The Anorectic Process in the Family: A Six-Stage Model as a Guide for Individual Therapy

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This article presents a conceptual framework for individual treatment with chronic anorectic patients. In the first part of the article, the six-stage model for the anorectic process developed over the past years by M. Selvini-Palazzoli and her team is briefly explained. After presenting the model, we then discuss some related concepts, namely, "family game," "rule," and "strategy." Finally, the therapeutic technique in individual treatment is discussed. Two basic assumptions underlie this technique: first, the therapeutic relationship is instrumental, its main purpose being to improve the patient's personal relations outside therapy; second, the focus of the treatment is on the strategic incapacity of the patient who is caught up in and unable to cope with the "concealed family game."

When "Paradox and Counterparadox" (8) was published, the Milan group then working together (one of whom is a coauthor of this article) had worked with 36 families of anorectic patients and set up a general pattern of therapeutic approach, which was based on reformulating the ongoing family "game," tagging a positive connotation onto the family members' behavior, and issuing the so-called "paradoxical prescription" to everyone in the family. The method proved to be a remarkable breakthrough in our clinical practice, enabling us to achieve heretofore unimaginable results. First and foremost, however, it made a bold statement: implicitly and explicitly, it linked the patient's anorectic behavior to a specific game being played out within the family. Whenever the therapist succeeds in breaking up this special game, we contended, the patient sheds the symptom. We believed at the time that what we needed most of all was to develop our skill in identifying this game as soon as possible.

We began to concentrate on refining our technique for the first interview with the family, and devised three guidelines for collecting as much relevant relational information as possible in the course of this crucial encounter. Prior to the interview, we would form a hypothesis concerning the ongoing game; we would then proceed toward our principal objective, namely, either the confirmation or the confutation of our initial hypothesis. It was this mental operation, however, which we dubbed "the hypothesizing phase," that became the source of our deepest frustrations. Each time we started with a new family, we would hypothesize about the ongoing game, working on the bare essentials available to us from the data on the telephone chart, fleshed out by our previous experience¾which at the time was sketchy and fragmentary at best. So eager were we to rush in and decode the ongoing game that we sometimes resorted to erratic interventions devoid of any clinical effectiveness.

Quite apart from the results themselves, this way of working was unsatisfactory in that it failed to increase our knowledge. We found that refining our interview technique and our interventions did not help us achieve any real progress in grasping the essential interactive pattern underlying the onset of anorectic behavior. Staggered by the bewildering plethora of variables accruing to each family, we were utterly unable to distinguish an unvarying, common pattern. We slowly came to understand that starting from scratch with each new family, like exploring unknown territory, certainly was a heady intellectual pursuit, but so formidable a task and one so fraught with pitfalls as to engender demoralization or, still worse, skepticism. This bears out what Morin says in his book on knowledge (5): "Pas assez de complexité, pas assez d'adversité atrophient l'intelligence, mais trop de complexité et trop d'adversité l'écrasent."

The Problem to Be Solved

Two members of the original group (Boscolo and Cecchin) left the team in 1979. The Center pursued its research on what by then had become a paramount methodological query: Can a schema be found to account for the essential interactions that will in time call forth the anorectic symptom?

In a recent article (see 7) we discussed in detail our line of research and its methodological implications. Only a brief summary needs to be given here. The so-called "paradoxical" interventions we had used when dealing with families of anorectic patients have been abandoned. Our new approach features an unvarying set of prescriptions to be issued to all members of the family. Besides being far more therapeutically effective than our previous method, it also proved to be a powerful generator of key relational information. Asking people to do something elicits far more revealing reactions than merely prompting them to say something. Moreover, this new approach was definitely more adequate as an instrument for acquiring knowledge. Precisely by virtue of its unvarying nature, the invariable prescription allows us to discover similarities and differences essential to the process of cognition. Thus, as the number of cases we handled increased, our team gradually came to an important conclusion: unlike the unpredictability of the reactions called forth by the previous, "paradoxical" interventions, many individual reactions elicited from family members by our prescriptions conformed to a few recurring types that could then be foreseen and classified.

This line of research, in which we have now been engaged for 8 years, centers on our work with 142 families with an anorectic patient. Aside from significantly increasing our knowledge, it brought a welcome bit of serendipity; we were delighted to find that we were no longer confined simply to mapping out the ongoing relational family organization basic to the emergence of the anorectic symptom. We realized the true importance of something we already knew, namely, that a family's relational organization is not a static phenomenon but a living, dynamic one. It evolves with time. The onset of anorectic behavior is linked to a specific evolution of relationships in the family¾for instance, abandonment, volte-face¾to which the patient both reacts and actively contributes. Anorexia, then, was the result of a process in the history of the relational organization of these families, the course of which we needed to retrace step by step.

From the Parents' Game to the Daughter's Anorectic Symptom: A Six-Stage Process

In describing the course of the anorectic process within a family, we selected as our arbitrary point of departure the game played by the parental couple. This consisted basically of each parent constantly provoking the other and failing to get an appropriate response. For example, a wife will start nagging her husband about something, whereupon he will either dodge the issue by remaining silent or else blow his top the moment she begins airing her grievances. In both instances, he successfully blocks all possibility of interaction. These two reactions, differing but producing an identical result, stem from the tactical choice the husband makes in the couple's game. We find that the most frequently recurring tactic is that of the silent, forbearing husband, powerless in the clutches of a meddling, harping, know-it-all wife. The tactic we find much less frequently is that of the domineering overlord. However, a close look at the transactional game will show that even in families with a husband like this, the wife, ostensibly a victim or referred to as such, is likely to be a provoking victim indeed. Not only does she go on endlessly about her martyrdom, but she also well knows how to make the most of her inferior position in order to get back at her husband in countless, crafty ways. Her husband, however blustering he may seem, has to put up with these subtle acts of revenge¾for example, his wife's fulfilling her unarguable duty toward her old parents, devoting much time and energy to them so as to keep her husband fuming with impotent rage.

At this point we must pause and set the record straight on an important matter. A stalemate of the type described above can also be found in families that do not have an anorectic member. However, it does assume specific forms and effects within a given set of rules variously described by a number of authors (2, 3, 4, 6). Two of the best known of these rules are:

1. The rules of the family game grant every member the right to reject anything he or she is offered, be it something concrete or simply a definition of the relationship.

2. Nobody has the right to assume a leadership stance. Each will tend to justify his or her behavior as obeying the requirements of others or as general principles (that which is best, most convenient, or most suitable for someone else in the family). Individual requirements are always proclaimed to be subordinate to those of others. Refusal to shoulder any of the blame¾thus implicitly placing it on someone else¾is characteristic of this type of interaction.

