Aust. J. Fam. Ther., 3:1, pp3-26

PAPERS

Debbie and her slurping stomach

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Debbie, a 16 year old girl, was referred for family therapy by a specialist physician with a diagnosis of anorexia nervosa. After 3 sessions her symptoms, which were defined by the family as under-eating and indigestion, were resolved. There was also a marked improvement in the functioning of both Debbie and her family. The paper consists of a slightly edited transcript of the first interview. This is interposed with comments by the authors based on repeated viewing of the videotape of this session. A detailed analysis of the homework task given in the first session is presented. Summaries of the second and third interviews and a follow-up questionnaire are included. Issues including rapid resolution, the importance of enjoyment in therapy and the irrelevance of diagnosis are discussed.

Background

The Lamb Family[1] was referred for family therapy by a specialist physician who had diagnosed the daughter, Debbie aged 16 years to be suffering from anorexia nervosa. My response to this referral was mixed. I felt anxious partially because I am always anxious at the thought of meeting a new family, but more so because anorexia nervosa is a very serious condition. In its extreme form it results in the death of some of its sufferers. (Bruch 1974, 1976; Crisp et al 1976; Langford 1972; Tolstrup 1975).

However, I also felt somewhat optimistic and excited at the prospect of working with the family. This was so because I have worked successfully with a number of such families. The recent family therapy literature provides some background for this optimism in that it quotes a good outcome in many cases and offers a useful conceptual framework for understanding this condition. (Minuchin et al 1978; Palazzoli 1974).

After the referral was received, mother rang my secretary who took some details[2] and indicated that I wanted to see the whole family. She also explained that as a private clinical psychologist my fees were not rebateable.

On the morning of the appointed date, father rang and said he had a very important meeting at work and asked if it was really necessary for him to come that afternoon. I replied that it was very important for him to be present and if he couldn't make it I preferred to change the day so he could be available. Father decided to change his meeting and come. This encounter with father was the beginning of therapy for this family. It set the stage for one of the central themes of therapy, namely father's involvement in the life of his daughter and the family. Father's telephone call was perfectly reasonable. His time was valuable and he did not wish to come unless he knew that his presence was important — his willingness to cooperate was a good omen.

This episode illustrates my belief that therapy often begins before the first interview. It is during this early time that the stage is set for therapy, and its participants are determined. It is unfortunate that very little has been written about the foreplay to family therapy.

On asking other therapists how they would have responded to father's question, many said they would have reflected his feeling or left him to decide whether to attend or not. When fathers get such a response it is no wonder many decide not to participate in therapy.

FIRST INTERVIEW

The Family Therapy Centre is located in a large Victorian home in an inner Melbourne suburb. On the appointed date, in the waiting room there was

1. All names and biographical details have been altered to protect the true identity of the family. The therapist was Moshe Lang.

2. These details were: The referring specialist, Dr. Ericson, his diagnosis and the members of the family, Mr & Mrs Lamb, the identified patient, Debbie, her 3 brothers, Bruce 26, Brian 23 and Barry 19, Bruce is married and living in New Guinea; the other three children are living at home.

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We wish to thank Gayle Brown for her secretarial help.

Debbie the identified patient, and her parents. I told them, as I do all families, that it is my custom to videotape the interview and I gave them two reasons.

1. As a record for myself, for without such a record I find it difficult or impossible to remember much of what happens in such interviews;
2. From time to time I find it useful to show segments of the work to the family.

They, like nearly all families I see, readily accepted this. I then escorted the family to the interviewing room. This is a large rectangular room with two good sized windows allowing natural light. There are 4-5 comfortable chairs arranged around a small coffee table which has the microphone on it. The camera is in a corner on the far side of the room.

Ther: (Gestures) Please sit down.
Mrs. L: (Jokingly) We'll show whichever profile is best towards the camera (general laughter).
Debbie: I'll sit in the main chair (i.e. facing the camera).
Ther: Debbie is getting star billing (general laughter).

> ***I left it to this family, as I always do, to sit wherever they choose. They seat themselves so that Debbie is facing the camera — to her right is mother and next to mother is father. I am on Debbie's left. It is interesting that the way this family seated itself is in fact (like most families I have seen) a reflection of the way this family is organised. Mother is the closest to Debbie and father is away, and Debbie is given centre stage and is closest to me.***

Ther: (Trying to put the family at ease) I was very anxious when I first worked in front of the camera but I got used to it very quickly. I notice families also get used to it and forget about it.
Ther: (To Mr. L.) You rang this morning saying it was difficult for you to come.
Mr. L: You convinced me that it was vital and set my priorities right.
Ther: (Half apologetically) I am a family therapist. I believe fathers are important and have an important role to play — though in your family in what way I don't know yet. (turns to father) What's your name?
Mr. L: My name is Fred, this is my wife, Mary and my daughter Debbie.
Ther: What do you do?
Mr. L: I am a lecturer in Mechanical Engineering. When I was young I used to do physical activities but now I sit down and talk about it.
Ther: (turns to mother) What do you do?
Mrs. L: I'm a teacher in a girls' college, teaching English.
Ther: (to Debbie) What school do you go to?
Debbie: Cranberry Girls' Grammar School.
Ther: (jokingly to Debbie) How does it feel to have parents in the educational field?
Debbie: (smiles) It's good.
Ther: They can help you?

> ***Whilst probably unintentional, this question is an early example of the search for and the emphasis on the positive, in my work with this family.***

Debbie: Yeah.
Ther: What form are you in?
Debbie: Five.
Ther: This is exam time?
Debbie: Yeah.
Ther: (jokingly) It's a good time to come and see me. (family laughs).

> ***At this point I feel that the introductory preliminaries are over and the family feels reasonably at ease. Contact has been made with each member of the family. It is now time for the real agenda of the meeting to be introduced.***

Ther: (deliberately not looking at anyone in particular) I know very little about your situation. Would you tell me between you why you are here?
Mr. L: Didn't Dr. Ericson write to you about us?
Ther: He wrote a very short note, but even if he did write a lot, I would still like to hear from you how you see this problem.
Mr. L: Mary being the English teacher (turns to wife) you start and I'll come in.
Mrs. L: (Gestures to Debbie and indicates that Debbie should take over, Debbie accepts and is about to begin).
Ther: (laughingly) Father passes to Mother, mother to Debbie (family laughs).
Mrs. L: It's known as passing the buck.

> ***This is the second time that Debbie is given "star billing", the central position. In my experience it is very unusual for a family to nominate the teenager to be the one to introduce the real problem.***

Debbie: Last year I went on a diet and got a bit obsessed with it. I lost two stone and got down to six and a half stone and (turning to mother) I had anorexia and then I realised what I had and I started to eat again and put on weight. Now I just get (embarrassed laugh) indigestion all the time. It's really a major problem.
Ther: So according to you, you ***had*** anorexia, and you got over it, you think.
Debbie: Oh, I don't know. I can't say. They say it's mental, a mental case. (mumbles indistinctly).

This sentence suggests the possibility that the diagnosis of anorexia nervosa given to Debbie may mean to her that "she is a mental case". Thus she may feel disqualified from having worthwhile opinions, and that she cannot trust her own experience. To counteract this danger I inquire meticulously about her opinions and display serious interest in her experiences.

Ther: They say it's mental, or you think it's mental?
Debbie: (laughs) Oh well it's a psychological disease.
Ther: It was about 2 years ago, you decided to go on a diet?
Debbie: It was last year ... Form 4 ... Yes.
Ther: Were you very fat?
Debbie: No, just average.
Ther: You started going on a diet and you got into it too good.

Probably this is the first relabelling attempted by me. Instead of Debbie being a mental case, I described her as someone who does something really well.

Debbie: It became an obsession.
Ther: What does it mean to you to say it became an obsession?
Debbie: Not an obsession — oh well — you're frightened to eat too much food because you'll get fat.
Ther: So you got frightened to eat food and you lost two stone. What happened then?
Debbie: Oh well I looked pretty terrible. I played a lot of tennis and I couldn't do that very well, no energy.
Ther: You were tired.
Debbie: Yeah. Then I realised that I was stupid.
Ther: Debbie, you thought to yourself, "you're stupid"?
Debbie: Oh, it's hard. People can look at you and say you're really stupid and look at how skinny you are, and you look really terrible. But the person themself doesn't realise it.
Ther: You didn't realise it?
Debbie: No you don't. It takes a while to sink in.
Ther: So you kept losing weight, felt tired and couldn't do anything, play with the kids at school — what comments did the kids at school make?
Debbie: Main thing was that one of my brother's friends said, "you used to look really alright — but now you're really ugly."
Ther: That hurt?
Debbie: Everyone starts saying things to you.
Ther: It eventually got through to you.
Debbie: I started eating again and put on half to three-quarters of a stone but now whenever I eat I get (turns to mother with embarrassed laugh) liquid in the stomach. I don't know, problems with digestion all the time ... I don't know what it is (moves her hand towards her stomach). Another reason I went on a diet mum says (turns to mother) was I am determined to do something just to prove I can do it; I've got a strong will. (turns to mother again).
Ther: Is that your opinion or your mother's?
Debbie: Oh, I agree with it and mum reinforces it.
Ther: Mother gives you an opportunity to show it?
Debbie: No — (jokingly) she suppresses me. (family laughs).
Mr. L: Must look back on this tape.
Ther: (kidding) Mum's the dictator.
Debbie: No. (laughing).
Ther: After two years and losing two stone you said to yourself enough is enough and you started eating again and gained weight?
Debbie: Oh, no. I'm seven and a half stone — but now everytime I eat — that's the problem — mother thought it might be tension — whether it's physical — I want to get back to about eight stone. (very embarrassed, unsure, and speaking indistinctly).
Ther: Now you want to eat but when you eat you get indigestion?
Debbie: Yeah. It's not actually indigestion (laughs) it's just liquid in the stomach.
Ther: So at the moment are you losing or gaining?
Debbie: Oh I lost a bit — I eat, then I get this ... and I can't eat.
Ther: You said you had anorexia — who said that — was it your term?
Debbie: (turns to mother) I don't know — you read a lot about it in magazines.
Ther: Have you seen any doctors?
Debbie: I saw my family physician Dr. Knight when I was six and a half stone. He said — "No need to worry."
Ther: I'll come back to you later. (turns to parents).

Reviewing the tape the lucid and detailed account Debbie gives of her problem is most impressive. She is an intelligent and articulate girl. It is important to note that her parents did not interrupt, and allowed her to speak for a long time. Their respect for her individuality and separateness is a very good sign. She uses a number of labels. It is not clear if they are hers or borrowed from others.

One aspect of beginning therapy is to ask her to separate her thoughts from others. It is also notable that on occasions when I repeat to Debbie her own descriptions of herself she rejects them. It appears as if she is going against me. Debbie talks about her anorexia and dieting with comfort, perhaps even with some pride.
She speaks about it clearly using the right words, as if she is discussing another case. She is obviously in control of herself and the situation. This is paralleled by her account, that she chose to diet because she is strong-willed and able to demonstrate control over her body.
This is in contrast with the affect she displays when talking about her indigestion. She is clearly embarrassed, displays discomfort perhaps even shame. Further she is inarticulate and unable to find words to describe this problem. It is the indigestion that makes her worried and confused, as if her body has got the better of her — she is not in control.
Surprisingly Debbie's lengthy account of her problem does not contain one direct reference to the family. In contrast, non verbally, she continually turns to mother presumably for help and reassurance. At no time does she turn to father.

