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«Αποζητώντας ασφάλεια»: μια νευροβιολογική οπτική της θεραπευτικής σχέσης

Μαρία Κωσταλά

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"Longing for safety": a neurobiological understanding of the therapeutic relationship

Maria Kostala

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"Longing for safety": a neurobiological understanding of the therapeutic relationship

"The ache for home lives in all of us. The safe place where we can go as we are and not be questioned."

Maya Angelou

Abstract

The present study describes the treatment of a young woman named Dora with panic disorder and depression, whose clinical presentation was complicated by fainting episodes during her panic attacks. The theoretical framework used in the assessment and treatment of Dora was the enriched systemic perspective SANE (System, Attachment, Narrative, Encephalon). The case was conceptualized by drawing upon neurobiological findings with regard to attachment theory. The main focus of therapy was the establishment of a good therapeutic relationship with Dora, which could provide her with a sense of safety which she was deprived of in her formative years. Utilizing this secure base and neurobiological findings, we focused on emotion regulation and integrating cognition and affect.

Key words: therapeutic relationship, neurobiology, attachment, secure base

Case Context and Method

The theoretical framework of the present study is the enriched systemic perspective SANE- System Attachment Narrative Encephalon, in which I have been trained (Androutsopoulou, Bafiti, Kalarritis, 2014). As is suggested by its name, the systemic approach is enriched with three additional perspectives: attachment theory, narrative/dialogical psychology and neuroscientific findings. Therapy is viewed as a process that follows certain stages, while utilizing a series of guiding questions stemming from the aforementioned theoretical perspectives, which explicate the goals set in each stage. The enriched systemic outlook is flexible, allowing for different types of sessions (individual, family and group), timeframes (short term/long term contracts), interventions and techniques. In the present study the case is conceptualized from a neuroscience perspective and its relation to attachment theory.

The stages suggested from this perspective are adapted from Cozolino (2002) and they include: (i) creating a safe and trusting relationship with an attuned therapist, (ii) maintaining moderate levels of arousal to encourage new learning, (iii) activating both cognition and emotion, (iv) co-constructing narratives that reflect a positive, optimistic self (Androutsopoulou, Bafiti, Kalarritis, 2014).

The guiding questions which are inspired by neurobiological findings and were helpful in my work with Dora were the following:

1. How can I help my client understand her complicated mind? How can I explain the idea of brain circuits being re-activated by old traumatic experiences and losses to explain her symptoms and the intensity of emotions that may seem disproportionate in the current situation?
2. How can I create optimism for change while still remaining realistic? How can I support her in becoming more encouraging of herself rather than being self-critical when change seems impossible? What is my position or understanding of resistance, and how can my understanding of effort which is required for learning new things allow me be more encouraging rather than being critical toward my client?
3. How can I help my client understand her brain as a social organ which changes through corrective experiences? How can our relationship be such an experience?

The client

"Dora" is an 18-year old single Greek woman, who lives with her mother and her older brother in Athens, Greece. She is a student of Sociology, and in her spare time she enjoys reading, practicing the violin and playing video-games. She has no history of romantic encounters, and her friend network is limited.

What brought her to therapy was her increasing anxiety, which was accompanied by fainting spells and depressive thoughts. She was referred to me by a friend of her brother's.
In the first session, she seemed anxious and shy, and she explained that she wished to feel better about herself and more comfortable in her relationships with others. She gave me the impression of a much younger person, with no confidence in her abilities and an unstable sense of self.

Ethical Issues

In order to ensure the anonymity of the client, in the present study, her name was changed to "Dora". In addition to this, to exclude any possibility of being identified some parts of her story were altered, or omitted, in a way that does not affect the understanding of her difficulties and the course of her therapy.

Guiding theoretical conception with research and clinical experience support

The impact of childhood trauma on the brain

Trauma can severely affect an individual's cognitive and emotional functioning. The earlier in life it occurs and the more severe and prolonged it is, the more negative its effects are (De Bellis & Zisk, 2014). However, trauma is not limited to life-threatening experiences (Cozolino, 2002). For young children, the experience of seeing their parents chronically depressed, or living in a household with high levels of tension could be traumatic (Cogill, Caplan, Alexandra, Robson, & Kumar, 1986). Watt observed, "if children grow up with dominant experiences of separation, distress, fear and rage, then they will go down a bad pathogenic developmental pathway, and it's not just a bad psychological pathway but a bad neurological pathway" (2003, p. 109).