The couple's mutual relationship almost invariably features a wife who is resentful of her husband. In line with the system's rules, her endless grievances never relate to a personal claim of her own but, rather, appeal to his duty as a father on behalf of the children, and so on. For his part, the husband dodges his wife's invective and recrimination by setting up his own definition of those same duties, which contradicts hers. He may, for instance, manage to get his work load increased in order to spend even less time at home, and will suffer her incessant griping in stoic silence. This is his way of conveying that he is going about his main duty, namely, to provide financial security for his family with unswerving diligence, to do his best, although sorely tried, to keep peace in the family by refusing to rise to her taunts. It also allows him to show her up as failing to fulfill her duty as a loving, well-balanced mother. The children's various requirements will, of course, be depicted in a totally different light by each parent, each staunchly rejecting the other's interpretation.

Once we had managed to discern a general pattern for the game played by the parental couple, we worked out a 6-stage model for charting the family's interactional course as it eventually leads to anorectic behavior: Stage 1, in which the parental couple is seen as playing the game described above, and the stalemate almost invariably enmeshes members of the extended family; and Stage 2, in which the anorectic-to-be at a very early age starts getting involved in the parental game.

As to the manner in which the patient gets involved during childhood and preadolescence, we were able to identify two separate types, described here under the headings A and B:

Type A: The daughter due to become an anorectic is totally in fealty to her mother who often confides to her the suffering she endures at the hands of her husband and, in some cases, her in-laws. The daughter tends to espouse her mother's relational viewpoint. She feels pity for her, although she does not really hold her in high regard. She is the only one in the family who will volunteer to help her mother with the housework. Given this context, the girl soon acquires the notion that she is a morally superior soul and has a deservedly preferential rapport with her mother, which empowers her to keep her behavior above reproach at all times.

Type B: The future anorectic has always been her father's favorite, quite overtly so. He feels she takes after him, and greatly appreciates her many good qualities. She, too, admires her father and considers him far superior to her mother. She can see no excuse for the way her mother rants at him.

In this initial stage, future patients of both types do not actively take sides against one of their parents; they steer an even course between the two.

Stage 3: Adolescence brings on a series of decisive events in the life of a future patient, abruptly changing the way she sees her father, or else tying her to him all the more closely:

Type A: Mom's "special little love" discovers, either with dramatic suddenness or gradual awareness, that her mother's real love has shifted somewhere else, usually to a sibling with whom the mother engages in constant emotional bickering, or, more rarely, to some new object of affection. Feeling forsaken, the future patient turns hopefully to her father. This stage is marked by highly intense, albeit subtle and disguised, seductive maneuvering on the part of both father and daughter. The daughter starts to see her father in a new light. She attributes to him a shared feeling of loneliness and abandonment and comes to appreciate his intrinsic qualities. She welcomes and reciprocates the hints and promises of a special affinity he holds out to her (what a perfect wife she would be for him!). At this stage, when her parents interact, the daughter covertly sides with her father. In her heart of hearts, she longs to see him react firmly and sternly to some of her mother's behavior, which up until now she had not noticed as being so provoking. For his part, the father takes every opportunity to signal to his daughter how trying and frustrating his wife is¾even as regards their intimate relationship¾and how he puts up with all this torment solely for the sake of peace in the family (mutual instigation against the mother).

Type B: As the future patient reaches adolescence, the seductive bond between father and daughter occasionally assumes embarassing proportions. The (mutual) instigation heightens in intensity.

In both types, due to this "father bias," the future patient feels bound to him; they are both "victims" of this insufferable woman.

Stage 4: This is a period of intense relational distress, during which the "diet ploy" comes onto the scene:

Type A: Forsaken by her mother and egged on by her father, the future patient feels a compelling urge to distinguish herself from her mother. She loathes the idea of resembling her in any way. She takes the unprecedented step of acting on her own behalf and sheds her mother's behavioral tenets in favor of those currently in vogue with her age group, in an as yet hazy attempt to achieve autonomy.

Type B: Dieting is seen from the start as a challenge to the mother. It is immediately flaunted in defiance. We have hypothesized that precocious amenorrhea frequently occurs in these cases. The decision to diet is often sparked by some specific behavior on the part of the mother that is especially disturbing to the father or the daughter.

No matter how the lowered intake of food begins, it rapidly develops into silent protest and rejection of the mother. Future patients of both types tend to view their decision as ushering in a change. Against the girl's expectations, however, the reduced food intake sets off an interactional spiral in the triad¾mother/father/daughter¾that reinforces the parents' game and, consequently, the daughter's involvement. The mother now pokes her nose into her daughter's dietary habits in her usual meddling fashion; the father feebly attempts to shut up his wife (and fails as usual); the girl gets angrier and angrier, and her urge to rebel leads her to eat less and less. The drift toward a radical hunger strike is furthered by her perception of father's attitude; she sees him as irresolute, utterly incapable of following her shining example and joining in the fray. To be sure, he deplores his wife's outrageous behavior, but he does nothing to grasp the scepter his daughter silently holds out to him. He passes up the opportunity of rallying to her side and joining in the exciting adventure that could ally them in the (covertly promised) special relationship he had so often hinted at before.

She senses that she has been left in the lurch and that her father prefers not to endanger his relationship with his wife.

Stage 5: This is marked by the father's volte-face. The daughter feels let down by her father, and her attitude toward him is now resentful, occasionally despairing, and spitefully contemptuous. She reduces her food intake to absurd extremes. This is the only way she has of getting her mother to knuckle under and of showing that fainthearted deserter of a father to what lengths his daughter can go.

Stage 6: The family game proceeds according to what we have termed "symptom-based strategies." The patient has tasted the extraordinary power the symptom confers upon her. It allows her to recapture the illusory privileged status she enjoyed during childhood and preadolescence. She often ties her mother to her by a pseudo-symbiotic bond that barely masks her hostility and control. Eventually, each member of the family will think up self-serving strategies based firmly on the notion that the symptom is here to stay. Should the patient attempt to shed the symptom, she would face strenuous, albeit camouflaged, resistance from somebody.

As can be inferred from this general pattern, the entire course of events described is thoroughly shot through with deceit. This we have termed "imbroglio," a complex interactional process that apparently gets under way and develops around the strategy of holding up as "privileged" a transgenerational dyadic relationship (mother/daughter, father/daughter) that is actually nothing of the sort. Such bogus privilege, in fact, is not genuinely grounded in affection, and is really a tactical weapon to be used against someone¾usually the spouse. Tactics of this sort are generally pathogenic in that they are transgenerational. They set up a precarious equilibrium that, when it comes crumbling down, ushers in a series of events that glaringly unmask the fiction of the presumed privileged rapport with devastating effects.

