Thus, a dissociative symptom, anorexia, or depressive behavior may be programmed to face the threat of momentary instability, such as the emancipation of a child, as well as in preparation for the distancing of other children, or the death of a parent with the consequent functional void produced by such an event. In this case the designation changes from fluctuating to fixed, producing a progressive crystallization of the symptomalogical function of the identified patient and of the interrelational functioning of the other family members.

This process of stabilization uses systemic energy for maintaining rigid functions which limit exchanges to redundant interactional schemes. In this way a "pathology-function," always increasingly irreversible in one family member, finds its counterpart, "health-function," comparably irreversible in the others. This stasis permeates the relationship between the system and the external world, whose influence will be filtered and used to maintain the accustomed equilibrium.

In exploring the double significance of the symptomatic behavior, we see that on one side it represents a transformation in the functioning of cohesion and on the other it is a sign of the pain and suffering resulting from the restrictions imposed on every member of the system. There is an attempt to blend the contradictory aspects of family reality, to "freeze" the conflict between the tendencies directed toward maintenance and those directed toward rupturing the acquired equilibrium. In this attempt, the symptom may be interpreted as a "metaphor" of instability and as an indicative sign of the fragility of the system. For this reason the utilization of the symptoms must become one of the priorities of intervention early on in therapy (Andolfi & Angelo, 1981).

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CHAPTER 2

The Diagnosis: Hypotheses to Be Tested in the Intervention

FAMILY SYSTEM AND THERAPEUTIC SYSTEM

If we evaluate the rigidity or flexibility of a family system, viewing the therapist as an "external," neutral observer of objective phenomena, the family's repetitive and stereotypical patterns of interaction will appear to be the material on which to base intervention.

However, a totally different perspective may emerge if we observe the *suprasystem family-therapists,* which results from the interaction between the two respective subsystems in the context of the intervention (Selvini-Palazzoli, 1980). A point of view which includes the entire therapeutic system forces us to reformulate the concept of diagnosis and change. In this view observation is focused both on the functional intertwining of the family and on the role assigned by them to the ther-

apist, who inevitably becomes an equal, active element in a system which includes them all. Part of the diagnostic process, therefore, must be directed to evaluating where and how to focus the therapeutic intervention and how it will be utilized by the family (Haley, 1976). Family members may adopt it to reinforce, once again, their own structure, forming a familiarly rigid therapeutic system; or the intervention of the therapist may act as a *destabilizing input,* disturbing their rigidity, causing a redistribution of the functions and capacities of each individual. The diagnosis depends on the ability of the therapist to assess the interaction, which co-involves him, as an outside observer might. He must be a musician who plays in the orchestra but also conducts it. To achieve a successful performance it is essential that the orchestra follow him, but he must not be so tied to that function that he cannot use his instrument to the optimum in the development of the musical theme.

The therapist encounters three problems: The first involves the necessity of *isolating the function that the family wishes to impose upon him.* As many parents-to-be anticipate the task and function of their unborn child, so the family imagines what the task and function of the therapist should be even before treatment begins. If the therapist wishes to be free of meeting this expectation, he must be able to clearly delimit his boundaries in respect to those of the family by immediately facing this in defining the therapeutic situation (Whitaker, 1975).

The second difficulty lies in searching out the definitions and images related to the functions of each family member. As a detective, he uncovers the role of each character in a plot which he must further. This serves to help him enter into the dilemmas in the life-style of the family. He is not yet ready to delineate the ties, the rules, or the "true" functions assigned, but he is in the process of constructing "his own truth" in the therapeutic context, which will shake that "truth" already programmed by the family. Through his perception of the family-therapist interaction, he *creates a new reality* together with the family.

The third difficulty is related to the necessity of evaluating the intensity, i.e., *the degree of force invested in his destabilizing input* which will break up the rigid patterns and still be acceptable to the family. Much depends on the family's response to the image which the therapist suggests after having explored certain contextual elements as they

have emerged during their interaction. From the mass of verbal and nonverbal information gathered, the therapist selects those elements which hold most significance. These are elements which refer to the observed interactions, attitudes, or behaviors which were ambiguous and contradictory in nature. The therapist can quite simply select an image of the family which differs from the habitual one. Both verbal and nonverbal contextual information can be highly significant because of the differing perceptions among family members. It is precisely through countering the image furnished by the family with an alternative that the therapist is able to release the tension which sustains the therapeutic process.

