before we start by some predetermined and inflexible method restricts full personal involvement, whether that method be a rigid ecclesiastical dogma or Pavlovian neurophysiology.

If the progress of truth is to be the aim of true dialogue it is essential that the polarities of thought, in this instance physiology and faith, are each fully explored and presented. Having read this lecture, and also *Battle for the Mind*, I gain the impression that the discussion is overloaded towards the polarity of physiology, and my purpose is, I hope, the eirenic one of giving the other polarity of the dimension, that of faith, a little more weight, so helping to restore the balance.

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Dear Sir,

As a Christian with experience abroad, I was most interested in Dr. Sargant's Maudsley Lecture 'The Physiology of Faith'. Some of the points he raises with regard to faith merit further discussion. He speaks of the value of faith in fervent terms, e.g. 'The possession of such states of faith is necessary not only for the holding of such exclusive religious beliefs; it is paradoxically needed to a lesser extent to support so many of all our own day to day much more ordinary beliefs and behaviour. Faith is especially necessary in our work as physicians and psychiatrists.' Or again 'The very importance of this whole subject is due to the fact that without a supporting faith of some sort or another few people can hope to live happy and constructive lives.'

Having spoken so eloquently on the value and need of a faith it is surprising that he deals with its acquisition and content in such a peremptory way, as if it were something totally irrational and only to be acquired in a state of mental abnormality.

If any Christian is asked why he believes, there will be many different answers according to his personality and experiences. Today my answer would be from experience, reason and intuition.

Experience. I was not leading a satisfactory life. I met others, some of whom had much less in the way of possessions and position than I, who lived a life of contentment and peace. They were making a great contribution to the welfare of others, appeared to be enjoying life to the full and there was a welcome in their homes for all. There was no doubt that their state reflected their ideology, or in Dr. Sargant's words 'The acid test of any faith is what it results in and makes of those who come to believe in it'.

Reason. As doctors we study medicine and then one day we are called 'Doctor' and a sometimes irresponsible medical student becomes quite changed. We accept a commitment to serve the public in this capacity. We are constantly upheld by the ideals of the medical profession, the goodwill of other doctors, the medical organisations and even the General Medical Council. These are not just abstract ideals, but humans held in authority, ideology and fraternity by a force like themselves but much greater than any one individual: 'The God' of the medical profession.

The seeker after Christianity accepts a similar commitment, to direct the highest and best in himself towards the highest and best purpose in life; and where possible to isolate the worst in himself from the lowest in life. Religion is also more than an ethic. It is to seek a goal, preferably in human fellowship, the essence of which is an attitude of love. The members contribute towards this, but are also supported and succoured by this quality even when alone. When one is sharing and receiving love this is more than ideal, it is more personal, its strength is more vital, and in its depth, constancy and reliability

reaches beyond anything that can be attained by normal human effort. It can best be described by the supra-human word God.

By intuition. I am greatly moved by, e.g. the chamber works of Beethoven and Bartok or the sculpture of Henry Moore. Some friends say to me 'This is nonsense—just a meaningless row of notes.' 'The artist is laughing at you, it is all a hoax.' I know that this is not so. I am quite unable to prove it. I am totally convinced of their artistic integrity. I know their work is a true and deeply personal composition which finds a sympathetic response in the public who are sensitive to the medium.

It is the same when I read the words of Jesus. Their beauty and truth are utterly convincing. There are parts of the Bible, as there is a proportion of what others assure me are major works of art to which I cannot as yet respond. The quality of the rest is such that some have to be taken on trust until one's artistic and spiritual development progresses.

I feel that Dr. Sargant will not find the answer to faith in a western person today from the study of Pavlov's experiments with dogs, or the ecstatic practices of the less sophisticated.

When an individual is dissatisfied with his life, and finds another has a sense of purpose, conviction and destiny which is upholding and satisfying the normal human response is to seek the faith of the other. If something irrational has been imparted it will sooner or later be rejected.

In my experience teaching groups of young people, half can name the exact time of conversion, the others grow into faith insensibly. As in a marriage it is more binding and helpful to publish the change of status in a sacramental setting, but the moment of acceptance in my experience has nearly always been the end point of several years seeking and gradual conviction under the influence of many.

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LAING'S MODELS OF MADNESS

Dear Sir,

The authors of the paper under this title (*Journal*, August, 1969, pp. 947–58) criticize R. D. Laing's approach to the understanding of schizophrenia for his failure to stick to what they have described as the 'medical model' (Siegler and Osmond, 1966). They say that 'as a physician he is not free to put forth the view that the social fiction called medicine is more harmful than helpful'. They say that Laing is 'a physician who uses the authority which derives from medicine to advocate a non-medical model', and they imply that he is wrong to do so.

This cannot be allowed to pass unchallenged. A physician's over-riding responsibility is to enable people to be as healthy as possible; and if he thinks that an approach other than the traditional one may be more effective it is his professional duty to pursue it, even if it turns out to be a failure. His model(s) may be criticized, but not his right as a doctor to construct them.

The 'medical model' as described in the earlier paper is so limited that it would be inadequate by itself in almost all fields of practice, let alone in psychiatry or schizophrenia. It only uses the word 'patient' to describe the doctor's clients. Yet a doctor can speak with authority to the not-yet-sick about the prevention of illness, and to those who are no longer sick about how to prevent a recurrence. Let us take a look at the first five headings under which they describe the medical model.

1. *Definition or diagnosis.* The doctor's task in this field is always two-fold. He has to diagnose the nature of the disorder and he has to diagnose the person who has the disorder. He has to ask 'what kind of person is this?' (Halliday, 1948). Often enough his observations under this head are minimal: he may merely note the age and sex and whether the person is fat or thin, anxious or placid. But even these minimal observations will affect his prescription in simple cases of organic illness, while in a case of schizophrenia diagnosis of the person may be all-important.

2. *Aetiology.* Even when the causes of the disorder are known, they have to be considered in relation to the particular person who has the disorder. We have to ask 'why did he become ill when he did?' and 'why did he react (to the pathogen) in the manner that he did?'. These questions are always relevant, and in schizophrenia particularly so.

3. *Behaviour.* It is true that behaviour is an inadequate measure of the degree of illness. But it is also indicative (if still inadequately) of the person's reaction to the illness—of what it means to him as a person; and this needs to be stated as an essential part of any useful medical model.

4. *Treatment.* Measures of treatment may be disease-attacking—treatment of *disease*; or health-enhancing —treatment of the *person*. In the one case we are thinking of destructive or inhibitory activities, and in the other of fostering or nurturing activities. It is only disease-attacking activities which are meant to be as specific as possible, as the authors say; health-enhancing measures often require to be general in character. In psychiatry, chemotherapy, surgery and