When we are born we have yet to form a true bond with another person. Ideally, infants are cared for by an attentive, attuned and loving caregiver. When they are hungry, cold or scared they will be fed, warmed, and soothed, thus creating a set of specific sensory stimuli

which are translated into specific neural activations in the areas of the developing brain whish are responsible for socio-emotional communication and bonding (Perry, 2002). The somatosensory stimuli provided by the loving caregiver allow the expression of the genetic potential of the child to form and maintain healthy relationships. This primary relationship is the *attachment bond*, which bears certain characteristics: (1) it is an enduring emotional relationship with a specific person; (2) it produces feelings of safety, comfort, and pleasure; (3) loss or threat of loss of the attachment figure induces acute distress (Perry, 2002). This special form of relationship provides the working framework for all subsequent relationships that the child will develop. A solid and healthy attachment with a primary caregiver appears to be associated with a high probability of healthy relationships with others while poor attachment with the mother or primary caregiver appears to be associated with a variety of emotional and behavioral problems in subsequent years (Perry, 2002; Riggs, 2010).

When the primary attachment bond is disrupted, especially early in life, brain circuitry can be affected. Chronic parental neglect, or abuse, can severely impact the infant's brain, impairing the corpus callosum which connects the two hemispheres (Siegel, 2003), the hippocampus which is central to memory function (Sapolsky, 2004), neural integration (Siegel, 2003), overall brain size, and growth of GABA fibers that moderates the limbic system (Siegel & Hartzell, 2003).

Many significant emotional memories take place before we have words or explicit recall, unconsciously influencing our lives at an implicit level. The hippocampus, which plays a significant role in explicit memory, is not developed until 18 months, whereas the limbic system, which is responsible for implicit memories, is available from birth. Although, traumatized people may not have explicit memory of the traumatic event, their body remembers (Fishbane, 200:7; Van der Kolk, 2014). ‘‘Unconscious fear memories established through the amygdala appear to be indelibly burned into the brain. They are probably with us for life’’ (LeDoux, 1996, p. 252).

A neurobiological approach to psychotherapy

Neurobiologically informed psychotherapists focus on facilitating emotional intelligence (Fishbane, 2007). According to Atkinson (2005) a therapist must serve as a teacher of emotional literacy, promoting acceptance and curiosity about one's own experience, normalizing one's reactivity. Providing knowledge of how psychotherapy works from a neurobiological viewpoint can facilitate transparency in the therapy and allow a more

equal and collaborative relationship between the therapist and the client (Fishbane, 2007). In addition to this, knowing about the brain can discourage self-judgement and nurture self-acceptance (Siegel & Hartzell, 2003).

Neuroscience holds great psychoeducational significance, especially when we are attempting to understand a current reaction triggered by old issues. The amygdala ‘‘is quick to learn and slow to forget. Learned fears are tenacious and tend to return when we are under stress’’ (Cozolino, 2006, p. 318). When these fears arise we lose control and we insight into our feelings, and we are unable to make any conscious connection to our original learned fear. Self-observation and self-empathy can help break this vicious circle. Goleman (2006) posits that the process of giving words to feelings can calm the amydgala, since observing our emotions activates the prefrontal cortex. In a similar fashion to keeping food or smoking records, the act of awareness increases the client's potential for flexibility (Fishbane, 2007). When clients find it difficult to get in touch with their body and emotions, other techniques can be used to promote somatic attunement, such as breathing, meditations and mindfulness techniques (Siegel & Hartzell, 2003).

In therapy we are working towards integrating cognitive and affective processes, cortex and limbic system, mind and body, explicit and implicit memory, and left and right hemispheres (Fishbane, 2007). However, it is also important to have patience and be respectful of the clients' rhythm. They are ‘‘laying new neurological cable’’ (Scheinkman & Fishbane, 2004, p. 296), but for these connections to last, much repetition of the new behavior or experience is required (Fishbane, 2007).

The therapist as an attachment figure

Bowlby believed that intimate attachment to other human beings is the foundation on which stable and self-reliant personality is built (Bowlby, 1973). He also pointed out the importance of the therapist's becoming a reliable and trustworthy figure to the client, a *secure base* (Bowlby, 1998).