With this perspective, even the gathering of information for diagnostic purposes takes on a new structure. Questions which give a confused mass of relevant and irrelevant information are replaced with those directed toward information which reveals the tendency for cohesion and for differentiation in the system. The new reality which is created becomes the frame of reference for the definition of the relationships within the therapeutic system. If the family continues to raise problems tied to its usual, habitual image, the therapist must create an alternative image which can break the circuit of redundancy in which the family system flounders.

The therapist must use this new image, then, as a destabilizing input in order to see how the system reacts. The family's responses to this therapeutic intervention, together with the therapist's ability to initiate change, give strong clues about the degree of rigidity. The danger that the family may reabsorb the intervention forces us to refine our diagnostic hypothesis continually rather than stay with one definition. At each point, we must be able to support our hypothesis, at least partially (Selvini-Palazzoli, 1980). We need not take it as a truth, but we must use it to draw out possibilities and alternatives already present in the system which can lead to new understanding. The therapist introduces alternatives and the element of surprise, but it is the family which will "justify" the diagnostic hypothesis through an internal reorganization, using abilities and values already present in its existential endowment.

Let us clarify this concept by describing factors we assume lead a family into therapy and then giving a range of possible therapeutic responses to the expectations of the family system.

In families where developmental processes are experienced as threatening, interactional patterns and individual functions become progressively rigidified until, ultimately, individual pathology is expressed. The greater the system's need for stability, the greater the severity and irreversibility of the resulting pathology. In other words, the system reorganizes itself so that it will not have to change. Roles, functions, relations, and interactive space become more rigid. To counteract the stress inherent in developmental change, the system substitutes the stress evoked by the symptomatic behavior of one family member, the identified patient, around which the anxieties of all family members revolve (Nicolò & Saccu, 1979). The identified patient thus represents both the impossibility of change and the only possibility of change. His behavior, with its contradictory aspects, has the effect of congealing processes which are moving in opposite directions while providing the possibility for new input, i.e., the therapeutic intervention. Simultaneously serving as both guardian of the system's stability and agent of systemic disruption, the identified patient's behavior represents a metaphor for the dilemma of a family that would like to move while standing still.

In the light of this premise, we can more easily understand the contradictions that the family brings to therapy, since the request for therapy is motivated by this same dilemma. Consequently, when a new element, the therapist, is introduced, he is expected to accept the family's paradoxical request by helping them to move while standing still (Angelo, 1981).

To grasp the complexity of the therapeutic situation, it is important to recognize that in rigid family systems the members become increasingly incapable of owning their own conflicts and contradictions (for example, concerning change and immobility, dependence and separation). These conflicts appear so threatening that they have to be neutralized by skillfully distributing their constituent parts within the family. Accordingly, each member adopts a vision of reality complementary to that of another; there is the sick member and the healthy one, the aggressor and the victim, the wise one and the incompetent one, with increasingly rigid rules determining when and where the respective functions are fulfilled.

Within the family some member represents the tendency toward

movement while another personifies the tendency to stand still; in a similar way the family predetermines the parts to be assigned to the therapist in the new therapeutic structure. The therapist, too, has to play a part in the family script, not as a whole person, but as another actor on whom some of the functions originally "impersonated" by someone in the family are projected (Andolfi & Angelo, 1981). In the therapeutic interaction the family's objective remains the same: *to separate into constituent parts those contradictions which each member is afraid to experience at a personal level.*

Telephone contacts by a family member, letters of presentation, the direct or indirect mediation of other professionals, institutions, or friends of the family represent some of the apparently neutral means the family uses to program in advance the rules of the therapeutic relationship and the parts that each person will play. The more rigid the relational script of the family, the more assiduous it will be in this effort. The family will try to pigeonhole the therapist, fitting him into its own framework of rules and functions even before meeting him.

