Enduring Change in Eating Disorders

- Interventions with long-term results

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http://www.intensivestructuraltherapy.com/eatdisordbook.htm

Chapter 3

IST: Basic Concepts

"**You know that after the therapy that we did the anorexia has never returned."**
Herb, referring to his wife's anorexia that had begun forty years before.

The Intensive Structural Therapy (IST) model is described in detail in my 1993 volume, *Intensive Structural Therapy: Treating Families in Their Social Context.* The brief summary that follows is designed simply to introduce the basic concepts, which are elaborated in the earlier book and—more importantly—throughout the cases that are described in this book.

The Importance of the Social Context

Intensive Structural Therapy has in common with all family therapies the principle that patients are seen in their social context. This approach is a profound shift from therapies in which the problem is seen as residing within the individual. The primary context that is focused on is the family—the nuclear family and often the extended family—particularly for the adolescent anorexics and bulimics described in most of the chapters in this book. The significant context includes all the people who are

influential in the person's life, however, and for older patients it is common to involve such contexts as friends, co-workers, and social agencies in the therapy.

Interactional Patterns

Unlike most family therapy models, IST follows the psychosomatic family model in focusing on specific interactional patterns that can be observed and addressed in the treatment room. The interactional patterns that characterize the psychosomatic families of eating-disorder patients are *enmeshment, overprotectiveness, rigidity,* and *conflict avoidance,* which may take the form of *conflict diffusion* or *triangulation.* Enmeshment is inappropriate closeness between family members gauged against a backdrop of they developmental stage. For example, the closeness between a parent and a 4 year old is much different when the child is 14. *Overprotectiveness* results when members of the family feel a tremendous responsibility for protecting the family unit. *Rigidity* in families means being heavily committed to maintaining the status quo and therefore having difficulty with inevitable periods of change and growth. In my experience with eating-disorder patients, *conflict avoidance* is a central characteristic that keeps these systems stuck. *Triangulation* is often a crucial dynamic in understanding eating disorders; when conflict starts to arise, a third person, often the symptomatic child, is recruited to activate to diffuse the conflict. Empirically, I have found a continuum: To the extent that there is conflict avoidance, the symptomatology is manifested; to the extent that conflict is addressed, the symptoms are controlled.

The Homeostatic Maintainer

IST also differs from other family therapy models in utilizing the concept of the homeostatic maintainer in assessing the family system. In the 1970s, Maria Selvini Palazolli and her colleagues at the Center for the Study of the Family in Milan did pioneering work with anorexia and family therapy. Their Milan systems therapy is unique in its description of the family as a rigidly organized homeostatic mechanism that remains resistant to change from any external factors. The therapist remains neutral, encouraging the family to become observers and challengers of their own treatment process.

Selvini depended heavily on the concept of family homeostasis but did not use the concept of the homeostatic maintainer. In her major work *Self-Starvation: From the Intrapsychic to the Transpersonal Approach to Anorexia Nervosa* (1974), she pioneered the concept of homeostatic systems in understanding anorexia: "I am absolutely convinced that mental 'symptoms' arise in rigid homeostatic systems, and that they are the more intense the more secret is the cold war waged by the sub-system (parent-child coalitions) (p. 239)."

Her concept differs from the one utilized in the psychosomatic model and in my work. What I don't see is the problem as wars between family members which imply conscious battles or even antipathy for that matter. Instead, I see the homeostasis of the system as being maintained by the emergence of the symptom. I don't see this as a conscious process- I often refer to it in my own mind as the 'sixth sense', this controlling force that affects us in systems but that we are not overtly conscious of.

As Selvini describes the process, “In other words psychiatric ‘symptoms’ tend to develop in family systems threatened with collapse; in such systems they play the same part as submission rites play in the animal kingdom: they help to ward off aggression from one’s own kind. There is just this tragic difference: the specific human rite, called ‘illness’ acquires its normative function from the very malfunction it is trying to eliminate.” (p. 239) In many ways this is what I have observed as manifested and maintained by specific interactional patterns. What is different in the IST model is the specific pinpointing of homeostatic maintainers, the forces that are leading to the maintenance of the status quo of these systems.