Ther: (turns to father) Any comments as to how you see the problem?
Mr. L: Debbie gave a pretty accurate description.
Debbie: (interrupts) Thanks very much (laughing).
Mr. L.: The actual liquid in the stomach, if you put your hand on Debbie's stomach and rattle it, you'd get it through your microphone.
Ther: (puts microphone near Debbie's stomach) Can you do it now — can you?

This I believe was a very significant intervention leading to a marked increase in energy and liveliness in the family. It can be understood on a number of levels. The simplest explanation is that it was just a humorous and playful action. On another level, father and earlier Debbie imply that the indigestion and the liquid in the stomach is out of Debbie's control. By asking her "Can you do it?" I may be implying the possibility that she can control it. On the third level, perhaps, there is a dual quality to father's behaviour. On the one hand he compliments his daughter, validates her position and offers her support in her assertion that her problem is "real". At the same time, he talks about her and her stomach as if they are objects as "Exhibit A and B". My intervention can be seen to contain a parallel duality. On the one hand, I support the father and do as he asks, but at the same time I am, perhaps mildly ridiculing his suggestion.

Debbie: (laughs) No. (whole family join in laughter).
Mr. L: It's an actual physical problem too.
Debbie: (interrupts loudly) They say that digestion's related to it that's why I think it's psychological.

This time Debbie disagrees with father. He says it's "physical", she "psychological".

Mr. L.: But it does exist.
Mrs. L.: I can vouch for that — it's like slurping in the bath. She did go to Dr. Knight and to my gynaecologist because she had her periods and they stopped.
Debbie: (interrupts) They stopped about 2 years ago.
Mrs. L.: And also Dr. Ericson — it was he who mentioned the anorexia for the first time as a medical opinion.
Ther: How come you went to Dr. Ericson?
Mrs. L.: I asked Dr. Knight to see a specialist because I wasn't happy with the situation. Although she was eating again, she was always saying "There's something wrong with me." So I had her checked.
Mr. L.: Actually she's getting us down now. (General laughter from family).
Mr. L.: I would say it has become a fair problem. Debbie is a good performer, both academically and at sport — a really good tennis player and a fairly normal person but since this thing happened she gets herself fairly miserable. I'd put us down as being a relatively happy sort of group — at times we have our own problems. It's having an effect because Debbie seems to be almost obsessed with this business of "I can't eat". So that one of the major things in our life now is wondering if Debbie is going to eat or not eat.
Ther: So that dominates, it is ***the*** topic of discussion. (all embracing gesture).
Mr. L.: Right — right)
Debbie: No.) simultaneously
Mr. L.: It certainly gets Mum down.

Father in his last few comments has extended the definition of the problem beyond Debbie and her symptoms, to include the rest of the family.

Mrs. L.: I just feel sorry for her, because I genuinely believe that she does want to put on weight, and to eat, and she does eat and I'm very sorry for her that she just can't eat without having this problem.
Debbie: (interrupting) Yes I just want to be a normal person and go and eat a meal. I eat a meal and then I get this clogging up and I can't eat the next meal and that's not how a normal person eats a meal (mumbles and trails off).
Mrs. L.: Don't get the impression that she isn't eating; at the moment she is eating. I can't verify for lunch, I'm not there, but I know what she eats for breakfast and dinner. But every now and then she'll

say "I don't want anything." Sometimes she will skip it or eat it later. But I feel sorry this is there all the time, for her at this age.

Ther: I notice Debbie says a few times that it's nerves.

Debbie: (interrupts) No I don't know. I don't think it is.

Mrs. L.: No, that's possibly just our talk. When she said that, I said butterflies in the stomach.

Debbie: That's just like indigestion.

Mrs. L.: (to therapist) I know the feeling (touches her own stomach and looks at her husband with some embarrassment saying, "I'm doing this again," turns back to therapist) and I think it's just tension or nerves.

This is a fascinating segment of the interview. Mother is clearly aware of the inappropriateness of her behaviour. She catches herself touching her own stomach as if it is her daughter's. It is very likely that she has done this on numerous occasions in the past but in this new and different social context she perceives it differently. Thus this unusual social situation may have led to spontaneous learning.

Debbie: What I think it is — it's just physical. I shouldn't be here if it's physical.

Mrs. L.: You think there's something physically wrong — but you see you've been told that there isn't.

Debbie: Yeah. It must be.

Mr. L.: Dr. Ericson said there's no physical basis for it.

Debbie: Yeah. If you do lose a whole lot of weight it's logical you might have a lot of trouble adjusting to it. It's been going on for a few months. (looks at mother).

Mrs. L.: Four to five months.

Ther: If I hear correctly, I hear you struggling within yourselves as individuals and as a family to come to terms with — "Is it physical or psychological or what the hell is it?"

Mrs. L.: **I'd just like to see it cured that's all.**

Debbie: Yeah.

Mr. L.: Yes. (General enthusiastic consensus).

This family, like practically all others, has very real problems in comprehending the idea of psychosomatic illness. When the family is told that a symptom is psychological, this usually means to them "it is not real" or "it is just made up". Such communication contains the risk of the patient or the whole family amplifying the symptoms in order to be believed. The family and the medical profession's preoccupation with the correct diagnosis becomes an end in itself, thus maintaining the problem by diverting energy from attempts at resolution. This search for the "correct diagnosis" can at times take years whilst no real attempt is made to resolve the problem. When I reflect to them their own confusion and struggle, they readily accept it and are able to say that they don't care what it is, but they want it fixed. This new definition of the problem allows all present to have a shared perception of the aim of therapy. This understanding frees the family to experience its feelings more fully and they all become tearful. Throughout the interview Debbie is confused as to whether her symptoms are "real", "physical" or "psychological", "mental or nerves". Her parents also find difficulty in defining the nature of the problem and at last all state that whatever is is, they want it cured.

Ther: (points out Debbie's tears and then points out tears in mother's and father's eyes also). I notice that talking about it, Debbie brings tears to your eyes and when you get tearful mum gets tearful and when mum gets tearful, dad gets a bit tearful. Didn't you notice that?

Mr. L.: Mm — yes.

Mrs. L.: I wasn't conscious of being tearful. (Therapist points out mother's tears). Debbie and Father laugh.

Mr. L.: We're interrelated, I'd agree with that statement. What affects one has an impression on the other. I'd say that's fair enough.

Debbie: (interrupts) Do you mean that literally?

Ther: (to whole family) I notice that your eyes were wet at the same time.

Mrs. L. : Heavens.

Ther: It's not criticism.

Mrs. L.: No, no ... I wasn't aware of that.

Ther: What it suggests to me and I'd like you to comment, is that you're a very close family and closely attuned to each other's feelings.

Unless special care is taken to prevent it, most families at such times would see any comment made by the therapist as criticism. I therefore made it clear that this was not the case and proceeded to label this example of enmeshment as "closeness".

Mrs. L.: Are we? (laughing and turning to husband, family laughs).

Mr. L.: I'd say we're fairly sensitive, but we're not a demonstrative family — in any way.

Mrs. L.: No.

Debbie: I don't know what demonstrative means.

Mrs. L.: Displaying dislike or affection or ...

Ther: You're not one of those families that likes to kiss and touch.

Debbie: Oh, no.

Ther: Not at all?

Family: No. (noticeable pause).

Ther: (to father) You mentioned earlier that we have our share of family problems. What were you referring to?
Mr. L.: We've been on a fairly even keel, we've been fortunate. No major incidents — I'd say we've been lucky. At the moment our major problem is Debbie and her eating habits.
Debbie: (interrupts) And her stomach.
Mr. L.: I'd suppose you expect to get your share of tragedy. But, no, the kids have done fairly well. Brian has finished an engineering degree. Barry is doing Arts, second year. Our married son, Bruce, finished medicine and is living in New Guinea. Debbie is probably the brightest of the four, highly motivated to succeed. If she decided to do something you don't stand in her way. If I made the remark, I don't remember.
Debbie: Mum and Dad have a few fights.
Mr. L.: Do we?
Debbie: Oh, hardly ever.
Mr. L.: Because Mum's the boss. (family laughs).
Mrs. L.: Yes, that's true.
Mr. L.: She's the organiser.
Mrs. L.: (looking at husband) That's a kinder term.
Ther: (to the family in general, not looking at anyone in particular) How concerned are you about what's happening to Debbie?

Originally I thought I introduced the above question because it seemed the right time. On review, it occurred to me that it was determined more by my perception of the family as perhaps not sufficiently serious or concerned. Earlier father had mentioned problems which he now denied, and the general demeanour of the family was fairly light-hearted. In other words on reviewing the video, I could appreciate the overall sequence of the interview. It seemed my response was determined by the interaction with the family, rather than just coming from within. I find this a very common experience.

Mrs. L.: I'm very concerned. I'm concerned to the point that I'm here because I want to try.
Mr. L.: I think we're exaggerating this (lifts chair and moves away and sits).

It is fascinating how commonly the family enacts or sculpts what they say in words. On this occasion father says mother is making too much of it. He does not want to be a party to this and so moves his chair and withdraws from mother or perhaps the whole situation. One doesn't need to orchestrate family sculpture — careful observation reveals that they do it spontaneously.

Mrs. L.: When this first came up the tendency was to say, "No, no, we're not going to get psychological help." I was the one who said "Yes we are" (Debbie interrupts saying "Try anything"). As we go along step by step local doctor, physical specialist and so on — you try to find some answer. I think it is making Debbie miserable.
Debbie: Yes, it gets you down.
Mrs. L.: I just don't like to see her. I know teenagers have all sorts of things, especially girls. I suppose you know life goes on and you like to make the most of it. It is affecting her life. I'm not concerned to the extent that I think anything drastic is going to happen. I must say that I want to see her free from it, "the it".

When mother talks about "the it" she again spontaneously comments about the inappropriateness of her behaviour. Her ability to use the session for spontaneous learning is an index of her strength and flexibility.
Mother's persistence in seeking help for Debbie despite the inappropriate reassurances from the local doctor is well justified and highly commendable. Debbie's problem clearly merits help. At a time when she is developing and should be gaining weight, she had lost two stone, her periods have ceased and her indigestion is disturbing her life and affecting the functioning of the family.

Mrs. L.: (to father) You're possibly less concerned.
Mr. L.: (to mother) Yes, I'm less concerned. I think she'll grow out of it. There must be a period of adaptation I suppose. (to therapist) That is a reasonable expectation, isn't it?
Ther: (to father) I don't know at this point. (to mother) You've been more concerned?
Mrs. L.: Yes — I don't know, perhaps I've been confronted by it — I'm there at the time when she says "I don't want anything to eat". She doesn't go to Fred and say she doesn't want anything.
Debbie: I want someone to say — take this tablet, you've got some poison and this will get rid of it. You'll be normal. I thought he'd tell me what to do — when I saw the specialist. But he said it would take some time. It's ***ridiculous*** that every time you eat you get "indigestion", inability to digest — it's just not normal. It's stupid.
Ther: (to father) Do you accept the explanation that you are less concerned than your wife because you're not confronted with it daily?
Mr. L.: I'd say that — I leave early and get home at seven and then I'm looking for my tea ... (Debbie cuts in).
Debbie: That's another thing, it really annoys me — the way they all don't have to worry about their eating, like iron men's stomachs, I'd really enjoy to eat, but I get indigestion (tapers off into a mumble).