If what the family really fears is change, and not the contrary, then the identified patient and his or her family members will present a united front in proposing a program for therapy that will not disturb the equilibrium they have acquired. If the therapist accepts their program, or gets drawn into it, he will inevitably reinforce the family's static-pathological tendencies. We are convinced that many therapists fall into playing the part the family "assigns" to them, not only because of inexperience but also to satisfy needs similar to those of the family—that is, the therapist's need to program highly stable relationships that will not threaten *his own security* (Andolfi, 1979).

When this occurs, the family does not learn anything substantially new. It merely utilizes its own dysfunctional patterns in a more refined way, maintaining intact the roles assigned to each member. The result is a progressive impoverishment of personal "identity," which is gradually replaced by repetitive and highly predictable functions (Piperno, 1979). In a context of this type, the function of the therapist is equally repetitive and predictable, for he, too, is afraid to change and to discover new parts of himself to utilize in his relations with others.

In other cases, it is the setting of the therapeutic encounter that rigidly defines the rules of the context and the parts to be played, preventing

both family and therapist from uncovering important parts of their own selves to invest in the therapeutic relationship. This is commonly the case in institutions where interventions are based on premises of "welfare," that is, where therapy is defined as doing something for or in place of someone else (whether an individual or a group) who presents himself or is described as helpless (Barrows, 1981).

It is clear, then, that we can evaluate a therapeutic situation using the same criteria of flexibility that we apply to a family system. We consider a therapeutic system flexible if it can alter its own systemic equilibrium so that the relation between functions (of therapist and family) and individuation can be modified in the process of therapy. Contrarily, a therapeutic system becomes rigid (this can occur during any phase of treatment) if it fails to offer its members the possibility of freeing themselves from static expectations and functions and of moving toward more integrated levels of functioning and greater differentiation (Andolfi et al., 1980).

The Utilization of Familial Defenses

An initial goal of intervention is to make the family's problem become the problem of the therapeutic system, and consequently to have the therapist share in the difficulties that previously belonged exclusively to the family. We will now describe specifically how this occurs and why *this redefinition of the therapeutic relationship represents an initial "therapeutic" response to the contradictory expectations of rigid families.*

The therapist's first problem is how to engage a family that simultaneously presents contradictory requests, without getting enmeshed in the family's paradoxical mechanisms. In fact, the family is prepared either to sabotage his efforts if he takes the initiative or to force him to attempt the impossible if he declares that the situation is hopeless.

Experience has taught us that the first step is not learning how to defend oneself from a manipulative family, but learning *how to avoid resorting to defensive maneuvers.* Defense and attack are complementary aspects of the same relational modality, which inevitably leads to sterile antagonism.

The many errors we have committed over the years, measured by

our failure to reach the core of a family's dilemma, have convinced us of one thing—that the therapist, instead of reacting to one of the two levels on which the family relates to him, *must accept the family's entire "paradoxical" mechanism.* In this way, he will not need to defend himself from the family's contradictory responses because the family will be automatically deprived of its only means of contradicting him (Andolfi & Menghi, 1977). If the family fails to trap the therapist in this futile, paralyzing game, it will be on the spot and will be forced either to find other ways of relating or to break off the therapeutic relationship. In either case, a situation of uncertainty is created that may disrupt the stasis of the family system, which will now find it more difficult to change while standing still. Regardless of the type of intervention used, the therapist's strategy must remain firm, incorporating both of the contradictory levels of the family's request and making the therapeutic system operate at a higher level, where the contradictions can be comprehended and resolved.

As Selvini has brilliantly described in her paper "Why a Long Interval between Sessions?" (Selvini-Palazzoli, 1980), we have seen a marked change in the rhythm and duration of our current therapies in contrast with those of past years. Previously, therapies were often long (lasting several years) and the intervals between sessions were brief, because we thought that *the family could not make progress by itself.* We did not realize that we were actually reinforcing family stasis. Consequently, we created therapeutic systems in which the therapist became the guardian of everyone's emotional stability (including his own).

Today, the course of our therapies is very different because we define the relationships more rapidly. Whether or not the therapist succeeds in entering the system is determined within the first few sessions, or even in the first encounter. He may fail to enter into contact with major areas of the family, either because they are too well concealed or because at times the family may precipitously terminate the therapy even where the therapist has succeeded in touching vital conflicts and important contradictions. It is almost as if they feared the effects of a vital reawakening much more than their apparent psychological death.

