Journal of Family Therapy (1980) 2: 311–326

Is there a 'psychosomatogenic' family?*

Peter J. Loader†, Warren Kinston‡ and Jackie Stratford†

Review of the literature revealed two family theories of psychosomatic illness: the 'enmeshed' family of Minuchin and the family with affect disturbances. We interviewed twelve families, each containing a child with eczema. Most, but not all, of the families do fit in with one or other or both of the proposed interactional patterns, but the theory of a single family type, the 'psychosomatogenic family', is not supported. This complements the studies of individuals where specificity hypotheses have proved oversimplified.

Introduction and review of the literature

This paper reports a study of interaction in families containing a child with atopic eczema. The study was designed as a preliminary to a controlled investigation of family interaction when one member has a psychosomatic illness.

Atopic eczema is a specific inflammatory disease of the skin and often appears in infancy (Pilsbury *et al.*, 1956). It may be of long duration and cause considerable disablement. Many children require hospitalization at some time and may never achieve more than a reasonable degree of control over their symptoms. The aetiology of atopic eczema includes allergic, genetic and psychological components (Whitlock, 1976).

Most of the psychological models focus on the individual. Intrapsychic formulations follow classic psychoanalytic lines, while personality profile studies seek to elicit a characteristic constellation of personality traits; however, there has been frequent lack of agreement between the findings

* Requests for reprints to Dr P. J. Loader, The Department of Psychological Medicine, The Hospital for Sick Children, Great Ormond Street, London, WC1N 3JH.

† The Department of Psychological Medicine, The Hospital for Sick Children, Great Ormond Street, London.

‡ The Academic Department of Child Psychiatry, Institute of Child Health, University of London, London, U.K.

0163+4445/80/030311+16 $02.00/0 © 1980 The Association for Family Therapy

of workers in both groups (Grolnick, 1972). The context of patients developing physical illness has also been intensively investigated, especially disorganizing events within the family (Kellner, 1963; Meyer and Haggarty, 1962; Mutter and Schleifer, 1966) and psycho-social stressors (Alexander and French, 1948; Wolff and Wolf, 1968; Rahe, 1968; Brown, 1972). Parental attitudes, usually rejection of the child by the mother, have been argued to be aetiologically important in eczema (Miller and Baruch, 1948; Williams, 1951; Marmor *et al.*, 1956; Jacobs *et al.*, 1966).

Much of this work has emerged from or led to treatment of the child by psychotherapy, behaviour therapy or environmental alteration. More recently family therapy has been used (Lask and Kirk, 1979). Here the ill child is regarded as an active member of a poorly-functioning family, i.e. his illness forms part of the family system and is related to the interaction that occurs among its members, especially the marital relationship. Family therapists have claimed that a typical family structure is to be found where there is a child with psychosomatic illness. A number of studies (Jackson and Yalom, 1966; Gehrke and Kirschenbaum, 1967; Looff, 1970; Goldberg, 1958; Satir, 1967) have emphasized that families with a member suffering from physical illness (headaches, eczema, ulcerative colitis and others) have difficulty in the direct expression of negative feelings and disagreement. Meissner's (1974) review of the literature regarded physical symptoms as an expression of an upset in the 'delicate emotional balance' of the family. These conclusions parallel findings from studies of the individual (Nemiah and Sifneos, 1970; Greer and Morris, 1975) and we shall refer to them as the 'affective hypothesis'.

Unfortunately, these family investigations have been seriously lacking in scientific precautions against error. Clinical impressions rather than systematic enquiry, use of idiosyncratic terminology, disregard for observer bias, and lack of controls are some of the more obvious defects.

Most recently, Minuchin and co-workers have postulated a more coherent model of the 'psychosomatogenic family' in a series of papers again unsubstantiated by any convincing data (Minuchin *et al.*, 1975; Liebman *et al.*, 1974 *a*, *b*). They describe families of children with a wide range of illness including superlabile diabetes, asthma, recurrent abdominal pain and anorexia nervosa. The model centres on the 'enmeshed' family whose characteristics include overprotectiveness, rigidity and lack of conflict resolution. The 'enmeshment' refers to the high degree of reactiveness and involvement amongst family members, their high interdependence, the intrusions on personal and family sub-system boundaries and the poor differentiation of 'self' within the family. The members are overconcerned for each other's welfare and their perceptions of each other are structured

around the wish to be protective. Change and growth in the family are perceived as threatening and consequently the *status quo* is rigidly maintained. There are no explicit negotiations of conflicts and a variety of mechanisms ensures that they are left unresolved, e.g. the ill child serves as a focus for concern and a detour for parental conflict.