The therapist-client relationship will manifest similar characteristics to the parent-child relationship, with the client seeking the therapist to discuss his worries, experiencing some degree of distress when the therapist is immediately not available in his time of need,

seeking the therapist when he is distressed, and using the therapist as a secure base to explore new experiences. In addition to this, the natural ruptures and reunions that occur in the psychotherapy are likely to activate the attachment behavioral system. For some individuals who have had immensely difficult experiences in their childhood, simply walking into the therapist's office is likely to cause anxiety. But in this relationship, the client has the opportunity to have these patterns acknowledged and challenged and subsequently learn new methods of regulating affect (Sonkin, 2005).

This process can be facilitated when therapists are attuned to the client's signals, both verbal and nonverbal, and at the same time they are attuned to their own internal experience (Sonkin, 2005). Like the mutual affect regulation that occurs between parent and child, a similar process is occurring in the therapeutic relationship.

Assessment of the client's problems, goals, strengths and history

Client's current problems

Dora is suffering from chronic depression and panic attacks, which have severely affected her quality of life and her relationships with others. She finds it hard to allow herself to be vulnerable and often suppresses her feelings. She is very conflicted about her relationship with her mother, balancing between anger and guilt. She believes she is a burden to her family and friends, and wishes she could be invisible. She prefers solitary activities and rarely socializes. She enjoys her studies, but her symptoms, especially the fainting spells, make it difficult for her to attend her classes. In the months preceding our first session, she became increasingly depressed and fearful of all activities involving her going outside the "safety" of her own house.

History

Dora's parents divorced when she was only 12 months old. She remembers her mother being depressed the years following the divorce, constantly watching TV and neglecting the care of her two children. There was animosity between her parents, and Dora's mother would regularly complain about her ex-husband to her children. Dora recalls her mother telling her she had regretted having children, and blaming her and her brother for her unhappiness. She described her mother as selfish and unpredictable and she feared her. She described her father

as sweet, but weak. Dora recalls being withdrawn and quiet from a very young age. Her parents briefly reunited when she was in her early teens (at the age of 13), and she remembers this period as very difficult due to the constant fighting between them, and her mother's violent outbursts towards her father. At this time she began to have the first symptoms of anxiety, which led to serious weight loss. She became even more withdrawn and her friendships suffered. At the age of 16 she had her first panic attack. Her parents eventually separated again, but since then her symptoms have increased, including two fainting spells in social situations, agoraphobia, depressive thoughts and anorexia. She has never engaged in any romantic encounters, and she has a limited support system comprising of two friends from high-school. Her relationship with her brother is distant and they rarely discuss their family issues.

Difficulties

Dora finds it challenging to open up to others, fearing that she will be viewed as tiresome and insufferable. She keeps to herself and has a limited support network to communicate her problems. She reports feeling that her life has no meaning and that she has nothing to look forward to. When talking about herself she becomes very self-critical and she accuses herself for her anxiety symptoms. She rarely draws parallels between her difficult childhood and her current difficulties, focusing more on the physical manifestations than the causes behind them. She regularly minimizes her negative experiences, using rationalization to justify the neglect and abuse she has suffered. She also tends to neglect her health and her self-care, which leads to increased physical symptoms. Quite often she thinks of things in a black and white fashion, interpreting her feelings or behaviors as either "bad" or "good".

Strengths

It was obvious from the first session that Dora is a highly intelligent and open minded individual and I always find our discussions interesting and stimulating. She has a proclivity towards art, enabling us to utilize movies and books in her therapy plan. In addition to this, she exhibits commitment to her therapy by being consistently punctual and completing the assigned tasks between sessions. She shows openness and trust towards the therapist and the therapeutic process, venturing into difficult and sensitive topics.