The rapidity and intensity of our contact with the family increase the risk of sudden termination; however, this approach also makes it high-

ly unlikely that the therapist will become enmeshed in an unproductive relationship. The sooner his redefinition occurs, the greater will be his incisiveness in the restructuring intervention. In some cases, the therapist may intentionally dwell at length on secondary details to confuse the family or distract attention from other therapeutic moves. In general, however, lingering over inessential elements while waiting for the "right moment" makes the therapist's moves more predictable, thus preventing tension from building. It appears to us that each system has a time limit within which a particular intervention has a chance to succeed. If this limit is passed without change having occurred, one must conclude that the family's ability to recognize and anticipate the pattern of the therapist's moves and to adjust their own responses to his moves are so adept as to annul any possible destabilizing effect.

We want to make clear that embracing the logic that imprisons the family and prevents the members from growing and individuating is not merely a technique, a method of using counterparadox in response to the paradox presented by the family. Rather, it is the result of the therapeutic choice in which the therapist determines how he intends to establish *his* relationship to the others. If he is able to accept the family's need to change and not to change, to request help and to refuse help, then the paradox presented by the family will probably become easier to understand. Its paradoxical dilemma will become a meeting ground instead of a phenomenon to judge or analyze with a microscope. By responding to both levels ("Yes, I will help you without changing you"), the therapist creates a strong bond with the family. The family will then perceive him as a person who can enter into its most intimate areas because he is able to neutralize the system's defenses without getting trapped in them.

If the therapist decides to work by observing the family's problems from "within," he will have to enter into the family's most obscure and hidden spaces. At the same time, he will need to distance himself from the family and return to his own space in every sequence of the therapeutic process. This engaging and disengaging, uniting and separating, that he uses as a model of relating requires him to be able to feel at once whole and divisible, to incorporate techniques and strategies without using them to avoid individuating himself in the therapeutic context (Minuchin & Fishman, 1981).

The Case of Tony: How to Identify Nodal Elements for an Alternative Structure

Tony is a young adult who was brought for therapy because of his catatonic symptomatology. His mother, who made the first contact by telephone, stated that her son had been behaving strangely for several months. He had not gone out of the house, had refused all contact with her and his siblings, and had withdrawn into complete mutism. He had had several psychiatric hospitalizations with no appreciable improvement. The mother presented the case as hopeless, but said she was confident that the therapist would be able to convince her son to return to normal.

The first session took place with the participation of Tony, his mother, his older brother, two sisters, and the five-year-old daughter of one of the sisters. Tony immediately took over the central role of identified patient. He paced slowly up and down the room, occasionally glancing wide-eyed at the other family members who huddled on a couch awaiting some resolutive response from the therapist.

The therapist, instead of sitting down and ignoring Tony's pacing, remained standing in a corner of the room, as though communicating to all present that only Tony had the right to decide when and how to begin the session. The therapist's behavior increased the tension already present in the context, transforming it into an interactional stress; instead of either enduring it or taking control over it, the therapist chose to participate in it. After a few minutes of silence that seemed full of mysterious significance, Tony decided to sit down, holding his body rigidly erect and tossing penetrating looks at the other family members who huddled even closer on the couch.

It was then the turn of the therapist, who sat down facing Tony. He finally broke the silence, addressing Tony's family in a firm voice: "I have a problem, and I don't think I can be of any help to you if you cannot first help me. I would like each of you to reassure me that you fully understand what Tony is saying to you." Then he invited each person, beginning with the mother, to find the best position from which to observe Tony and to listen carefully to everything that Tony wanted to say to him or her. Each member was asked to comply with this task without speaking.

What was the therapist trying to do by beginning this way? First of all, after transforming the tension that was initially directed at him alone by making it interactive, the therapist became even more unpredictable by presenting himself as the person with a problem and leaving it to the others to help him first (Andolfi & Angelo, 1981).

This is an example of what we have described as embracing the family's paradoxical logic and of responding simultaneously on two levels: We are willing to help (e.g., by actively participating in the encounter) without helping (that is, by redefining the family's expectations so radically that even the roles of help-seeker and help-giver are reversed).

If the therapist wants to avoid being trapped in a role by passively accepting the functions that others assign to him and participating in a drama with a foregone conclusion, then he must take part in the action. He has to redefine each player's role (including his own) and alter the timing and modality of each sequence, introducing new ways of playing the game.