Minuchin avoids conflict with other family theorists and says little about dysphoric affect or its expression in disagreement or attacking behaviour. We wanted to investigate whether the families were structured as Minuchin's or the Affective hypothesis claimed, and chose families containing a child with eczema.

Materials and methods

Sample

Families were recruited following their appointment with the dermatologist in the out-patient clinic of a busy children's hospital. Successive children with a definite diagnosis of atopic eczema, together with their accompanying parent(s), were seen by a member of the research team until twelve families were obtained.

We explained that we were investigating the effect of eczema on family life and were seeking their participation in a study which would involve no treatment. The parents were given a brief outline of the procedure and permission for observation and recording of the interviews was obtained.

Families were excluded from the study if the household contained only one parent, when there were more than three children, if no child was over the age of three years, if family members did not speak English fluently, and if any member of the family was receiving current psychiatric treatment.

Of the 39 cases screened, five families were excluded (two one-parent families; two with more than three children; one currently receiving family therapy), and 22 refused to participate. The data collected at initial contact of the 12 families that joined the study are presented in Table 1.

Procedure

Each of the 12 families was interviewed on two occasions, with a 3 to 4 month interval. Two members of the research team (P.L. and J.S.) acted alternately as interviewer and observer: whilst one was interviewing a family the other observed via a closed-circuit television system. At the second interview rôles were reversed so that each family was interviewed by both interviewers. A sound recording was made of all interviews.

On each occasion the whole family was seen for approximately 1 h.

TABLE 1. *Basic data on the families and the eczema**

No. of children	No. of families
1 child:	1
2 children:	8
3 children:	3
Age–median, (range)	
Child with eczema	6.0 years (2–11 years)
All children	6.0 years (2–11 years)
Age at onset of eczema median, (range)	3 months (1–30 months)
No. of eczema children hospitalized for eczema/asthma	5 (38%)
Family history of atopic illness	11 (92%)
Social Class	No. of families
I	3
II	6
III	2
IV	0
V	1

* 12 families, 13 children with eczema.

The family interview was standardized and semi-structured (Kinston *et al.*, 1976), and aimed to promote spontaneous family discussion and allow the family to come alive in its characteristic way. Immediately following each interview both interviewer and observer completed independent ratings of family interaction, using the Current Family State Assessment (C.F.S.A.) (Kinston *et al.*, 1979). During the 6 months of data collection they were not given access to their previous ratings. They were required not to discuss the ratings of families in the study nor to discuss the families in any other way.

About a week after their second interview each family was sent a brief questionnaire in which we enquired after the family's experience of the interview and their reaction to the different interviewers.

Measures

Measurements were of two kinds: observational and clinical. Observational ratings of each interview were carried out independently by the interviewer

and observer immediately after the interview. Clinical ratings of the family were made by the three authors following a review of both interviews.

Preceding this study the authors had developed the Current Family State Assessment (Kinston *et al.*, 1979) which is a method of recording and scaling observations of family interaction. Description of categories and details of the inter-rater reliability obtained are provided in that paper. The 4th edition of the C.F.S.A. consists of 33 items of interaction each of which was scored on a 5-point scale. Ratings were made on the basis of direct observation of family interaction over the whole interview. The family group was considered as a whole unit and the raters were not to be too influenced by any one member. The C.F.S.A. items relevant to Minuchin's hypothesis are: *Resonance, Flexibility, Overprotection, Neglect* and *Conflict Resolution*. The items relevant to the Affective hypothesis are: *Disagreement* and *Attack*.

After completion of all interviews, each family was reviewed using the audio-tapes and the authors exchanged clinical impressions. At this stage the C.F.S.A. ratings were still unavailable and the large number of ratings made meant that there was little memory effect. Each author then rated the family on a 7-point clinical scale of Boundary Integrity. This scale is part of current research work and has not been adequately psychometrically investigated. We used a consensus score which was reached in all cases but one.

