But occasionally the family is so disharmonious and unlikely to respond to therapy that we have to be realistic and separate the child from his family. Of course, we must be extremely careful not to deprive him by the separation, but to place him in the best possible substitute care.

Health-promoting community

Now we come to the final possibility in our therapeutic programme. We could try to create a health-promoting community. Looking back over the developments in medicine during the last 50 years, we may be justly proud of our curative efforts, but we know full well that the main advances have been in the preventive services. For instance, bone tuberculosis in children has been practically eradicated not by curative medicine, but by preventing the use of milk from infected cows. We have changed most of the factors which were antagonistic to physical health, and we are now in a position to do the same with emotional health. We should look at society as a whole and identify those elements in society that are antagonistic to healthy emotional living. We should scrutinise every principle, every practice, and every institution in society and ask ourselves whether it promotes good healthy emotional living. If it does not, then we should change it.

These are only some of the factors that we can deal with in our therapeutic programme; our aim is to break into the vicious emotional circle which perpetuates the unloving family.

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THE INDIVIDUAL AND THE GROUP—A GENERAL PRACTITIONER'S VIEW OF BEHAVIOURAL REACTIONS TO ISOLATION

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SUMMARY. I suggest that many of the common psychoneuroses are behavioural reactions which arise in response to isolation of an individual from his group. This hypothesis is difficult to substantiate by statistical means and no attempt has been made to do so.

These behavioural reactions are of two types:

(1) *Recognition-hunger reactions*

These are reactions of diffidence, self-consciousness, tension states, "*promotion*" and "*tired housewife*" syndromes, where the individual is isolated because he undervalues himself in relation to his group.

(2) *Status-protection reactions*

These are reactions of resentment, jealousy, "chip-on-shoulder", compensation cases, and hypochondriasis where the individual is isolated because he overvalues himself in relation to the group.

The behavioural grid provides a model to illustrate this thesis.

I think that great opportunities for friendship in our communities are likely to be of greater therapeutic value than psychotropic drugs—these opportunities are discussed.

Introduction

Our training as doctors conditions us to think mechanistically about individuals who are diseased i.e. have a defect that causes the bodily machine to function inefficiently. This mechanical model has encouraged many advances in medicine but is inadequate in the behavioural field.

Laughter, blushing, the effects of anger or fear are all recognised by every individual as behavioural reactions. My thesis is that many of the so called " common psychoneuroses " are similar potentially-reversible behavioural reactions and not due to defects in the bodily machine.

Direct objective confirmation of this hypothesis is difficult (perhaps impossible) to obtain. Despite this the general practitioner has two valuable sources of understanding:

(1) *Personal introspection.* Most practitioners are often uncomfortably aware that the so-called psychoneuroses of their patients are also present to some extent in themselves.

(2) *Numbers.* The large numbers of patients who report with relatively minor degrees of psychoneurosis. In my practice 60 per cent of a random sample of 200 adult women were found retrospectively to have reported one or more psychoneurotic complaint during a period of five years.

These complaints can be classified into two distinct groups which gives us possible insight into their behavioural origins:

(1) Recognition-hunger reactions,

(2) Status-protection reactions.

The practitioner can identify these two distinct and complementary classes in most of the patients with so-called psychoneursosis. *Both kinds arise when an individual is isolated from his peer group. In both classes isolation may be followed by group insecurity with loss of self-confidence and both can be improved or cured by group activities.* Here however the similarities between the two types end.

It is important that these are not personality types and that any individual may swing from one type of behaviour to the other, although habit and circumstances tend to modify such swings.

Type 1—Recognition-hunger reactions

The characteristic of these reactions is that the individual needs recognition by a peer group; insecurity is felt because the individual feels ' on approval ', and lacks recognition. Once approval is gained self-confidence rapidly increases and the reaction tends to disappear. These reactions tend to occur in new situations and shy, diffident or immature individuals are especially prone.

They include the following:

(a) Simple reactions of self-consciousness e.g. blushing, stammer, palpitations, and clumsiness.

These reactions are significant because they are known to every individual. The doctor's own insight and self-perception allows extrapolation of understanding to other similar " psychoneurotic " reactions.

