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ΣΕΙΡΑ ΚΕΙΜΕΝΩΝ ΕΡΓΑΣΙΑΣ

Η εμπλουτισμένη συστημική οπτική *SANE-System Attachment Narrative Encephalon* στην ειδίκευση θεραπευτών: Επιλεγμένες κατευθυντήριες γραμμές κλινικής πρακτικής.

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The enriched systemic perspective *SANE-System Attachment Narrative Encephalon*: Selected training guidelines for clinical practice

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Training and Research Institute for Systemic Psychotherapy

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Οι συγγραφείς είναι κλινικοί ψυχολόγοι και ψυχοθεραπευτές, συν-ιδρυτές και επιστημονικοί συνυπεύθυνοι του Λόγω Ψυχής-Ινστιτούτο Εκπαίδευσης και Έρευνας στη Συστημική Ψυχοθεραπεία.

The authors are clinical psychologists and psychotherapists, co-founders and co-directors of the Training and Research Institute for Systemic Psychotherapy (www.logopsychis.gr)

Contents

Abstract

The authors of this paper are among the increasing number of systemic therapists and supervisors that have come to realize that humans organise their experiences by storytelling, and see therapy as a dialogue for forming coherent and meaningful narratives. Joining others in the field, the authors have additionally informed their work by findings from attachment and neuroscience research. The authors will here present the basic theoretical formulations of their enriched systemic perspective *SANE-System Attachment Narrative Encephalon* ® that guide training and supervision of mental health professionals at the Training and Research Institute for Systemic Psychotherapy. They will present some basic training guidelines which include: (i) stages and goals of the therapy process stated in parallel from four interrelated perspectives, (ii) a concise list of guiding questions for clinical practice that trainees learn to ask themselves, again phrased from a multiplicity of interrelated perspectives. These perspectives help therapists proceed from "mind to culture" and vice versa in the phrase of Jerome Bruner, or "zoom in and out from neurons to neighbourhoods" in the phrase of Louis Cozolino.

Introduction

In this paper we will present the basic theoretical formulations of the enriched systemic perspective *SANE-System Attachment Narrative Encephalon* ® used in training and supervising mental health professionals at the Training and Research Institute for Systemic Psychotherapy, which we founded in 2011.

We are among the increasing number of systemic therapists that have come to realize that humans organise their experiences by storytelling, and see therapy as an exchange of stories in dialogue, both external and internal, for forming coherent and meaningful narratives. Joining others in the field, we have additionally informed our work by findings from attachment and neuroscience research.

In the last two decades, many systemic therapists have informed their clinical and training work by narrative ideas and/or attachment theory (eg. Dallos, 2006, 2004, Dallos & Vetere, 2009; Fishbane, 2001; Hughes, (2007). The interest of systemic therapists in neuroscience findings and in ways to incorporate such findings in training models is also growing (Sluzki, 2007). According to Fishbane (2007), many of our best systemic practices and theories are strengthened by the field of interpersonal neurobiology. In her view:

> "Our basic beliefs about systems, contexts, and socially constructed meaning are validated by brain science; clearly, what is emerging is a relational view of the person and the vital importance of relationships for our survival and for the wiring of our brains. The use of narrative in therapy as a process of integrating thought and feeling is supported by interpersonal neurobiology […]. Differentiation, the integration of thought and feeling, the capacity to be calm in oneself while being present to others emerges as central to social and emotional intelligence" (p. 410).

A multiplicity of perspectives

Our training enriches systemic therapy with attachment theory, basic premises from narrative psychology and psychotherapy, and relevant findings from neurosciences. With our help, our trainees face the challenge of combining these interrelated perspectives while also retaining a basic systemic outlook. We will illustrate our theoretical formulations by referring to guidelines for clinical practice, including stages and goals as well as guiding questions that trainees learn to ask themselves when conceptualizing a case.