The fact that we were able to identify individuals¾that is, single members of the family¾as being to a greater or lesser degree skilled in making strategic moves in the interactional family game allowed us to lay bare many aspects of the patient's relative lack of skill as a strategist. It was this revelation that prompted us to devise a method for treating chronic anorectics individually. Before we tackle this subject, however, a few introductory remarks concerning rules and strategies¾or rather, our theoretical concept of them¾are in order.

The 6-stage schema briefly outlined here attempts to describe how the onset of the anorectic symptom is the expression of a global interactional process within the family, which we call the interaction game. The notion of "game" that is basic to our definition is purely intuitive. The word is used here as in other expressions such as "the money game," "a power game," "a political game," all of which obviously lack any connotation of entertainment. The adoption of the "game" metaphor was a first step away from our previous systemic reductionism and toward a complex line of thought that stresses two dimensions we had tended to underestimate, namely, time and the individual. Furthermore, the notion of "game" in itself implies that rules and strategies are involved.

Rules

A "rule" is defined here in contrast to a "natural law." So-called natural laws define the conditions that determine behavior "naturally" possible for an individual. Thus, a set of natural laws enables man to walk but not to fly, to swim but not to breathe under water. Conversely, behavior governed by rules is subject to "nonnatural" bounds and restrictions; it is not determined by the individual's biophysical makeup, by a given set of circumstances, or by the laws of chance. The concept of rule here has a synchronic meaning. A rule is a rule if it selects only a few from among the several kinds

of behavior naturally available to a subject at a given time and under conditions in which the rule is to apply. The concept of rules has been widely used in systems family therapy and has come in for much discussion. Jackson (3) proposed that the term be used to designate "as-if" rules, constructs that the observer resorts to in mapping out the interplay among family members. Dell (1), however, pointed out that family therapists refer to rules as though they were proper entities; he therefore criticized this use of the term and suggested it be discarded. For our purpose, we need only remark that members of a family (and the therapist) go on using the rules concept, at least insofar as it is covered by three distinct definitions: rules are used (a) in order to elicit behavior, (b) in order to describe behavior, and (c) in order to foresee behavior.

Under definition (a) are the rules that have an essentially normative character. They are used to produce behavior. If a father tells his children they must wash their hands before they come to the table, he sets up a rule simply by enunciating it and because he has sufficient authority to do so. The rule goes on being a rule, then, irrespective of whether the children consistently obey it or not. Therapists, too, will resort to rules in order to elicit specific behavior, as when they tell the patient they will be meeting once a week, or when they issue a prescription.

In the case of definition (b), the notion of rule takes on an essentially descriptive meaning. A mother may say, "Whenever my daughter stays out late, my husband will start fidgeting, and then he'll take it out on me." She is describing the regularity of a sequence. Such rules are ways of representing behavior as something other than natural or random. Therapists, in the course of their meetings, will point out such regular patterns in the behavior of family members and use them to represent how the family interacts.

As for definition (c), because rules set up or presuppose restrictions in a range of behavior naturally available to the individuals involved, they are used to predict the behavior of others and to plan one's own behavior accordingly. Rules actually make "living together" possible by diminishing the surprise element in the behavior of others and establishing a repertoire of what is acceptable.

In summary, we view a natural law as an intrinsic limitation that cannot be overstepped, whereas a rule, according to the meanings assigned to it here, is a bound that may be broken, altered, and renegotiated. When we say that a standing rule in a family with an anorectic member forbids other members to assume a leadership stance, we mean that all of them claim that their decisions spring from the desire to cater to someone else's needs or demands, whether real or imagined. Furthermore, if the rule is infringed by a member who announces that he or she is about to make a personal decision, one not subservient to the requirements of others, such behavior will be regarded by the others as the infringement it is, and it will meet with resistance and disapproval. This rule, then, is designed to describe how a specific piece of behavior is produced; its purpose is to forecast the behavior that will ensue.

The distinction between rules and natural laws has far-reaching implications. For one thing, it questions the legitimacy of transferring concepts and principles¾as they apply in fields such as physics, chemistry, or biology, governed solely by natural laws¾to the study of human behavior, governed by natural laws and rules.

Strategies

A strategy may be defined as a succession of acts arranged in an orderly time sequence and directed to the attainment of a specific goal. A strategy may be readjusted at any time to meet changes in the attendant circumstances as they occur.

The concept of strategy immediately implies notions of time, intention, aim, and motive. Indirectly, it also introduces the idea of a planned operation, of success or failure, advantage or disadvantage. All we need say here is that certain intentions or motives, operational master plans, and so on, endure regardless of whether their outcome is successful or not, or whether or not they translate into coherent behavior. On the other hand, attributing intentions, aims, and strategies to other people when these have not been made manifest, or are different from those professed, is a common form of representing someone else's behavior in the diachronic dimension. The outcome of any sequence of behavior exhibited by a family member obviously depends also on the order in which the single pieces of behavior follow one another in time. Each item in the series, in fact, is aimed at setting the scene for the following piece of behavior to have one effect rather than another. Setting up strategies and medium- or long-range plans almost invariably requires the joint effort of two or more individuals having¾or professing to have¾common or compatible objectives. What happens is that two individuals agree to start a family. They do this by drawing up a pact, quite literally one of cooperation, with a view to attaining a well-defined set of common objectives. Now, gauging a partner's objectives and motives correctly¾whether these are made manifest or not¾is a matter of vital importance for those entering the pact. The danger is, of course, that one family member's cooperation, to the extent that it affects another member, may veer abruptly and radically from cooperation to obstruction, for instance, if a second member's behavior starts interfering with some high-priority objective the first member has kept under cover and the second has failed to detect. The latter may then feel disappointed or cheated, the more so the longer he or she has been postponing urgent personal needs to further the other's, and all the while reckoning on the pay-off. This change of attitude is what we call a volte-face; it is crucially relevant in bringing on the anorectic symptom.

In systems family therapy there has long been a call for proper consideration of the time element. Nonetheless, the concept of a family life cycle is perhaps the only one to use the time dimension as a structural factor. However, the family-life-cycle concept applies essentially to natural and biological bonds. It provides an adequate basis for describing how the generational structure of the family evolves, and may also account to some extent for distortions; but it tells us nothing about the way a given family organizes and changes with time, albeit within the framework of such "inescapable" bonds.

The pattern of the anorectic process in a family, as we have outlined it above, places the onset of the symptom at a focal point of specific "configurations" in the family's interaction game. It takes into account variations due to the life cycle, as well as the special family rules, but it goes beyond this in trying to ferret out each member's favorite strategies and how these integrate and alter over time.

