perhaps as our successors to demonstrate—if they can—that they are more fitted than we are to survive.

The title of this symposium is *The hostile environment of man.* We say that the environment is hostile, harsh or unfriendly, but this is to misunderstand its nature and to confer on it some of our own attributes, almost as if it were capable of choice. The blunt truth is that the rules of our world and universe are fixed, and we must learn to take advantage of them. We must do this, moreover, without destroying the systems that make our own enjoyment of life possible.

Above all, we must not deceive ourselves into believing that we are a privileged species, or that we can alter the rules of the world by making speeches. We want to survive; but it is no use saying that we have a right to survive—we shall soon find that we have not.

THE UNLOVING FAMILY

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The following three examples will help to make it clear what I mean by " the unloving family."

First example

A young woman found herself with an unwanted child; as she had no love for the father, it was not surprising that she had very little love for this child. She tried to bring him up, but failed, and in her distress she went to the child care authorities for assistance. She told them that she was neglecting her baby and that they should take him from her. The child care authorities told her that she was being very silly; she should try to be a good mother and keep the child. So the baby remained with her but he did not thrive and was increasingly neglected. Eventually her general practitioner heard her story and called on the child care officer for a conference. They agreed that the child should be taken into care, but the child care authorities said that this was nonsense and that the mother should keep her child. The mother kept her child. A few months later he died from neglect. The coroner commented that he was extremely puzzled as to why the child had to remain in the family, even to the point of death.

Second example

One day, as a man was leaving his house, his little boy tumbled down the steps and lay at the bottom crying. The father came out of the house, ignored the child, but very tenderly lifted up his whippet greyhound, carried it carefully down the steps and deposited it on the ground, commenting to a passer-by " I can't have him breaking his legs."

Third example

A mother was afraid that she might kill her second son. This was no idle threat, because the hospital notes showed that this child, when an infant, had been admitted with broken legs. The mother told me how she had caused the injury; one day she had been so angry that she had picked him up when he cried and squeezed his legs until they broke. A more recent record showed that this child had been admitted to the paediatric ward with a fractured skull. Again the mother had felt so hostile towards her child that she had broken his skull with a poker.

Why should she feel so hostile towards her son and, in particular, why only to him, and not to her other children? On investigation I found that her marriage was very unhappy; her husband was a sullen, difficult, aggressive, awkward man who made her feel unloved. She could not express her own hostility directly to him, but the second boy was the image of his father and therefore her hostility extended itself to this son who to her, was the personification of the husband.

What is the family?

The point of these illustrations is that families can be disharmonious, families can be hostile, and families can be dangerous. We should ask ourselves " what is the family? " When we see people coming out of the factories at the end of a working day, we might be inclined to look at them as individuals or as the basic units of society. They wend their way down the road, until ultimately each one opens a door and walks into a home.

He is a member of a unit, or a group, which we call ' the family ' and this is the basic cell of society. An individual cannot propagate by himself, and this has led to the formation of the family unit, which in turn produces more families. The basic family unit of two people procreates so that there are more people in the family. When the children leave home, they in turn set out to form more family units. Thus the original family has sent out its messengers into the future, to form further biological cells. The significance of the family is that it makes more families.

A family chain reaction

Why should we regard the family as a unit? A boy of 18 was referred to our adolescent clinic suffering from abdominal pain, which had started at the end of August. Naturally, his family was concerned about it and the boy was sent to the family doctor accompanied by his father. As they were leaving the house, the mother remarked to the father that he had better see the doctor as well, as he had developed migraine in the early part of August.

So the family doctor referred the boy to a surgeon and the father to a neurologist. The boy was admitted to a surgical ward for investigation and no abnormality was found. The surgeon, being very understanding, thought that some family stress or strain might be responsible for the abdominal pain. Meanwhile the neurologist had been examining the father and had reached the conclusion that there was no organic lesion; however, he tried to handle his psychiatric problems and continued to see him in the neurological outpatient department.

In the meantime, as the boy had been referred to our Institute of Family Psychiatry, we invited the whole family to come along. I began by asking about the cause of the abdominal pain, but in no time the father was talking about his migraine and then mother was complaining that from the middle of August she had been depressed and indeed had become frigid.