Just as father starts to talk about His day, and His coming home ready for his dinner, wanting some time and attention for himself, Debbie interrupts him to talk again about Her dinner and Her difficulties in eating — not allowing father in the session his due — just as she does at home. Thus what is described as happenings at another time and place is paralleled in the here and now of therapy.

Ther: (to Debbie) How much do you eat?
Debbie: I have cereal and toast and tea. At school I get all this oogle oogle (rubs stomach) so I don't eat lunch. Then I come home, have a biscuit and I may have tea. I wake up in the morning and I have all this liquid in my stomach.
Ther: So when you feel that liquid in the stomach what do you do?
Mrs. L.: (interrupting) Come and tell me probably.
Debbie: Oh I think, "not again", and I feel sorry for myself.
Ther: You feel sorry for yourself? (Therapist points out how at this moment mother's and Debbie's eyes are full of tears).
Ther: (to all) There's the waterworks that doesn't happen. (family laughs, clearly accepting that this occurs).
Ther: So when you feel sorry for yourself what do you think?
Debbie: Why can't I be normal? It'd be really good to get rid of it. I'm basically happy. I like school and I've got a good bunch of friends and we go out to parties. But I've just got this one thing.
Ther: So you say, "I wish I could get rid of this because it stands in the way of me really enjoying myself". But it's not going away — do you think what will happen if it doesn't?
Debbie: I think, "What if I've got it for the rest of my life?"
Ther: Then what?
Debbie: Yes. What'll I do — it scares me. I don't know. (turns to mother).
Ther: Then what do you think?
Debbie: I don't know, what will I do? (turns to mother).
Mrs. L.: (sadly) I don't know.

Asking Debbie to think of the future in this manner increases her worry and escalates stress (Minuchin et al, 1978) for the whole family and thus builds up motivation for them to change.

Ther: I also notice that you said you feel sorry for yourself. Mother says you tell her. Both happen, do they?

Mrs. L.: Do you always come and tell me?
Debbie: No — not so much now because I know it gets her down. I don't tell my friends I get this oogle oogle — they'd think I'm one of those crazy people and I never want to tell anyone because they'd think ...
Ther: You're a nut?
Debbie: Not a nut — a hypochondriac.

The theme alluded to earlier, of her embarrassment and shame in relation to her indigestion, is restated here — she can't tell her friends etc. To counteract this I use stronger words than Debbie as if implying total disregard of any possibility of embarrassment and shame. I also try to undervalue the importance of these words by making such casual reference to them.

Ther: I notice it's different. You don't want to tell your friends because they'll think you're a hypochondriac. You don't want to tell your mother because you don't want to worry and upset her. What does it do to her, according to you?
Debbie: Well — she gets upset too, I suppose.
Ther: How do you know she gets upset?
Debbie: She just goes ... (throws up hands, imitating mother).
Ther: She goes "Oh"? (gesturing)
Debbie: She gets a little bit mad. I can see why because what can she do?
Ther: But how do you know she gets upset?
Debbie: She goes, "I can't do anything about it" ... I can't do it that well.
Ther: She gets mad?
Debbie: A bit mad at me.
Ther: What is it — she gets upset or mad?
Debbie: She gets upset which influences her to get mad.
Ther: Then she says, "Oh — leave me alone, I'm sick of it"?
Debbie: Oh, no.
Ther: So show me exactly what you do and say to her.
Debbie: I've got liquid in my stomach again. I can't eat. She says, "Oh — (sighs heavily) Okay."
Ther: Sometimes she's upset and frustrated and other times just ...
Debbie: (interrupts) Of course she'll be upset and frustrated. She doesn't want one of her children not eating. Mothers always worry when their child doesn't eat.
Ther: So when she says that, what do you do?
Debbie: Go away I suppose.
Ther: Feeling what?
Debbie: Feeling sorry for myself. Just go away and forget about it.
Ther: So one of the things you do is try to tell yourself to forget about it -stop being preoccupied with it?

Debbie: Yeah.

In this sequence I try very hard to obtain from Debbie a clear description of the cyclic interaction around the symptom what they actually do and say in relation to the presenting problem. This proves to be difficult. Debbie is ready with explanations of why her mother behaves in a certain manner and of how her mother feels — but the task of getting specificity is difficult.

Ther: (to mother) How would you describe that interaction?

Mrs. L.: She described it pretty accurately. Sometimes I say, "Yes, I know it's there". I believe it's there — I can put my hand on her stomach and feel it and I say, "Yes, that's terrible, eat your food slowly". "Eat something to sop up all that liquid ..." Sometimes I tend to lose patience. Exactly as Debbie says.

Ther: When you lose patience what do you do?

Mrs. L.: I say I've taken you to the doctor and he says there is nothing wrong with you and I don't know what else I can do.

Ther: So you experience it, that when Debbie comes to you, she comes with the expectation that you should do something, and you respond — but what can I do? — I've done all I can?

Mrs. L.: Yes, that's probably — she experiences this, this, got to tell somebody. She's not going to go to the boys.

It is interesting to note that in relation to Debbie's symptoms this is the first time the boys are mentioned. Mother asserts unquestioningly that Debbie could not "go to the boys" — this is clearly mother/daughter or women's matters.

Ther: But you're not responding as if she's just telling you. You describe it as if you experience it as "Do something mum, don't just stand there."

Mrs. L.: That may be me. Because I feel I should be doing something. Naturally, I don't know if it's natural or not, if there's anything wrong, you take steps to see what can be done. But I feel frustrated because I don't know. I think, "She has a right to expect her parents to do something and help her." But when I answer her abruptly it's because I don't know and I'm frustrated. I'd do what I could do if I could do it.

The last sentence illustrates an important aspect of mother's character — she is a practical person, committed to action not words. In this short sentence the word "do" appears three times.

Ther: It's the not knowing?

Mrs. L.: It's the not knowing what to do next — not having had the experience of anything like this, we can't find an easy remedy. I'd be inclined to say that at times I'm abrupt but not often, sometimes I say okay, if you don't want to eat, don't eat — I play it down.

Ther: You used the words, "If you don't want to eat".

Mrs. L.: If you don't feel like it, perhaps have it later, or just have a little bit, and I give her as much as I always do. I don't know if she's woken up to it.

Ther: One of the feelings I guess — is a feeling of impotence. Here is something that beats you. Neither of you know what to do — that's very frustrating.

Debbie: That's very true. Exactly.

Debbie and Mrs. L.: Yes (mother nods many times).

Again there is general consensus in the family. They all agree with my statement that they feel impotent and frustrated. Clearly they have tried in every way they can to cope with the problem, and cannot think of anything else to do. As mother stated, "We can't find an easy remedy".

Debbie: Especially when you sort of said (looks at mother) that physicians can't do anything — well what can you do? Another thing is I really do want to put on weight now because of clothes. I want to choose a whole lot of clothes for summer. I've been through about three different wardrobes of clothes. I want to get to eight stone — I can't fit into — they don't come in my size.

Ther: Do you have any bathers for summer?

I asked this somewhat irrelevant question because the story of another therapist flashed across my mind. He was working with fat women to try to help them lose weight. He suggested they come to the session wearing a bikini under their clothes. Thus there was always the possibility that he may ask them to parade in their bikinis, and this was a motivation for them to lose weight. However, I rejected this almost as I asked the question, feeling it was perhaps a little improper.

Debbie: No, I haven't got any right clothes until I put on weight.

Mrs. L.: You have got bathers.

Debbie: Yes, I've got clothes — all girls want clothes. I don't look that good in any clothes.

Ther: Your period hasn't returned?

Debbie: No.

Ther: Does that worry you at all?

Debbie: No. I tend to forget that people have it. I haven't had it for so long.

Ther: People don't have it — women have it. (family laugh — particularly father).

Mr. L.: Very good.

Debbie: Naturally. The girls at school sometimes get

very worried — it doesn't worry me at all. I think it's quite good. Maybe when I get married and have to have a baby.

Ther: What happened when you were about to get it and you didn't get it? Do you remember how you felt about it? (therapist notices father's discomfort). Is that something you can talk about in front of your parents?

Debbie: Oh, yes, yes. It was just a nuisance I thought. No great feeling of womanhood or anything like that.

Ther: Because, if nothing else, the not eating is a blessing in that way — it stops you having a period?

Debbie: No, I have heard that; I've read it. No, it was not that really.

Ther: What do you mean — it was not that really?

Debbie: I read about it, some of them do it because they're scared of being a woman. It's definitely not that.

Ther: That's not what I said. I said it might have been a nuisance in many other ways. I said it was a blessing in the way it has stopped you having a period which you said was a bit of a nuisance.

Debbie: Oh, I thought you meant that some people get anorexia.

Ther: That's true. That's a common belief, one of the reasons why girls of your age may develop anorexia is to somehow stop their womanhood.

Debbie: Yes.

Ther: You have been doing a little bit of reading on the subject, have you?

Debbie: Oh, about three or four articles. People hand them to me and say, "Read this".

Ther: That'll do you good.

Debbie: It's quite interesting really.

Ther: What else have you read?

Therapist and Debbie have a scholarly discussion on the subject of anorexia like two very interested colleagues.

Debbie: Just a lot of the times the parents of ... are ... you know ... are middle class ... comfortable ... well to do ... (long mumbles and silence) ... intelligent ... (with lots of prompting from mother).

Ther: Do you want to know what I think?

Debbie: What?

Ther: You are probably a girl who is very concerned and over-protective of her parents. (Debbie and mother laugh).

Ther: (continues) A very dutiful daughter. I'll tell you why. I don't know which articles you have read but most of these articles tend to blame the parents.

Debbie: That's right. (mother claps).

Ther: I think you know that, and you were about to tell them and thought, "I couldn't hurt my parents ... so I had better be nice."

Debbie: That's where I don't agree.

Mr. L.: (jokingly) I think I might buy this tape.

Ther: (to Debbie) Hang on ... that's different. I didn't ask if you agreed. I asked you what do these articles say (pointing to Debbie), you didn't want them to know what the articles say.

Debbie: They know anyhow.

Mrs. L.: But we have really talked about that.

Ther: But you notice she didn't say ... as if she was trying to protect you. Maybe she thinks you can't take it.

Mrs. L.: But it's been mentioned.

Debbie: Remember when we talked to Dr. Knight? He said it's all your fault because you work or something.

Mrs. L.: Well, he just asked me ... at the interview ... he just mentioned it ... so I started to get ... no, I didn't start to get ...

Ther: (jokingly) By and large everybody knows that ... when children have problems it's mum's fault. It's a scientific fact.

Mr. L.: A good diagnosis. I agree with that (everyone laughing).

Ther: (to mother — laughing) You know it's your fault.

Mrs. L.: It's possible. Yes, it's possible. (with some seriousness and sadness).

Ther: But what was interesting, to me it's very interesting ... (gesturing from mother to Debbie) I don't know what articles you read but I am sure that they made some critical comments about parents (then to Debbie) You would not tell them about it. Would that be true?

Debbie: They can't take it ... (laughingly)

Ther: That's what has me worrying a bit ... that mum gets upset and dad maybe too. So you have two worries. You have the worry of your tummy and what it does to you — your figure and your social life and everything else, but you are also worried about the fact that they are worried.

Debbie: I think it's sort of the opposite — I still have anorexia and it gets me ... and I want to put on weight. It's sort of the reverse.

I think time is running out. I continue the interview somewhat automatically and at the same time start thinking about whether to give a homework task and if so what.

Ther: Are you a family that fights? Do you fight?

Mrs. L.: No, well it all depends.

Debbie: No. Hardly ever.

Mrs. L.: Very little.