Rules and Strategies

A model of the "interaction game," therefore, can be plotted in two main dimensions. In the synchronic dimension we represent family interaction as governed by rules that remain constant over a certain period of time; in the diachronic dimension we link each individual's behavior, as it occurs, to some other instance of his or her behavior, either preceding or following it, because all these pieces of behavior will be aimed at something. In this sense, then, we see individual behavior as strategic behavior.1

The relationship between rules and strategies must be examined in all its complexity. It is generally assumed that the members of a family tend to choose behavior strategies compatible with family rules, and to engage in extrafamilial relationships governed by similar rules. However, it does not

seem possible to derive individual strategies from the set of rules alone. This impossibility is founded on two considerations:

1. Within one and the same set of rules, each individual has a choice of several alternative strategies. The ability to work out different strategies for solving the same problem, and of reformulating the terms of the problem, are operations naturally within the scope of human capacity.

2. Negotiating about rules is an integral and essential part of the family's interaction game. In every family an individual will progress from total dependency to substantial autonomy. This evolution requires constant redefinition of relationships, reciprocal rights, duties, and, consequently, of the rules governing them. A child will have to bargain with its parents for permission to spend more time with kids his or her age, whereas an adolescent will negotiate about the right to do so. So if, on the one hand, several strategies can be elaborated within a single set of rules, on the other hand, every family member can (or has to) be in a position to work out strategies aimed at redefining the very rules by which the interaction game is played.

These two considerations have a bearing on the therapeutic approach. When working with a family, we try to modify the rules of the interaction game, mainly by the use of our prescription, in order to induce individual members to change their strategies. Conversely, in individual therapy we suggest new strategies to the patients in order to enable them to modify the family rules.

Rules, Strategies, and Skills

In order to implement a strategy, every member of a family must be in a position to acquire the skills necessary for making moves in the game. Individual psychobiological evolution comes about by stages, each of them marked by the emergence of new potentialities. Adolescence, for instance, is the period during which new biological, cognitive, and relational potentialities are particularly rife. In order for these capacities to develop into proper skills¾sexual, intellectual, and social¾a learning process is necessary within the family circle and outside it, as well as a redefinition of the family rules. Acquiring these skills may be defined positively (by what is learned) or negatively (by what cannot be learned because the learning context does not allow for it). In our clinical practice we often see chronic patients whose symptoms correlate with a long-standing limitation on extrafamilial relationships. Skills normally acquired by others in the same age group are here found to be sorely lacking. This problem has special relevance for pathology such as anorexia, which surfaces during puberty when the ability to learn is at its peak. Even in cases where the symptomatology eventually subsides, belated apprenticeship is never a match for learning acquired at its proper time.

Generally, this view does not agree well with the so-called "principle of equifinality" (10), which states that family interplay, as observed at any given point of time, contains all the information necessary to bring about a change, in exactly the same way as the arrangement of pieces on a chess board contains all the information needed to make the next move. In neither case does it seem important to know how the situation got that way in the first place. We cannot really subscribe to this principle. In a game of chess, each piece's "skills" (moves) remain unvaried throughout, so that a pawn that has not yet moved has exactly the same potential for moves as one that has moved several times. The pawn "learns" nothing by moving; this is certainly not true of human beings.

Strategies and Symptoms

To get us out of metaphor and into clinical observation, let us remember that chronicity and the presence of certain psychopathological circumstances preceding the onset of anorectic symptoms should be regarded as valid pointers for predicting the outcome. Thus, a family's evolution may be plotted in a succession of several "configurations" (stages) in the interaction game. Each such configuration, in turn, will be defined by several elements: a given phase in the family life cycle, a set of relatively stable interaction rules, an integral of the interaction tactics most favored by each member. Piecing together the various ways in which an individual family member¾and especially the patient¾interacts, we obtain a "strategic" representation of his or her behavior, including symptomatic behavior. If we apply this model to the behavior of the anorectic patient (who we will assume is a daughter), and using the 6-stage pattern outlined above, we find that the onset of the symptom correlates with three crucial events:

1. There will be a bitter end to the patient's fond belief that she holds a privileged position in both the nuclear and the extended family. Regaining this lost status then becomes a primary objective. The patient believes that she is reclaiming a right acquired during the long years of fealty to her mother. In fact, the mother's betrayal first, and the father's volte-face that follows, reverse the patient's status entirely. Little Miss nonpareil, who never inconvenienced anyone in the slightest, suddenly becomes the prime cause of everyone's unhappiness.

2. The patient will fail in her attempt to devise suitable strategies for attaining this goal. As a child, the patient (Type A) consistently followed a preferred course of behavior modeled on her mother's standards, and carried compliance to such extremes as to outdo everyone. When her mother's betrayal hits home, she ruefully realizes that a rival¾usually a far less deserving sibling¾has managed to gain more influence with her mother than she ever could, for all her strict compliance with her parents' every wish. The father's volte-face (Type A and B) suddenly reveals to her how ineffectual he is and what little help he has to offer at the crucial moment when she starts openly defying her mother.

3. The patient discovers that her symptom is a tool for influencing other people's behavior. The following excerpt from a patient's diary will serve as an example: "All I've ever accomplished, my brilliant school record, carries less weight than the whims of that featherhead [sister]. Believe it or not, the only thing that really works is refusing to eat! Still, I'm a bit scared it might get out of hand." The significance of the symptom in its strategic dimension is clear if one considers what "skills" the patient-to-be has managed to develop in a context riddled with the tactical intrigue we have called "imbroglio" relationships.

Imbroglio, as defined above, has two distinct characteristics. First, it is an oblique tactic; one member will adopt an approving stance toward another with the chief intent of conveying a message to a third. Second, it is a covert tactic; in order to achieve its purpose, the real objective of the move must be adroitly concealed. If the member at the receiving end of flattering messages takes them at face value, he or she will tend to reciprocate by catering to the demands and requirements of the sender because all this approval will seem genuine and will deserve a devoted attitude (fealty) in return.

Such relational tactics color a mother's attitude toward her offspring. She is not so much intent on correctly interpreting her children's needs (nutritional at first, then affective and relational as well) as in satisfying her own need to show some third person how wonderful she is at nurturing and educating. There is almost always another woman (usually a grandmother) whom the husband esteems as the ideal nurturing mother. To a far greater extent than her siblings, the future patient gets enmeshed in this maze of oblique relationships based on disapproval and dissembled rivalry

from early childhood on. The girl who never causes any trouble, by virtue of never being at fault, tends to assume a position of subservience toward her mother, not because she holds her mother in special regard but, rather, out of a need to compete with her peer group. In a learning context of this kind, the patient-to-be "learns" to forfeit any requirements of her own¾including those related to food¾in order to further the demands of her entourage and the tenets of the relational game. She will call upon this tactic when she resolves to embark on her fasting and to carry on with it. What she cannot learn in a context so infused with deceit, however, is the capacity to set up "empathic" rapports, that is, to correctly decode, over and beyond verbal manifestations, other people's feelings and emotions while letting her own shine through. Thus, when the imbroglio finally surfaces, she fails to foresee that neither parent will be willing to jeopardize the equilibrium of their rapport as a couple, even though this rapport has always been decried as the source of endless suffering and dissatisfaction. Her mother will staunchly refuse to admit she has ever been at fault or mistaken, and her father shows himself totally unwilling to risk a head-on collision with his wife for his daughter's benefit.