(b) Tension reactions (anxiety states). In this often encountered group, our current thinking tends to incriminate " stress " without adequately defining what the common stress factor is.

The practitioner may thus advise the bored housewife with tension symptoms to *do more* and the executive under pressure with the same symptoms to *do less.* In most such tension reactions it is, however, possible to identify the individual's

underlying need for recognition from peers—husband, relatives—as in the " promotion syndrome ", the " tired housewife syndrome " or the many similar long drawn out, searching situations that occur when raising a family, looking after aged relatives, or dealing with a difficult spouse.

Transient tension symptoms may arise in an individual who is isolated from his group by feeling on trial, e.g. " driving test syndrome " or " examination nerves ".

Another large group of tension reactions arises when an individual is isolated by a conflict of loyalties—the individual fails to gain acceptance or recognition from one group because of loyalty to another, e.g. the foreman with loyalty to both management and labour, or the daughter with a loyalty divided between a mother and her husband.

In all these tension reactions we find the common factor of individual isolation with an underlying hunger for recognition.

(c) In some of the disorders we now label psychosomatic, e.g. tension headache, functional aphonia, or functional frequency, it is often possible to find similar factors of isolation with hunger for recognition.

(d) Many childish behavioural reactions, sibling jealousy, soiling, school phobia, and some cases of enuresis appear to arise directly from the failure of the child to relate to either family or peers. Studies of both animals and autistic children show us how early and basic is the need of every individual to relate to the group.

Characteristics

These type (1) recognition-hunger behavioural syndromes all have the following characteristics:

(a) The patient tends to undervalue himself in relation to the group. The doctor is often aware that the patient tends to " look up " to people and that such patients respond to an " outgoing " approach.

(b) These patients are prepared to admit and discuss their feelings of insecurity and lack of confidence in a sympathetic atmosphere.

(c) Symptoms hamper the very thing the patient wants—to gain acceptance, as in self-consciousness, or sibling jealousy.

(c) In adults attempts to master symptoms consciously makes them worse e.g. blushing. In children threats, punishments and rewards may similarly be counter-productive because they tend to increase the individual's feelings of isolation.

(e) In adults symptoms are usually vague, ill-defined and often reported tentatively under a cover story—the diffident approach. Such adult patients are constantly afraid that others will consider that their symptoms are ' imaginary ' or hypochondriacal. Children are shy about symptoms e.g. they may hide underclothes that have been soiled.

(f) In adult patients, insight is good initially but as insecurity increases so confidence and insight decrease. Ultimately there may be a ' cry for help ' gesture. Internal conflicts are usually apparent to both patient and doctor.

(g) Adult patients do not resist referral to a psychiatrist and may initiate this themselves.

(h) Such patients easily become dependant on drugs, especially those which increase confidence e.g. amphetamines, alcohol, or tranquillisers.

(i) Doctor-patient relationships may be temporarily strained because patient and doctor have different objectives. The patient (whether child or adults) enjoys attention, finding that dependance on others gives a false feeling of group

contact and that psychotropic drugs may provide spurious feelings of self-confidence. The doctor on the other hand may consider that the patient attends surgery too often and is too dependant on both doctor and drugs.

A good doctor-patient relationship is, however, not difficult to achieve in most cases.

Type 2 status-protection reactions

Hypochondriasis and compensation neurosis are probably the best known of these reactions.

If for some reason an individual is forced to lower his self-evaluation within a group, instead of accepting the lowered status, the individual develops a number of reactions that attempt to prevent this unpleasant process.

Self-centred personalities with self-orientated values are especially prone to these status-protection reactions. Such individuals are often reasonably established and of an older age group than those suffering from type 1 reactions.

Upbringing and education, if they encourage false personal values with too high a self-evaluation, will tend to predispose individuals to this type of reaction.

Several of these reactions have been described but some are so commonplace that we often tend to regard them as due to variations in personality and not as behavioural disorders.

They include the following:

(a) *Simple resentment and jealousy.* Like the type 1 reaction of self-consciousness, these reactions are significant because they are known to every individual and by extrapolation give us insight into the more extreme reactions in this group. Introspection may help us to understand the distortion and misinterpretation of evidence combined with a reluctance to face facts that are so characteristic of all type 2 status protection reactions.