What was responsible for this chapter of events? The father developed symptoms in early August, the mother in mid-August and the boy in late August. The key to this sequence of events was the fourth member of the family, an art student at Edinburgh, who had returned home in June. During his year at art school, he had considerably changed, not only in dress but also in demeanour and, most upsetting of all, he had announced that he did not intend to work during the summer vacation. This had upset the father who felt that the boy ought to contribute something to the family's finances during the long holiday period. Thus tension had developed between father and son, soon reaching such a state of hostility that the father thought that he would be assaulted by his son. It was then that the father developed migraine.

The wife, not unnaturally, was torn between loyalty towards her husband and the need to protect her son against his father's unreasonable attitude. Hence she became

depressed and exhibited signs of frigidity, which the father interpreted as evidence that his wife was turning against him and supporting her son. This placed the father in a state of hostility to his elder son, but as he was afraid that the boy might knock him down, he displaced the hostility on his second son, for whom he had very little affection. It was at the time of these events that the boy developed acute abdominal pain. So here we have not just three sick people—father, mother and son—but a sick family.

The family as a unit of clinical practice

This situation is common and this leads me to believe that the family ought to be the primary unit in clinical practice. If we accept this, we can regard the family as an organism in its own right. Indeed the family has its own characteristics and a well defined structure, just like an individual. The family has also paths of communication within itself. It has also a group mind, and it is this family group mind that concerns us in clinical practice. To help us understand this concept, let us assume that a hawk is hovering over a field. When a starling flies by, its individual mind decides that it should get as far away from the hawk as possible. But if a cloud of starlings flew by, their group mind may come to an entirely different conclusion from that of the individual mind of one starling. The group mind may say " attack ", so they would attack and the hawk would disappear. Similarly groups and families have minds and it is essential that in practice we address ourselves to the group or family mind.

If we accept this idea of the family unit, we have to concern ourselves with a growing number of disharmonious families. Some years ago the Royal College of General Practitioners explored the incidence of emotional disorders in general practice and found an incidence of 30 per cent of disharmonious individuals among patients, which means 30 per cent of disharmonious families. Therefore there is at least this proportion of families in society that need our care.

Family structure

How do families become disharmonious? We need to understand the structure of the family in order to understand the disharmony within it. Our assessment should include all aspects of the family. The model I suggest is in five dimensions, each dimension taking account of the past, the present and the future. Thus we would assess:

(1) The individual as an amalgam of the physical and mental; his whole functioning in health and disease, at all times of life.

(2) The reciprocal interactions in the family involving individuals, dyads, family coalitions, and the whole family.

(3) The family group characteristics, structure and properties—roles, leadership patterns, qualities, and standards.

(4) The material structure of the family—its diet, its income, and its housing.

(5) The family-society relationship—how the family as a whole interacts with the community, e.g., school, work, and social activities.

These five family dimensions—the individual, the interactions between individuals, the group characteristics, the material circumstances, and the family-society interaction —make a composite whole.

The process of family dysfunction

I still have not answered the question " how does the family become disharmonious? " Sir Winston Churchill used to say " the farther back you look the farther forward you can see "; on the same principles the key of disharmonious families lies in their past. Each family has a past, having been started by two individuals coming together. These two

individuals are representatives of other families; if the two families were harmonious then the present couple will be harmonious. Conversely if these two individuals are disharmonious it is because their families, in the past, were disharmonious. The key to the psychopathology of the family lies not in the present, but in the past.

What can we do about the disharmonious family? If an individual child, who is the representative of the future, has been subjected to negative emotional forces in his formative years, he will become emotionally ill. If nothing intervenes, the emotionally ill child becomes the emotionally ill adolescent, then the emotionally ill adult and finally the emotionally ill parent. It is precisely these negative or emotionally handicapped parents who are the origin of these adverse forces and the begetters of another generation of disturbed children. We therefore have a vicious circle perpetuating emotional disorders or neuroses. The question before us is " how can we break into this vicious circle?"

Family therapy

We can now study the therapy of the family in more detail and consider therapeutic programmes. Firstly there is *family psychotherapy*, where the psyche of the therapist confronts the family group mind and produces some adjustment in the disharmonious family. How does one select a good therapist? We should not try to evaluate the therapist, but to evaluate and assess his family; if this is adequate, then you will find that the therapist will be able to confront the family effectively. What we want is not a confrontation between the psyche of the therapist and the disharmonious family, but a confrontation between the family of the therapist and the problem family. Many of Galen's writings were concerned with the selection of the right people for psychotherapy, and he believed in these same principles.

