Systemic Therapy Using the Digital, Analogue, and Narrative Method

By

Mauro Mariotti

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Preface

Author's declaration. *This book is based on my clinical, theoretical and teaching work on systemic brief therapy and the DAN model. Artificial intelligence tools, where used, supported drafting, language revision, organization or editorial refinement; they did not replace my intellectual authorship, clinical responsibility, conceptual decisions or ownership of the model. All final choices, interpretations, clinical positions, references and formulations remain my responsibility as author.*

How to use this manual. This manual is designed as a progressive learning pathway. The reader should first understand the epistemology of DAN, then learn to recognize the three clinical levels, then practise the core instruments, and only afterwards apply the protocols to couples, families, adolescents and groups. Each chapter should therefore be read with one practical question in mind: what must the therapist be able to observe, decide and do after this section? This manual is also closely related to the previous volume published by Ethic Press, *Systemic Psychotherapy Strategies to Intervene on Trauma and Stress* (2026). That book describes in greater depth the DAN exercises and the relevant theoretical foundations concerning the trigenerational aspects of trauma and stress, including the concepts of trigenerational adaptive and maladaptive schemas. Readers are therefore encouraged to refer to that volume for a fuller and more precise understanding of the use of DAN instruments, especially when these tools are applied to trauma, stress and their transgenerational transmission.

DAN in the Broader Field of Psychotherapy

Contemporary psychotherapy is increasingly called upon to respond to complex forms of suffering that cannot be understood solely as individual symptoms or isolated intrapsychic events. Emotional distress, rela-

tional conflict, family impasses and developmental crises often emerge within networks of meanings, bonds, expectations and repeated interactional patterns. For this reason, the systemic-relational tradition, together with narrative, constructivist and experiential approaches, has progressively emphasized context, communication, embodied experience and the co-construction of meaning as central dimensions of clinical change (McNamee & Gergen, 1992; White & Epston, 1990).

Within this broader clinical landscape, the DAN model—Digital, Analogic and Narrative—organizes therapeutic work around three fundamental languages of experience. The digital level structures words, roles, boundaries and agreements; the analogic level works through the body, images, symbols, emotional resonance and non-verbal experience; and the narrative level integrates events into stories that can be re-authored and transformed. DAN therefore does not present itself as a closed school or self-sufficient doctrine, but as an operational grammar that dialogues with different psychotherapeutic traditions while maintaining systemic attention to relationships and contexts.

This volume was born from a precise clinical and theoretical intention: to take complexity seriously without turning it into confusion. Psychotherapy has long recognized that problems do not live only "inside" people, but also in the meanings they inherit, the relationships they inhabit, the loyalties they carry and the stories through which they understand themselves and others. The DAN model brings this intuition into an essential operational grammar. Digital, Analogic and Narrative are not three techniques or three rigid phases, but three fundamental ways in which experience becomes accessible to change. If something cannot yet be said, it can perhaps be shown; if it cannot be shown directly, it can be approached through metaphor; if a story has become a prison, it can return to being a path. In this direction, DAN does not claim to explain the human being in full; it proposes a way to make human experience encounterable in therapy.

The heart of DAN is a logic of integration. The digital level organizes: it defines boundaries, roles and contracts, and makes what was previously confused distinguishable. The analogic level calms and gives form: it allows emotions to exist without overwhelming the system, lowers defensiveness and creates protective distance through symbols, objects, images and the body. The narrative level integrates: it gives continuity, restores a sense of future and transforms the symptom from an identity condemnation into an event within a history, and therefore into a possibility. The sequence is not always linear. Rather, the therapist learns to recognize which level is accessible, which is blocked and which is hyperactivated. In other words, DAN does not simply say what to do; it offers criteria for deciding *when* and *why* to do something, and above all for doing it without betraying the therapeutic relationship.

For this reason, throughout the volume, instruments are never separated from therapeutic attitudes. Equi-vicinity, curiosity, positive connotation and the calibrated use of irony and irreverence are not accessory communication skills; they are the ways in which the model protects the therapeutic process from abuses of power, moralism, the search for a culprit and the seduction of definitive explanations. In DAN, the therapist's posture is a discipline: maintaining multiple loyalties, staying close to the system without colluding with its polarizations, and learning to see function before error, protection before attack and need before symptom. This posture allows the tools to become genuinely transformative, because it creates a shared experience in which no one is forced beyond their window of tolerance and no one is reduced to their most problematic part.