First, let us take a brief, separate look at each perspective that **enriches our basic systemic outlook**:

I. John Bowlby's theory of **attachment** in its current form, shaped through careful long-term experimental and observational research, offers a developmental theory of the way personality is formed and of reasons for later life difficulties (Parkes, Stevenson-Hinde, & Marris, 1991). It relates such difficulties and/or symptoms with family functioning without blaming the family: specifically, it detects transgenarational patterns that transfer emotional insecurity to children and points to ways that this insecurity influences adult relationships. In the words of Byng-Hall (1998), one of the first and most important figures who introduced attachment theory to family therapists, "attachment theory suggests an overall aim of increasing the security of the family base, thus helping all family members to be self-sufficient". In his opinion, many different family therapy techniques can be used at the appropriate moment. "In other words, attachment theory provides a

framework that can integrate several ways of working, as opposed to providing a school of family therapy with set premises and specific techniques. It has the potential to offer something to all therapists".

II. A key to the transgeneration nature of emotional security-insecurity is **narratives** and their level of **coherence** (Byng-Hall, 2008, 1998). Secure relationships are associated with coherent narratives and vice versa. Coherent narratives are told by parents who are in touch with emotions, their own and those of their child, and are appreciative with the child rather than indifferent or strict. A child's sense of self is constructed in dialogue with the narrating parents and this **dialogue** is internalized (Hermans & Dimaggio, 2004). An internalized dialogue of good quality does not tend to become monologue (Penn, 2001,1994), it allows for many internal voices to be heard rather than one dominant voice (i.e. the internalized voice of a strict parent).

III. Finally, findings from **neurosciences** in regards to the brain, the most complicated system known to us, emphasize the imprinting of early and later experiences, positive and negative, on our neural circuits. Researchers place particular emphasis in the importance of early attachment bonds and of narratives as the means of shaping the brain. Even specific contemporary concepts, such as *unique outcomes* (White & Epston, 1990) or of *internal dialogues* (Hermans & Dimaggio, 2004) in dialogical approaches, to name just two, are now explained by or associated with specific brain structures (Beaudon, & Zimmerman, 2011; Lewis & Todd, 2004). Luckily, we now know that our brain continues to be shaped throughout our lives and can develop in a positive direction through corrective social interactions and particularly by corrective relationships such as those offered in the psychotherapy setting.

Combining perspectives

How are the multiple perspectives combined in our training and supervising? Our enriched systemic outlook is therapist-centered: rather than being a "prescriptive" integrative model, offering an organized set of strict practice directives, it allows for a **personal -but *guided*- synthesis** of ideas, interventions and techniques, types of sessions (individual, family and group) and contracts (short and long). For the distinction between "prescriptive" and "therapist-centered" see the work of Lebow (1997).

A basic premise for this combination is that each perspective directs clinical attention to a different aspect of the therapy process: Attachment theory directs attention to the **therapeutic relationship**, systemic theory to the **content** of therapy discourse, narrative psychology to the **form** of therapy discourse, and neuroscience findings teaches one to be **tolerant of impasses and to have faith** in the process of therapy;

We draw from our readings of authors such as *Daniel Siegel, Luis Cozolino, Alan Shore, Joseph. LeDoux,* for their brain studies and offered links to narrative and attachment, *Jeremy Holmes* for his comprehensive applications of attachment theory, *John Byng-Hall* for his writings on the importance of connecting family therapy with attachment theory and research, *James Pennebaker* for his studies of expressive writing, coherent narratives and health, *Hubert Hermans* for the understanding of self as narrative multiplicity of various voices, and *Peggy Penn* who made this multiplicity of internal voices more approachable for systemic and family therapists. Also, *Jerome Bruner* and *Theodore Sarbin* who made a major contribution to the

narrative turn of psychology, and *John McLeod* for the comprehensive history of narrative in psychotherapy, which is a broad approach much wider than any specific model which includes the word "narrative" in its title. (Angus, & McLeod, 2004; Bruner, 1990; Byng-Hall, 2008, 1998, 1995a,b; Cozolino, 2010,2006,2002; Fosha, Siegel, & Solomon, 2009; Hermans, & Dimaggio, 2004; Holmes, 2001; LeDoux, 2002, 1996; McLeod, 1997; Penn, 2001, 1994; Pennebaker, 1997, 1993; Schore, 1994, 2003a,b; Siegel, 2010,2007,1999; Siegel,. & Solomon, 2003;