Mr. L.: We fight with Debbie a bit every now and then.
Mrs. L. and Debbie: No.
Debbie: With the boys every now and then.
Ther: (to Debbie) Do you?
Debbie: We get on well.

Ther: (to Debbie) But you are a fairly gentle sort of a girl who sometimes needs to kick, but rather than kick you let them kick you. (Parents look at each other and laugh and then Debbie joins in laughter).
Ther: (to Debbie) Can you kick when you need?
Debbie: Yes, I hit with words, not physically (makes hitting gesture).
Ther: But you can punch. You can give as good as you can take?
Mr. L.: Better.
Debbie: Yes, I can give better.
Ther: In what way?
Mr. L.: Oh, well, she is not lost for a word.

Mrs. L.: She wouldn't be likely to lash out at the boys because they are much bigger. They could hold her with one hand. (mother makes gesture with hand).
Mr. L.: She usually tends to adopt an attitude that after we fight, "Well right, I'll get you a cup of tea or do something".
Debbie: I do?
Mr. L.: Oh, yes.
Ther: As if she feels guilty; is she usually the one in the family, if there is a fight, who feels responsible to make amends to bring peace?
Debbie: No.
Mrs. L.: I don't think there are many fights. I think we are talking about something that doesn't happen you know.

Mr. L.: It's usually only interaction.
Mrs. L.: But it's not a great big family fight, is it?
Mr. L.: No. I cannot remember one for a long time.
Mrs. L.: But you know ... Barry will say, "You have got the tapes" or something and Debbie will say, "You have got the tapes" ... there might be a loud screaming match and then that's the end and everything just goes on.

Mr. L.: It's a life style in which we have been probably protected from over interaction, in that Debbie will either be playing tennis, or have her head in a book, and she's certainly not there washing the dishes or ...

Father's choice of words, "being protected from over interaction" is most unusual. It seems he is describing a family in which perhaps there is far too little interaction.

Debbie: This is how you tell me — I find out I'm n doing enough work around the house.
Ther: You mean she doesn't help as much as yc think she should?
Mr. L.: Every now and again.

It is interesting to note that this is the first and only critical comment — if at all — made by either paren about Debbie. This is very unusual.

Mrs. L.: She does what she is asked but I must adm that I am at fault here I suppose, that the three them don't do very much about the house.
Mr. L.: Mum does everything.
Mrs. L.: No, I don't do everything. They do it if the are asked, but they are not the sort to offe although, Debbie of the three of them, is the or who will come out and say, "I'll do this or I'll c that" and if she has something to do she does it.
Ther: (to mother) Rather than ask them to do it, tell them to do it, you do it yourself?
Mrs. L.: I tend to do it myself.
Mrs. L. and Debbie: Yes.
Mrs. L.: That's right, and I know that, and I'll adm that.
Ther: You're admitting it as if you are confessing t your sins.
Mrs. L.: Well I think it is. I think that I have don them a disservice in bringing them up that way when I think about it, but that's just the nature c the beast.
Ther: (to mother and father) That's the way yo both see it. You agree on that? (They both nod i agreement).
Mr. L.: I'd agree.
Debbie: I heard you say it's all her fault. (to father).
Mrs. L.: (interjects) My fault?
Mr. L.: I said that was because she does.
Mrs. L.: (interrupts) In that regard. I do all the work.
Mr. L.: (to mother) That's why they don't do things because you do ... (turns to therapist) Mary woul do a day's work — perform a day's work that is t me impossible. So I react by trying to close my eye to it.
Ther: It sounds very unfair in two ways. One i (looking at mother) you do a great amount of th work, more than your fair share, and at the end of i — at the end of the day, you don't sit back and sa at least, a good day's work, but you also feel guilt because you shouldn't have — the kids should hav done it. (father makes agreeing noises as therapist i speaking).
Mrs. L.: Oh, no, I don't really feel guilty. Sometime when I think of it, I think well perhaps I should hav brought them up to do more. I haven't done i

because I like things done my way. (Mother here denies guilt feelings which she freely volunteered earlier).

Debbie: (interjects) To perfection.

Mrs. L.: (continues) Because I like things done my way. I become impatient — I think, "Well that's not done well enough" and I go and fix it up then, and think, "Well I might as well do it myself in the first place". But I really don't feel guilty about it. That's the way it has been and so (she then points to father) when I married him, his mother hadn't brought him up better so ...

Mr. L.: As she said, after a while you begin to relax.

Mrs. L.: (reflectively) Yes, but that's the way it is and also I suppose they have all been students. That's another aspect. See, Brian just sort of finished now at the age of 23. When they are studying too, you just don't ask them to do anything unnecessarily. They do some things around the house — they aren't sort of there saying, "I'll do this and I'll do that", but if I want anything done, well it gets done. I ask and they do it.

THE HOMEWORK TASKS

Ther: Okay. What I would like to suggest to you is this. I want to give a lot of thought to what has been said. I want to watch your tape very closely.

> ***I am the only family therapist I know who prior to giving the family a homework task, gives himself one.***

In the meantime, I would like to suggest that you should do a number of things, and come back next time to report to me how things have worked out in relation to this. The first thing I want you to do Debbie is to write the most detailed account of everything you eat, or try to eat, and what happens. The most detailed account, okay? The next thing I want you to do is, when your father comes home I want you show him the list of what you have written and discuss it with him, okay?

Debbie: Yes. He'll love that.

Ther: The next thing I want you to do is, when you are concerned about your eating or not eating, I don't want you to talk to your mother about it. I want her to have a rest, and I want her to learn, or see if she can learn to sit back and relax. And I want therefore, when your father comes home, for you to talk to him about it. One, the list (therapist ticks off on fingers) and two, what it has been like for you. Okay? Would you do that?

Debbie: Yes.

Ther: (emphasising) You can do it?

Debbie: Yes.

Ther: Okay ... (then to father) I want you to just be available when you come home, go over the list with Debbie, get the details and see you understand what is in it. Find out how it has all been for her ... (then to mother) What I want you to do is, if Debbie tries to get you involved — if it is alright with you — tell her that it is your job now to take a back seat and relax, and she should go to your husband.

Ther: (speaking slowly to mother) The other thing that I am wondering about, that I want to check with you, I wonder if you could try and do a second thing ... and the second thing is, I'd like just as an experiment until I see you again, for you not to do any of the housework, or very little. (they all laugh).

Ther: (to father) And for you Fred, to tell the family, we are doing an experiment in which mum is having a rest. Annual holiday has started.

Mr. L.: (laughing heartily) I knew I shouldn't have come.

Mrs. L.: (protests) You don't mean I have got to hand over the cooking and everything do you? (gestures to Debbie).

Ther: We can work out the details later ... and for Fred to tell Debbie and your sons that we are organising family life differently. It's for you to take as much of the load off mum as possible. Now I have some ideas, and because of this I want you to try it out. We can talk about it next time we meet, because, that would give some further ideas to all of us as to what happened. The question is, whether you will also be prepared to, and able to do the next thing I suggest, or will you all then starve to death, and I will have a family of five anorexias, because they will cook so badly nobody will be able to eat. (family laughing loudly, particularly father).

Debbie: (enthusiastically with a marked change in her voice) What if one night say, one person could be in charge of the tea?

Mrs. L.: I am sorry but I think it would be impossible for me, unless I went away, to stand back and not ... also Barry is doing exams, she's doing exams you know. I'll try ... but not even cooking?

Mr. L.: What say we accept all of it except the cooking.

Debbie: (interrupts excitedly) That's the major thing ... that's the major thing, the cooking.

Ther: Could you then ... could we compromise?

Mr. L.: Compromise is the word, I'd say.

Ther: (to mother) How many nights in the week can you stay out of the kitchen, as far as cooking goes?

Mr. L.: Saturday?

Mrs. L.: Oh ... I'll stay out, I'll have to stay out, but God knows what they'll eat ... does that matter?

Debbie: No.

Ther: (to mother) No it doesn't matter. What mat-

ters, is whether at this point you can stay out of the kitchen, whether ***you*** know how to look after yourself. Whether you can sit back and relax — let them do it.

Mrs. L.: Whether ***I*** can?

Ther: Whether the whole family can. Don't forget that this is a family dance you are dancing together. This is an arrangement and you all need to change.

Mrs. L.: Well what do I do then, when Brian comes home, or somebody else comes home and says, "There's no dinner"? I just go down the street and buy some?

Debbie: (interrupts protesting lively) All you do is ...

Ther: You send them to Fred and to Debbie.

Mrs. L.: That's a bit hard isn't it?

Debbie: (interrupts loudly and energetically) No, there are four of us. One night somebody is in charge of the tea. They come home and they complain to the person who is in charge of the tea ...

Ther: (half jokingly to mother) I'll tell you what. It is quite clear that Debbie is a very intelligent woman, and that your husband made a mistake when he came. I'm sure of that (gestures toward Debbie and father and more seriously), I would leave it for them to discuss, and put a proposition to you which they believe is viable, as to how you will allow the others to take some of the load and the responsibility, and how you could take a more comfortable and more relaxed role.

Mrs. L.: How long do you see this going on?

Ther: Well I think we will talk about it when I see you again. I want you to try it until next time, and of course it would be very significant for me if you feel you are unable to do it. It may well be very significant for me, to know that you would not be able to change. I want you to try. So what I want you to do, is an experiment. You see, there are many ways of finding out how things happen. You could talk and talk till the cows come home, or you can go home and behave differently and see what happens.

(The therapist discusses the next appointment emphasising that it is most important for all members of the family to come. He goes to great lengths to find a time which is suitable to all. This proves impossible, because Brian has important exams and is unable to come for the next appointment).

Ther: I will be very very interested in what happens as a result of what I asked you to do.

(The family, appearing confident and purposeful, leave the session).

COMMENTS ON HOMEWORK TASKS

The family all agreed that they have a problem which they want cured. They do not know what to do about it, they feel frustrated and impotent and believe there is no "easy remedy". It is a reasonable expectation on the family's part to be told how to deal with the situation. Failure on my part to do so would be unjustified. Giving the family a homework task places the responsibility on them to behave differently, to ensure that further changes will occur.

Homework, as a way of achieving desired goals is consistent with the family's own orientation and experience, as both parents are in the teaching profession. This family places greater emphasis on actions, rather than on thoughts and feelings.

Debbie is given the homework task of writing "the most detailed account" for several reasons.

1. It puts her in charge of her problem and gives her something to do about it; it requires her to study and report back on her "very serious problem".
2. Self monitoring is known to bring about a change in the very behaviour being monitored (Kazdin 1974; Nelson 1977).
3. Debbie herself claims to be obsessed and forever pre-occupied by her problem. Thus the task prescribed the symptom (Jackson 1963). If she persevered with the symptom, it is partially because she has been told to do so — and thus it is no longer an obsession but simply co-operating with the therapist. Thus she is likely to respond by totally rejecting her "obsession" or perhaps all her symptoms. This could be described as "defiance-based" therapy (Papp 1980).
4. From another perspective this task pits one symptom against others — that of obsessionality against indigestion and under eating. Thus they are likely to cancel each other out or at least one symptom may be inhibited by the other (Haley 1976).
5. Throughout the interview it is noticed that Debbie is very good with words. The family itself asserts this fact. She also displays a keen scholarly interest in her "anorexia". This task should appeal to her because it caters to these interests. On the face of it therefore, this task is very good, for whatever the outcome, everyone wins.