The term *homeostasis* has had a bad press in the last number of years, as connoting a linear process. I believe that family therapy orthodoxy has often led to paralysis in therapy. Everything in life is circular or linear depending on how one analyzes the periodicity of the sequences. In my experience, the reality is that certain forces and individuals in systems are more influential than others in keeping the systems stuck. I have found that identification of this mechanism serves to direct therapy as it provides a clear roadmap for the clinician. The next chapter will discuss in more detail how the concept is used in the model of treatment.

Grounded Observation

The utilization of grounded observation is key feature to both psychosomatic family theory and IST. By grounded observation I mean theory that is based on direct

observation of data. An anecdote from the work of the Philadelphia Child Guidance Clinic will illustrate the power of this concept and its use as a tool in therapy.

During the 1970s, when the researchers at the Clinic were actively treating many anorectics, a 13-year-old girl was referred from the adjacent Children's Hospital. She had been steadily losing weight, and when her doctors could find no medical reason, they concluded she must be anorectic. The medical psychosomatic team at PCGC did a family task test to see whether her family displayed the characteristic patterns of the psychosomatic family, such as enmeshment and conflict avoidance. The researchers reported that they found no psychological grounds for the child's continuing loss of weight. The doctors at Children's Hospital redoubled their diagnostic efforts and found that the girl had a pineal tumor.

That's almost science! Rarely in our fuzzy field of mental health are hard decisions made on such objective data. Grounded theory, originally described by Barony Glaser and Anselm Strauss (1967), mandates "the discovery of theory from data" (p. 1) in doing social research. Ian Dey, in his important book *Grounding Grounded Theory* (1999), compares this approach to the work of physicist Richard Feynman, who, he says, "believed in the accumulated wisdom of science, but never took it on trust" (p. xii). Similarly, in psychiatry it is necessary to find objective ways of getting data, not relying on what we are told in the therapy room. People say things for a variety of reasons, not the least of which is to please the clinician.

The area of mental health is largely a data-free zone. There are legions of theories and descriptions, but few that are based on direct observation that emerges from, at the very least, a semi-objective manner. Over the years, Grounded theory has diverged into

hotly contested versions, but for the purposes of this book I use my own version of grounded observation. That is, the theory has emanated from the observations of the clinical process as it unfolds in the clinical session. Whereas the fields of psychiatry and psychology are dependent on intangible data such as subjective affect for assessment and treatment intervention, the data that emerges in a family session are more objective, observable interactional patterns that the therapist can use as a guide to questioning and intervention. As long as the clinician remains decentralized and the family (members and other influential members of the system) talks to each other, the patterns that emerge are for the most part below the level of consciousness and therefore approximate what occurs at home. (I say "for the most part" because the presence of the therapist must constrain the family to some extent, but these patterns in these enmeshed families have their own compelling authority that produces patterned responses.)

The concept of grounded observation is central to my practices and indeed, of course, the work described in the remainder of this book. Before going on to the specifics of the model and the cases that follow, it will be worthwhile to examine closely some brief portions of a case transcript to bring out this essential technique. The case is one that I have previously reported in detail in *Treating Troubled Adolescents* (Fishman, 1988). In the segments that follow, I will focus specifically on how I use grounded theory with the psychosomatic family patterns. In addition, since I treated the family in 1980, I have the rare opportunity of reporting 20-year follow-up on a course of psychotherapy; after 8 months of weekly outpatient treatment, the symptomatic behavior had ceased, and the eating disorder had not recurred.

Dorothy: The "World's Oldest Anorexic"

Dorothy was 42 years old when I saw her. Dorothy presented with an eating disorder that, in addition to self-starvation, included taking laxatives – as many as one or two boxes of laxatives per day. A number of times, she was rushed to the emergency room in metabolic crisis. Her family consisted of her husband, Herb, her parents, and her two children, aged at the time 12 and 16, all of them tied in a classic psychosomatic family system of enmeshment, overprotectiveness, rigidity, and conflict avoidance.