Beyond studying recognized authors, the project of enriching systemic therapy is achieved through our personal attempts in writing, and through accumulated experience in clinical practice, research, training and supervision (Androutsopoulou, 2005; Androutsopoulou, Thanopoulou, Economou, Bafiti, 2004; Bafiti, 2009a,b; Bafiti & Kalarritis, 2009; Kalarritis, 2013, 2005; Kalarritis & Bafiti, 2005). Finally we owe a great deal to our original training at and later professional involvement with the Laboratory for the Study of Human Relations, Athens the synthetic approach of which encouraged both diversity and synthesis (see; Katakis, 1990; Katakis, Androutsopoulou, Kalarritis, & Bafiti, (2011).

Training challenges

Training at the Institute is completed in two 2-year levels (4 years in all). A total of 1440 hours direct contact with course staff, plus independent study is required.

- ***Theoretical learning***: (500 hours) Includes academic teaching, case discussion and planning, skill and technique workshops.

• ***Clinical practice***: (370 hours) Entails direct contact with clients in individual, family and group therapy sessions. Also (a minimum of 200 hours of) working with clients outside of the course -their work setting or on a voluntary basis- is required.

• ***Clinical Supervision***: (260 hours) is direct and indirect in this course.

• ***Long-term personal therapy***: (310 hours minimum) 2/3 must take place in group therapy with 'ordinary' clients, 1/3 may take place in individual and/or family sessions.

Theoretical learning and the largest part of clinical supervision takes place within a group where trainees have the opportunity to learn from listening, observing and participating in the learning process of fellow trainees.

Our trainees are faced with two major challenges. The first is the challenge of attempting a personal synthesis by attending seminars and studying a variety of literature, but mostly through experiential learning in workshops, clinical practice, group supervision and personal therapy. The second challenge is to be able to apply this synthesis on working with individuals, families *and* groups, in short *and* long term therapy.

To meet these challenges we go beyond teaching our trainees theories, informing them on research findings, and providing them with multiple opportunities of experiential learning; we additionally offer them some guidelines for clinical practice which include:

(i) an understanding of therapy process as following certain **stages,** stated in parallel from all four perspectives: systemic, attachment, narrative, brain. Each stage comes with basic goals to be sought for.

(ii) guiding **questions** for clinical practice, phrased from all four perspectives. Guiding questions explicate the goals set in each stage as stated from all four perspectives. As mentioned, each perspective directs attention to a different aspect of the therapy process.

Parallel therapy stages and goals from four perspectives

Parallel therapy stages and goals from four perspectives are presented below (see also diagram 1):

I. Attachment perspective *(Stages adapted from Holmes, 2001)*

- **Building a safe therapeutic relationship** (offer a corrective attachment experience, a safe base for exploring inner and outer experiences)
- **Being in touch with 'ghosts' of the past** (help detect unresolved attachment issues and their present influence)
- **Fighting against 'ghosts' of the past** (provide a safe place for dealing with unsaid emotions; work with transferences or 'recruitment' of therapist or therapy group members as participants in familiar scenarios)
- **Reconciling with 'ghosts' of the past** (help acceptance of past experiences based on the idea of transgenerational patterns; help to 'let go' and to minimize influence on present relationships, to invest on new relationships).