In our experience we have found that the therapist can achieve this if he is able to promptly propose a different version of the family's script, changing it by amplifying the significance of the various functions. He will be effective as a director if the family group accepts him, and if, in the situation presented to him, he is able to differentiate the *nodal elements* on which to base his proposal for an alternative structure. These nodal elements exist in the contextual data most clearly indicative of the functional patterning of the system and of the relation that each member seeks to establish with the therapist. This exploration will not be easy because the family will reinforce its own definitions, insisting on the importance of more obvious and predictable data and indicating interconnections which deny any personal involvement (Andolfi & Angelo, 1981).

In the case of Tony, the boy's refusal to speak and the whole family's complicity concerning silence seemed to represent a focal element. Had the therapist addressed the boy, Tony's refusal to speak would have reinforced that horn of the family dilemma that needed the therapist to fail in order to prove that the situation was hopeless. If the therapist had spoken about Tony to the mother and siblings, he would have inevitably accentuated the division between the normal members (who speak) and the deviant member (who refuses to speak).

Instead, by asking the family members to help him precisely in that area where any initiative on his part was destined to fail, the therapist successfully thwarted any program the family might have had for the session. The therapist then implicitly redefined Tony's refusal to speak as another way of communicating something to the others. The other members were forced to abandon the role of passive, impotent spectators and to become cotherapists-protagonists in a situation that obliged them to differentiate themselves (instead of presenting themselves as a fused entity) and to expose themselves personally. By listening to Tony (who doesn't speak) and then reporting what they understood to the therapist, each person was forced to draw on and express his or her own fantasies and could not defend him/herself by giving stereotyped, impersonal information about Tony's behavior.

Asking the family members to collaborate by utilizing the system's defenses was a way of disrupting the rigid patterns that prevented each member from individuating and that kept Tony locked into the role of sentinel of the family fortress. And this would be exactly what the family wanted if it were not afraid of losing the security it had acquired by artificially dividing reality into separate parts. If the family members express resistance, saying it is impossible to communicate with Tony without using words, the therapist can insist that if Tony can speak with glances, then they must try harder to learn to do what Tony does so easily. In this way, the problem of refusing to speak is *reframed as a special ability*—to speak without words—that can be learned by the others as well. No one will refuse to try, because that would imply an explicit refusal to collaborate, which would be contrary to the real desire to change which is also present in the family system.

Once the context has been transformed in this way, even the identified patient no longer feels "free" to act out his refusal to speak because the therapist can ask him to do what he has asked the others to do: to *communicate without words* (that is, to engage in his symptomatic behavior—but at the therapist's request). Whether he speaks or refuses to speak, Tony will lose his function of controlling the family, which now perceives the therapist as an even greater threat to its stability.

In recomposing a mosaic, the addition of new fragments enables one to fit more pieces into place. Similarly, in the therapeutic scenario the individual family actors are encouraged to perform, utilizing parts of

themselves which they had hoped to keep concealed, fearing their strong emotional implications. For this game of recomposition to take place, the therapist, too, has to risk exposure, utilizing his own fantasies in his relationship with the family. These fantasies, in which the elements supplied by the family are reintroduced in the form of images, actions, or scenes, stimulate the others to offer new information or to make further associations, in a circular process (Whitaker, 1975). An *intensification of the therapeutic relationship* occurs, as the nodal elements of the family script are brought together and reorganized by the therapist's suggestions, and he becomes an integral part of the new system.

As we can see from the case of Tony, the therapist immediately selects a *few* of the elements supplied by the family. These are magnified and made to serve as structural supports for an alternative script. Emphasis is placed on the *functions* of the various members, which are revealed through their nonverbal communications, such as posture, physical characteristics, the spatial positioning of the patient and of the others. The "historical" and "emotional" elements that have contributed to the definition of the respective functions are added gradually, as the therapist probes their significance in the developmental cycle of the family.

The family provides the "material," while the therapist places the trial markers for the course of associations.

THE THERAPIST AS DIRECTOR OF THE FAMILY DRAMA

What counts are not the facts in themselves but their unfolding in each member's personal interpretation, the way in which each one links himself, his needs, his function within the family and the familial events perceived as most important along the continuum of the life-cycle (Andolfi & Angelo, 1981).