A second guiding theme of this manual is transferability. In psychotherapy, change becomes more stable when the experience of the session can be translated into everyday life, relational habits and concrete practices. From this perspective, tools and homework are

not behavioural extras, but continuations of symbolic, emotional and narrative work outside the therapeutic setting. When a couple, a family or an individual uses a Shield, a Better Formed Story, a Role Reversal or an Object Letter beyond the session, therapy stops being only a place of analysis and becomes a place of relational practice. Change does not remain in the room; it enters rituals, micro-choices, conversations and daily gestures, supporting continuity between therapeutic insight and lived experience.

This volume also addresses an often-delicate point in systemic culture: the relationship between evidence and creativity. Manualizing does not mean stiffening; it means making shareable what would otherwise remain entrusted to individual talent. DAN manualization aims to describe processes and define choices, sequences and criteria for the use of tools so that the work can be supervised, taught and assessed. Research, in this perspective, is not an external control that impoverishes clinical practice, but an act of responsibility: to say clearly what we do, why we do it and with what observable results. It is also a way to protect therapy from rhetoric and improvisation while preserving creative freedom within an ethical and replicable framework.

The same logic runs through the chapters dedicated to supervision, training and communities of practice. Clinical competence does not coincide with the mechanical mastery of tools, but with the ability to inhabit complexity with ethical responsibility. Learning a model means learning to tolerate uncertainty without taking refuge in technique, to contain activation without extinguishing it, to use structure without transforming it into control, and to build narratives without imposing them. Supervision is therefore not only the verification of procedures, but a space in which the therapist observes positioning, automatisms and resonances. A community of practice keeps a model alive because psychotherapy, by definition, grows through dialogue, critique, experience, transmission and revision.

If there is an image that can conclude this preface, it is that of psychotherapy as rigorous craftsmanship: hands that build form, eyes that know how to see, words that do not wound and stories that reopen the future. In the DAN model, the analogic level calms, the digital level organizes and the narrative level integrates. These three simple functions become, session after session, a clinical ethic of work. Using this volume means holding together structure and freedom, method and invention, evidence and creativity. It means remembering that every tool is an invitation and never an imposition, that every person and every family is larger than their symptom, and that sustainable change is born when what was unspeakable becomes representable, what was unmanageable becomes nameable, and what seemed destined becomes history again. With this compass, DAN does not promise easy solutions; it offers a way to walk together with respect, precision and hope.

Epistemological Premise

Why a Model Based on Communication?

The DAN model is an applied epistemology rather than a theory of the human being. It does not try to define persons ontologically; instead, it identifies the conditions through which experience becomes clinically accessible, shareable and transformable. Communication is therefore treated as a threshold: bodily states, emotions, symptoms, silences, metaphors and stories enter the therapeutic relationship in forms that can be regulated, symbolized, negotiated and reorganized.

This distinction is fundamental. The primary task of a clinical model is not to offer an ontological description of the human being, but to identify the operational thresholds through which experience becomes observable, shareable and transformable within the therapeutic relationship.

DAN assumes that communication, in its different forms, represents this threshold. Psychotherapy can work on experience only when that experience has become, in some way, expressible, observable and shareable. This assumption is rooted in the systemic tradition: Watzlawick, Beavin and Jackson argued that all behaviour has communicative value and that interactional patterns must be understood within their relational context (Watzlawick, Beavin and Jackson, 1967). Bateson's cybernetic and ecological epistemology similarly placed communication at the centre of mental life, showing that meaning emerges through differences, feedback, context and relationship rather than inside an isolated individual (Bateson, 1972). More recent descriptions of systemic psychotherapy also identify communication theory, systems theory and constructivism as core foundations of clinical work, emphasizing that symptoms and suffering become intelligible within the relational contexts in which they are communicated and maintained (von Sydow, Beher and Retzlaff, 2024).