II. Systemic perspective *(Stages adapted from Katakis, 1990)*

- **Owing a non-relational view of life** (map the rigid emotional-cognitive construction of the individualistic notion of 'self'; examine communication patterns and family structure or usual 'scenarios')

- **Experiencing an inner void** (help deconstruct the 'individual self'; challenge rigid psychological roles or 'scripts')
- **Taking an inner journey** (help co-construct a 'relational self'; challenge family myths and dominant cultural values, help create a sense of differentiated 'self' or identity)
- **Beginning a new trip to life** (help re-investment on life; expect a gained relational view of life, family and 'self'; expect an emerging sense of meaning)

III. Narrative/dialogical perspective *(Stages adapted from Androutsopoulou, 2011, 2013,a,b)*

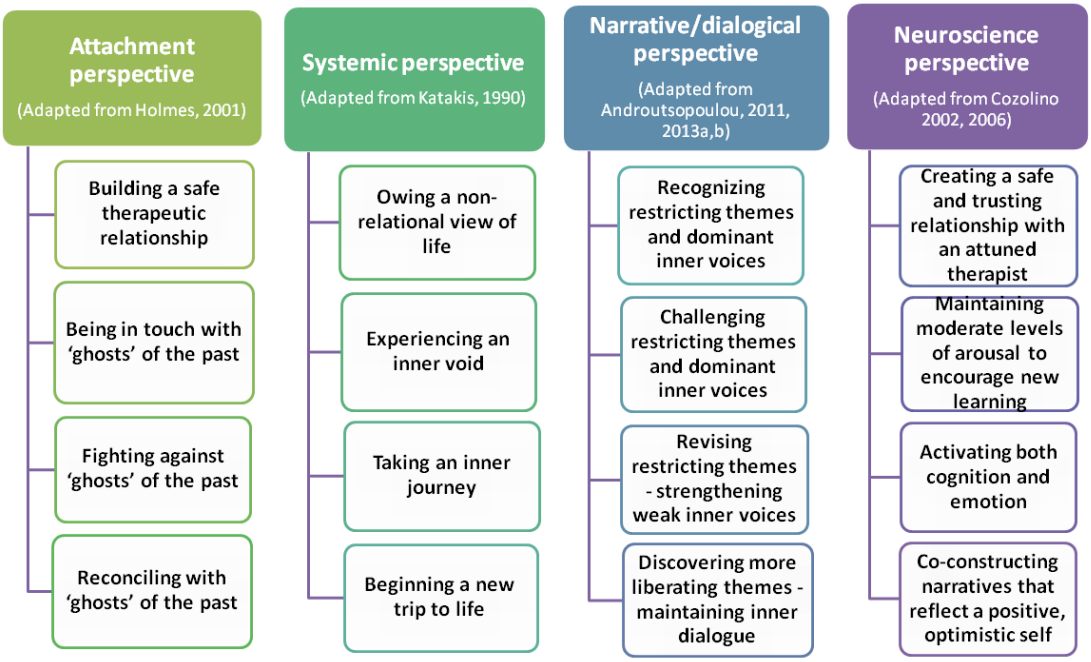
- **Recognizing restricting themes and dominant** (strict or neglectful) **inner voices** (help name dominant inner voices; help realize difficulties in using inner dialogue)
- **Challenging restricting themes and dominant inner voices** (use deconstructing questions; help discover silenced or weak inner voices)
- **Revising restricting themes - strengthening weak** (tender, caring) **inner voices** (encourage the borrowing of voices from supportive others, including therapist and therapy group, encourage exercises in inner dialogue)
- **Discovering more liberating themes - maintaining a revising/ reflexive stance or 'authorial'** (compassionate) **voice** (help establish a self-observing position or meta-position that facilitates the creation of dialogical space and coherence).