The next task involves father and Debbie. It requires father and Debbie to increase their involvement and for mother and Debbie to decrease theirs, and to cease any interaction around Debbie's symptoms. Mother is also required to have a rest. Each one is instructed separately about his task and is contracted to do it. Since the tasks involve them with each other, it maximises the chance of them being carried out. The family readily accepts these tasks.

Father has said that his wife is overworked and over concerned about Debbie's symptoms. The

task gives him a chance to remedy this situation. It also increases his involvement with his daughter, whom he clearly likes and of whom he thinks highly. The task is based on father's description of the family. The therapist accepts father's assessment and bases his task on this understanding. Thus father's position in the family is enhanced and he is more likely to co-operate. Mother has clearly stated she has done everything she knows for Debbie and it hasn't worked. My request for her to withdraw and give father a chance to see what he can do, can hardly be refused.

Debbie said that she is worried about upsetting her mother. The task gives her the opportunity to stop doing this. Jay Haley (1976) once said, that when there is a symptomatic child, usually one parent (often mother) is over-involved, and the other is under-involved. The reversal of this situation is likely to bring about symptomatic improvement. Mother and Debbie are over-involved, over-sensitive and over-concerned for each other, particularly in relation to Debbie's symptoms. Their interaction reciprocally amplifies their anxiety — they are caught in a vicious circle. These tasks have the potential of breaking this feed-back loop.

The second family task was for mother to reduce her workload and stay out of the kitchen, and for father and Debbie to take over.

The reasons for this from a family view point are similar to those already stated, namely father's concern about his wife's general overworking etc. From my view point they are also similar, in that it achieves the same re-alignment in family structure.

The second task was suggested because the first was accepted so readily. It achieves what Minuchin (1978) describes as "creating intensity" — thus increasing the likelihood of change. This is a capable family and the second task is more challenging. Debbie obviously gets very excited about this task — she gets really worked up by the possibility of having more responsibility and more independence. It was mother who found the relinquishing of her duties so difficult. Perhaps this revealed an over-anxiety about her family's food.

The homework task is useful in assessment. The family's response even in the session alone, to the task given can often bring further understanding of the way it functions. A demand or expectation for them to change or behave differently, may reveal resistance previously unsuspected. Some people who have watched the tape, said that the family response to the second task brought about a radical change in their perception. Until then they saw mother as "good" and "reasonable" and as the "victim" of a "difficult" and nagging daughter; subsequently, they saw her as rigidly clinging to an inappropriate mother role — not giving her daughter a chance to grow up. Debbie in turn was seen as a young person eager to become more independent and responsible. Others saw mother's reluctance to get out of the kitchen as reasonable and understandable, in view of the fact that the task required her to give up a way of life that she felt had worked well for her and the family for 25 years. It was partially the enthusiasm with which Debbie and to some extent father took up this challenge that swept away most of mother's resistance and eventually won the day. When mother asks "how long do I have to stay out of the kitchen?", she raises a very important question regarding the homework task. To me, the homework task is not a prescription for how people should live, but rather a therapeutic experiment between sessions, a search for a better way for people to organise their lives.

Towards the end of the session I tell mother that if she is unable to perform the task it would be very significant. A psychoanalytically orientated friend on seeing this said, "That is what analysts think but never say to their patients". This is also true of family therapists. When I told mother that non-performance would be meaningful to me, it could be said that I was being open and honest. Other people watching this said "That was highly manipulative". Usually the interpretation of my behaviour is argued very energetically by the professionals watching. In my opinion it was both — open and honest, as well as manipulative. Further I confess that sometimes when I watch, I feel it was perhaps a little below the belt.

The advantages to mother and father resulting from the homework task have been mentioned. The benefits to Debbie need to be clarified. In return for the potential loss of attention, involvement and control, resulting from her giving up her symptoms, she could gain recognition and influence as a useful member of the family, as well as become freer and more independent. Thus, the tasks, apart from dealing directly with the presenting problems, offer extra benefits to every member of the family.

GENERAL COMMENTS ON THE FIRST INTERVIEW

This transcript is not a full one — it is slightly edited to reduce repetition and maintain interest. At times it is impossible to hear and comprehend what is being said when two or more people speak

together and more often when Debbie mumbles quietly. I regard this as a reasonably good interview though if assessed against the final outcome it would be regarded as a very good one. It would have been better if I had maintained tighter control over the communication to prevent people from speaking together. Themes I introduced should have been more carefully followed up. Questions asked were not always answered and I should have seen to this. At times, I tended to jump from one thing to another and didn't always clarify the issues raised. However, there was a good balance in the level of control exercised during the interview — so that I am in charge whilst at the same time not stifling the spontaneity of the family.

The interview moves well and has moments of humour and lightheartedness, as well as seriousness and appropriate sadness. Most importantly the family is seriously and intensely engaged on the task in hand and is working in a co-operative way on the resolution of the problem. The family arrived demoralised and left with hope.

A central problem for the family was "is it psychological, is it real?" Towards the end of the session an interpersonal definition of the problem had been accepted. The shift to this new definition was rather gradual, in fact almost imperceptible. This was achieved primarily by the therapist's attention to detail, and his interest in the specific and concrete. Father's contribution to the widening of the definition to include the whole family should not be overlooked. This redefinition of the problem, in interpersonal terms, makes the family ready and even eager to accept the homework tasks and the resulting changes.

SUMMARY OF THE SECOND AND THIRD INTERVIEWS

The second and third sessions were not video taped due to some technical difficulties. Thus the following is a summary of these two sessions written from notes I made after the sessions. The contrast between this summary and the richness of an actual transcript from the video is obvious.

Second Interview (6 days later)

Four family members came, father, mother, Debbie and Barry (the third born). Brian, as expected, did not come. Debbie apologetically said that she did not do her task properly. She only recorded what she ate. She did not write what she experienced. She kept repeating that it was very boring and it made her self conscious. She had hardly talked to her father and said she had excluded mother as instructed. Father agreed that his daughter hardly came to him. He was in a quandary as to what to do, and correctly said that I did not specify for him what to do in such a situation.

Mother did her task faithfully. According to her, Debbie did come to her a few times with her problem. However, mother said it was her job to rest now. Furthermore, mother stayed out of the kitchen. She claimed it was very hard for her. To cope with this she visited some old friends and spent time listening to music.

To everyone's astonishment Debbie's problem totally disappeared during the week. However, it returned on the week-end when father was away. It was then that Debbie tried to involve mother but she refused. I told the family that the symptomatic improvements occurred too fast. The symptoms may have had some particular importance or meaning for the family and for them to disappear so quickly was somewhat of a worry to me. I, therefore, recommended a slow-down in the rate of improvement.

Barry was irate with his sister. He was never told that her problem was so serious and such a worry to her. He wanted to know why she had hidden it and not told him. Debbie said it was because she thought he wouldn't understand. This only increased his annoyance. He claimed he always thought of himself as a good and understanding brother, and couldn't accept why she should think him so lacking in consideration.

Debbie's homework task was to continue the detailed recording of what she ate and experienced. She was to show this record to her father and brothers and tell them about it in detail. Father and brothers were to take an active interest in Debbie's problems.

Father then asked what is he to do if Debbie doesn't come to him. I said that father should take the initiative in this and it was his right as a father to know what was happening to his daughter. He asked, what he should do if she still did not want to share her problem with him. I said he was a reasonable and enterprising man and would be able to work out an adequate solution.

I instructed mother to continue to stay out of the kitchen. Then I discussed at length with Debbie and Barry what and how they might cook. Father indicated that whilst he didn't mind them doing the cooking he didn't really care for their food. I then suggested to mother and father to meet after work, go out to eat and leave the children to fend for themselves. The parents thought this a reasonable

suggestion, whilst the children were delighted and thought it was fantastic. They were really excited about the prospect of having the run of the house, and said they were sorry they hadn't come to a family therapist earlier.

Third Interview (2 weeks later)

All five family members living at home were present. They walked in looking very excited, saying "everything is very good, fantastic". There was no suggestion of any digestive problems during the last two weeks. Furthermore, Debbie had eaten like a glutton and gained 10 lbs. I said, "I find this difficult to believe, it's impossible — nearly 1 lb. per day". Father and Brian reassured me that this was perfectly correct. They weighed Debbie every day. They indicated they may not know about psychology and all that mumbo jumbo, but being scientists they know about weight.

Brian said he couldn't understand it. To begin with he didn't know there was such a serious problem. He asked me if it was so serious, then how had the improvement come about, what had happened? I suggested he re-direct this question to the family. Debbie took over and said:-

1. "I had my exams so I was too busy to worry about food."
2. "As I was cooking my own food I had to eat it."
3. "Things were better because mum was out of it."

The family talked at some length about the first point, but didn't appear to have heard the last two points. I indicated this to them and asked them to talk about the other two comments Debbie had made. I further suggested, that whether you eat your mother's food or your own, may be seen by some people as symbolic of dependence or independence. Debbie said, "Yeah, I guess so — I guess wanting to cook my own food means I want to become independent." The discussion seemed to mean more to mother and she queried if I thought Debbie wanted to be freer of her. Again I directed mother to check directly with Debbie. Debbie acknowledged that she wanted more freedom.

Throughout all this father kept repeating that the changes in Debbie were not just to do with digestion and food. She was a changed person. She had a big smile on her face, was happy and chirpy. He said in many ways the experience of therapy was very moving for him. Somehow he conveyed to me that therapy was much more important to him than he would say.

The family all agreed that there were changes in the whole family. There was a happier atmosphere at home, and they talked more freely to each other. They all agreed that Brian had missed out by not being involved till now.

I then said, "It's all very well but I'm still rather worried that the changes occurred too fast and you may not have considered the consequences." I asked now that the exams are over, whether Debbie would start worrying about food again. In jest, I suggested that maybe the parents, being in education, might organise exams for Debbie during the holidays. Debbie assured me that her problems would not recur. I asked how she could be so sure. She said she knew. I said she sounded confident, why so confident? She said she was confident, because she felt confident, because she knew. I said I was worried that soon Debbie would get her period back and this might cause more problems. Again I was reassured that it would be alright. I then suggested that now Debbie was eating, she would develop and fill out and become an even more attractive young woman. Young men would start noticing her and want to take her out. All tried to comfort me.

Father said that he had no problems with his sons, so he couldn't see why he should have a problem with his daughter. I suggested it may be different with a daughter, than with sons — but he was adamant that all would be well.

Mother then said, "It's all very well, but I'm still missing my kitchen — can I go back?" I said that I would hate to deprive her of something that meant so much to her. Addressing the whole family, I asked whether mother's return to the kitchen and cooking would lead to Debbie feeling that she had lost her newly-found independence and that her problems would return. Again I was reassured by all that it would not happen.

Debbie in fact said that the holidays were coming and she had better things to do than have anorexia. Brian said that if she had problems again she should come to him, not to mother because mother worried too much.

They all agreed that at this point there was no need to continue to come. Brian wanted to know whether I thought they would need to come back in the future. I suggested that one never knows. In my experience sometimes resolving one problem leads to the emergence of others and if so, then they may need to come back. A firm agreement was made that if any past or new problem arose they would come back.

I asked the family's permission to show the video tape of the first interview for teaching purposes — they all agreed. They said they would like to see the

first interview themselves. I offered to make them a copy, send it to them and then after reviewing it they could change their mind about this permission. This was accepted enthusiastically. Prior to giving permission father asked whether people involved in education are likely to see the tapes. I said yes. After thinking for a while, he said, "Come to think about it, I came out rather well. Didn't I?"