For this reason, communication is not understood here as a mere exchange of words, nor as a reduction of the person to what is said. It is a clinical threshold: the point at which bodily states, emotions, symptoms, silences, conflicts, metaphors and stories become available to the therapeutic relationship. Before this threshold is reached, suffering may be lived, acted out or embodied, but it remains difficult to regulate together. Once it enters a communicative form—digital, analogic or narrative—it can be named, mirrored, symbolized, negotiated and transformed. In this sense, the communicative threshold marks the passage from private or dysregulated experience to shared clinical work.

Communication as Clinical Access, Not Reduction

To say that clinical work is based on communication does not mean reducing the person to communication itself. It means recognizing

that bodily states, thoughts, emotions and relationships become clinically accessible through the ways in which they are expressed, regulated and represented.

Within this framework, thought enters the clinical field through words, definitions, rules, boundaries and interpretations, which constitute the digital language of therapy. Bodily experience becomes clinically accessible through posture, muscular tension, symptoms, movement, rhythm and intensity, thereby expressing the analogic language. Emotional and identity experience, in turn, reaches the therapeutic field through images, metaphors, stories and narratives of the self and others, which organize the narrative and symbolic language. The three modalities should therefore be understood as complementary clinical access routes through which cognition, embodiment, emotion and identity become observable, shareable and transformable within the therapeutic relationship.

The DAN model does not privilege one aspect of life at the expense of the others. Rather, it organizes the complexity of human experience according to the ways in which that experience becomes clinically transformable.

What cannot yet be placed into a communicable form cannot easily be shared, regulated or reorganized within a therapeutic process.

An Operational, Not Ontological, Epistemology

The DAN model is explicitly situated within a systemic-constructivist perspective. It integrates contributions from embodied cognition and affective neuroscience and assumes that clinical reality is co-constructed within the therapeutic relationship. This position is coherent with constructivist and autopoietic perspectives that understand living systems as self-organizing systems whose meanings emerge

through recursive interaction rather than through simple linear causality (Maturana & Varela, 1980).

At the same time, the epistemological field of this book is not limited to constructivism. It also belongs to the biopsychosocial paradigm, because one aim of the DAN model is to show that systemic psychotherapy can operate both from the top down and from the bottom up. From the top down, it reorganizes meanings, narratives, roles, rules and relational interpretations; from the bottom up, it works through the body, emotion, implicit memory, symbols, images and regulation. In this way, DAN helps systemic psychotherapy move beyond the old dichotomy between therapies that change through cognition and meaning and therapies that change through bodily and emotional regulation (Engel, 1977).

Today, many bottom-up approaches appear as separate streams, including EMDR, Ericksonian hypnosis, PNL, mindfulness, meditation and other experiential or body-oriented practices. Each has opened an important clinical path, yet each often remains a partial language. The challenge for contemporary psychotherapy is to develop an epistemology capable of bringing these streams into dialogue without reducing their specificity. Systemic psychotherapy, renewed through the DAN model, can offer this integrative frame because it holds together biological regulation, psychological meaning and social-relational context within one clinical field.

In this framework, the model does not oppose communication to the inner world of the person. On the contrary, it assumes that personality organization, emotional life, bodily regulation, defensive styles, attachment patterns and relational positions are inseparable dimensions of the same clinical field. The contemporary movement toward psychotherapy integration supports this position: psychodynamic, relational, systemic, experiential and constructivist approaches increasingly converge around the idea that change occurs through the interaction

between intrapsychic processes, emotional regulation, interpersonal patterns and the therapeutic relationship. Emotion regulation, for example, has been described as a trans-theoretical meta-factor of change, linking psychodynamic constructs such as defences and internal working models with relational phenomena such as alliance ruptures, repairs and interpersonal regulation (Palmieri et al., 2022). Relational and integrative perspectives also emphasize that personality patterns are not only internal structures, but circular processes maintained and transformed through relationships, feedback and enactments inside and outside the consulting room (Wachtel, 2014). Systemic psychotherapy, in turn, locates symptoms within communication, multigenerational processes, attachment and social context, without reducing the person to interaction alone (von Sydow, Beher & Retzlaff, 2024).

This position does not deny the existence of emotion, personality, fantasy, attachment or unconscious dynamics, nor does it treat communication as a superficial exchange of messages. On the contrary, it assumes that these dimensions become clinically meaningful when they are expressed, regulated and transformed within a relational field. DAN therefore avoids reducing human functioning to isolated biological, intrapsychic, relational or communicational dimensions; instead, it considers these domains as interdependent aspects of a complex clinical system that can be approached through the communicative forms in which experience becomes observable, shareable and open to change.