Formulation and treatment plan

Dora’s difficulties can be traced to her relationship with her primary caregiver, her mother. In her formative years she lived in fear of her mother’s unpredictable reactions and bursts of anger, which she dealt with blindly catering to her every need and trying to become invisible. It was always safer for her to be quiet, withdrawn and docile, and her own attachment needs went unnoticed. The lack of affection and support by her mother was perceived as normal, as she never knew anything else. Her nutritional and health needs were also neglected. Her father also feared her mother, thus leaving her feeling unprotected and alone. Due to their divorce his presence was minimal and they never formed a close attachment bond. She interpreted his mild manner as weakness, and her mother’s cruel behavior as strength. Viewing herself as similar to her father, she grew to feel weak and unable to confront the harsh realities of life. With no sense of security in her family she became fearful of every close relationship, anticipating rejection and pain. Since she would not acknowledge all her negative emotions, they began manifesting themselves through symptoms, such as panic attacks. Her body, which was as neglected as her spirit, rose up against her and left her no choice but to get help. It was crucial to tend to her mind and her body simultaneously, and start forming a newfound sense of security.

Hence, the goal of therapy was to create a safe and trusting relationship with Dora, where she would be taken care of and she would “feel felt” (Siegel & Hartzell, 2003). By enhancing security, she could explore forbidden feelings, become more flexible and daring in her relationships and create opportunities for interactions that could alter her neural functioning.

Course of therapy

Initially, I focused on obtaining information concerning the origin and evolution of her symptoms, her family history, and her current life circumstances. Additionally, I requested that she visit a general practitioner to exclude the possibility of physical illness related to her fainting spells. When it was confirmed that her symptoms could not be attributed to physical causes, our focus shifted to the inner workings of her mind.

The process of Dora’s therapy will be presented in connection to the relevant stages mentioned in SANE. During the first phase of our work together, emphasis was placed in building a safe and trusting relationship with her, and ensuring that I was emotionally attuned

to both our internal states. This would establish an emotional and neurobiological context for neural reorganization, allowing Dora to endure the stress brought upon by this process.

Our sessions took place on a weekly basis, at a set time and place, so as to provide a consistent and predictable framework for our relationship. Given the fact that Dora grew up in a chaotic environment where boundaries were absent, it was a first step towards creating a new relationship model. I encouraged her to ask any questions she might have and I assured her that all information will remain confidential, with the exceptions that were stated in the written contract I provided. The discussion on the practical aspects of therapy aimed to familiarize her with this new "experiment" and give her a sense of control in this turbulent period of her life.

Dora appeared to be open to discuss her past and current experiences, but it was important not to mistake her compliance with trust. She was very preoccupied with doing the "right" thing, and being a "good" daughter, and answering all my questions, without taking her feelings into account, was exactly what she thought a "good" client should do. It was my job to understand her rhythm; sense the underlying reluctance to delve into specific subjects and work through my own emotions regarding the course of her therapy. There was a fine line between pushing her too hard and being too safe, and her feelings and the feelings that arose in me were our guide.

The following example reflects how I used the awareness of my own body and mind to connect with Dora and explore her feelings about therapy and our relationship.

Therapist: So, in our last session we discussed the possibility of bringing your mother in for a family session. Did you get a chance to think about it?

Dora: *(Using a low voice and avoiding eye-contact.)* Yes, I thought about it and I am ok with it, if you really think it is necessary.

Therapist: *(I begin to feel anxious that I am pressuring her. I could feel myself withdrawing and our connection diminishing.)* There is no need to decide anything yet. I just wanted to discuss the possibility and how it makes you feel.

Dora: (*Still avoiding eye-contact. She was playing with a strand of her hair, and she looked like a confused little girl*.) I just don't understand why you want to meet with her.

Therapist: (*My sympathetic nervous system was activated. I begin to doubt myself and regret suggesting a family session. A relational disconnection was occurring.)*

I thought it could be helpful. Maybe it could be a way to address the issues you have with each other in a safe and controlled space.

Dora: *(She looks at me with a sad facial expression.)* What if I don't want to address those issues? She never listens, it's a lost cause.

Therapist: (*I exhale slowly, trying to calm myself. I briefly reflected on my internal distancing and I invited my attention back to the moment and Dora. I looked into Dora's eyes and I used a soft and warm voice.)* Dora, with me you never have to do anything you don't want to. I can feel how tense this subject is making you and I want you to know that we can discuss it as much, or as little as you'd like. How does this sound to you?

Dora: (*Her body relaxes and she lets go of her hair. She looks at me and there is a slight smile in her eyes.)* I don't want to be difficult. It is just hard for me.