(b) *The poor-little-me reaction.* In its extreme form this reaction is most commonly encountered in women under 40. Often attractive—they are used to getting their own way. Husbands tend to fuss round the patient whose family may be small. Symptoms are usually definite, e.g. constant pains that can be easily interpreted to others and are often related to some previous organic medical experience. Symptoms allow pleasant activities but excuse the patient from the unpleasant. The vague initial symptoms of the tension reaction are not encountered and major investigations or operations may be performed; the medical findings of these latter may be suppressed or distorted to bolster up the patient's already false self-evaluation.

A possessive attitude is developed to the complaints e.g. " my rheumatism." In this frame of mind the patient is resentful of criticism, but very prepared to criticise.

Relationships with others. While in this state patients are aware of status and may be high handed with surgery staff. Relations with doctor outwardly good but easily pained or aggressive and the patient may get her husband to be aggressive on her behalf. Friendships often appear superficial.

Course. This type of reaction is often prolonged and as life ' closes in ' the patients may gradually develop a chronic hypochondriasis of middle age. In the early stages such patients rarely bother the doctor excessively—perhaps they resent the doctor's attempts to steer them away from this potentially self-destructive behavioural reaction.

(c) *Chronic hypochondriasis.* This is well known to all of us and is often the ultimate end result of any intractable status-protection reaction.

(d) *Chip-on-shoulder reaction.* This is perhaps the male equivalent of the poor-little-me reaction and is similarly often both intractable and self-destructive. The combination of laziness and intelligence appears to predispose. The patient appears to resent being left behind in the status race. He may try to talk himself up the status ladder but more often achieves the same effect by denigrating everyone else. He often invokes his wife's support of his actions—" my wife says I neeed 14 days off work." He may also be a tyrant in the home and tends to make a three-day illness last three weeks.

Relationship with others. Poor work record tends to isolate him gradually from workmates, then from friends and even family. Relationships with authority (including doctors) are liable to be strained.

Course. This is prolonged and intractable. General deterioration, alcoholism, or chronic hypochondriasis may develop.

(e) *Compensation (accident) neurosis, post-concussional syndromes.* These are probably extreme forms of the previous reaction. The picture is well known to doctors. Their possible development is discussed below.

(f) *Paranoia of the isolated elderly.* Death of close relatives or friends isolates the elderly individual who is unable to make the necessary status devaluation either to join fresh old people's activities, or to adjust to their social standards—" I don't like the old people's centre they only play bingo and gossip about everyone else."

(g) Dermatitis artefacta, Munchausen Syndrome and similar diseases.

(h) Some hysterical syndromes.

Characteristics

The characteristics of these type 2—status-protecting reactions are by contrast almost the exact reverse of the type 1—recognition-hunger reactions.

(a) The patients while in this state tend to overvalue themselves in relation to others. For this reason they are often overbearing with surgery staff and appear to get satisfaction from putting the doctor in the wrong.

(b) These patients appear to obtain false feelings of confidence by looking down on other individuals and not through the ordinary give and take of healthy human relationships.

(c) Symptoms allow the patients to do what they want and protect them from the unpleasant. There is thus a clear motivation that is often apparent to all but the patient. This motivation further prevents the individual from making full and satisfying relationships.

(d) These patients rarely attempt to " master " their symptoms and resent any suggestion that they should try.

(e) Symptoms are usually definite and often lead to extensive investigations and operations.

(f) Insight is poor. Self-deception may be considerable. Therefore ' cry for help ' gestures and suicidal attempts are rare. Often everyone but the patient is aware of the underlying motive.

(g) The patient resents psychiatric referral.

(h) These patients like to take some form of medicine as a token of their illness but dependancy on psychotropic drugs is usually a late or iatrogenic feature.

(i) The doctor-patient relationship is usually difficult because the doctor's awareness of the patient's motivation distorts understanding and prevents the development of mutual respect.