Instead, DAN adopts an integrative and operational epistemology. The person is always more than any model can describe; nevertheless, the clinical process needs points of access through which experience can be approached without being fragmented. Communication, in this sense, is neither the cause of everything nor the whole of therapy. It is the threshold at which inner dynamics, emotions, personality styles and relational patterns become shareable, observable, co-regulated and therefore transformable.

How does an inner experience—an emotion, a defence, a desire, a fear, a relational expectation or a personality pattern—become accessible to therapeutic encounter and change?

The answer offered by the DAN model is that change occurs through the reorganization of the languages of experience, understood as the meeting point between intrapsychic dynamics, emotional regulation, relational patterns and communicative forms. The digital level offers structure and meaning; the analogic level allows emotions, body and implicit experience to become tolerable and representable; and the narrative level integrates these dimensions into a more flexible identity story, in continuity with narrative approaches that treat therapeutic change as the re-authoring of problem-saturated accounts into more complex and generative stories (White & Epston, 1990). In this way, DAN does not replace psychodynamic depth with communication, nor relational complexity with technique. It uses communication as the clinical surface on which depth becomes encounterable.

Digital, Analogic and Narrative as Levels of Experience

The three levels of the DAN model are not communication channels in a merely technical sense, nor evolutionary phases, nor separate compartments. They represent three fundamental ways in which human experience is organized:

- the digital level structures meanings, roles, rules, boundaries and contracts;
- the analogic level regulates emotional and bodily experience, intensity, proximity, distance and resonance;
- the narrative level gives continuity, identity and meaning to experience over time.

Clinical work does not consist in permanently prioritizing one of these levels, but in recognizing which level is primarily accessible, blocked or hyperactivated at a given moment in the therapeutic process and intervening in a coherent way. This emphasis on transforming experience into a more workable communicative and narrative form is also consistent with Sluzki's description of well-formed stories as clinical markers of narrative transformation (Sluzki, 2022).

DAN as an Operational and Integrative Clinical Epistemology

The DAN model is not a collection of techniques, but an operational epistemology that organizes clinical decision-making. Its tools do not precede the reading of the system; rather, they derive from a systemic assessment of which level of experience is most accessible, blocked or hyperactivated at a given moment. In this sense, DAN offers the therapist a criterion for choosing interventions according to the organization of the clinical field, rather than applying procedures independently of context.

This operational structure gives the model three scientific and clinical qualities:

This operational structure gives the model three interrelated scientific and clinical qualities. First, it is sufficiently structured to be taught, supervised, compared and progressively evaluated. At the same time, it remains sufficiently open to avoid becoming a totalizing theory of the human being. Finally, it can integrate different therapeutic instruments when they are coherent with the digital, analogic and narrative levels of experience and with the biopsychosocial organization of the clinical system.

From this perspective, communication is not considered one isolated dimension among others. It is the clinical threshold through which biological regulation, emotional states, relational patterns and narrative meanings become observable, shareable and transformable within the therapeutic relationship.

DAN assumes that the person always exceeds any model. For this reason, it does not attempt to define the human being ontologically, but focuses its theoretical rigour on the conditions that make experience clinically transformable. Digital, analogic and narrative communication do not exhaust human complexity; they identify the relational space in which this complexity can be encountered without being reduced, regulated without being controlled and modified without being violated.

Basic Tools and Attitudes

In systemic psychotherapy and, more specifically, within the DAN model, certain tools and attitudes function as pillars of clinical work. The genogram, the life cycle, the social network, circular and triadic questions, metaphor, emotion and paradox are essential for exploring the complexity of family and individual relationships. They make it possible to visualize dynamics, roles and relational nodes, supporting a systemic reading of clinical experience (Carter & McGoldrick, 1989; Mariotti, Bassoli, & Frison, 2004; McGoldrick, Gerson, & Petry, 2020).

In DAN, metaphor, paradox and emotion are transversal clinical devices. They help calm and shape experience at the analogic level, organize it into meanings, boundaries and choices at the digital level, and integrate it into a more flexible plot of meaning at the narrative level. In this perspective, they are not additional techniques, but ways in which the therapist activates passages between levels when the system is blocked: metaphor makes the unspeakable speakable, para-

dox allows the family to recognize and interrupt its repetitive relational game by experiencing it in a safe and protected therapeutic form, and emotion becomes relational information and transformative material.

