

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

conditioning techniques are of the disease-attacking sort, and should be as specific as possible, while all relationship therapies, from psycho-analysis onwards, are non-specific.

5. *Prognosis.* It is within the proper exercise of the doctor's authority to decide how far the sufferer's environment (as contrasted with his disorder) affects the prognosis. Environmental stress, whether social or other, affects prognosis whenever specific treatments for disease are less than 100 per cent successful. In psychiatry this means almost always.

These comments should suffice to show that the kind of depersonalized model described by these authors cannot be an exclusive source of the doctor's authority. Medicine may be, as they say (p. 955) a 'dirty, rough business', but it is still, at least on this side of the Atlantic, concerned with real human beings as well as models.

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#### REFERENCES

- HALLIDAY, JAMES L. (1948). *Psychological Medicine*, London, William Heinemann p. 30.  
SIEGLER, MIRIAM, and OSMOND, HUMPHRY (1966). 'Models of madness.' *Brit. J. Psychiat.*, 112, 1193-203.

DEAR SIR,

In reference to our paper, 'Laing's Models of Madness', we quite agree with Dr. Mathers that our description of the medical model in our original paper is 'limited'. In another of our papers on this topic 'Models of Alcoholism' (1) we attempted to deal with the problem of limitation. We said: 'The models are abstractions, or "ideal types". The reality from which they are abstracted is extremely complex, and in order to make models which can be compared the complexity must be reduced to manageable proportions. In doing so, we are aware that we have necessarily distorted the reality which is experienced by the proponents of the various points of view. We trust that the exercise of constructing and contrasting models will prove sufficiently useful to compensate for the inevitable distortions occasioned by this method.

A model is only a point of view or theory arranged in such a way that it can be compared with some other point of view or theory. We are in the process of collecting all the many and varied points of view about schizophrenia which we can find. We hope to encourage others to do the same. We would be particularly pleased if someone whose model we have described would say to us: 'You have got my model quite wrong. In the dimension of aetiology, it really

ought to read . . .' We feel it would then be possible to have much more focused discussions of actual differences in opinion than we have had so far.

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1. SIEGLER, MIRIAM, OSMOND, HUMPHRY, and NEWELL, STEPHENS. (1968) 'Models of alcoholism.' *Quart. J. Stud. Alcohol*, 29, 3, 571-91.

### CLASSIFICATION OF DEPRESSIVE ILLNESS

DEAR SIR,

I should like to report the findings from an attempt to replicate Kendell's discriminant analysis of the features of depressive illness (1968), using data from item-sheets completed on patients admitted to the Professorial Psychiatric Unit, the University of Melbourne.

This unit provides training facilities over a six-month period for postgraduates in the third year of their appointment to the State Mental Health Service. As part of their duties these postgraduates, of equivalent status to registrars in the British system, had to complete an item-sheet whose design was largely influenced by the Maudsley 'item-sheet'. The appearance of Kendell's monograph provided an opportunity for a test of the value of this method of collecting data and a fortuitous chance to replicate the basic study, as all the sixty items selected by Kendell were included in this item-sheet, and were recorded by trainee psychiatrists as in the Maudsley study.

Kendell's choice of discriminant analysis was determined by his preference for a linear canonical variate capable of handling data dichotomized as coming from patients with either psychotic or neurotic depression. The procedure in summary was to calculate the percentage frequency (p) with which each of the sixty items occurred in the two diagnostic categories; to calculate the standard error of the difference between the two percentages for each item, and to use the critical ratio (CR) with its positive or negative sign as the diagnostic weighting. The formula for the critical ratio (from which, incidentally, the square root has been omitted in the monograph) is

$$CR = \frac{p^1 - p^2}{\sqrt{\frac{p^1(100 - p^1)}{N_1} + \frac{p^2(100 - p^2)}{N_2}}}$$