Boundary Integrity relates to Minuchin's concept of enmeshment and refers to the rules which govern separateness and connectedness within the family. It is inferred from (a) the individuals' responsibility for their own inner states; (b) intrusiveness amongst family members; (c) maintenance of inter-generational distinctions within the family; (d) reactiveness amongst family members; and (e) the security of the individual's self-concept. A score of 1 indicates the pathological extremes of too-rigid or too-diffuse boundaries. A score of 7 indicates that the boundaries are firm yet permeable.

Data analysis

Inter-rater reliability on the C.F.S.A. items was measured using degree of agreement and weighted kappa (Cohen, 1968; Hall, 1974). Mean scores on the reliably rated items were converted by weightings on categories belonging to the two hypotheses. Table 3 details this conversion and shows why it was necessary: it allowed easy comparison between our results and the two hypotheses. + + indicated that the C.F.S.A. score strongly suggested the presence of the corresponding characteristic described in the hypotheses. + indicated that the characteristic was probably present. 0 indicated that

although the characteristic was not present there was no suggestion that a contradictory state of affairs was present. – – indicated the presence of family interaction almost opposite to that postulated. – indicated that such opposite interaction was probably present.

Results

In a previous study (Kinston *et al.*, 1979) we discovered that inter-rater reliability on interactional categories was possible but could not be taken for granted. Agreement between raters over the first series of interviews was almost identical to that obtained in the second series. Table 2 shows

TABLE 2. *Inter-rater reliability of C.F.S.A. categories*

Category	Range	D (No. of points disagreement)				Percentage when $D = 0$ or 1	K_w
		0	1	2	3/4		
Resonance	2–5	18	5	–	–	100	0.67***
Flexibility	1–4	14	7	2	–	91	0.33*
Overprotection	1–4	11	8	4	–	83	0.62***
Neglect	1–3	20	3	–	–	100	0.62***
Conflict resolution	1–4	15	8	–	–	100	0.53***
Disagreement	1–5	9	12	2	–	91	0.34**
Attack	1–3	8	11	4	–	83	0.11

Data from both interviews ($N = 23$).
*** $P < 0.001$
** $P < 0.01$
* $P < 0.025$

the degree of agreement obtained over the total of 23 interviews. Ninety-two per cent of all ratings were identical or within 1 point, and there were no cases of 3 or 4-point disagreements. Values of weighted kappa (K_w) are provided. This statistic, resembling a correlation coefficient, is non-parametric and corrects for differences in rater mean scores, corrects for rater agreement due to chance, and gives credit for partial agreement. When a scale is used over a restricted range, high correlations are not to be expected. Correlations between the two raters are low but statistically significant, except for one item: *Attack*. This meant that *Disagreement* was the sole indicator for the Affective hypothesis.

If Minuchin's hypothesis is correct families should score high on *Resonance* and *Overprotection* and low on *Flexibility*, *Neglect* and *Conflict Resolution*. If the Affective hypothesis is correct families should score low on *Disagreement*. The structure of the C.F.S.A. scales required us to convert the scores to weightings on new categories relevant to the investigation of the two hypotheses. Table 3 details this conversion.

TABLE 3. *Conversion of mean C.F.S.A. scores to a weighting on categories described in Minuchin's hypothesis and the Affective hypothesis*

C.F.S.A. category	Resonance	Flexibility	Over-protection	Neglect	Conflict resolution	Disagree-ment
Mean C.F.S.A. Scale score		Weighting on hypothesis categories				
4.5–5	++	−−	++	−−	−−	−−
3.5–4	+	−	++	−−	−	−
3	0	0	+	−	0	0
2–2.5	−	+	+	−	+	+
1–1.5	−−	++	0	0	++	++
Hypoth-esis category	Enmesh-ment	Rigidity	Overprotection		Lack of conflict resolution	Lack of Disagree-ment

Using Table 3, the mean scores for each family on the C.F.S.A. categories *Resonance*, *Flexibility* and *Conflict Resolution* were converted to weightings for Minuchin's categories of Enmeshment, Rigidity and Lack of Conflict Resolution. The mean scores on C.F.S.A. categories *Overprotection* and *Neglect* are both utilized to give separate weightings for Minuchin's category of Overprotection.