The therapist's conducting style is equally central. Equi-vicinity, curiosity, calibrated irony, irreverence, paradox and positive connotation create an open and non-judgmental therapeutic field in which new meanings and possibilities for change can emerge. In the DAN model, the therapist's posture is not limited to interpreting or correcting; it facilitates emotional regulation, supports the emergence of more habitable narratives and protects the therapeutic relationship from blame, moralization and premature closure.

These tools and attitudes have been explored in Fabio Bassoli's research as foundational dimensions of systemic psychotherapy. The conscious use of the genogram, life cycle, circular and triadic questions, metaphor, emotion and paradox, together with a therapeutic posture marked by equi-vicinity, curiosity, irony and positive connotation, supports processes of change that are both relationally respectful and clinically effective.

The centrality of these elements in DAN is therefore not accidental. They represent the meeting point between clinical practice and epistemological reflection. Their integration allows therapy to remain effective, adaptable and respectful of human complexity, marking the difference between a superficial intervention and a therapeutic process capable of generating sustainable change.

Before turning to the operational definition of each DAN tool, it is useful to clarify the therapeutic attitudes that orient their use. The first are equi-vicinity and curiosity, which derive from the legacy of Gianfranco Cecchin and the Milan School but are reformulated here in a contemporary clinical language (Boscolo, Cecchin, Hoffman, & Penn, 1987; Cecchin, 1987).

In the classical Milan tradition, neutrality was introduced by Cecchin, Boscolo and Prata as a clinical stance that prevents the therapist from being captured by one party, one explanation or one coalition within the system (Selvini Palazzoli, Boscolo, Cecchin, & Prata, 1980). In contemporary practice, however, the term can be misunderstood as emotional distance or indifference. For this reason, DAN prefers the notion of *equi-vicinity*: the therapist remains equally close to each participant, recognizing suffering, protective functions and responsibilities without assigning blame or constructing a culprit-victim opposition.

Curiosity is the active movement that makes equi-vicinity possible. It keeps the therapist from becoming rigidly attached to a hypothesis and invites the system to explore meanings, differences and unexpected connections. Curiosity does not mean asking questions for their own sake; it means remaining open to what is not yet known and helping the family, couple or individual discover alternatives to the dominant narrative.

Together, equi-vicinity and curiosity create the basic relational climate of DAN. They allow the therapist to hold multiple loyalties, to suspend premature judgment and to protect the therapeutic space from polarization. In this climate, digital clarification, analogic regulation and narrative transformation can occur without forcing the system beyond its tolerance.

Alongside curiosity, Cecchin's notion of irreverence remains clinically important. Irreverence does not mean lack of respect; it means the therapist's capacity to question personal certainties, theoretical dogmas and habitual clinical routines. It protects the therapist from becoming trapped in fixed roles or rigid explanations and keeps the therapeutic process alive, flexible and creative.

In this sense, irreverence is closely connected to clinical irony. Used with tact and ethical care, irony can interrupt rigid narratives, loosen

defensive positions and open space for alternative meanings. It should never humiliate or minimize suffering; its function is to introduce movement where the system has become overly serious, repetitive or trapped in its own certainties.

Positive connotation is another key attitude in systemic therapeutic style. It has both a strategic and a relational meaning. Strategically, it helps make painful or conflictual narratives more acceptable by identifying the protective or adaptive function hidden within apparently problematic behaviour. Relationally, it expresses the therapist's sincere capacity to recognize value, effort and meaning even in actions that the family experiences only as negative.

In the DAN model, positive connotation is not a rhetorical technique and not an attempt to deny suffering. It is a disciplined clinical posture that searches for function before fault and protection before attack. This attitude helps the therapist reframe symptomatic or conflictual behaviour as an attempted solution, thereby reducing blame and opening the way to responsibility, negotiation and change.

Adopting this posture requires practice and emotional discipline. The therapist must suspend judgment without losing clarity, remain empathic without colluding, and maintain firmness without becoming punitive. In this way, positive connotation becomes not only a strategy, but a relational art that transforms the therapist's way of being with the system.