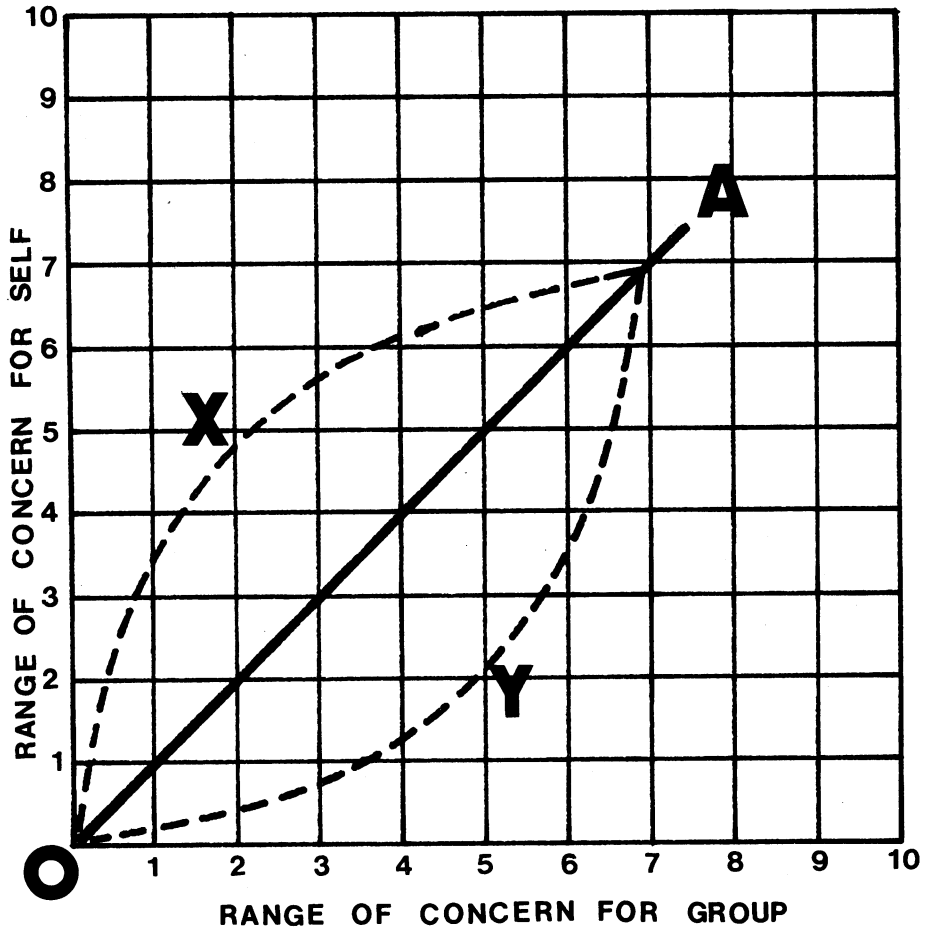

Figure 1 The behavioural grid

The behavioural grid

This is a simple model that enables us to relate the individual to his group and to see why there are only two types of isolation reaction and why these tend to be complementary.

Every individual obtains that sense of well-being and vital driving force—his self-confidence from his group and tends to lose it in isolation. Most of our important actions require that we resolve the " food queue " dilemma; thus if we overvalue our status and go before our turn, the queue will turn against us, while if we undervalue ourselves and always allow others to go first, we will starve.

The behavioural grid assumes that the normally balanced individual knows his place in the food queue because a concern for self is balanced by an equal concern for the group. There are many arguments in favour of this hypothesis but the strongest is a simple evolutionary fact—*evolution requires the survival of the fittest species not the fittest individual.* Evolution over millions of years would have failed if the behavioural drives of the individual members of any species had not been firmly subjugated to the needs of the species or group as a whole.

If we consider any community of individuals the balanced majority will lie on or near

to the hypothetical line OA (figure 1). Those lying above the line will overvalue themselves in relation to the majority and those below will undervalue their position. Individuals lying towards the edge of the group (dotted lines) will not only feel increasingly isolated and insecure but those below the line will become increasingly hungry for individual recognition from the group (type 1 reaction); while those above the line will feel increasing pressure from the group to devalue their individual status. All individuals dislike devaluation of status, hence the protective and intractable nature of those type 2 behavioural reactions.