An illustration of this can be drawn from the first session with the family of Giorgio, a 26-year-old psychotic patient. Present besides the patient are: his 72-year-old father, who wears a hearing aid and sits at a considerable distance from the others, slumped over, giving the appearance of a man long dead whose position in the family has been taken over by his own ghost; his mother with a suffering expression, seated

next to the patient, and an older brother and his wife who take the responsibility for relating the history of Giorgio's "illness." The brother's description emphasizes the organic aspect, tracing the origins to a cranial trauma caused by an automobile accident. He speaks with an air of competence, using a plethora of psychiatric terms ("delusional syndrome," "paranoid traits," etc.). He details the various diagnoses that have been made and the drugs that have been prescribed, continually asking the therapist which ones are most effective. A distinctly medical context is emerging, in which the symptoms discussed are seen as organically caused.

At this point the therapist interrupts the sequence by introducing a question to disrupt the script proposed by the family for this encounter. In trying to redefine the context, the language employed is of crucial importance. The therapist introduces a new language which translates and integrates the various nodal elements, pointing out interconnections that the family has not yet discerned and about which they are now forced to furnish new information. Once this occurs, the family has to become aware of this new input, thus laying the basis for change.

Therapist (*to Giorgio, who has been obtusely silent until now*): When did your father die, before or after you got sick?
Giorgio (*clearly perplexed, he stalls for time, asks for explanations; finally, sighing*): . . . Your question makes me feel uncomfortable really uncomfortable, yes, because . . . (*silence*). Excuse me, I have to go to the bathroom for a minute.
Mother: Yes, go ahead, you wanted to go even earlier.
Therapist: I think you can answer before you go.
Giorgio: Yes, I can say that . . . (*goes off the track*).
Therapist: Before or after?
Giorgio: Well, it happened after I got sick.

(*The same question is now posed to the other family members.*)

Brother: The truth is, I don't think he sees my father anymore as a person he can . . .
Therapist: But I'm not talking about Giorgio, I'm trying to find out how long your father has been dead.

(*The mother interrupts; she hasn't been able to stand it these last four years, the worries . . .*)

Brother: For about a year, I'd say, ever since he completely lost his hearing.
Therapist Later, then?
Brother: Yes, yes.
Mother: After (*silence*).
Therapist: Did he die of heartbreak?
Mother: Well, well, sure . . . after, you see, a little bit at a time.
Therapist: So now you have a new head of the family?
Mother: That's just it, we don't know what to do. We have to find the right medicine. (*She continues talking about how hard it is for her to bear the situation.*)
Therapist: (*He takes out a prescription pad and leans toward the mother, as though intending to comply with her request to prescribe effective medication.*) If I am to prescribe the right medication, you will have to help me understand whether it should be medicine for a crazy guy who suddenly had to take over his father's place, or medicine for a crazy guy who purposely killed his father so he could take his place. I think that's the problem, and we can't continue until we get an answer.

It becomes clear here that the language utilized by the therapist is of fundamental importance. Through its judicious use he has been able to integrate certain nodal elements, finding connections which the family has not yet established but with which it is now forced to deal. As the family participates in this process it must accept the therapist into its system, thereby laying the foundation for change.

Just what is it that enables him to grasp the distribution and characteristics of the reciprocal functions rapidly? In the first contact and during the course of the first session, the family members supply many elements through their verbal and nonverbal communications and through interactional redundancies. These elements are perceived by the therapist in the form of a comprehensive gestalt on which he bases his effort to redefine the situation. In the case cited above, he noticed the father's posture and spatial position, the older brother's behavior,

the mother's position next to the patient and her blank expression, and the fact that she sat between her two sons. These elements all seemed to indicate that the father had long lost his position in the family and that his two sons had been delegated to take over for him, one with the function of "the wise one"; the other of "the crazy one." The therapist actively organizes the elements supplied by the family to construct a new framework which will be gradually built upon during the course of the session as new information emerges.

In other words, the material that the family presents contains certain elements that are particularly significant and pertinent to any redefinition of the existing relations among the family members. These elements, which we describe as "nodal," represent points of intersection of the different and mutually exclusive scripts proposed respectively by the family and the therapist as frameworks for ordering the family's history.