Patterns with the Parents

When Dorothy called to make a first appointment I asked something generic about what are the issues. She blurted out, "My parents are driving me crazy." The first session, therefore, involved Dorothy and her parents and her husband. One issue that arose was a habitual pattern on her parents' part of coming for brunch every Sunday without ever telling her when they would arrive; Dorothy and her family felt like hostages but had never expressed their annoyance. An agreement was reached that the parents would call and arrange a time, but at the second session patterns of extreme conflict avoidance, rigidity, and enmeshment emerged. Following are short excerpts from that session.

DR. FISHMAN: (Entering) How is everybody?

When using grounded observation it is essential for the clinician to be decentralized, so that the naturalistic patterns of the family emerge. As we begin this session, I very neutrally try to leave the door open for the patterns to emerge.

FATHER: Good. How've you been?

MOTHER: Great

DOROTHY: Except for me, I'm never great. They [referring to her parents] think this is very easy but I say it isn't easy for me [laughs]

Everyone in the room is tense, and Dorothy diffuses the tension by identifying herself as having a problem. This is a microcosm of the pattern that leads to her symptoms: At moments of stress and potential conflict, she becomes symptomatic by gorging herself with laxatives. This time, while less intense—she is only complaining that she is "not okay"—it is the same pattern. By presenting herself as having a problem, she draws the attention to herself, thereby diffusing the tension in the room between the other members of the family.

I must emphasize that the obvious relevance of these patterns is that there is an extrapolation to the home setting. At home as in the therapy room, Dorothy acts

as the homeostatic maintainer; she activates whenever conflict emerges. The result is that the system does not change. When Dorothy gets upset with her parents and her husband, she does not deal with the conflict. Instead, she becomes symptomatic.

DR. FISHMAN: How come?

DOROTHY: This is the *worst* thing I have ever done

DR. FISHMAN: It is?

What Dorothy is referring to is bringing her parents in for a therapy session the previous week. This speaks to the rigidity, the overprotectiveness, and the conflict avoidance of the system. Here she is, a woman well into middle age, yet in all her life the worst thing she has ever done is being with her parents in a therapy session! This comment reflects the extreme amounts of conflict avoidance in the system.

As Dorothy is speaking, her husband has been sitting to the side, outside of the circle that includes Dorothy, her parents, and me. Here is another pattern that has been in many ways the tragedy in Dorothy's life: just as he is not now rolling up his sleeves and participating in this family session to address his wife's life-threatening problems, he has stayed on the sidelines as Dorothy was immersed in her profoundly dysfunctional relationship with her parents. I now ask him to move his chair into the circle. This move foreshadows the therapeutic goal of getting him to be more a part

of the family. He needs to be available to pull his wife out of the enmeshment with her parents.

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[Dorothy has been talking about something that happened many years ago.]

DR. FISHMAN: See, I thought you were going to be talking about Sunday mornings. [Every body laughs]

I am seeking to deal with a problem in the present. We can do nothing with the events of 25 years ago, but I can support Dorothy to challenge issues that are maintaining the anorexia. To the extent that she can address the key interactional patterns, especially the extreme conflict avoidance, she will be released from the anorexia. I use conflict as the lever to move the system. As it is successfully introduced and issues resolved, the other parameters are also changed, since they form a unit, each part of the same process.

MOTHER: I wish it was that simple.

MOTHER/FATHER: [talking over each other] We figured leave them alone…we don't …you know when they are ready they will tell us when to come over…[laughing]

FATHER: I'm not going to give them a guilt complex but I miss my grandchildren, but it's all right…[Mother and Father laughing]

The anger is heavy in the room. This is the retribution that Dorothy has incurred by drawing boundaries, apparently for one of the first times in her life. The father is on the counterattack. The artillery in these systems is not overt conflict—they are too conflict-avoidant for that—it is guilt and passive aggressiveness. Those are the materiel used in waging war. When challenged about this statement, father can step aside and say, "I was just kidding."

DR. FISHMAN: Do you really miss your grandchildren a lot?

I am attempting to exacerbate the situation so that conflict will emerge.

FATHER: Oh, I see them, they miss me more than I miss them.