A teenage girl at 2,2 marries and moves to the comparative isolation of her nuclear home at point Y; she must then either get recognition through a new group of similarly placed housewives, from a job, a housewives' association, an antenatal clinic, or she must return to her previous family situation at 2,2. If she is unable to do this she is liable to develop a type 1 reaction with increasing loss of confidence.

A steelworker at 4,3 suffers from a major works' accident and is removed from his group (4,2). In the hospital setting he is the centre of attention and his sense of self-importance might increase (5,2); when the medical profession says he's cured he is stranded at point X and the vicious cycle of isolation and reluctance to revalue individual status begins with a vengeance.

Discussion and conclusions

(1) In our mobile, urban, still largely male-orientated society the nuclear family has isolated many young housewives from group activities. Type 1 (recognition-hunger) reactions are therefore common in this female group.

Psychotropic and other drugs are unlikely to reduce the incidence of these reactions in any group because they do not provide recognition. Such drugs may even have the reverse effect of numbing the individual's search for recognition.

(2) A behavioural origin of the so-called psychoneuroses suggests that we should concentrate on behavioural as opposed to medicinal therapy.

Many different forms of group activity would be expected to reduce the frequency of these reactions:

(a) greater opportunities for friendship in our communities.

(b) extension of co-operative baby sitting and child minding arrangements to allow housewives greater opportunities for group activities.

(c) more group activities within the community—i.e. associations of all kinds—weight watchers, politics, women's lib., night classes, and bingo.

(d) provision of temporary therapeutic jobs for individuals who need increased group contact.

(e) financial recognition of the housewife by the whole community might also help.

(f) education and understanding of the nature of these reactions to isolation by husbands.

(3) The realisation that the correction of the intractable type 2—status-protective reactions lies in prevention by:

(a) education that discourages social attitudes with false values and false ideas of status.

(b) greater efforts to maintain an individual's contacts at work after disease and accident.

(c) early recognition of the effects of isolation on all who, like the elderly, may find it difficult to lower their status within any community.

(4) Recognition by individuals and communities alike that the health and confidence of each of us is as dependant on normal balanced group contacts as on a normal balanced diet.

DISCUSSION

Floor

In using the term ' group mind ' does Dr Howells imply that he believes that there is a group consciousness?

Dr Howells

There is a group consciousness but also a group unconsciousness. The term consciousness needs re-evaluating in view of its particular use by the psychoanalysts. Strictly speaking, consciousness means that the higher brain stem is alert and awake, and if something puts this area of the brain out of business we become unconscious.

It would be better to keep the term ' consciousness ' for this particular activity and use other terms such as ' directed activity ' and ' automatic activity ' for our more commonly accepted definitions. By ' directed activity ' I mean that one decides to perform a certain action, whereas with ' automatic activity ' no such decision is made. An example of this is the typist who reads a letter but does not take in its contents. This allows her to maintain a very high speed because of her ' automatic activity '. In the physical field there is ' directed activity ' through the central nervous system and ' automatic activity ' through the autonomic nervous system.

I think we have also an automatic psychic activity which is enormously important. Our individual psyches have direct and automatic activities, and it is equally true that the family mind has direct and automatic activities as well. Many family issues arise and are subconsciously resolved without the need for family discussion. The family rarely discuss the summer holiday, because it has been automatically agreed that father is the person to solve this problem. The family mind has agreed that father is the person to make such decisions; however I agree with the questioner that what I am describing is a collective activity by the family, both ' directed ' and ' automatic '.

A further important point in understanding families is what might be called positive and negative family action. Activities of a negative nature may be highly significant. The family may not directly teach its children that sexual activity is wrong, but by ignoring sexuality it gets the same message across.

Professor Oakley

I would like to suggest that in most groups of people there are certain common assumptions; they are either deeply conditioned when young or they are developed by the use of argument when older. The agreement of a family to do certain things comes from the acceptance of certain assumptions that are natural for that family. These assumptions may not apply to any other family, or even be sensible and effective, but they are accepted. The real question at issue is the depth in the mind at which the assumption is made.

Dr Hodgkin

You implied that a family could not change, and this worries me. I feel that a negative family might become a positive family.