The systemic tools described in this section acquire their full clinical value when they are used together with these therapeutic attitudes. The genogram, for example, does not simply map family relationships and transgenerational dynamics; when combined with the life cycle, it helps the therapist understand how current symptoms are connected to developmental passages, inherited expectations, rela-

tional mandates and moments of transition (Carter & McGoldrick, 1989; McGoldrick, Gerson, & Petry, 2020).

The integration of genogram and life cycle allows the therapist to move from the question of "who" belongs to the system to the question of "how" relationships are organized over time. It shifts attention from linear causes to lived temporality, from individual blame to relational and developmental context. The symptom can then be read not as an isolated event, but as part of a family history and of a specific moment in the life cycle.

Circular and triadic questions, introduced by the Milan School, are equally central. They invite participants to describe relationships among others rather than only their own position, thereby loosening linear causality and making systemic patterns visible (Selvini Palazzoli, Boscolo, Cecchin, & Prata, 1980). In DAN, these questions support the relational style profile because they help map how family members perceive influence, difference, alliance, distance and change across generations and current relationships.

When triadic questions are translated into dyadic pairs and later integrated into a relational profile, they allow apparently simple answers to become part of a more complex systemic map. The process helps participants observe the influence of previous generations, current relational patterns and possible transformations without reducing the work to direct confrontation or individual accusation.

The triadic question therefore promotes metacommunication. By asking one member of the system what they think about the relationship between two others, the therapist invites the family to observe its own relational field from a new position. This shift can interrupt automatic patterns, soften rigid assumptions and open a broader vision of relationships.

Social network mapping is another essential systemic tool. It allows the therapist to identify the significant ties that surround the person or family—family, friends, work, institutions and community—and to distinguish resources from critical points. Following Sluzki's contribution, the social network can be understood as the dynamic set of relationships that may provide emotional support, practical help, orientation and identity confirmation, while also sometimes becoming a source of stress, isolation or constraint.

Operationally, network mapping may begin by identifying significant people and contexts, then clarifying the frequency of contact, reciprocity, degree of trust and function of each tie. The therapist can distinguish emotional support, practical help, guidance, companionship and mediation, while also identifying emptiness, ruptures or overload. This makes it possible to activate resources and to connect therapeutic work with daily life.

Taken together, these tools and attitudes form the basic framework for systemic clinical work within DAN. They support the therapist in reading family complexity, reducing blame, making relational patterns visible and preparing the ground for more specific digital, analogic and narrative interventions.

The following section defines the basic DAN tools more operationally, moving from the therapeutic attitudes that orient the model to the instruments through which those attitudes are translated into clinical practice.

Definition of Basic DAN Tools

Systemic clinical practice rests on a set of tools and attitudes that, when integrated into the DAN model, help the therapist accompany the person, couple or family through processes of concrete

and sustainable change. Positive connotation, equi-vicinity, curiosity, social network mapping, and circular and triadic questions are not merely techniques; they are relational postures and operational devices that require practice, reflection and clinical sensitivity. Used consciously, they allow the therapist to read the complexity of family systems, reduce linear blame and intervene in a focused way while preserving respect for the system's own meanings and resources.

Positive Connotation: Definition, Application and Examples

Positive connotation consists in identifying meaning, function and value even in behaviours that appear problematic, defensive or conflictual. It is not a rhetorical device and it does not deny suffering. Rather, it allows the therapist to suspend premature judgment and to search for the protective or adaptive intention that may be hidden within the symptom or conflict. In clinical practice, positive connotation can reframe a symptomatic behaviour as an attempted solution, or a parental conflict as a sign that both partners are still trying to be recognized and to influence the family field. This reframing reduces blame, supports circular responsibility and opens possibilities for change. The exercise of positive connotation requires time and training, but it becomes a valuable resource for strengthening motivation, trust and therapeutic alliance.

Equi-vicinity and Curiosity: Post-Milan Systemic Attitudes

The classical concept of neutrality, central in the early Milan School, was progressively criticized during the 1980s because it could be misunderstood as emotional distance, absence of positioning or an impossible claim of objectivity. In contemporary systemic practice, and in the DAN model, this concept is better reformulated as *equi-vicinity*: the therapist does not stand far from everyone, but remains