This is bringing up the big guns, powerful guilt. I assume that this is the kind of guilt induction that gets Dorothy to capitulate.

DR. FISHMAN: You missed the kids last weekend, didn't you?

Again, I stir things up, so that conflict emerges.

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MOTHER: I think that Dorothy just said that…

DOROTHY: I didn't say it.

Dorothy's mother enters to diffuse the conflict between her husband and Dorothy. She is about to demonstrate the extreme enmeshment in the system by stating what her daughter meant. Dorothy activates by further conflict avoiding. She denies having said that, and in so doing, she effectively pulls the air out of the father's sails, and as for her mother's defense, the very problem has evaporated.

One can imagine at home how unsatisfactory the problem solving in this system is. Look at the Sundays: week after week, month after month, indeed, generation after generation, the couples, held hostage, waiting to the older generation to arrive.

MOTHER: Yeah, you said come at 12:30 instead of 2.

DOROTHY: I'll tell you why because I know that he (pointing to her husband) gets aggravated. I know that it bothers him. So as a result I'm like that because I don't want you to know that he's annoyed. So I try to make peace and I don't do it very well.

Dorothy, clearly a woman of peace, has now disowned even being upset by the visits. She says that she gets upset only because her husband gets upset. That, of course, indicates her triangulation. Indeed, she is very light on her feet and very hard to challenge back—she's always ducking the blows. She provides no resistance, so issues cannot be address and perhaps resolved.

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DOROTHY: And I think it's also I had always done that. You had spent every Sunday at my Grandmother's house for my whole life and I just felt that it was part of a pattern.

DR. FISHMAN: So you went to your mother's house?

MOTHER: Everyone would just pile in.

DOROTHY: Every Sunday of my entire life was spent there.

MOTHER: Yes!

These are the everyday-appearing but profoundly powerful patterns. Every week Dorothy and her family are trapped at home, waiting for her parents. The rigid pattern in fact

replicates the rigid pattern of the previous generation. The grandparents, for their part, are equally trapped, not wanting to upset their labile, deathly frail anorectic daughter—who might at any moment be rushed to the Emergency Room!

MOTHER: When you cut your finger it's a big thing, believe me! [Laughing]

The previous Sunday, the parents unexpectedly came over very early and Dorothy cut her finger when her parents arrived. I see Mother as chastising her daughter, suggesting that her visit is more important than the cut finger and that Dorothy shouldn't be upset about the finger. Furthermore, with her laughter, she is trivializing her daughter's injury. Communication like this is serving to increase the ambient guilt that paralyzes Dorothy. If she complains about her finger, she doesn't love her mother; if she doesn't say anything, she is disrespecting her own feelings.

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HERB: It doesn't bother me. It really doesn't. When you go back over things, Dorothy used to get uptight and all excited, when the kids were little, Grandpa would come in and wake 'em up to look at 'em. Little things like that. Then the kids started screaming and they were up all night. . . .The only thing I object to is that she would get all excited, and that would make me aggravated because I had to live with her.

Talk about conflict avoidance! Grandpa would want to see the kids, so he would wake them, and they would be up all night. Herb would be upset, but he would not blame the man who woke them. If he were to do that, he would have had to address conflict. Indeed, he denies that he is personally piqued—he is only responsive because his wife gets upset. The system will not allow that!

Of course, to the extent that conflict is not expressed the system, the system does not change. But systems must change in order to accommodate to the changing developmental needs of its members.

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DOROTHY: I was getting upset about things that were imaginary, things that maybe I didn't need to get upset about. Maybe I was exaggerating.

This is a consistent theme in the work with this family. Dorothy was consistently "gaslighted": She would feel rightfully indignant, and members of the family would tell her, "No, it's all in your head."

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DR. FISHMAN: What's a conflict that you avoided this week?

DOROTHY: I'm trying to remember…

DOROTHY: We didn't have one this week.

DR. FISHMAN: I know, what's one that you avoided? I'm sure you didn't have one.

DOROTHY: I can't…

DR. FISHMAN: How about today?

DOROTHY: No…

DR. FISHMAN: How about this year?