Table 3 also details the conversion of the mean C.F.S.A. scores for the category *Disagreement* to weightings on a Lack of Disagreement category. Table 4 uses the weightings to demonstrate the degree to which the families interacted in the patterns proposed by the two hypotheses.

We regarded a family interactional pattern as supporting Minuchin's hypothesis when, for at least one of the interviews, there was a positive weighting for each of his proposed categories, and no negative weightings. The presence of a negative weighting, or an equivocal weighting (0) at

TABLE 4. *Looking at the hypotheses*

Family	Interview	Enmesh-ment	Rigidity	Over-protection	Lack of Conflict Resolution	Lack of Disagree-ment
Supporting both hypotheses						
12	1st	++	+	++	+	0
	2nd	+	+	++	+	+
03	1st	+	+	++	++	++
	2nd	+	+	++	++	0
10	1st	++	+	++	+	+
	2nd	+	+	++	0	0
08	1st	0	+	+	++	+
	2nd	+	+	+	+	++
Supporting Minuchin's hypothesis only						
05	1st	++	++	++	+	−−
	2nd	0	+	0	+	0
06	1st	+	0	+	0	0
	2nd	0	+	+	+	0
Supporting Affective hypothesis only						
01	1st	+	0	++	+	++
11	1st	+	0	++	0	0
	2nd	+	0	++	+	+
04	1st	+	0	+	+	++
	2nd	0	+	++	−	0
07	1st	0	−	+	++	++
	2nd	−	0	−	+	++
Supporting neither hypothesis						
09	1st	+	0	+	−	0
	2nd	+	0	+	+	0
02	1st	+	−	+	+	0
	2nd	0	+	+	0	0

both interviews, for any of the four categories was seen as opposing the hypothesis. Similarly, the interaction in each family can be considered as for or against the Affective hypothesis with regard to the Lack of Disagreement category.

Using the above criteria, it can be seen from Table 4 that the interactional patterns of six of the families support Minuchin's hypothesis (Nos 03, 05, 06, 08, 10 and 12), while those of the remaining six do not (Nos 01,

02, 04, 07, 09 and 11). Eight of the families show patterns supporting the Affective hypothesis (Nos 01, 03, 04, 07, 08, 10, 11 and 12) and four do not (Nos 02, 05, 06 and 09).

Thus, the families can be divided into four groups according to how their interactional patterns fit the two hypotheses:

(a) supporting both hypotheses: families 03, 08, 10, 12;
(b) supporting Minuchin's hypothesis only: families 05, 06;
(c) supporting the Affective hypothesis only: families 01, 04, 07, 11;
(d) supporting neither hypothesis: families 02, 09.

Clinical ratings

The consensus clinical ratings of Boundary Integrity varied from 3 to 6. All families scoring 3 (or possibly 3 as in the case of one family where the raters failed to reach agreement on a consensus score) belonged to the group which supported Minuchin's hypothesis. However, this group also contained two families scoring 5 and 6 respectively, i.e. rated as having adequate boundaries.

Discussion

We have investigated interaction in twelve families containing a child with eczema to examine two hypothetical types of 'psychosomatogenic family'. Minuchin has proposed an enmeshed pattern and other writers have emphasized characteristic ways of handling affects. We labelled these 'Minuchin's hypothesis' and the 'Affective hypothesis' respectively. Table 4 shows that two families do not fit into either pattern while four families fit into both. Minuchin's hypothesis is supported fully in six families, and partially in a number of the others. The clinical rating of Boundary Integrity confirmed this wide variation in family structure. The Affective hypothesis is supported in eight families, but this is less noteworthy as only a single indicator was considered.

Our impressions of the families were of variety rather than uniformity (see Appendix). Baker and Barcai (1970) in their study of juvenile diabetes also found several family patterns. As well as enmeshed families and those repressing affects, they listed some unable to negotiate issues, some with problems of control, some over-conscientious and some healthy families. Their work is part of a trend towards an integrated approach which includes but is not dominated by family functioning.