I wholeheartedly agreed and added that this was true for him and the whole family. Father also said, "To tell you the truth, before we came, I didn't think we'd tell you the truth. In fact 95% of what we told you was the truth." I said I was sure this was much more than in most cases.

I asked the family if it would be alright to send them a follow up questionnaire in a few months, if I hadn't heard from them. They agreed.

COMMENTS ON THE SECOND AND THIRD INTERVIEWS

The second and third interviews can be seen as representing primarily, a continuation of the major interventions started in the first interview. A few minor adjustments and refinements were made after the outcome of the homework tasks was reported. The main new themes introduced in these sessions were:-

1. That of warning the family about changing too fast and recommending a slow down (Palazzoli et al 1978).
2. My decision to describe myself as anxious and worried about these fast changes, since they could have dangerous and unknown consequences. Thus an interesting reversal occurred. Before therapy the family was worried and came to the therapist for reassurance. He offered reassurance and they failed to be reassured. By the end of the therapy, the therapist was the one who worried and the family was doing the reassuring. The therapist failed to be reassured, and the family increased and magnified its attempts at reassurance and so on.

My decision to make the above interventions was for a series of interrelated reasons.

1. I **was** anxious about the very fast rate of change and the possible consequences and I **needed** reassurance.
2. By choosing to express my anxiety, I was probably expressing the covert worries and anxieties of the family.
3. By my choosing to be the worrier, it made it difficult for the family to have any role but that of being confident and capable.
4. The symptomatic improvement as a result of the original homework task could be understood as partially paradoxical — "defiance based" (Papp 1980).

Thus telling the family to slow down was building on what I believed was a successful form of intervention.

Follow up

As I hadn't heard from the family for three months I sent them the follow up questionnaire*. It was returned with a letter from mother. These are reproduced in full.

QUESTIONNAIRE
PLEASE INSERT NAME OF RESPONDENT

A.	FRED						
B.	MARY						
C.	BRIAN						
D.	BARRY						
E.	DEBBIE						
F.							

1. The presenting problem/s or complaint/s.

COMMENTS	A.	B.	C.	D.	E.	F.
Much worse						
Moderately worse						
Slightly worse						
Just the same						
Slightly improved						
Moderately improved			✓			
Greatly improved	✓	✓		✓	✓	

2. General relationship in the family.

COMMENTS	A.	B.	C.	D.	E.	F.
Much worse						
Moderately worse						
Slightly worse						
Just the same						
Slightly improved						
Moderately improved			✓			
Greatly improved	✓	✓		✓	✓	

3. Now looking back we are:

COMMENTS	A.	B.	C.	D.	E.	F.
Very displeased we came						
Slightly displeased we came						
Just the same						
Slightly pleased we came			✓			
Moderately pleased we came	✓			✓		
Very pleased we came		✓			✓	

* This follow up questionnaire was developed by Moshe Lang in 1979. This, however, is the first time it appears in print.

4. Quality of relationship between the therapist and family was:

COMMENTS	A.	B.	C.	D.	E.	F.
Very poor						
Moderately poor						
Poor						
Neutral						
Reasonably good						
Moderately good			✓	✓	✓	
Very good	✓	✓				

5. Family therapy sessions were:

COMMENTS	A.	B.	C.	D.	E.	F.
Very painful						
Moderately painful						
Slightly painful						
Neutral						
Slightly enjoyable						
Moderately enjoyable						
Very enjoyable	✓	✓	✓	✓	✓	

6. The general functioning of the family today compared with when you came has become:

COMMENTS	A.	B.	C.	D.	E.	F.
Much worse						
Moderately worse						
Slightly worse						
Just the same				✓		
Slightly improved	✓	✓	✓		✓	
Moderately improved						
Greatly improved						

7. If we encounter serious problems in the future which we could not deal with we would feel:

COMMENTS	A.	B.	C.	D.	E.	F.
Great hesitation in coming						
Moderate hesitation						
Slight hesitation						
Neutral						
Slightly confident			✓			
Moderately confident				✓		
Very confident in coming	✓	✓			✓	

8. Our ability today to deal with or cope with problems has become:

COMMENTS	A.	B.	C.	D.	E.	F.
Much worse						
Moderately worse						
Slightly worse						
Just the same			✓	✓		
Slightly improved	✓				✓	
Moderately improved		✓				
Greatly improved						

LETTER FROM MRS. LAMB

Dear Mr. Lang,

At last everyone has got around to filling out the questionnaire! Debbie's recovery has been spectacular — she now weighs just under nine stone and there is absolutely no mention of any digestive problems. Over the Christmas vacation, she had the opportunity of going away for a few days on several occasions (without any of us) — this may have helped. She has her monthly period again — a fact which she appears to have accepted quite nonchalantly (and which I did too). She has settled into her H.S.C. year and was elected a school leader — this gave her a great boost. Although I see the problem no longer existing, I remember your saying that you might have occasion to see us again. So far, so good — I hope all continues well.

Thank you for your help — apart from the fact that our visits with you have obviously been instrumental in solving ***the*** *problem, we found the experience interesting and in many ways very rewarding. Having had no experience in this field before, we probably started out with a rather non-committal attitude towards the idea of therapy. In fact, you will probably pick up from the questionnaire responses, that we see ourselves as not being in great need of family therapy! Hence the fact that our immediate problem was so suddenly reversed is a source of surprise and wonder to us. I suppose what I'm trying to say is that we (or at least I) view the area of psychological medicine with more respect!*

Thank you Mr. Lang — I hope you won't have to see us again, but if the necessity should arise, I will not hesitate to contact you with confidence.

Yours sincerely,
MARY LAMB

DISCUSSION

It would be possible to discuss at some length the family's response to the questionnaire and mother's letter. I choose not to do so primarily because it is self evident. But, I wish to draw particular attention to the fact that there is total consensus. All five members experienced the family therapy sessions as "very enjoyable". I find this very pleasing. There is a deeply held myth amongst professional and lay people, that therapy by definition "must be painful to be useful". I have never shared this belief but rather think that more often outcome is favourable when therapy is lively, engaging and enjoyable. The question whether or not Debbie was suffering from anorexia nervosa, was not at any stage discussed with the family or in this paper. This avoidance was deliberate.

The family defined Debbie's problem as:

a) UNDER EATING — losing weight
b) INDIGESTION

This definition has sufficient precision and specificity which in no way would be enhanced by a diagnosis of anorexia nervosa or not. Further, such a diagnosis would not alter my theoretical understanding of the problem, or my practical management of it (Haley 1980).

Diagnosis may imply aetiology, causality, linear thinking, an implication that things happened in the past to cause anorexia. As a family therapist, I do not ask such questions, but rather "What is there in the structure and interaction within the family that maintains the problem?"

In this family, Debbie's symptom was embedded in the mother-daughter relationship. Father was on the periphery and all others were excluded. Therapy changed this structural arrangement of the family, by disengaging mother from involvement with her daughter vis-a-vis the symptom, and increasingly involved the three other family members who were previously uninvolved.

The mother and daughter's involvement with Debbie's symptom increased their mutual anxiety; the realignment within the family blocked this interactive pattern. Thus when the structure and interaction, that are assumed to maintain the symptom, were changed, the symptom disappeared.

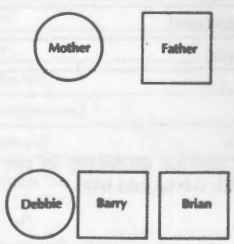
The only time Debbie was criticised by either parent was when father suggests that she could help mother more. Everyone working with anorexics knows that often they take over the kitchen completely, to the annoyance and detriment of other family members.

It was the relative freedom from any diagnostic considerations of anorexia nervosa that curiously and perhaps ironically allowed me to prescribe a "missing symptom" (taking over the kitchen) as part of "the cure" for "the illness".

Immediately after the first session I made a symbolic drawing of the family (reproduced here). Gedes and Medway (1977) described "the symbolic drawing of the family life space". From them I borrowed the component of distance. The idea of the size component is mine. I have used this technique for years and at times have found it very useful.

SIZE: Each person's size indicated the amount of space each occupies in the life of the family. Thus, this diagram shows Debbie and her stomach to be taking the major space in the family, mother comes next and father occupies relatively little space and the brothers are barely noticed.

DISTANCE: This distance between people in the diagram represents the psychological distance between them. The overlaps represent the degree of enmeshment or over involvement. Debbie and mother are very close, in fact they show a mild to moderate degree of enmeshment. Mother is between Debbie and father. Whilst in retrospect it seems Debbie and her stomach came between the parents — this is not shown on the diagram. Father is on the periphery and the brothers are beyond the blue horizon.



The aims of therapy are represented in this drawing. Being two dimensional it has many short-comings. However it draws attention to the following:

1. Family members to occupy similar psychological space.
2. Increased closeness between Mr & Mrs Lamb both as husband and wife as well as parents.
3. Increased closeness between the siblings. Debbie to be further from her parents and closer to her brothers — thus there would be an appropriate separation between the generations.

It is widely assumed that therapy needs to be long, and that quick results cannot be trusted.

One of the main reasons for writing this paper is to present a case of family therapy where a quick and satisfactory resolution of the presenting problem occurred (Lang and McCallum 1980).

There is little reason to doubt the reliability and stability of the symptomatic improvement in this case, or the general improvement in the life of the patient and her family.

How can this rapid cure be accounted for and understood?

a) The family had many strengths and assets:
Father's willingness and desire to involve himself with his daughter and family — even though he may have been on the periphery. Father's relative lack of anxiety. He may have been under-involved with his daughter in relation to her symptoms, but he was obviously a caring and responsible father.

Mother was a very capable person and though over involved with Debbie still had her own life. Her ability and willingness to go against her local doctor is evidence of her strength. Her ability to carry out her homework tasks was very impressive. Some colleagues were anxious and critical of the homework tasks I gave mother. Their anxiety was that I placed excessive demands on her, greater than on any other family member. The homework task required her to relinquish her habitual role of housewife and mother, thus, perhaps, creating a vacuum which she could not fill, possibly resulting in her becoming depressed. However, I believe it is better to assume that a person is — psychopathologically speaking — innocent until proven guilty. The reverse is unfair and may even be destructive. Mother saw herself as a strong and capable person, an assessment which I totally agreed with. Thus expecting her to be able to make good use of her free time seemed to accept and respect her definition of herself. She had stated that for their serious problem there was no "easy remedy". Thus she expected that "the cure" would require hard work and difficult adjustments.

Debbie's strengths have been mentioned. In general she had many assets, such as her academic and sporting success, her many friends and social interests, determination and intelligence. The brothers were caring and interested. The outcome of therapy was favourable because it emphasised family strengths and made use of them. The major interventions in therapy were based on the family's own ideas and wishes. It was also helpful that the family had basically one problem, was able to define it appropriately, wished it changed and expressed this wish clearly.

In general I find it a good prognostic sign that the family expressed a wish for behavioural change, rather than requested understanding (i.e. "Why does she do it?") or validation ("Don't you think I'm right?") or arbitration ("Who do you think is right?"). Possibly the dramatic response to therapy was also greatly facilitated by the fact that this was their first encounter with therapy. It is important to note that after the completion of therapy, little is known of the general life of the family. There is often a temptation to embark on a series of unnecessary questions.

However, ideally, therapists should not seek any information unless they can justify to themselves and the family that it is indeed necessary for the task at hand. In this case the family provided sufficient information with which to work and to make interventions that facilitated change.