DOROTHY: I don't have conflicts…

. . . . . .

DR. FISHMAN: One characteristic, it seems to me, of your family is that everybody is a conflict avoider.

DOROTHY: Ignore it and it will go away.

DR. FISHMAN: Mm hmm. Everyone seems to thrive on [avoiding] it—well, almost everyone. (Looking at Dorothy)

DOROTHY: Well, what happens when you avoid conflict all the time?

DR. FISHMAN: Things don't change. And to the extent that things don't change, you are focused on not eating, on the anorexia.

DOROTHY: Then how do I feel conflict when I don't feel it anymore?

She is inured from feeling angry. In this system, conflict is atavistic; they have evolved beyond this—no conflict, no change, only manners! Not feeling conflict is her response to living in a system where it considered hubris to feel indignation. She has therefore learned to guard herself by not feeling anything.

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MOTHER: If we are talking about conflict now…

DOROTHY: In anything…

MOTHER: In anything…for years I've been aware, not to upset you in any way, to try to avoid offering any advice unless you said, "Mother, what do you think of this?" I was conscious of the fact that I better wait till she asks, I don't want to upset her.

This is the circularity. Dorothy does not confront her parents, and they do not confront her. They live in terror that she will get even sicker with her anorexia. They dance around each other—and nothing changes

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DR. FISHMAN: What about that, are there any areas of your relationship that you think need to change? Are there things that Dorothy does that bother you? Even things that have been in cold storage for all these years.

MOTHER: Sure. Well…I would like her…

DOROTHY: To eat [Laughs]

MOTHER: No, we've talked about it and I've accepted it.

DOROTHY: I think that may be the basis of the whole thing, you know…

MOTHER: I would like to be closer to her, I would like to feel free and relaxed and say, "Hey, Dorothy, why don't we—" whatever, like free. I would like to be able to not have to think, will it upset her? will I look at her wrong? I'm conscious of everything I must say to her. I would like that to change. How, I don't know…it's just I don't want to upset her [weakly, while looking to Father]

[Father begins to say something but Dr. Fishman intervenes]

DR. FISHMAN: No, let them talk about it. Go ahead and upset her…if you have to.

MOTHER: Oh, I wouldn't…I don't even know how I want her to be towards…how we…how I should be towards her or she towards me.

DR. FISHMAN: Well, what you're describing here is 22 years of blackmail.

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FATHER: May I add something? From my perspective I don't think it's important as far as how we [indicating Mother and him] feel, whether or not I annoy Herby on a Sunday morning because I come up. The primary purpose is how do we get Dorothy back in good physical health. Now please don't misunderstand me, if it means it's better for her Mother and I to stay the hell away and get

lost, then that's the best thing to do. Regardless of whether it upset us in any way would be immaterial, I think, insofar as if it accomplished the best…

Father is attempting to diffuse the conflict. That is the pattern that has kept the conflicts from being resolved. As I listen to this, I also sense the generosity. It would be a great loss to not visit their daughter and her family.

DR. FISHMAN: So your father-in-law's the peacemaker, Herb?
This is another challenge to the system—I know he is a hell raiser!

FATHER: I'd be subtler about it.

DOROTHY: No, he raises hell, he is not a peacemaker.

DR. FISHMAN: No, between you and your mother? He's the peacemaker?

MOTHER: No, I always quiet him down about her.

DOROTHY: No, definitely not.

[Everybody is talking over one another.]
FATHER: You have to realize when you love somebody…
DOROTHY: When he gets mad he really gets mad.

MOTHER: And I have to quiet him…

From a phenomenological standpoint, I think another reason for the conflict avoidance in this system is that everyone is afraid of Father--.

Patterns with the Children

The first session with Dorothy and Herb's adolescent children revealed patterns of extreme enmeshment and overprotectiveness. Greg, age 16, and Jenny, age 12, had taken on the role of looking after their mother, to avoid the repetition of a terrifying experience when she went into shock after taking a large dose of laxatives.

DR. FISHMAN: You're there to keep an eye on your mom.

JENNY: To keep her company.

DOROTHY: I didn't know that.