Therapist: *(I feel closer to her and my nervousness subsides.)* You are not being difficult. You are being true to your feelings, and that is exactly what you are here to do. We will take it one step at a time, there is no hurry.

My present moment awareness allowed me to notice Dora's discomfort, but also self-regulate (through deep breathing and awareness), put aside self-doubt and return with full open presence to the client. This reconnection invited her back to a place of safety with me, and the message that she could be accepted, despite being "difficult", was conveyed. Providing her with unconditional support triggered a neuroception of safety (Porges, 2004) in her nervous system that would enable her to process her difficult feelings about her mother.

The second phase involved maintaining moderate levels of arousal to encourage new learning. My goal was to allow Dora to re-experience dysregulating feelings in affectively tolerable doses in the context of a safe environment, so that her overwhelming feelings could be regulated and integrated into her emotional life. In the words of Bromberg (2006), the therapeutic relationship "*must feel safe but not perfectly safe. If it were even possible for the relationship to be perfectly safe, which it is not, there would be no potential for safe surprises…"* (p. 95).

Once the therapeutic alliance was established we began to dig deeper into the causes behind her symptoms. We attempted to understand what was causing her body to rebel in such a way, and it became increasingly apparent that her symptoms were a way to avoid engaging in relationships and her life in general. Her symptoms served as indicators of hyperarousal and we knew that we were getting close to something significant when dizziness

and heart palpitations would occur. We would then take a step back, and focus on the physical sensations she had until they had settled down. In this way, I acted as an auxiliary cortex, modulating her levels of arousal and keeping her from going into hyperarousal, where it becomes difficult to process information without dissociating. This also taught her how to self-regulate, limiting the amount of information she had to process in any moment.

When we talked about her family she would sometimes have panic attacks between sessions. At those times we would often turn to art, and discuss movies and books that she enjoyed, using them as an implicit way to access her feelings on relationships and life. On numerous occasions she drew parallels between herself and fictional characters, in an attempt to make sense of her difficulties. She found courage in their actions and the resolution of their troubles gave her hope. Never before had she been able to share her thoughts on art with someone else, and it seemed to make her feel closer to me.

The next phase involved activating both her cognition and emotion, in an attempt to integrate the two hemispheres of her brain. I provided her with a psychoeducational background concerning the physical manifestations of her anxiety. I explained how childhood neglect can lead to a heightened sense of danger due to hypersensitivity of the fight or flight response. She expressed much interest in these concepts and she began reading relevant books and articles in her spare time. Her body's response was always a mystery to her, and now it gradually began to make sense.

Moreover, interpretations and reality testing were used to enhance awareness of inhibited and repressed thoughts and emotions. For example:

Dora: I don't want to go to my mother's birthday celebration. I am sure I'll get a panic attack and she'll get mad at me.

Therapist: What makes you so sure that you will have a panic attack?

Dora: I just know. It will be better if I stay at home.

Therapist: Let's do a mental experiment. Let's imagine for a moment that somehow we could guarantee that you would not have any symptoms that day. Would you want to go to your mother's birthday party?

Dora: No. But that is beside the point.

Therapist: Why is it beside the point? Are your feelings insignificant?

Dora: Yes. Nobody cares how I feel, anyway.

Therapist: I care. So maybe the symptoms are a way for you to show your feelings?

Dora: Maybe. But it doesn’t matter. My mother wouldn’t care even if I dropped dead.

Therapist: What makes you think that?

Dora: She is always annoyed when I tell her that I feel dizzy. She tells me that I am causing trouble and I should get over myself.

Therapist: And how does that make you feel?

Dora: Terrible. I feel lonely and sad. Sometimes I wish I could just disappear, so I would not be a burden anymore.

Therapist: But what makes you a burden? It is my understanding that you are a very self-sufficient and independent person.

Dora: Maybe. But that doesn’t seem to be enough for my mother.

Therapist: That must be very difficult for you, but it doesn’t change the fact that you have those positive qualities, does it?

Dora: I guess not. I just feel bad that I can never satisfy her.

Therapist: It seems perfectly normal to me that you wouldn’t want to go to her birthday celebration then. Yet that doesn’t mean that you are bound to have a panic attack if you did go. What do you think?

Dora: Maybe it is easier to “use” my anxiety to get out of things, instead of expressing how I feel.