Certain objections can be raised to our study and findings. First, have we understood the terminology and put it into operation adequately?

Minuchin's concepts are broad, loosely defined, and allow for much latitude in interpretation. Most difficulty arose with the crucial concept of enmeshment which Minuchin regards as a bi-polar concept (Minuchin, 1974, p. 54). However, we found evidence for both enmeshment and disengagement within any one family interview. Our clinical measure 'Boundary Integrity' was an attempt to deal with this conceptual problem. The Affective hypothesis was more problematic, as we failed to operationalize it in the same detail.

Second, the validity of the observer ratings is unknown and the lack of blindness means observer bias may have influenced findings. At the onset of the study one of the raters intuitively agreed with both hypotheses and one denied bias but felt affected by the other's expectations. Such bias could operate via perceptual distortion or interview manipulation.

Raters might see what they expect to see or bend over backwards not to, so as to avoid being guilty of bias. This could only be obviated by using blind raters and a videotaped inverview with references to the illness removed. Our adequate inter-rater reliability, similar to that previously obtained, suggests that bias was not excessive.

The interviewer can consciously or unconsciously manipulate family members into producing certain types of behaviour. We tried to limit this by standardizing the interview and providing interviewer training. We also analysed the data looking for any 'interviewer effect', and did find some evidence of unconscious bias. One set of interviews had been rated as showing significantly more Conflict Resolution ($P < 0.01$, Wilcoxon Matched Pairs Signed Ranks Test). We then recalled that this interviewer had consistently emphasized the existence of hidden conflict when we were discussing the families.

The third objection is that our method of eliciting family interaction in the research situation was ineffective. Clinicians derive their hypotheses in the context of treatment, where there is an emphasis on change in the family and an active involvement of the therapist. We had no therapeutic intent and tried to minimize the interviewer affect. It could be argued that our interview was not revealing what was 'actually' there.

We had an opportunity to look for an 'interview effect', by comparing the first and second interviews. *Resonance* was significantly reduced in the second interview ($P < 0.05$, Wilcoxon Matched Pairs Signed Ranks Test.) We had observed that families were less challenged, even slightly bored, in the second interview. This suggests that clinical findings may be an artefact of therapy, e.g. involvement of the whole family may imply blame and lead to overprotective behaviour; and tension, often maintained by the therapist, could lead to rigidity. The authors' impressions were that the families did

reveal themselves to a remarkable extent and more so in the second interview. Feedback from the questionnaire showed that the families believed they had presented a true picture of themselves.

Fourth, our conclusions are limited by the sampling bias. This differed from the bias of impressionistic reports in the literature which involved families referred for psychiatric treatment. During the course of the study six referred families were also examined and five of these were consistent with Minuchin's hypothesis. These numbers are too small for conclusions to be drawn.

Our sampling frame consisted of children attending a prestigious paediatric hospital and many families we asked to participate refused. Finally, we do not doubt that our sample differs from families referred with psychiatric problems only, but we regard it as an open question whether the patterns we found are specific to psychosomatic illness or occur in the presence of any chronic illness. Only controlled investigations can answer this question.

Acknowledgments

We wish to thank Miss Rita Nani for her secretarial assistance and The Sembal Trust for financial assistance.

References

Alexander, F. and French, T. M. (1948) *Studies in Psychosomatic Medicine.* New York. Ronald Press Co.

Baker, L. and Barcai, A. (1970) Psychosomatic aspects of diabetes mellitus. In: O. W. Hill (Ed.), *Modern Trends in Psychosomatic Medicine, Vol. 2.* London. Butterworth.

Brown, D. G. (1972) Stress as a precipitant factor of eczema. *Journal of Psychosomatic Research,* **16**: 321–327.

Cohen, J. (1968) Weighted kappa: provision for scaled disagreement or partial credit. *Psychological Bulletin,* **70**: 213–220.

Gehrke, S. and Kirschenbaum, M. (1967) Survival patterns in family conjoint therapy. *Family Process,* **6**: 67–80.

Goldberg, E. M. (1958) *Family Influences and Psychosomatic Illness.* London. Tavistock Publications.

Greer, S. and Morris, T. (1975) Psychological attributes of women who develop breast cancer: a controlled study. *Journal of Psychosomatic Research,* **19**: 147.