JENNY: You know I always ask you, "Do you want me to keep you company?"

DOROTHY: I always tell you, "No, go. I don't want any company."

DR. FISHMAN: But you know she doesn't really mean it.

DOROTHY: But I do mean it. . . . I keep telling you, Jenny, I'd always rather see you with your friends.

JENNY: Well, I don't always want to be with my friends. Sometimes I just feel like staying home.

DOROTHY: As long as you feel like staying home just to stay home because you feel like it, not so . . .

JENNY: I didn't feel like going anywhere. I felt like staying home.

The children's staying home is in many ways the ultimate conflict avoidance. The conflict that they are terrified may emerge is their mother being rushed to the hospital. Of course, their social isolation is detrimental to their development. Furthermore, the kids are being protective of Mother by not acknowledging the real reason why they are staying home. We see here how these patterns pervade the system transgenerationally—Dorothy and her husband, her parents, and the children.

DR. FISHMAN: Really, she needs you there to take care of her, doesn't she?

My customary role in this therapy is a gentle confirming yet challenging. I'm really talking to Dorothy here and challenging her that she's allowing her children to live as her caretakers. On some level that could be construed as child abuse to the extent that it is impeding their development.

JENNY: Yeah.

DOROTHY: No, I don't.

GREG: I always feel guilty about the time she got real sick and I was out—the first time.

JENNY: I was there.

GREG: You were there and I wasn't.

DOROTHY: You feel guilty about that?

GREG: Yes, because Jenny was there and I wasn't, and you got real sick.

JENNY: I didn't know what to do.

DR. FISHMAN: So one of the two of you is always there.

JENNY: Uh-huh.

GREG: Chances are if you came to our house at any time one of us would be there.

JENNY: Or both of us.

It is shocking that neither child seems to see father as a resource. He has taken cover and is simply not there. The valuable part of grounded theory is that it provides a roadmap for interventions. Here, it tells us that it is important to activate father so that he can be there to relieve the kids and, equally importantly, to support his wife, both in terms of her battles with her parents and in her steps towards personal development, such as getting a job. Indeed, as we worked, one of their central goals was increased intimacy between the two of them and his increased participation in the life of their nuclear family.

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HERB: Yeah, but isn't that why the kids won't leave the house?

DR. FISHMAN: No. The kids are in the house because there is somehow an inappropriate job in your home.

HERB: (laughing) Well, they're not in any trouble.

Here father seems to be subscribing to a conflict avoidance manual: As long as the kids are in the house, they aren't getting into trouble. In his defense, I will say that that may reflect the common lay understanding of how families get through adolescence without great upheaval, but it is fairly consistent with the pattern of conflict.

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DOROTHY: Would you feel better about leaving if I ate more? Not if I ate more—if I weighed fifteen pounds more?

GREG: Twenty.

JENNY: I don't know. (pointing to her mother's arm) You're bleeding.

DR. FISHMAN: Look at how they watch you. He says "Twenty" and she says "You're bleeding."

JENNY: Well, look at her arm.

DR. FISHMAN: (to Herb) Did you see that? The way she says "You're bleeding," as though her mother were not competent enough to know that her own body is bleeding?

This is a clear demonstration of the enmeshment in the family: These adolescent children are acutely tuned into the status of Mother's body!

Patterns with the Couple

Toward the goal of grounded observation, there is an additional pattern I track when working with couples: complementary and symmetrical sequences, as described by Gregory Bateson in *Steps to an Ecology of Mind* (1972). *Complementary* sequences occur when one behavior is responded to with a reciprocal behavior—in this case, a challenge and a response in which the other person becomes ill. In *symmetrical* sequences, one behavior is mirrored in the response, as in a tennis match.

The beauty of these sequences is they are readily observable. The clinician doesn't have to rely on subjective responses ("Are you feeling less angry?") Such grounded observation was invaluable in providing markers for conducting and indeed, ending therapy.

HERB: But isn't part of life forgiving and forgetting, and going on?