IV. Neuroscience perspective *(Stages adapted from Cozolino 2002)*

- **Creating a safe and trusting relationship with an attuned therapist** (use empathy to "reactivate attachment circuitry making it available to neuroplastic processes") *(Cozolino, 2006, p. 308*)
- **Maintaining moderate levels of arousal to encourage new learning** (keep client interested but not too anxious; help "maximizes the biochemical processes that drive protein synthesis necessary for modifying neural structures") (ibid)
- **Activating both cognition and emotion** (use or improvise multiple means or clinical tools; help utilize or seek multiple sources of support; utilize help from other professionals)
- **Co-constructing narratives that reflect a positive, optimistic self** (cultivate ongoing optimism based on personal therapy and on "the physiological reality of ongoing neuroplasticity and neurogenesis" (ibid); explain the healing effects of connecting for the social brain)

Diagram 1

Summary of therapy stages from four perspectives



Guiding questions for clinical practice inspired by four perspective

Guiding questions for clinical practice inspired by four perspectives are presented below (see also diagrams 2a, 2b, 2c, 2d):

I. Guiding questions inspired by attachment theory*: Importance of therapeutic relationship*

1. What sort of attachment pattern does my client appear to be mostly familiar with, deriving from her family of origin? How does this pattern influence her adult relationships, including the relationship with me, her therapist? (According to attachment theory, patterns regard feelings about relationships. Insecure patterns are divided into *avoidant*, *ambivalent*, and *disorganized*.(ref)

2. What sort of corrective experiences can I provide in individual, family and/or group psychotherapy for my client? What additional steps can I take to make my client feel that our relationship is a "secure base" for facing both her external and her inner world?

3. What have I understood in my personal therapy about the attachment patterns in my family? How is my own history affecting my understanding of my client's needs and our relationship? To what extent does my familial attachment pattern help/does not help my client have a corrective attachment experience?

II. Guiding questions inspired by systemic thinking*: Noticing the content of therapy discourse*.

1. Does my client understand and practice skills of good communication, does she set protective boundaries for herself and her family, does she understand the challenges of her family life cycle and stresses of transitions?

2. Can she understand her own thoughts and feelings and distinguish them from those of her family? Is she able to challenge family and dominant cultural values and myths? Can she construct a sense of identity that she can recognize as her own? Does she see this identity as helping her be functional, happy and optimistic?

3. What have I understood in my personal therapy about the functioning of my own family, communication patters, psychological roles, myths and values? Am I engaged in a continuous effort to differentiate my beliefs and emotions from my family of origin, whether alive or not, but still be in contact with my family from an equal, adult position? Do I feel free to question or challenge beliefs/stereotypes of the dominant culture?

III. Guiding questions inspired by narrative inquiry: *Noticing the form of therapy discourse*

1. Does my client's narrative appear coherent? Which stories appear less coherent than others? Less coherent narratives are associated with emotionally loaded or sensitive issues (see Androutsopoulou, Thanopoulou, Economou, Bafiti, 2004).

2. What are the central themes in my client's narratives? Is there one or more such themes that appear to restrict her life? (eg. unlovable). Does she appear to be the protagonist in her stories (eg. use of "I" pronoun)? Is there a voice that appears to be dominant in her internal dialogues and her narrations? Is this voice strict or rejecting? Whose voice is this? Are there any other, weaker voices, more tender and appreciative, in my client's inner dialogue that I can help strengthen?

3. What have I understood in my personal therapy about repeated themes in my life? Am I the protagonist of my narrations? What voices are dominant in my internal dialogues? Do I have a strict internal voice that becomes external in the therapeutic dialogue and negatively affects my client's effort to become more appreciative of herself?

IV. **Guiding questions inspired by findings from neurosciences: *Tolerance of impasses and faith in therapeutic change***

1. What examples, metaphors or imageries can I use to help my client understand her complicated mind? How can I inform her in a comprehensive way about issues such as brain synapses, explicit and implicit memory, brain laterality? How can I explain the idea of brain circuits being re-activated by old traumatic experiences and losses to explain mood disorders, phobias and so on, and to explain the intensity of emotions that may seem disproportionate in the current situation?