Grolnick, L. (1972) A family perspective of psychosomatic factors in illness: a review of the literature. *Family Process,* **11**: 457–486.

Hall, J. N. (1974) Inter-rater reliability of ward rating scales. *British Journal of Psychiatry,* **125**: 248–255.

JACKSON, D. D. and YALOM, I. (1966) Family research on the problem of ulcerative colitis. *Archives of General Psychiatry*, **15**: 410–418.

JACOBS, M. A., FRIEDMAN, S., FRANKLIN, M. J., ANDERSON, L., MULLER, J. J. and EISMAN, H. D. (1966) Incidence of psychosomatic predisposing factors in allergic disorders. *Psychosomatic Medicine*, **28**: 679–695.

KELLNER, R. (1963) *Family Ill Health. An Investigation in General Practice.* London. Tavistock Publications.

KINSTON, W., LOADER, P. J. and STRATFORD, J. (1976) A Standard Family Interview for research in family therapy. (Unpublished manuscript.)

KINSTON, W., LOADER, P. J. and STRATFORD, J. (1979) Clinical assessment of family interaction: a reliability study. *Journal of Family Therapy*, **1**: 291–312.

LASK, B. and KIRK, M. (1979) Childhood asthma: family therapy as an adjunct to routine management. *Journal of Family Therapy*, **1**: 33–49.

LIEBMAN, R., MINUCHIN, S. and BAKER, L. (1974*a*) The use of structural family therapy in the treatment of intractable asthma. *American Journal of Psychiatry*, **131**: 535–540.

LIEBMAN, R., MINUCHIN, S. and BAKER, L. (1974*b*) The rôle of the family in the treatment of anorexia nervosa. *Journal of the American Academy of Child Psychiatry*, **13**: 264–274.

LOOFF, D. (1970) Psychophysiologic and conversion reactions in children—selective incidence in verbal and non-verbal families. *Journal of the American Academy of Child Psychiatry*, **9**: 318–331.

MARMOR, J., ASHLEY, M., TABACHNIK, N., STORKMAN, M. and MCDONALD, F. (1956) The Mother-Child relationship in the genesis of neurodermatitis. *Archives of Dermatology and Syphilology*, **74**: 599–605.

MEISSNER, W. W. (1974) Family process and psychosomatic disease. *International Journal of Psychiatry in Medicine*, **5**: 411–430.

MEYER, R. J. and HAGGARTY, R. J. (1962) Steptococcal infections in families. *Paediatrics*, **29**: 539–549.

MILLER, H. and BARUCH, D. W. (1948) Psychosomatic studies of children with allergic manifestations. *Psychosomatic Medicine*, **10**: 274–278.

MINUCHIN, S. (1974) *Families and Family Therapy*. London. Tavistock Publications.

MINUCHIN, S., BAKER, L., ROSMAN, B. L., LIEBMAN, R., MILMAN, L. and TODD, T. C. (1975) A conceptual model of psychosomatic illness in children. *Archives of General Psychiatry*, **32**: 1031–1038.

MUTTER, A. Z. and SCHLEIFER, M. J. (1966) The rôle of psychological and social factors in the onset of somatic illness in children. *Psychosomatic Medicine*, **28**: 333–343.

NEMIAH, J. C. and SIFNEOS, P. E. (1970) Affect and fantasy in patients with psychosomatic disorders. In: O. W. Hill (Ed.), *Modern Trends in Psychosomatic Medicine, Vol. 2*. London. Butterworths.

PILSBURY, D. M., SHELLEY, W. B. and KLIGMAN, A. M. (1956) *Dermatology*. London. Saunders.

RAHE, R. H. (1968) Life change measurement as a predictor of illness. *Proceedings of the Royal Society of Medicine*, **61**: 1124–1126.

SATIR, V. S. (1967) *Conjoint Family Therapy*. Palo Alto. Science & Behaviour Books, Inc.

WHITLOCK, F. A. (1976) *Psychophysiological Aspects of Skin Disease.* London. Saunders.

WILLIAMS, D. H. (1951) Management of atopic dermatitis in children: control of the maternal rejection factor. *Archives of Dermatology and Syphilology*, **63**: 545–560.