DOROTHY: Yes, but I can't. I told you that meant a lot to me. I told you, "You kick me out once too often, and that was it." And you did. I told you, "You will never do that to me again, ever." Never, never again. Now you forget all these things. But I don't forget them. Because they were very, very painful, really painful. It is only now that I can even talk about it. You wonder why I think there is something wrong with me; I think you have given me every reason to think that there is

something wrong with me. My whole way was not the way a lovely woman and a mother should behave.

DR. FISHMAN: What about from now on? What do you want?

HERB: What I said before—come out of this thing and whatever your personality is . . .

DOROTHY: I don't think you could handle me. Honest to goodness, I don't think you could.

Dorothy is suggesting that if she were herself and that if she didn't capitulate every time there was a conflict but instead challenged her husband back, he would not be able to handle it.

HERB: If I can't, I can't.

DOROTHY: But are you going to make me feel like some sort of an inferior creep, like a streetwalker? Are you going to make me feel common? I don't want to be common, because I'm not, *really*. (Dorothy affects an upper class accent)

HERB: I never said you were.

DOROTHY: I don't believe you. I don't believe you.

DR. FISHMAN: See, Dorothy thinks you are weak. She thinks you are very weak. The only way she can support you as a husband is by being weaker. And I don't think you are weak. I think you can take having a strong wife. You will be more alive than you have ever been.

My intervention here is that on some level Dorothy has been so conflict avoiding of her husband because on many levels she thinks he is weak. She thinks as she said earlier, he couldn't handle having a strong woman, so I challenge him about his weakness. It is essential that I bolster him a bit in order for Dorothy to be able to challenge him.

HERB: I think I can too.

DR. FISHMAN: You better tell her that. I think you will be ten times more alive than you were a year ago, when you have a strong wife.

HERB: Dorothy, I want you to come out of this and be a strong personality—or whatever it takes.

DOROTHY: If you are willing to take the chance.

HERB: I'll take the chance. Is it a deal?

DR. FISHMAN: Shake on it.

Her husband challenges Dorothy by saying, come on and be strong. There is an underlying suggestion in his voice as I read it that she is blowing smoke and that she's really weak and cannot stand up and be strong. The question is, if he gets stronger, will she then capitulate? That has been the pattern—he is strong, she is weak. But a systemic change in which Herb then became the weak one would be no better. The goal is for both of them to be strong, and both to be complementary one strong and one being taken care of, a reciprocal relationship. That, according to Gregory Bateson (CITE) and I agree, according to my clinical experience, is the flexibility that a functional system needs.

DOROTHY: Hey, I can't take the humiliation again, you know that.

HERB: There will be no humiliation.

DOROTHY: You know I can't face that.

HERB: There will be no humiliation. Shake.

DOROTHY: (shaking his hand) I will have to think whether it is worth it.

DR. FISHMAN: It is worth it. The fact is you don't really have a choice. Because if you don't do it, you'll die--either physically or emotionally.

(I get up, put on my jacket, and walk out of the room.)

Dorothy challenges him back, saying she can't tolerate the humiliation. The session ends when finally a symmetrical pattern emerges. Again, we don't want an isomorphic transformation where there is still no true change, where it's just that the other person is down. The functional system now allows for flexibility; they can be symmetrical in challenging each other and complementary in taking care of each other. At this point the therapy had reached its goal. Both patterns were emerging.

A New Structure

The goals of the therapy were thus to change the destructive patterns of conflict avoidance, enmeshment, overprotectiveness, and rigidity. A new structure had to be created within the family, one in which appropriate boundaries were established between

generations so that all members could meet their developmental needs. The relationship between Dorothy and her parents needed to become less intrusive on the parents' part, less needy on Dorothy's part and more open to challenge on everyone's part. The children had to be freed from their self-imposed responsibility for their mother so that they could resume a normal adolescent distancing. At the same time, the distance between Dorothy and Herb had to be reduced so that he could have what they both sought, increased intimacy with Dorothy taking responsibility for her own health.