Therapist: There is nothing easy in what you are experiencing. But your theory makes sense.

In the aforementioned dialogue, I attempted to illuminate the significance of her symptoms, while bringing her in touch with her primary trauma; the rejection of her mother. These feelings were so disorganizing for her that she would get lost in her symptoms, focusing on them and disassociating from her true needs. Instead of talking about the pain she has experienced in her relationship with her mother, we would routinely talk about her symptoms, and she struggled to link the two. During our work together this connection became increasingly clear to her, and our focus shifted to her feelings about her mother. Within the safety of the therapeutic relationship she mourned her childhood and she gradually came to terms with her losses.

Currently, our work together is in the last phase, focusing on co-constructing narratives that reflect a positive, optimistic self. Together we worked on changing her identity from victim to survivor and emphasized her healthy attributes. Instead of viewing herself as helpless and feeling shame for not being loved by her mother, she moved towards

acknowledging how well she has coped in a very challenging family environment. Dora does not have to be invisible anymore. She dares to be seen and to become the protagonist of her story.

Supervision and personal reflection

Throughout the two years that we have worked together there have been certain issues that required careful management from my part. In the beginning, I caught myself becoming impatient and hoping for quick results. This can be partly attributed to the overenthusiasm that often characterizes new therapists. I offered many interpretations and gave her multiple exercises to do in between our sessions. This backfired, and as per usual she showed her discomfort through her symptoms. She began to have frequent panic attacks, and she lost a significant amount of weight. I was very worried and I reached out to my supervisor for help. Supervision helped me understand that this apparent "setback" in our therapy, was Dora's way of telling me to take things a little bit slower. She was gradually becoming more and more fragile, so I focused my energy on taking care of her and giving her time. The importance of eating and sleeping well was highlighted, and through these practical interventions I managed to provide a different attachment experience. Instead of getting angry with her for being an inconvenience, I understood that she needed more care and less pressure and she began to feel much better in the coming sessions. She gained back the lost weight and her symptoms subsided.

Another very important issue that I needed to work through was the effect of countertransference in the therapeutic relationship. More often than not, I felt like a worried mother, and I would view Dora as in need of help and guidance. In part that was true, but it also perpetuated the narrative of Dora being a helpless child, thus hindering her evolution into a resilient adult. In an attempt to rectify her experience of having an indifferent mother, I became overprotective and overinvolved. Discussing it with my supervisor, it become clear to me that I was projecting personal experiences on Dora and taking a step back was required. Dora needed to take ownership of her share of the therapeutic work and become actively engaged in her own progress. I began trusting her more and letting her learn through her mistakes. Initially she was confused and felt abandoned. This issue was addressed openly and I explained that it came from a place of trust and not from disinterest. Gradually she become more independent and daring and she began to trust her voice and her instincts.

Concluding evaluation of the process and outcome of therapy

Looking at Dora now, after two years of therapy, I can see a young confident woman emerging. She is daring to leave the hurt child behind her and form new, healthier relationships with others. She is much closer to her friends, and recently she has reached out to her brother, in an attempt to create a sense of family for herself.

In the present moment, Dora has an increased ability to self-regulate, and this dynamic has become apparent in our relationship too, as she is able to handle the natural ruptures that occur in our sessions (beginning and ending the sessions, holidays, vacations, illnesses, etc.) and work through the intense feelings of vulnerability that these events evoke in her. By connecting with her body, and understanding the connection between her feelings and her symptoms, she was able to learn a new language of communication. She also learned how her past experiences would intrude on her current experiences (implicit memory) and developed an ability to connect past, present, and future and therefore has the ability to make a choice in her response to the situation. This has provided her with a sense of control over her feelings and her life in general.

Currently we are working towards placing Dora in a therapeutic group, so she can use her newfound sense of security to create healthier attachments to other people. The issue of her romantic relationships is also pending, since the very thought of getting that close to someone triggers old fears. Although she feels more comfortable with her friends, it is difficult for her to engage in physical proximity with others. Nevertheless, she is willing to explore new possibilities and has recently began flirting with a young man in her sociology class.

A whole new world has opened for Dora and she is just beginning to discover it. In her own words “maybe I didn’t want to grow up without having been loved by my mother. Now, with your help, I feel ready to let go, and move forward.”

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