WOLFF, H. and WOLF, S. (1968) *Stress and Disease.* Springfield. Charles C. Thomas.

Appendix

A brief description of one family from each group in Table 4 is provided here to give the reader a clinical impression of the families as revealed by our interview. These descriptions do not aim to justify our ratings. Pseudonyms are used throughout.

Supporting both hypotheses—Family 03

The Brown family consisted of mother, father, Margaret, 5 years and William, 3 years. At our first meeting, mother was 7 months pregnant and on the second interview Stephen was 3 months old.

Mr Brown sat limply a little apart from his wife and children. He spoke in a resigned monotonous way about everything, using drawn out, repetitive statements. Often other family members would cut across him mistakenly thinking he had finished speaking. If he ever noticed this, he did not remark on it or complain. His most characteristic statement was 'um-h-mmm'. Mrs Brown was at times irritated by her husband's behaviour and his tendency to generate confusion, but she usually dealt with it by taking over with a matter-of-fact approach that relieved the family's tension. Father said of himself . . . 'I'm probably indecisive . . . she wouldn't be satisfied if I did make decisions . . . I'm rather a witterer'.

In both of our interviews, Margaret and William related more easily to mother, and Mrs Brown responded by encouraging and assisting them in playing. At one point Margaret climbed on her father's lap, but he failed to try and hold her, or even change his own body position to offer her a comfortable place in his lap. In the first interview William was more dependent on mother, making many demands of her while ignoring father and Margaret. In the subsequent interview, however, he was more aware of his father and played co-operatively with Margaret. Neither child took notice of the baby who was held throughout by mother.

The most striking feature of the family was that marital conflict was revealed with little overt discord or discomfort. Mr and Mrs Brown described their lack of common interests and said that during the evenings Mrs Brown would usually spend her time reading whilst her husband sat with headphones on listening to music. On the second occasion we saw them, they were more specific about their disagreements and Mr Brown gave us an example of his wife's directive that he must have a vasectomy, which he had complied with. He said this without complaint. Mrs Brown was more openly critical of him too, and he agreed that they had serious difficulties.

After the first interview we had believed that Mr Brown's submission and im-

potence and Mrs Brown's power and contempt for him reflected sex rôle problems. This was confirmed by a story Margaret wrote at the end of the second interview,

> Daddy can you be boy
> Mummy can you be girl
> Stephen can you be baby
> William can you be boy
> Margaret can you be girl.

Supporting Minuchin's hypothesis only—Family 05

The Russell family consisted of mother, father, Andrew, 8 years, Jane, 5 years, and Laura, 3 years. They had received some psychiatric help following the referral of Jane 18 months previously.

Amidst a background of continual din and chaos, Mr Russell remained impassive. Although he enthusiastically involved himself in the interview process, and expressed his feelings without reticence, he sat as an onlooker, detached from his wife's struggle to control the children's behaviour.

Within the few minutes of entering the interview room, the two girls became restless and did not want to use the play materials. Andrew however sat drawing quietly and only speaking briefly if requested by the interviewer. As if on purpose, the girls noisily disrupted the interviews. They climbed on window-sills, chairs and cupboards, tried to reach the video cameras and became preoccupied with what was happening in the adjoining room. Repetitive moans and cries of 'I'm tired', 'I wanna go home'—'Now!' intruded whenever conversation was not directed towards them, and there was much shouting as family members and the interviewers strove to be heard.

None of the children approached father. He did not touch them, rarely spoke to them directly and failed to show interest in Andrew's quieter meaningful play. All the girls' demands were directed at mother. She sought alternatively to ignore them, to distract them, or to threaten them with a smack, and repeatedly replied to the girls' demand that they be allowed to leave the room by promising unrealistically 'Yes, in a minute'. Mrs Russell seemed tired and resigned to her own ineffectiveness against the children's verbal and physical battering. She said that things were much the same at home and added—'Until I had these two, I thought I was quite a good mother'.

Mr Russell's withdrawal from this area of family life had a controlling quality. He intervened only once, just after the male interviewer had firmly prevented Jane from leaving the room. After saying strictly to Jane. 'You've been told to stay away from the door', Jane stopped pestering for a few minutes. She soon began again and Mr Russell made no further attempts to control her. When discipline was discussed, father said . . . 'We have our own views on what to tell them off about—I tend to turn a blind eye', and in reply mother added . . . 'I feel he leaves too much up to me'.