This concept is illustrated in Figure 3. Diagrams of two different suits of clothing are represented in a limited space which they in part share. Imagine that the outer circle enclosing the diagrams contain all

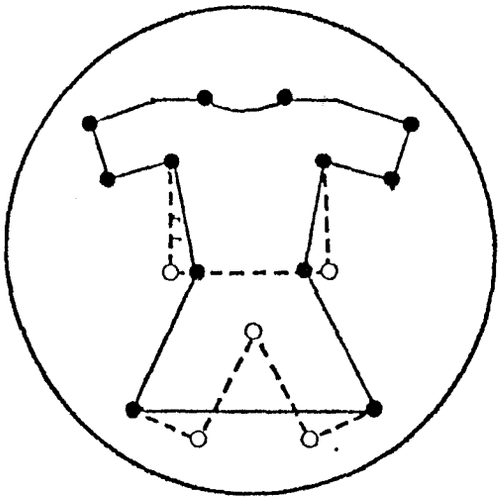

Figure 3

of the available information concerning the family's history. If we suppose that the model proposed by the family corresponds to the "dress" outlined by the black dots and continuous lines, then the model constructed by the therapist corresponds to the "shirt and pants" represented by the same black dots plus the white dots and the broken lines. With the introduction of a few "nodal" points we can draw new outlines which change the gestalt and the overall significance of the image.

The family will try to impose its own "suit of clothes," describing it in minute detail and inviting the therapist to share its own frame of reference. If he lets himself become enmeshed in this operation, the therapist risks accepting the family's model as his own. In the case of Giorgio, if the therapist had allowed the family to continue at length describing all of the patient's past medical and psychiatric history, he would have automatically reinforced the family's image of the patient and of the correlated functions of the other members. Therefore it becomes crucial that he quickly gather in all of the significant elements which surface, reorganizing them into an alternative script. With the success of this move he takes control of the therapeutic process. He also creates an unanticipated imbalance in the rigid definition of each one's assigned function which interferes with the family's attempts at homeostatic compensation.

The analysis presented here can easily give rise to misunderstandings. For example, it may seem as though the therapist is trying to impose on the family an arbitrary framework that is "extraneous" to the family's problems. Similar doubts may be reinforced by the therapist's extremely active behavior, which may at times seem "manipulative." However, it is our view that the therapist does not introduce "extraneous" elements into the script that is being dramatized by the family in its encounter with the therapist. Everything the therapist says or does during the session is based on material that emerges from the transactions. He merely *restructures* the elements that are offered (Menghi, 1977): emphasizing some which have previously gone unnoticed; relegating others that had been overemphasized to the background, or altering their sequential positions. He proposes an alternative structure by introducing isolated and vaguely defined images which stimulate the family to elaborate on them further. These images serve as a skeletal structure for the family to build on, which takes form gradually

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only as new information is added. By information we mean not static historical data but information concerning interactive patterns.

On the other hand, utilizing the data in the family history enables the therapist to create a strong bond with the family, and this is a prerequisite for the continuation of therapy. Certain interventions which seem totally arbitrary and interrupt interactive sequences in reality serve to translate on a verbal level what the therapist has perceived nonverbally or through his own associations. The organization of the material is clearly the result of an active process on the part of the therapist and is influenced by his personal history and personality. In this sense, we can say that the therapist and his perceptive power are the "extraneous elements" that are introduced into the system. If we ask what it is that the therapist is trying to achieve, the immediate answer is: to change the family's rules.

If the therapy is successful, the family's original functional rigidity gradually gives way to increased elasticity in the attribution of individual functions. The initial, highly stabilized family structure is gradually replaced by a new organization, the therapeutic one which is *unstable* and *provisory*. The process is complete when the family members have learned to make their own choices, free of rigid models, when they have developed the capacity to accept the "unpredictable," when the unexpected itself forms a part of their "rules" (Andolfi & Angelo, 1981).

To accomplish this they must learn and learn again the ways to modify their former blueprints for elaborating experience. An event of this magnitude justifies the resistance which the family brings into play. Now the principal problem becomes how to overcome this resistance. The method presented in this book is one possible response.