Symptom-Based Strategies

The onset of the symptoms corresponds to a reshuffling of the cards in the family game, not to a change in the rules. In anorexia, the symptom abides by the rules to an almost grotesque extent; everyone, in fact, has the right to rebuff whatever anyone else offers. Moreover, the patient will flatly deny she is asking anyone for anything on her own behalf, and usually claims she feels fine. The outward evidence of her condition, however, gets all the others moving. They take action "for the patient's own good." Naturally, everyone's idea of who should do what for the patient stems from each member's jumping at the chance to obliquely influence some third party's behavior. This is the state of affairs we generally find when a family comes seeking therapy for a chronic patient. Very often, for example, a mother will indirectly be trying to stop another of her children from leaving home by appealing to the would-be runaway's sense of duty and saddling him or her with the "sick one's" care.

As a rule, the freezing in of the symptom will correspond to a collusion of all members in setting up strategies based on the patient's symptom. Hence, it is clear that any change in the patient's conduct, especially if it is sudden, will be a windfall to someone and a stumbling block to someone else who will likely try to hinder the change in some way.

The phenomenon of a family resisting change in a patient's condition is one well-known to therapists. It was formerly accounted for by calling up the concept of homoeostasis. This concept has recently been widely criticized and mostly discarded, although no other convincing explanation has yet been proposed to take its place. The idea of symptom-based strategies, as we posit it here, attempts to deal with these phenomena in a less abstract fashion and, we believe, one richer in therapeutic fall-out. All these considerations, then, are basic to our attempt to devise a technique for individual intervention in cases of chronic anorexia when family therapy cannot be undertaken.2

Requesting Therapy

Requesting therapy may be viewed as tantamount to making a "move" to extend the family game to the outside environment. Any member of the family, not only the patient, can make the move in the presence of symptoms. There are several possible responses. Suggesting individual therapy is a likely one when only the patient is willing to take a leap in the dark, on the off chance that it will advance her position. Individual therapy requires therapist and patient to draw up a contract for the purpose of improving the patient's standing in the interaction game while getting her to renounce

symptom-based strategies. Any possibility of the therapist involving other family members in order to favor the patient is strictly ruled out. Thus, the therapeutic relationship is, by the terms of the contract, an instrumental one, its sole purpose being to better the patient's standing in her relationships outside therapy. Translating this principle into clinical practice raises a number of problems that can best be tackled by breaking the course of therapy into a succession of subunits.

The Preliminary Sessions

Two of these are needed before the actual therapeutic contract is drawn up. The therapist's main efforts during these sessions are concentrated on properly construing the configuration of the family game at that particular moment, and in tracing the antecedents and motives that have led to the request for therapy.

The following configurations corresponding to Stage 6 in our schema (symptom-based strategies) are those we have encountered most frequently in our practice:

1. Equilibrium: In chronic anorexia, the request for therapy often comes at a time when the system is in a relatively balanced state. The patient is going about her work normally, and although she is to a greater or lesser extent underweight, her weight is stable. The family's "configuration" is still the one that set in during Stage 2; that is, the patient, by using the symptom, seems to have regained the illusory position of level-headed and esteemed chief counselor to her mother (Type A) or father (Type B). It is typical for these patients to show up at the first meeting accompanied by the respective parent. They will profess their desire to "get well" and often complain of a fiasco during some earlier attempt to tackle the problem. Repeated requests for therapy, in fact, are a characteristic element in an equilibrium of this type. The parents will show their interest by urging the patient to seek treatment, and the patient, for her part, will show good will by agreeing to make regular visits to a doctor and embark on some sort of therapy, which will quickly be interrupted. Such requests for therapy have a ritualistic aspect and are not genuinely indicative of a will to change.

2. Vicious circle: In other cases, the request for therapy follows a breakdown in the former equilibrium, almost always due to some decisive move on the part of a rival sibling planning to leave the family for reasons of work, marriage, or the like. These preliminary signs of a coming breakaway confer enormous power to the rival sibling vis à vis the parents, which the patient cannot counteract. A gradual or dramatic worsening of the symptom ensues, often compounded by suicide attempts and obsessive or phobic manifestations. The rivalry between siblings breaks out into open hostility and the patient makes life at home unbearable for her opponent. This state of affairs, far from furthering the rival's attempt to leave the stage, actually keeps him or her tied down because of the patient's worsening condition. The parents will use their daughter's plight to keep a favorite son or daughter cooped up at home, claiming they are not able to cope with the problem on their own. This, in our experience, is the family configuration we find most frequently when a chronic patient and her family "move" to request therapy.

3. Loss of pathological power: At times, after many years of sustained equilibrium, the family may gradually become immune to the influence the patient wields by virtue of her symptom. Interest in her condition tends to be perfunctory, no bright new ideas about therapy are forthcoming. The patient will sometimes react to this waning of pathological clout by getting depressed. This, then, may be the real reason for seeking individual therapy.

4. Relentless insistence on therapy: In a small number of cases, some special turn of events may cause the patient's symptom to develop into a severe obstacle to everyone's plans. If, for instance,

the father should die and the mother resolve to go and live with a married daughter who is unwilling to get deeply involved with her ailing sister, the family will not want to abandon the patient to her fate and will resort to relentless therapeutic "hounding" in an effort to force the girl to tackle and overcome her problem. Should the therapist inadvertently join in this persecution, he or she may be increasing the risk of the patient's dying.

At the end of the second preliminary session, once the therapist has managed to construe the likely configuration of the family game, he or she will voice an opinion as to the motives underlying the patient's request for therapy, give a brief explanation of his or her method of working, and draw up the terms of the contract. Therapy will always be offered, even though the therapist may have stated that the patient's motives seem to be insufficient or unsound. In all cases, the therapist will ask the patient to think things over for a brief period, after which she may contact him or her again and start therapy.3

The Rules of Therapy

The therapeutic context is subject to rules that we will mention briefly. Sessions are held once a week so that the cost of therapy will be reasonable, and the patient should bear the cost without falling back on the family budget. From the outset, therapists will, during the sessions, address their patients exactly as they would in ordinary conversations (9); in other words, they will follow social customs that apply in everyday life, constrained only by the limitations stemming from the difference in their two roles. Next, therapists are explicit about their hypotheses, never concealing or disguising them. A hypothesis, in this context, is a conjecture based on at least one unit of interaction (defined below). In other words, therapists will never resort to covert strategies or address the patient as one would a "sick" person. This is essential for establishing proper empathic rapport, the conditio sine qua non for therapy to be effective.