2. How can I help her appreciate the importance of brain plasticity and keep/create optimism for change joined by realism? How can I support her in becoming more encouraging of herself rather than being self-critical when facing difficulties in making changes? What is my position or understanding of resistance, and how can my understanding of brain effort in learning new things help me be more encouraging rather than being critical toward my client? How can I keep moderate levels of arousal in the psychotherapeutic process to encourage learning, keep my client interested and avoid extreme "resistance"?

3. How can I help my client understand her brain as a social organ which changes through making corrective attachments? If I work with groups in psychotherapy, how can I promote the idea of working with other brains? What dialogues can I help generate to make Cozolino's phrase ("Human brains have vulnerabilities and weaknesses that only other brains are capable to mend") have practical value?

Diagram 2

Perspectives and examples of guiding questions

Diagram 2a

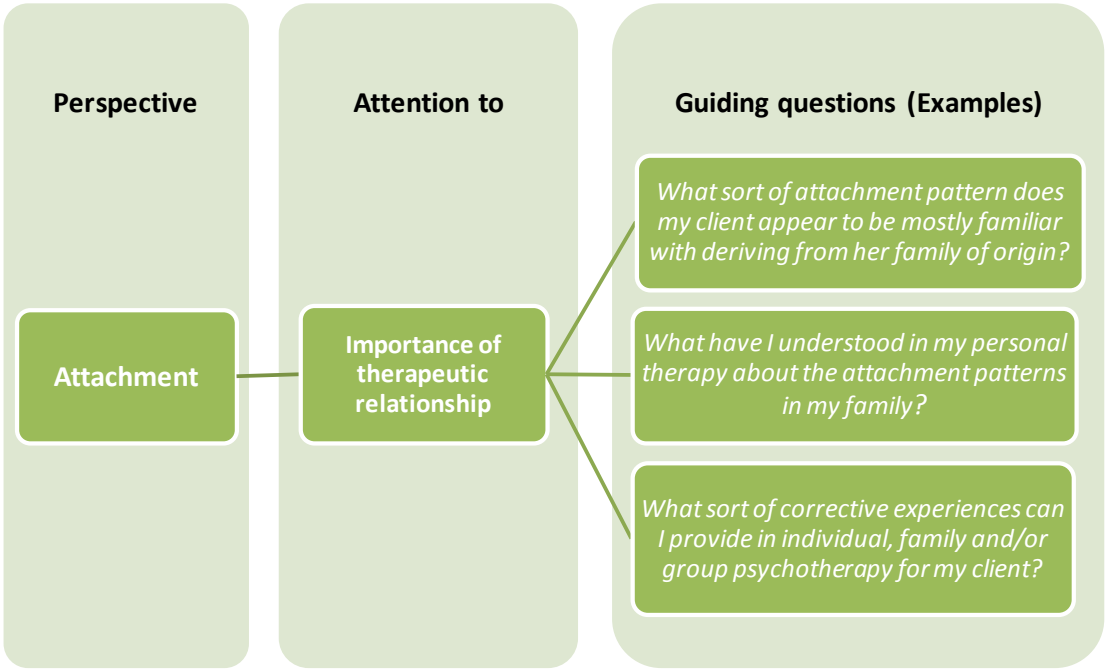


Diagram 2b

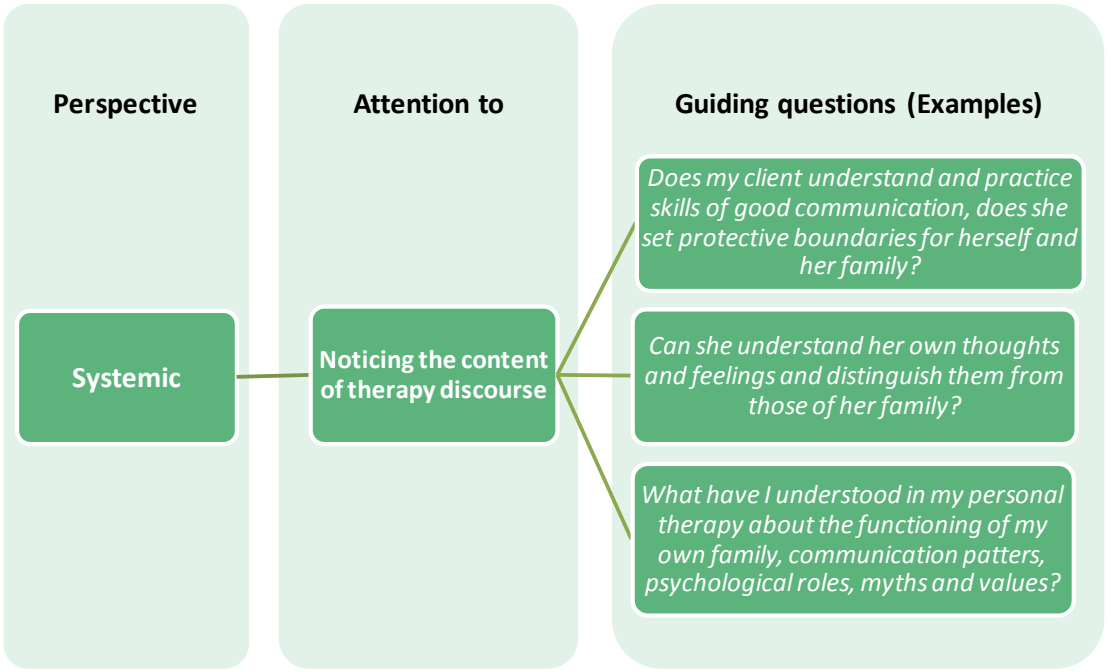


Diagram 2c

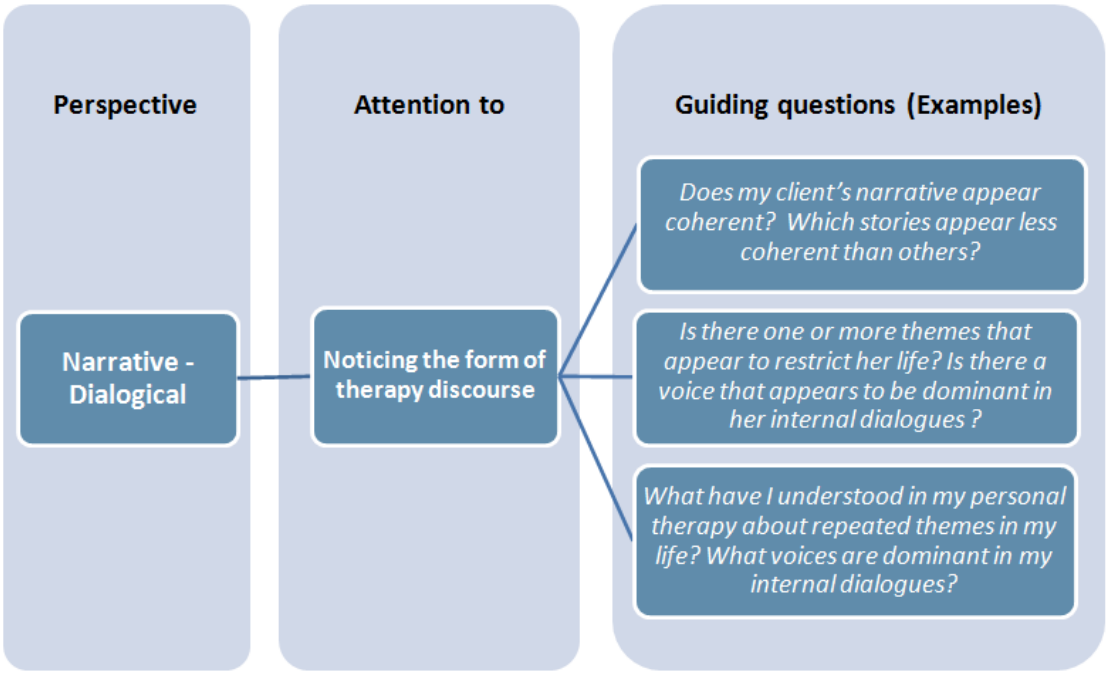
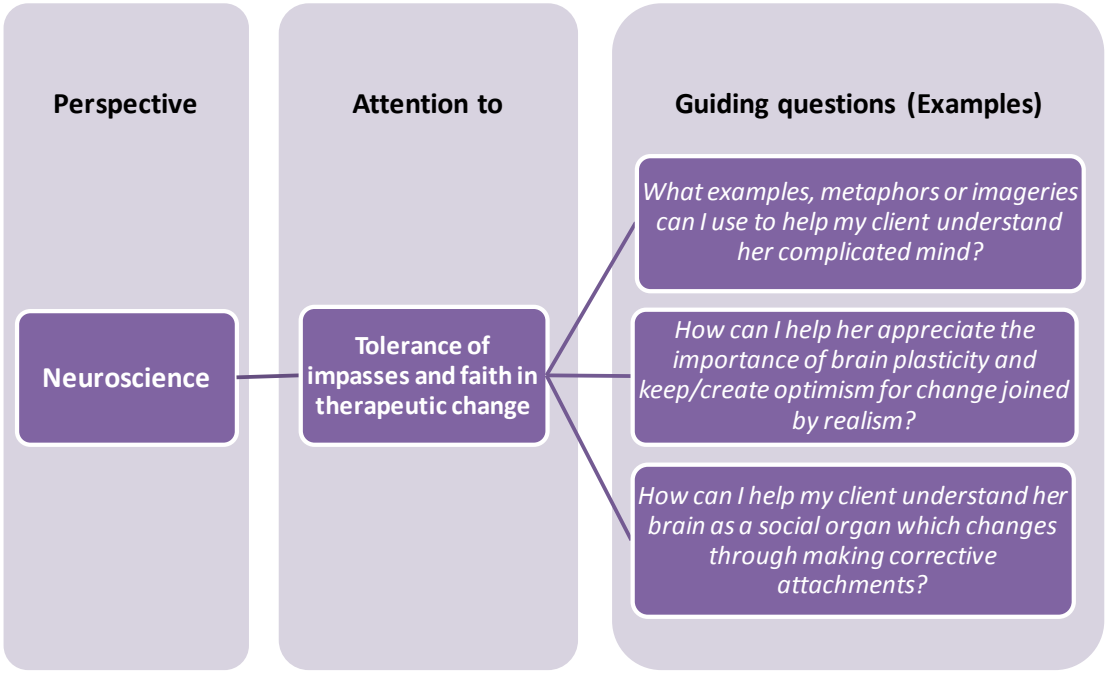


Diagram 2d



Conclusion

In our training of mental health professionals, we retain a basic systemic outlook while enriching our training with three additional perspectives: attachment theory, narrative/dialogic psychology and findings from neurosciences. Our endeavour is based on general guidelines that we provide our trainees with. These include: (i) an understanding of therapy process as following certain stages, stated in parallel from all four perspectives, and (ii) a list of guiding questions for clinical practice, again stated from all four perspectives.

In many countries, including Greece, the training of systemic therapists takes many different forms and follows many different trends (see Tseliou, 2013). In the design of our training programme, we went along the claim that the future of systemic and family approaches depends on updating theories to view humans as biopsychosocial beings, and understand them at a truly multisystemic level (Fishbane, 2007). We believe that our training programme helps our trainees do exactly that: proceed in conceptualizing cases from "mind to culture" and vice versa in the phrase of Jerome Bruner, or "zoom in and out from neurons to neighbourhoods" in the phrase of Louis Cozolino (2006). This way they gain "a deeper understanding of the interwoven tapestry of biological, psychological, and social processes that comprise human life" (Cozolino, 2006, p. 4).

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