During eight months of therapy, these goals were addressed successfully. The overly enmeshed relationships with Dorothy's parents and with the children were loosened. That brought pressure to bear on the dyad, on changing the structure in which Dorothy had to be symptomatic in order to get her husband's attention. Toward the end of therapy, had one more crisis: after a fight with her father, she took a massive dose of laxatives (a few boxes) and went into a coma. When she came to in the hospital, Herb was finally able to challenge her, telling her in essence that he was sick of her behavior and she had to stop it. The implied ultimatum was "shape up, or I'm going to leave."

The psychosomatic family that had entered my office eight months before was transformed, and the triangulation and other interactional patterns that had numerous times almost led to Dorothy's death no longer had a hold on her. The big question now would be whether these changes would hold. What would happen as new stresses began to work on this changed structure?

Follow-ups of cases are normally limited to a matter of months or at most a year, but this case has been followed for a full 20 years. Both one year later and two years and three months after cessation of therapy, it was clear that the changes had been maintained. The anorexia and laxative use had disappeared, and Dorothy and her family were leading happier lives. Even Dorothy's parents were happier. Dorothy still had to resist their tendency toward intrusiveness, but now she could do it without either alienating them or becoming symptomatic. The children were leading normal teenage lives and doing well. Dorothy and Herb were functioning as equals, in a symmetrical rather than a reciprocal relationship.

The initial follow-ups thus were promising. The treatment had addressed the patterns of the psychosomatic family, and the system had been transformed by the process interventions. There was still a question in my mind, however: Had the changes held over the long term? Twenty years after the conclusion of therapy, therefore, I called the family. I spoke with Herb. He told me that things had gone well for many years. The problem that we had addressed had never recurred. The couple were in business together, and Dorothy had had no emotional distress whatsoever over the years.

Then, a year ago, their son, Greg, had died of an apparent overdose of drugs; he had had a drug problem and had been in a detoxification program. After Greg's death, Dorothy and Herb took a cruise. On the cruise Dorothy began drinking heavily. When she returned home, she couldn't stop drinking and had to go into treatment. The husband said, "you know, the problem we saw your for—the laxatives, never returned. We were successful for that."

I invited the couple to come in for a follow-up interview. Herb said that it was not a good time and asked me to call back in a few months. When I did, I was greeted with more bad news. Dorothy had been diagnosed with colon cancer. He said that when things stabilized, he would get back to me. I have not heard from them.

As I look at this transcript from the vantage point of time, I am struck by the power of the model of therapy addressing the day-to-day interactional patterns. Sometimes I think of it as therapy of the banal, of the everyday. Addressing these patterns led to amelioration of a problem that had been life threatening. This was treatment over 8 months, weekly at the beginning, sometimes bi-weekly after that. No psychiatric hospitalization, no medications, no long-term care from the therapist (who, frankly, was still relatively new in the field) or any additional treatment over the years, until very recently and then for a different problem.

I have thought many times about Greg's death. Did I miss something during the course of the therapy? Did I not do enough work with the youngsters to address any developmental lacunae that might have resulted from the effects of their mother's illness on the family? I frankly don't know what I would have addressed even if he could have been convinced to come to treatment. Greg was in 11th grade when I treated the family and already had one foot out the door, although during his first two years of college he did live at home.

But there is an important question regarding the nature of success. I don't believe that success in a course of therapy guarantees a problem-free life. At best, it simply

sustains the person's capability to withstand extreme hardship and difficulties without totally collapsing. I am frankly impressed that when Greg killed himself, Dorothy was in good enough shape not to collapse back to anorexia. The amazing thing is that she didn't become a total mess.

The sense of omnipotence can be an occupational hazard in medicine and should be avoided. Once when I presented this case and the follow-up to a psychodynamic and psychoanalytic audience, the criticism was offered that if Greg killed himself Dorothy she must have still been very pathologic. I think that is stretching it, going to extremes in family theory and intergenerational effects that are not warranted. As they say in AA, "Shit happens." A course of psychotherapy, even effective therapy, is not a vaccine, immunizing people from the "slings and arrows of outrageous fortune." A lot of life goes on that has its own impact.

In the final analysis, our impact is humble, compared with the big world out there. We are kidding ourselves if we think otherwise. I make no pretence that at the end of this work people will from then on be symptom-free and strong in every aspect of life.