Therapy, as we have seen, conforms to simple rules. Therapists, once they have drawn up a hypothesis, propose it to the patient, who is by no means obliged to accept it uncritically. For her part, the patient is expected to modify her behavior outside therapy in such a way that the validity of the hypothesis can be checked, by observing how other members of the family react. If for any reason these rules are not followed, therapists will be unable to use this method and therapy will have to be discontinued.

Example 1

Anna, a 22-year-old physical education instructor, started therapy after five years of an anorexia consisting solely of dietary restrictions. The patient came under Type A in our schema. She described her father as being a "non-person" during her childhood, at which time she was under absolute fealty to her mother and acted as an attentive audience for the latter's grievances and confidential outpourings. The patient reported having begun to lose weight when her mother's attention gradually shifted to her younger brother, Giovanni, then an adolescent. Anna, who became an anorectic at the age of 17, managed to use her symptom to counteract Giovanni's heightened influence over her mother and seemingly recovered the position of trusted confidante she had temporarily lost.

This equilibrium persisted for about 4 years and began to falter when Giovanni got back from his stint with the army. The young man showed no inclination to look for a job, and all he did was have a good rest between one round of pleasure and the next. The patient reports that although her parents are clearly alarmed, they avoid taking any action to curb his behavior. Her mother complains endlessly to Anna about her son's disgraceful conduct, but often gets into a huddle with

him and holds long, whispered conversations. The patient believes her mother is "making him understand how bad his conduct is."

The father seems mainly intent on keeping out of things. He gives Giovanni a noisy tongue-lashing now and again, but the storms blow over with no visible results. What is more, he leaves sums of money lying around the house, quite obviously meant to cover Giovanni's escapades. Anna, thoroughly outraged, keeps close tabs on her father's "oversights" and tries in vain to get her mother to control her husband's absent-mindedness and her son's extravagance more effectively.

In order to offset her brother's idleness, Anna has redoubled her own activity. In her spare time after school, she supervises sports for children and cares for a group of needy old people. Her loss of weight, which gradually gets more alarming, has apparently gone unnoticed in the family. At this point, Anna decided to come for therapy.

During her first month of therapy, Anna uses her sessions mainly to supply the information given above, and to describe herself and her parents as Giovanni's victims. In this initial phase, the therapist tries to help the patient keep Giovanni's effrontery in check; the symptom has quite obviously failed to accomplish this (a "vicious circle" configuration). The therapist proposes the following hypothesis: according to him, her mother is mainly intent on not endangering her rapport with her son, and Anna's symptoms are a useful means of controlling him indirectly. He adds that during the whispered tête-à-têtes, Anna's mother is probably not reproaching Giovanni at all, but simply begging him to change his ways in order to prevent the inevitable rows with his father from worsening Anna's condition. This would also explain why Giovanni has now become so openly hostile toward his sister. The therapist, noticing that Anna looks doubtful upon hearing this, points out, session after session, how events in the family, as Anna herself reports, bear out these assumptions.

After a few more sessions, Anna attempts a surprise move in the family game. She sees her chance during one of her mother's endless litanies of complaints about Giovanni and abruptly informs her that she no longer intends to be drawn into the matter: "From now on," she states, "don't come complaining to me about Giovanni. If you feel like griping, you can go directly to him. You see, I'm quite sure that you talk to him about me exactly the same way when I'm not around." The mother's only reaction was one of great surprise. The patient reports that during the following days she steadfastly refused to heed any of her mother's several attempts to grumble about Giovanni. Immediately after this episode, the constant bickering between Anna and Giovanni starts to subside. Giovanni scouts around for work and lands a few odd jobs. He also demands less money at home. Her mother, on the other hand, becomes remarkably more tense and edgy; she flares up at her daughter at the slightest provocation, and is then obliged to apologize.

The reactions of her mother and brother are seen by the patient as corroborating the therapist's hypothesis, and Anna stops losing weight. It should be stressed that Anna's "move" (refusing to join her mother in grumbling about Giovanni) violated no family rule and therefore did not lay her open to blame by anyone.

As we define it, a phase in therapy is a certain lapse of time, usually a lengthy one, during which the patient works on redefining her rapport with some specific subgroup of family members. In order to read a correct meaning into the patient's behavior, it is important to single out which family members, and how many of them, are involved in whatever phase is under way. It is equally essential to construe the behavior strategies of each of these members so as to be able to suggest possible alternative behavior patterns for the patient. This is why a historic reconstruction of the

family's life events is such a fundamental part of each single phase of therapy. The favorite strategies of the members most involved in each phase may be inferred from an analysis of how their attitude has varied during the preceding "configurations." Our experience tells us that the first phase of therapy generally finds the patient redefining her rapport with her siblings as it affects her relationship with their mother. The father comes forcefully onto the scene in a later phase, and at such a time the patient will have to tackle her involvement in the couple's relationship. In this second phase, the father resorts to maneuvers of seduction, instigation, and volte-face, all of which will be of paramount importance during this time period.

Example 2

Sandra, age 22, exhibited significant bulimic symptomatology and wildly fluctuating weight levels when she first came for treatment.4 Having come to see herself as a "monster," Sandra gradually cut off all social ties. For two years she rarely left her room except to watch TV in the evenings and raid the icebox at night. We classified her as Type B. During her childhood, she had reluctantly submitted to her mother, whom she consciously but secretly despised. All her admiration had been for her father who openly showed pride in her brilliant intellectual prowess. However, ever since she isolated herself, her father avoids encountering her by spending little time at home.

After a few months of therapy, during which Sandra starts going out again and tones down her dietary symptoms, her father suddenly confronts her and says, "This therapy of yours obviously isn't getting us anywhere and I've decided to have you sent to a psychiatric hospital. The only way you can make me go back on my decision is to stop your absurd food habits once and for all. Immediately!" Sandra protests that for almost two months she has only eaten whatever food her mother has brought to her room, that she has started going out again, and that she does all her gorging on her own allowance, which means she can rarely indulge. Her father, unaware of what goes on in his own house, asks his younger son, Rodolfo, to confirm this, which he does. His attitude changes immediately. He confesses to Sandra that he had reluctantly threatened her with hospitalization because his wife had put him up to it. He begs her to forgive him and tries to enlist her sympathy and understanding. After all, his marriage is such an unhappy one, and she should remember that her mother has had a lot to do with psychiatrists in the past on account of her own bouts of depression. Sandra should be patient with her suffering mother, just as he is. After this conversation, Sandra goes back to eating her meals at the family table. Not for long, however, as whenever his wife is present, her father behaves toward Sandra in his former offhand or openly taunting fashion. Because they are illicit, such seduction/instigation maneuvers between father and daughter are rarely disclosed to the therapist, who must nonetheless be quick to discern them.