There are five techniques that one can employ in the confrontation of the psyche. Firstly, there is individual therapy. The second approach is to take the couples in the family and treat the family in terms of these couples, e.g. mother and father, or mother and child, or father and child. This is a better approach, as it carries a built-in correction factor. If one member of the family relates some incident inaccurately and with bias, the other member of the family has an opportunity to correct it.

The third approach is family group therapy, where the family is treated as a whole. The fourth approach is to treat a number of families as one large group in what is called ' multiple family therapy ', which is a rather superficial technique. Lastly, there is the technique called ' multiple impact therapy ', whereby a family is taken into residential care to allow a team of therapists to work continuously on it for two or three days.

Vector therapy

One technique we can employ is called *vector therapy* and is particularly valuable in general practice. What is vector therapy? A vector is a force that has direction; therefore forces within and without the family are vectors. Vector therapy does not make a direct attack on the psyche of the family, but after defining the pattern of the emotional forces within and without the family, it tries to change the pattern to the advantage of the family.

A simple example might illustrate the practice of vector therapy. We have a wealthy family of a father, mother and four boys. The first three children were brought up by nannies because the parents were busy building up their business. But when the fourth child was born, the mother decided that she should raise it herself. At the age of three this child was referred to a paediatrician suffering from status asthmaticus, severe weight loss, and insomnia. The paediatrician came to the conclusion that this seriously ill child was under some stress or strain at home and referred him to our children's clinic with a request to explore the family dynamics.

We found that the mother was a rigid, awkward, aggressive woman, impatient of her

child, with the result that they were locked in a struggle within a negative relationship. She was also extremely frustrated because, having been a successful business woman used to handling a large number of employees, she found it hard to accept that she could not handle her child. She applied pressure on the child and the tension grew until the child's sobs became asthma and finally status asthmaticus.

Here we had a negative disharmonious force between mother and child which we could treat in one of two ways:

(1) We could offer the mother psychotherapy, with the possibility that after four years' work with a good therapist she might have been suitably adjusted (but the paediatrician had warned that this child could not wait) or,

(2) we could employ vector therapy to change the forces within the family.

The second choice was obviously better, thus we persuaded the mother to return to business and let a nanny bring up her child. Hence we had changed the forces; what had been disharmonious became harmonious and immediately the child's status asthmaticus cleared up, appetitite returned, weight increased and a normal sleep pattern returned.

One of the first principles of effective vector therapy is to make a correct analysis of the interactions within the family; the general practitioner, because of his continuous contact with the family, is in the best position to know likely weak points. An accurate assessment of the dynamics of the family is essential. If the assessment is wrong then the manoeuvres and probable results will also be wrong and unsuccessful.

Vector therapy depends upon the use of several facilities in the community, some of which need to be created for this special purpose. What facilities can we employ to assist children? In the higher income groups, we can use the nanny. In less rich groups we can use the ' day foster care ' movement, where children are separated from their families for short periods during the week and placed with carefully selected substitute parents, or day foster parents.

It is possible, under the Child Minders' Act, for a local authority to prepare a list of suitable people. An unwanted child can be taken out of parental control during the day and placed into a carefully selected foster home. This may prevent a difficult child turning into a delinquent, with even more serious consequences for his adult life. The day nursery can be used for the same purpose, as this is another form of foster care. There are also special boarding schools, hostels, or clubs for disturbed children. The traditional youth club does not tolerate disturbed children, and they are quickly excluded.

In Ipswich, we have already formed clubs for these children. To get into our clubs they have to satisfy the essential criteria of membership—they have to be " d.d." or " damned difficult ". In the club we try to provide them with substitute parental care. It is thus possible to organise a community programme; when children from unloving families do not get the correct emotional nurturing, then we, the community, should supply it.

Apart from humanitarian considerations, it would pay us to do so, as we would save in terms of police investigations, approved schools, prisons, magistrates' courts, and the enormous burden placed on the National Health Service by the emotionally ill.

An important element of vector therapy is child/family separation. Many people have condemned the separation of a child from his family. The cry " A child's own home is better than any other home ", is entirely fallacious; the investigators who propounded this doctrine confused two separate entities, deprivation and separation.

Most deprived children live with their parents; 99 per cent of children who visit child psychiatric clinics are living with their parents, a fact that does not prevent them being deprived. Most of us would accept that the first aim of any therapeutic programme should be to change the family so that children can remain with it; probably in 90 per cent of cases this is the target, and in a number of cases it is achieved.

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.