Later on, talking about their marital conflict, Mrs Russell complained, 'I'm the one who rows the most—he never does—it's infuriating'. Her husband confirmed this . . . 'I know as soon as someone starts shouting I've won'. These marital conflicts impinged on other aspects of family affairs, including financial arrangements.

Supporting Affective hypothesis only—Family 04

The Graham family consisted of mother, father, Elenor, 4 years, and John, 2 years.

This was an attractive family who were pleasing to be with. Mr Graham was relaxed and displayed a confidence in himself and his family. He related easily to his wife, and played naturally with the children. Mrs Graham was a slightly anxious person. She laughed pleasantly to cover up her nervousness and often glanced at her husband to gain reassurance.

Both parents freely touched and held John and Elenor and enjoyed being with them. However, Mr and Mrs Graham also enjoyed being without the children. They had a babysitting arrangement and went out regularly together. Mr Graham was a regular footballer and involved with his local club; and Mrs Graham went to evening classes. They all spent a lot of time with mother's extended family who lived nearby.

Conflict in this family was described as a rare occurrence. Although mother and father acknowledged some mild disagreements, they said these never occurred in front of the children. In our first interview John and Elenor ended up squabbling over the play material. However, mother quickly intervened by persuading Elenor to offer John some of her plasticine. Parent–child as well as marital disagreements were played down and humour was used to cover over the more destructive possibilities. For example, after saying he rarely rowed with his wife, Mr Graham said with a laugh, 'No blood's been spilt yet'.

This was another family seen during a transitional period in their family life cycle. Between our first and second interview, John began attending full-time nursery school. Mrs Graham had told us she was worried about getting depressed once John was at school. Afterwards she said how much she was able to enjoy the extra time. John himself had matured too. No longer the grizzling toddler we had first met, he now enjoyed sharing his play animals with Elenor to make a zoo.

Supporting neither hypothesis—Family 02

The Appleyard family consisted of mother, father, Janet, 10 years, and twins Peter and Gerald, 6 years.

All the members of this family had a strong commitment to each other and yet individuality was respected. They described themselves as 'family-centred' and were a warm, open, family group with a great deal of character. The members involved themselves equally in our interviews without prompting. The three children quickly moved to the play table and shared the materials there with no fuss and little discussion. In the initial interview, Gerald handed a picture message to the female interviewer which said 'I hate my mummy'. In the second interview, Janet spent most of the time making an expressive plasticine model of the male interviewer. They were all well able to express their own views and verbalize their feelings and did so throughout. Both parents valued this and encouraged it explicitly, and to an unusual degree in our sample the children reciprocated.

Mr Appleyard weighed his own contributions carefully and gave precise, if lengthy, replies to our questions. He pursued issues raised by the children until a definite conclusion was reached. Mrs Appleyard was less collected in her manner. She got flustered by the children and told them off much more frequently than her husband did. In discussing the issue of discipline in the family, father said he

tended to leave this mostly to his wife and explained that he and she had different ideas on what needed to be dealt with. All the children disagreed with the family's method of discipline. The twins disliked Janet being given authority over them at times of parental absence. When Gerald complained 'Janet's always in charge . . . I hate it', Janet replied . . . 'Because Gerry keeps on like that it makes me want to hit him'. Mr and Mrs Appleyard were unhappy that Janet resorted to smacking the twins but were unable to prevent it.

Gerald was seen as the trouble-maker in the family and both parents described him as responsible for taking things, leaving messes and generally being unco-operative. The Appleyards also told us of the long-standing rivalry between the twins at home and school. Peter and Gerald began friendly fighting towards the end of our first interview. Neither parent was effective in managing this conflict.

At the second interview father was more assertive in handling their behaviour. In this interview, there was more open expression of parental disagreement. In particular, Mrs Appleyard criticized her husband . . . 'I feel if I had more help with things that need doing we could both relax together . . . rather than you just relaxing and reading'. Father was unrepentant, acknowledging that he avoided his share of the family chores.