Example 3

After about 6 months of therapy, Adele (age 26), who for ten years has exhibited symptoms of anorexia and bulimia and been classified by us as Type B, suddenly blurts out in the session her intense aversion for her father. He is a domineering tyrant, she claims, and has ruined her life from childhood on. The therapist, once he has made out the immediate reasons for this outburst of fury (Adele has repeatedly been first led on and then ditched by her father), shows himself reluctant to believe her. He suggests that Adele's propensity to take every sign of accommodation to her by her father as the promise of an exclusive rapport shows that such rapport must have existed some time in the past. He remarks that she behaves differently toward her mother in similar situations. To the therapist's great surprise¾he had merely commented on a general pattern¾Adele takes a snapshot of her father and herself at age four out of her handbag and says, "Just look how handsome he was!"

She adds that for 6 years, since she first left home, she has been carrying the snapshot with her all the time.

In this crucial phase of therapy the patient may make an attempt to renegotiate the family "rules" with her parents. Such attempts will often lay her open to their disapproval or attack. We believe there is a difference, as regards this issue, between our Type A patient¾who will run the risk of a break, even a permanent one, with her father but not with her mother¾and Type B subjects, for whom the opposite is true.

Example 4

Maria is a young married woman, age 25, who has exhibited typical anorectic symptoms for 8 years. Her history places her in Type A. Well into the second phase of therapy, she reports that her mother has asked her to take her heavy-drinking father to task. He has shunned all communication with both his wife and the other three children, and only Maria "can make him see reason." Maria says she has reluctantly agreed to undertake this chore, but has informed her mother that she will do so just one more time. Being asked to approach her father on this subject brings back painful memories of the time when she was always the one who had to make the rounds of pubs, find her father, and persuade him to come home with her before he got too drunk. During a heated exchange with her father, Maria lets him know that the real purpose of her "mission" is to convince him to take the cure. She adds that she very much hopes he will do so but that, whatever he does, she will never again try to persuade him because all her efforts are useless and extremely painful for her. She adds that she has resolved to tackle her own problems and that this will prevent her from worrying about other people's. The father's reaction to this statement is unexpected and tinged with despair: "Oh well," he says pathetically, "if you, too, have decided to think only of yourself, then you have ceased to be my daughter, along with the rest of them."

Redefining the relationship with the parents often ushers in the final phase of treatment, during which the patient is increasingly involved in working out her relationships with her peer group. This entails a number of problems because such patients have often missed out on experience they should have acquired during adolescence. They therefore tend to carry over into their extrafamilial relations the dysfunctional patterns, according to which they see themselves as having a right to special privileges and attention. Failure to acknowledge and cater to her wishes¾which she takes great care to conceal¾will call forth a negative reaction from the patient. Real interest in her condition could only come, she feels, from someone able to grasp and respond to her hidden demands without being told.

Units of Interaction

The data the patient supplies during the sessions, interpreted according to our 6-stage schema, allows therapists to make hypotheses as to moves that most likely have been made by the various family members. Therapists will, however, also need a criterion for interpreting their patients' attitudes toward them. As outlined above, every attitude of a patient during the sessions may be seen as a move designed to induce therapists to make their own moves, which a patient then uses outside therapy. Thus, the information exchanged between the therapist and patient in one session has, or may have, the effect of inducing the patient to explore the possibility of making some fresh move¾different from those made previously and, therefore, unexpected by her family.

For example, if a therapist should make any critical remark about either parent or sibling, the patient may seize the opportunity to use this authorization to attack someone. Various family members will then counter with some reaction of their own, to which the patient will respond in turn, and so on. In

the following session, the patient's attitude will then correspond to the final outcome of this series of reactions, which we have called the exploratory sequence. The therapist's chief difficulty in reconstructing this exploratory sequence is the fact that both the patient and the members of her family resort to covert and oblique strategies. What is more, the patient will not spontaneously volunteer the information needed to reconstruct the sequence, let alone what is needed to link the various bits of information. This is why the main part of every session will be given over to a detailed account of the week's events. Only toward the end of this report will the therapist perhaps be in a position to make out how the information exchanged during the previous session was brought into play in the interaction game between the patient and her family. This knowledge will then enable the therapist to exert a directive influence on the way the patient behaves outside therapy.

Example 5

This example concerns Anna, the patient referred to in Example 1. She has now started on phase 2 of her therapy. Anna turns up for one of her sessions looking quite unlike her usual self. She is disheveled and is wearing clothes that call attention to her skinniness. Anna starts off with a long tirade against her mother. She says her mother is a fanatic stickler for so-called proper food habits and has always pestered the whole family with her obsession about diet and her wily attempts to get one or the other of them either to gulp food down or forfeit an extra calorie or two. Naturally enough, the father sees his wife's obsessive insistence as the prime reason for his daughter's anorexia. The mother, on the other hand, attributes all her daughter's woes to her husband's noisy, unpredictable outbursts. In this session, the therapist contributes only noncommittal remarks to Anna's report.

During the next session, Anna comes in wearing an attractive dress, one that flatters her figure. She is all spruced up and her manner is seductive. She starts the session by speaking of her father in critical and contemptuous tones. Among other items, the week's report centers on the following events. On the day following the previous session, Anna's father had gone to the market for the family groceries, as he always does on Fridays. As usual, Anna and her mother had made out a shopping list, which included a few things especially requested by Anna, mainly vegetables and low-fat mozzarella cheese. Back from the market, the father dumped the shopping bags on the kitchen table and bolted out the front door. Mother and daughter started unpacking the groceries and discovered that, as usual, the father had forgotten a number of things. This time, however, he had also made a big mistake: instead of the low-fat cheese he had bought extra-rich mozzarella, which has a high calorie content. When Anna sees this, she makes a scene, which she herself describes as "hysterical," and shouts abuse and obscenities at her absent father. Her mother takes no part in this mudslinging and quietly reminds Anna how forgetful her father always is. However, the moment her husband gets back, she flies at him in a blind rage and relays all his daughter's insults to him word for word. She ends up by saying, "Either you make up your mind and do something about this or you'll have to choose either me or her." The father has a terrible row with his daughter. This mollifies the mother, who takes Anna aside and apologizes for having called down her father's "exaggerated" bombast on her head. That same afternoon, mother and daughter go shopping and together they buy the dress Anna is now wearing to the session. In the days following this episode, mother and daughter frequently get together to exchange confidential, critical remarks about the father's many shortcomings.