At first I was keen to check with the family that all was well, and to invite them to read this article and make comments. I decided against this because I felt certain that they wanted to put this episode behind them and go on with their life. This family seemed to be present and future orientated and this tendency not to dwell on the past may partially account for the fact that I know little or nothing about their past life.

In conclusion this family came with a fairly serious problem which they could not resolve. They asked me to help in its resolution. The problem solving approach used with this family is clearly what they requested and was thus respectful of their wishes. The fact that there were additional gains that they didn't bargain for was their good luck — though perhaps predictable from a family therapist's perspective.

INTRODUCTION TO COMMENTARIES

The advent of the video tape provides new opportunities in the exploration and study of the psychotherapeutic process. It offered the authors the opportunity of repeated viewing and thus careful examination of the verbal and non verbal behaviour. As a result, interactive sequences, gestures, nuances and subtle changes were noted. It was possible for different professional groups to view the video tape, ask questions, and make comments. This helped to enrich and stimulate the authors' thoughts. This constitutes the background to this paper.

Discussion, debate and further exploration of any psychotherapy paper may take a qualitative leap forward if use is made of the corresponding video tape. Then comments on the written work can be made on the basis of this "raw data". It was with this in mind that this paper with the video tape was offered to a number of colleagues, inviting them to comment.

J. Milgrom-Friedman*

Having read Moshe and Tesse Lang's article and seen the video tape, I was intrigued by the question, "What was the mechanism of change?" Related to that question is a second one, "Would different therapists have intervened in the same way?"

In order to speculate about the answers to the first question I will briefly outline some of the interventions carried out by Moshe which struck me as especially potent. To deal with the second one I will, to a lesser extent, comment on where I might have been tempted to intervene differently.

At the outset I was taken with the way Moshe 'set the scene' for the family interview. Not just by making it clear that fathers are important, but by his individual manner. Moshe speaks very softly, so that maximum concentration is required to hear his words. There is a feeling that each word is very precious, not to be lost. He is also unassuming and casual, voicing his uncertainties and limitations ("I need the video because I cannot remember all that happens") and speaking as another human being rather than as "the expert". I wonder whether this model of quiet power was important in a family dominated by Debbie and her eating problems. Moshe turns to Debbie intensely initially, focussing on what she says, full of attention. When it is her parents' turn and she interrupts, he quietly ignores her; she is not allowed to take all the space. Moshe is also comfortable with prolonged silences; again in contrast to Debbie's behaviour. Nonverbally, alternative structures for the family's functioning are being demonstrated.

Early in the first session Moshe accepted the family's choice of Debbie as "the spokesman" and showed a remarkable ability to avoid being sidetracked. As Debbie related the history of her symptoms and her eating behaviour he avoided probing at length her comments about 'psychological disease' or 'mum suppresses me'. He takes these points up later in the interview, at his choice, and when the whole family is in on the discussion.

I was interested in how Moshe eventually dealt with the family's diagnostic indecision: 'Is it physical or is it psychological'. As he points out, very often families such as these have difficulty comprehending the proposition of psychosomatic illness. Rather than helping them understand the concept, Moshe latches on to their wish to 'have it cured' whatever it is. Thus he has avoided a potential struggle between therapist and psychosomatic patient in which I have often found myself involved. Refusal to accept the concept can lead to refusal to be involved in therapy.

There were other times when Moshe demonstrated his indirect approach. For instance, although he notices that Debbie interrupts father when he is talking, Moshe does not confront this behaviour, and turns his attention to Debbie as she demands. Only in the homework task do we see Moshe's handling of this problem by giving mum and dad time away alone, and dad and Debbie time together.

Finally the most critical intervention, as I saw it, was the setting of the homework task two (no housework for mother). Out of the many options available I am still uncertain (and fascinated by) what it was that made Moshe choose that specific one. I believe that a lot of the success of therapy revolved around the importance of this task in restructuring the family. Yet until the end of the interview we heard little about mum doing all the cooking. Moshe had talked of mother's over-involvement with Debbie's symptoms; of how the family doesn't fight or over "interact" — many alternative homeworks suggest themselves. Perhaps Moshe was influenced by his theoretical orientation — the enmeshment described by Minuchin for psychosomatic families and Jay Hayley's concept of an over-involved parent. Undoubtedly those mechanisms were operating in this family. But was the homework primarily based on a theoretical rather than session-content basis?

The above observations clearly do not attempt to fully answer the questions raised in the introduction, but perhaps cast some light on some of the important variables that I believe to have influenced outcome. In summary, they were to do with Moshe's style, his dealing with the concept of 'psychosomatic', his indirect interventions and his choice of homework tasks. I would also like the opportunity to comment that I found Moshe's boxed statements on the transcript which were retrospective analyses of why he chose to say certain things at certain points in time, very revealing. More therapists should attempt that exercise which reflects the framework being used and the decision-making process.

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Aija Wilson*

I think this is an elegant piece of work both the interview and the interventions. As Jay Haley (1976) puts it; "If therapy is to end properly, it must begin properly — by negotiating a solvable problem and discovering the social situation that makes the problem necessary".

To be able to do this the therapist needs to interview the natural group in which the problem is expressed. Thus, when Moshe Lang received a call about an adolescent with a problem, he invited all the family to be present and emphasised that father was necessary too. One might hypothesize before this family's arrival that the adolescent could need help to disengage from the family. The therapist must bring people together to help them individuate (Haley 1976).

This girl's problems began with an exaggerated response to dieting; withdrawal from food became a way of being in control of her life. She admitted that she did not really see herself as too fat, but that she wanted to do something just to prove that she could do it — to show that she had a strong will.

At this stage her body was changing, becoming curvy and taller, taking on the shape of a woman. She was changing in a way over which she had no control.

Debbie refused food long enough to lose two stone in weight, making her quite thin, straightening out her curves, stopping her menstruation and also causing her to become quite weak. As

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Orbach (1978) a feminist puts it — "Anorexia reflects on ambivalence about feminity, a rebellion against feminisation that in its specific form expresses both a rejection and an exaggeration of the image". So, paradoxically as she exerted her will she became physically weaker.

Then Debbie heard a comment from one of her brother's friends that she was ugly and began to eat again. However, before regaining her normal weight, she got "stuck" and developed a problem of indigestion or "slurping stomach". Debbie seemed as if she was in control of herself, yet rarely made an "I statement", even when allowed the opportunity by her parents to speak for herself. She continually turned to her mother for support of her description of the problem. From another perspective this mother, who, had an outside job and did most of the housework and cooking for her near adult family, provided a strong model for her daughter or as Palazzoli (1974) described the mothers of anorexia patients — "Ladies bountiful completely dedicated to the good of others".

The experienced therapist seeks to devise a method of intervention that is suited to the particular needs of the family. The intervention that Moshe Lang makes is multi-level:

a) Strategic or paradoxical
   i) in that he arraigns one symptom against another as he has already observed that the girl is both oppositional and obsessional.
   ii) he prescribes the symptom of obsessionability by asking her to note down the details of her stomach's symptoms.
   iii) he asks the family to slow down the rapid rate of their improvement.

b) Structural — in that he reorganises the relationship between the members of the family. He draws daughter and father into an alliance.

Palazzoli (1974) also advises that this type of alliance be only temporary and great care be taken that it is not destructive to the mother, who may feel excluded and then become depressed or hostile. The ultimate purpose of this type of intervention is to open the generation gap, so that the daughter may at long last start living her own life.

Despite the mixed comments of observers of the tape, it is clear that this restructuring of the family worked out well. Mother was not offended and was enabled to do less work and also be less involved with her daughter. Debbie made only partial use of her father and discovered a great opportunity to begin taking over in the kitchen and exerting her own growing independence.

Thus the family as a whole was freed from its "stuck" position in its life cycle at the same time as Debbie was freed from being "stuck" with her slurping stomach. Mother may revert to her hard work again but it can never be quite the same once her daughter has begun to exert her independence in a healthy fashion.

Michael Jonas*

Having the opportunity of viewing a videotaped session and then reading the therapist's comments and discussion is a new experience for me. It overcomes one of the major questions when reading clinical papers: How much of the process in the actual interview has been suppressed or distorted to support a particular thesis? I am pleased to be able to attest to the accuracy of the edited transcript supporting wnat I see as an elegant piece of therapeutic work, neat in execution and persuasive in formulation.

There are several points in the discussion section of the paper which I would like to comment on:

1. Moshe highlights the importance of enjoyment in therapy. While eschewing the myth that therapy must be painful to be useful, it is, I believe, equally important to beware colluding with undue comfort if this involves conflict avoidance. Perhaps outcome is most favourable when sessions are regularly lively and engaging, sometimes enjoyable, sometimes painful but always intense and exciting while negotiating the pathway between pleasant avoidance on the one hand and excessive pain on the other. This has been nicely achieved in the first session with this family. All members expressed and exhibited some pain during the session, with Moshe at times deliberately escalating stress, but in an atmosphere of acceptance and good humour which contained the "pain". It is probably his skill in such containment which resulted in a retrospective perception of the sessions as having been "very enjoyable".
2. With regard to the question of diagnosis:

Whilst diagnosis does imply aetiology, I do not see it as necessarily involving linear thinking. Therapy would not have been possible without some family diagnostic formulation, in this instance using the structural paradigm. And non-linear aetiology is implicit in the multi-generational diagnostic view taken by the psychodynamic family therapist. At the same time diagnosis of the individual is incomplete without considering family context in terms of genesis and maintenance within the system. Diagnosis in this sense is imperative in assessing prognosis, natural course, treatment of choice, nature of intervention within this treatment model and especially research. If then one does view Debbie from such a diagnostic framework there is little doubt that, in terms of symptoms and signs, she suffered from anorexia nervosa. It seems her condition had undergone spontaneous improvement prior to her development of the "slurping stomach" and thus was not typical of the embedded pathology with which anorexia nervosa so often presents clinically. In my experience the symptom picture is frequently embedded in an individual with borderline personality structure and/or embedded in the typical "psychosomatic family" as described by Minuchin (1978). Debbie's individual ego resources allowed spontaneous improvement prior to therapy and her family, as seen in the initial interview, lacked the rigidity and high degree of conflict avoidance which Minuchin describes in his families. Though at the time of treatment some enmeshment and over-protectiveness were evident, these were relatively mild and responsive to fairly simple structural moves.

Viewed from an individual diagnostic viewpoint, a significant improvement in ego functioning and shift to more healthy defenses had already taken place with change in the clinical picture from that of anorexia nervosa to that of "indigestion". The "slurping stomach" can be viewed as a conversion reaction (polydipsia? aerophagia?) or psycho-physiological G.I. reaction (gastric hypersecretion? disturbed gastric motility? pylone sphincter dysfunction?). Experience has shown that either diagnosis implies a better prognosis than classical anorexia nervosa at the time of clinical presentation. It would be unfortunate if readers of the paper were to conclude that the typical anorexic patient and her family could so rapidly be helped if only the right intervention were employed. I know this is not Moshe's belief and that he shares my concern that

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dramatic cures of various types can be mis-used to buttress claims of universal effectiveness for brief therapy, be it family therapy, individual therapy, hypnotherapy, or pharmacotherapy.

In Moshe's understanding of the rapidity of the cure, I believe he has correctly isolated some of the factors. I would like to emphasise absence of rigidity and fluidity of family pathology as important additional features. It seems likely to me that the family took the opportunity through therapy to crystallise a resolution which had already been under way when the anorectic symptomatology changed.