This information helps the therapist hypothesize that the father's purchase of rich mozzarella was tantamount, in the patient's eyes, to a volte-face. This accounts for Anna's exaggerated reaction. In

order to check on his assumption, he asks the patient for further information: "I have an idea that after our last meeting, and before the next morning, you must have had a private conversation with your father. But I can't understand when this could have taken place because I know you always get home late when you come here." Anna reluctantly concedes that she took the train home as usual after their last session but got off at a station midway, where her father was waiting in the car to save her time by driving her home. She flushes and says she can't recall what they talked about during the drive home.

This additional information helps the therapist reconstruct the exploratory sequence as follows:

1. During the first of these two sessions, the patient's attitude was a move to elicit critical comment from the therapist about her mother, which she could report to her father during the drive home.

2. During their ride in the car, the patient gains the impression she has succeeded, by reporting the therapist's remarks, in reestablishing her alliance with her father against her mother.

3. Her insistence on low-fat cheese amounted to an attack on her mother, which she felt sure would have her father's complicity. His buying the rich mozzarella, therefore, takes on the significance of a volte-face, and this explains Anna's violent anger.

4. Her mother uses Anna's invective against her father to reaffirm her own power over her husband and score a point against Anna.

5. The frock that disguises Anna's skinniness is the sign of the patient's renewed fealty to her mother, which is then further reinforced by the two women getting together to criticize the father.

6. The patient's attitude at the beginning of the second session may be considered a move to enlist the therapist in making further critical comments about the father.

As a general rule, therapists will not voice such explicit hypotheses unless they are founded on a full reconstruction of the exploratory sequence. This does not mean these will be the only kind of interventions made during the session. However, only on the basis of such a reconstruction can therapists expect patients to change their behavior so that hypotheses can be checked by observing the parents' reactions. An incomplete reconstruction of the sequence may lead to a number of errors:

·By assuming that a patient's attitude within the therapeutic session is a thing in itself, therapists may mistake it for a growing involvement with them (believing, for instance, that the patient spruced herself up for them).

·By neglecting to consider covert moves by others in the family, therapists may be led to see the patient's reactions as "sick" (for example, Anna's hysterics about the high-fat cheese).

·By, failing to discover a patient's covert moves, whether directed at the therapist or at family members, therapists may be led to view a patient as her parents' "victim," with the disastrous effect of instigating her against them.

Termination

The patient is ready to terminate therapy if she has been able to renegotiate her relationship to other people without resorting to her symptom. Normally, the more consistent the therapist has been throughout in abiding by his or her stated principles and the terms of their contract, the less problematic termination is likely to be. If the therapeutic rapport has at all times been regarded as functional to the patient's extratherapeutic relationships, improvement in her condition will coincide with her growing involvement with others. New projects will clash with continuation of therapy and

bring about its coming to a natural end. If, however, the therapeutic relation has become a privileged relational context for the patient, she may tend to revert to her symptoms as termination draws near. We are inclined to think that such an occurrence is due to an error on the part of the therapist.

Follow-up

When the therapeutic rapport comes to an end, the patient is requested to submit to two follow-ups, one after 6 months and the other after 5 years. Basically, the short-term follow-up is a check on whether the changes achieved during therapy have been accompanied or followed by other important changes in the life of the patient or that of other family members. Once we have collected a sufficient number of cases, we will be able to test and refine our schema by eliminating any possible redundancies.

Example 6

This follow-up concerns Maria, the patient referred to in Example 4, who had a history of 8 years of anorexia when she started therapy. When she came for her short-term follow-up, she was 4 months pregnant. Her elder sister and her sister-in-law were also expecting their first child. She reported that her sister had confided to her that in the past she had put off motherhood at the urging of their mother, who insisted that if she got pregnant it would be a fatal blow to the patient. The father, always a heavy drinker, had by now given himself over entirely to alcohol, and was no longer able to manage the family business, which had been taken over by his son and his oldest daughter. Also, the patient's husband had accidentally lost three fingers of one hand while working at home. The patient states that she is delighted to become a mother and that she went through a particularly difficult time on account of her husband's misfortune, but she came through with flying colors and without enlisting anyone's assistance. We checked the accuracy of this information in a separate conversation with the patient's husband.

To date, only a few short-term follow-ups have been carried out. Of the first group of ten patients referred to us for treatment, only four patients underwent therapy. These patients, who had shown symptoms for an average of 7 years, terminated therapy in less than one year, and were found to be free of symptoms at the 6-month follow-up.

The long-term follow-up, which we have scheduled for 5 years after termination of therapy, will consist of both a clinical interview and the use of standardized psychodiagnostic instruments, which will enable us to compare long-term follow-up studies that have used similar methods. No long-term follow-up has as yet come due for any of our patients.

Conclusions

Clinical practice carried out over the past 10 years in our Center was the groundwork for tracing the anorectic process as it develops in a family. The study entailed reconsideration of a number of fundamental concepts. Our newly acquired knowledge, in turn, suggested a novel approach to individual therapy for chronic patients. Despite the relatively few treatments completed to date, and the lack of long-term follow-up controls, we consider our results highly promising.

REFERENCES

1. Dell, P., (1982) Beyond Homeostasis: Toward a concept of coherence, Family Process, 21, 21-41.

2. Haley, J., (1959) The family of the schizophrenic: A model system, Journal of Nervous and Mental Disease, 129, 357-374.

3. Jackson, D. D., (1965) Family rules: Marital quid pro quo, Archives of General Psychiatry, 12, 589-594.

4. Minuchin, S., Rosman, B. L. and Baker, L., (1978) Psychosomatic families: Anorexia nervosa in context. Cambridge: Harvard University Press.

5. Morin, E., (1986) La méthode. 3: La conaissance de la conaissance. Paris: Seuil.

6. Selvini-Palazzoli, M., (1978) Self starvation: From individual to family therapy in treatment of anorexia nervosa (translator, A. Pomerans). New York: Jason Aronson.

7. Selvini-Palazzoli, M., (1986) Towards a general model of psychotic family games, Journal of Marital and Family Therapy, 12, 339-349.

8. Selvini-Palazzoli, M., Boscolo, L., Cecchin, G. F. and Prata, G., (1978) Paradox and counterparadox: A new model in the therapy of the family in the schizophrenic transaction (translator, E.V. Burt). New York: Jason Aronson.

9. Viaro, M. and Leonardi, P., (1986) The evolution of an interview technique: A comparison between former and present strategy, Journal of Strategic and Systemic Therapies, 5 (1-2), 14-30.

10. Watzlawick, P., Beavin, J. H. and Jackson, D. D., (1967) Pragmatics of human communication: A study of interactional patterns, pathologies, and paradoxes. New York: W.W. Norton.

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