Moshe points out how little is known of the general life of the family at the completion of therapy. This, together with our ignorance of the family's past history, makes a detailed diagnostic formulation impossible. And I agree that such knowledge is academic in view of the effectiveness of the therapy without it. Having identified certain structural diagnostic characteristics (e.g. enmeshment) and making a partial diagnostic formulation, Moshe was able to intervene effectively. The response to the intervention confirmed the formulation and allowed further, though still limited understanding. Treatment ended successfully before a full diagnostic formulation was possible. Had the first structural moves failed, therapy would undoubtedly have extended over more sessions and a fuller formulation would perhaps have been necessary to govern subsequent therapeutic strategy. I wonder if this is perhaps generally true: In the case of complex psychopathology, the more effective and brief the intervention, the less one has opportunity to explore in depth the nature of the process underlying the pathology, and hence the greater the danger of naive generalisation about the universal effectiveness of brief intervention.

This paper impressively exemplifies the benefits of sensitive focal intervention using the structural model. Whilst fully acknowledging this, my discussion has also alluded to the dangers which could arise if the material is viewed out of diagnostic context.

David Bathgate*

This interview, the follow up and the successful outcome demonstrate with elegance and admirable but deceptive simplicity, the power of the family therapy approach, particularly when the therapist is both skilled and committed. The combined effects arising from viewing the videotape and being able to peruse the script afford a valuable opportunity to learn from and share in the therapeutic process; not the least of the benefit derives from a concurrent reading of the therapist's reflections on his own work.

I would like to confine my specific comments to three points only, recognising that much of a positive nature could be said.

i. Firstly, I felt the most important process therapeutically was that displayed in the careful and sensitive work of distangling the confusion of symptoms, feelings and responsibilities, work which occupied the greater part of the first interview. This work restored, to each of the family members present, an increased sense of their own individuality (**this** is mine and **that** is yours, not "first up, best dressed"). This separation and definition of boundaries prefigured and made possible the assignment of the home work tasks, which flowed on naturally from the previous work.

Secondly, the sense of optimism with avoidance of power struggles, especially those related to labelling, conferred on the hitherto demoralised family, a sense of hope. Jerome Frank, writing late in his professional life, reached the view that the single most important positive ingredient in therapy was the instillation of hope in those seeking help. Lastly, I believe that the frequent struggles between families with a symptomatic member and the medical profession, involves complex, deep issues, both political and philosophical.

ii. Those suffering apparently physical troubles turn to those considered to be skilled in treating such troubles (medical practitioners). It is my experience that patients press for a physical diagnosis, much preferring it to the psychological or psychosocial; it is in effect a physical signal concealing a non-physical stress situation.

iii. The psychosomatic diagnosis is the now traditional medical way of saying, "It's not in my (physical) sphere of competence" — and heretofor doctors have received little if any training in a systems approach to such problems. What the family often rejects in my experience is the implication of non-physicality. So a struggle ensues over the issue of "to what category should this (symptom/symptom bearer) be assigned?" However, both categories (physical and psychological) for the purposes of the struggle, belong to an either-or logical system and are on the same logical level (the implied moral level — who's responsible?). The therapist knowingly and expertly makes his interventions in a higher-order category, moving from the causal-moral position to no-fault, let's-all-try-an-experiment position. By implication, this category includes all family members and the adversary position, vis a vis family members or client/patient/family versus therapist is transcended in a co-operative venture.

iv. The doctor's role in medicine reflects the families' (and societies') concern with the "really real". For our culture the real has the quality of thing-ness ("reality" and "res" = a thing/things have a common derivation). The family support this and give Debbie's stomach a life of its own. The therapist's gentle debunking aids a category shift.

Michael White*

Moshe's transcript of and comments on the first family interview with the Lamb family make a significant contribution to Family Therapy literature. Rarely do experienced clinicians make publicly available an entire transcript of an interview with a family. This transcript clearly demonstrates certain essential stages in Family Therapy and documents some of the struggles of an experienced therapist in his attempt to join, map and intervene into a family system.

Moshe pays careful attention to eliciting each family member's view of the problem and gathers some history about the family members' involvement with the problem. It is clear that, for whatever reason, family members have organised themselves around Debbie's symptoms; in the first place her anorexia nervosa and in the second, her slurping stomach. These symptoms dominate life in the family above all other considerations and provide an ever present concern.

One of the first major shifts that takes place during this interview occurs when Moshe, after listening to family members struggle with each other and themselves over the nature of the

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symptoms, says, "If I hear correctly, I hear you struggling with yourselves as individuals and as a family to come to terms with — is it physical or psychological or what the hell is it?" This explicit comment on process has the effect of enabling the family members to abandon the struggle and together lobby for a cure, regardless of the exact nature of the problem. It is often tempting for therapists, when dealing with psychosomatic conditions, to accept considerable responsibility in proving to family members that such symptoms are not physical, but psychological, emotional, or interactional in origin. When this occurs, therapists find themselves having to work extremely hard to convince family members of the correctness of their argument. Unfortunately, charged with this responsibility, the therapist finds all of the onus for change on his shoulders as he attempts to provide the energy to produce the changes required, rather than have the family argue for such changes. Moshe's intervention sidesteps this impasse and family members unite and argue for change regardless of the origin of the symptom. This is the point at which members of the Lamb family become committed to therapy.

Moshe then proceeds to comment on the enmeshment and overprotection in a sensitive manner. He supports these observations by 'here and now' evidence which is difficult for family members to dispute. He then challenges this enmeshment in a variety of ways.

A little later in the interview I am reminded of what Murray Bowen has said about the "Undifferentiated Family Ego Mass" (Bowen 1976). This family has an undifferentiated period and Moshe skilfully intervenes at this point in an attempt to break up the enmeshment or fusion. He says, "people don't have it, women have it".

Moshe then identifies and explores the sequence within which the symptom of the slurping stomach is embedded. A certain sequence surrounding Debbie's symptoms then becomes evident. Analysis of the sequence is enlightening. Debbie and her mother appear stuck in some sort of vicious cycle. Debbie invites her mother to help her with her problem of having liquid in her stomach. However, all of Mrs. Lamb's attempts to deal with the problem fail and this eventually results in considerable frustration for her. Mr. Lamb is somewhat peripheral to this sequence. I am left with the impression that no-one is quite able to take responsibility for Debbie's symptoms, including herself. She attempts to give the responsibility to her mother, and when she attempts to take over Debbie quickly defeats her. (This punctuation is, as is all punctuation, artificial. For example, it could be asked, "what signals Debbie to consult her mother about her symptoms?" etc.).

This repetitive cycle would suggest that certain contradictory injunctions prevail. It could be speculated that these include injunctions at a covert level that Debbie must keep including her mother in her life as a mother, and injunctions at an overt level demanding that Debbie grow up and be in charge of herself. As these injunctions are on different levels and are contradictory, they could be seen to contribute to a paradox and thus an impasse. Such a "bind" would undoubtedly lead to the perpetuation of a "symptomatic cycle" in which Mrs. Lamb and Debbie must take charge of the symptom and not be in charge of it simultaneously.

Later in the interview, Moshe focuses on "fights", enabling him to comment on how Mrs. Lamb avoids conflict with other family members and how she is always ready to take responsibility for others. Mrs. Lamb then denies this. This appears similar to the above-mentioned sequence but implicates other family members as well as Debbie.

I was impressed by Moshe's comments about popular notions regarding the causes of anorexic symptoms, especially those related to the notion about such conditions being caused by parents and particularly so by mothers. Moshe chooses to explicitly broach the subject and at the same time strategically uses this opportunity to comment on Debbie's protectiveness and parent centredness. I have found in my work with anorexic families that this is a very important issue and needs discussion. Frequently at the point of referral, parents have had access to some of these popular notions and this usually serves to reinforce their feelings of guilt which provokes them to work harder to rescue and help their daughters. This is clearly a counter-productive solution as it increases devoted and loyal behaviour and feelings of indebtedness on behalf of all family members and thus escalates the enmeshment and over-protectiveness. Moshe makes light of this popular myth, non-vervably indicating that it should not be taken seriously. He then draws attention to the mutual hypersensitivity within the family with comments such as those relating to how when one family member worries, all worry.

Moshe introduces a homework task that encourages Debbie to monitor, and thus take more responsibility for, her own problem, engages the somewhat peripheral father and excludes the over-involved mother. This first part of the homework task is designed to restructure the family via a focus on the symptom. He then introduces an experiment in which Mrs. Lamb is required to move away from her central switchboard position within the family. Whilst Debbie and Mr. Lamb appear somewhat enthusiastic about this task, Mrs. Lamb shows some resistance. Moshe suggests a compromise and then attempts to enlist Mrs. Lamb's support for the task. He then challenges her as he throws a question mark over whether or not she can undertake the task. Mrs. Lamb then again resists the task and Moshe counters this by telling her that it would be very significant for him if she was unable to follow through with the task and thus not be able to change. This is one of the most important interventions during the task-setting section of the interview. By saying that it would be highly significant if Mrs. Lamb did not succeed in the task, Moshe is throwing out a challenge to her and implies that such failure would cement certain speculations. Moshe then closes the session by arranging another appointment and emphasis again, "I'll be very, very interested in what happens as a result of what I asked you to do."

Apart from the structural re-arrangements that are likely to occur upon the successful completion of the tasks, it could also be considered that the earlier mentioned covert injunction requiring Debbie to keep her mother involved in her life is effectively countered by such a task that explicitly requires family members, including Debbie, to exclude Mrs. Lamb from two major areas of life in this family. After viewing the video tape and reading the transcript I am impressed with Moshe's sensitivity to the process during the interview. He challenges the family in ways that are not abrasive to the members, organises his material so that family members experience a new and different reality relating to the symptoms and family organisation, and provokes the family members to argue for change in a constructive direction.

ACKNOWLEDGEMENTS

We wish to thank the Australian Journal of Family Therapy for accepting this paper for publication with the full transcript of the first interview. We are grateful since we strongly believe that the retention of the full transcript made it possible to bring this interview to life.

Increasingly it has been argued that the language of change and of psychotherapy is the language of poetry and metaphor rather than the language of logic and science. It is the language of the right not the left hemisphere (Penman 1981, Watzlawick 1978).

To describe psychotherapy in the careful language of logic and science parallels the anorexic control that leads to self starvation and death. It is to impose a strict diet devoid of richness, subtlety, nuance and flavour. If in turn this idea of the language of psychotherapy is taken seriously — then the appropriate way to describe it is by retaining the full transcript. Leaving the richness of expression and metaphor used by all participants, which also includes the use of "bad" English. It is amazing how often when we resisted the temptation to correct the spoken English, we were able to discover the importance and significance of their phraseology. It appears that in conversation, good and correct English imposes restrictions on full expression. Even if this idea is not valid it at least provided some comfort to the authors.

The philosophy that assumes the best way to understand Debbie's slurping stomach is by studying the social context in which it occurs, must assume that this paper cannot be the product of one or two minds. In fact it is the product of lengthy ongoing interaction between the authors, and between them and other friends and colleagues. We wish to thank all those people in Australia and New Zealand who shared their thoughts, comments and queries with us.

It is often forgotten how difficult and painful it is for most families to take that first step of seeking help from a psychotherapist. It is more difficult still for them to agree to the interview being video taped, to talk about themselves openly and co-operate with the therapist. The final difficulty of actually consenting for the videotape to be shown to professional audiences must be enormous. For all of this our deepest thanks go to the Lamb family.

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