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"Learning to feel good about positive emotions with the Positive Affect Tolerance and Integration protocol"

"A case series with principles and procedures for applying the standard EMDR procedural steps to improving self-regulation and social functioning for survivors of early emotional neglect."

Spectrum of emotional neglect in early home life with or without overt abuse

- 1) Stable, superficially functional family with *primary* (maternal) attachment figure who fails to show or respond to positive affect (depressed) or imposes rigid standards (narcissistic).
 - a) Secondary attachment figure (paternal) shows appropriate interest and encourages shared positive affect.
 - b) *Secondary* attachment figure *also* fails to show or respond to positive affect (depressed) or shows rigid standards (narcissistic).
- 2) Extensive parental neglect and chaotic environment with domestic abuse ranging from frequent arguments to witnessing substance abuse and violence in home.
- 3) Severe parental neglect and overt physical or sexual abuse
 - a) by *secondary* caregiver with failure to protect and emotional neglect from impaired *primary* caregiver.
 - b) by *primary* caregiver with failure to protect and emotional neglect or abandonment by secondary caregiver.

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The standard EMDR procedural steps (Shapiro, 2001)

- Generally used within the standard EMDR PTSD protocol (Shapiro, 2001)
- to treat maladaptive responses (cognitive, affective, sensory, or somatic intrusive re-experiencing and avoidant behavior)
- associated with (i.e. believed to be caused by) an identifiable, discrete conditioning (traumatic) event or cluster of such events.

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The standard EMDR PTSD protocol (Shapiro, 2001)

- Based on Shapiro's (2001) general treatment planning principle of the three-pronged protocol:
 - Past: standard EMDR procedural steps are first used to reprocess one or more traumatic memories,
 - Present: later to reprocess current external or internal cues that still evoke maladaptive responses, and
 - Future: finally for imaginal rehearsal of more adaptive responses in the future.

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Empirical support for application of EMDR to PTSD

- Data from a large number of randomized clinical trials and meta-analyses (Shapiro, 2001) indicate the standard PTSD protocol (past, present, future) and standard EMDR procedural steps provide an effective and efficient treatment for posttraumatic stress disorder.

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Adaptive Information Processing Model and Emotional Neglect

- Maladaptive responses (ignored, shamed or hurt) to early experiences of positive affect create dysfunctional memory networks that produce positive affect phobias, mistrust and avoidance for shared positive affect.
- Lack of exposure to adaptive responses to positive affect leads to an absence of functional memory networks to organize adaptive responses shared positive affect.
- Self-concept is forced to develop around simulations of observed social behavior not linked to adaptive experiences of shared positive affect resulting in a persistently "hollow" or "false" sense of self and low-self esteem in spite of competence or social recognition.

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PTSD with Comorbid Cluster C and Dismissing insecure attachment

- Some patients:
 - meet full or partial criteria for PTSD;
 - have histories that reflect significant (or extensive) emotional neglect;
 - present with comorbid DSM IV-TR Cluster C Axis II symptoms (Avoidant, Dependent, or Obsessive-Compulsive Personality Disorder).
 - show dismissing insecure attachment (Cassidy & Shaver, 1999; Main, 1996).

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Vulnerabilities in patients with Comorbid Cluster C with PTSD and Dismissing insecure attachment

- They may show superficial characteristics of competence, interpersonal skills, or emotional stability.
- On closer examination they prove to be more fragile or may even collapse in the face of social stressors.
- Clinical assessment reveals these patients have
 - low tolerance for positive interpersonal emotions
 - and engage in defensive strategies to dismiss, minimize, deny or subtly avoid experiencing and assimilating positive emotional states into their internal models of self-identity or worth.

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Insecure attachment and impaired emotional self-regulation

- The inability of survivors of neglect to regulate their emotional states is not solely the result of the adverse effects of traumatizing events.
- Their deficits are significantly linked to lack of exposure to a secure, developmental attachment sequence needed to foster neurobiologically mediated capacities for self-regulation.
 - See: Alexander, 1992, 1993; Fonagy et al., 2002; Schore, 1994, 1996, 1997, 2000, 2001a, 2001b; Siegel, 1999; Teicher, 2000, 2002; Teicher et al., 1993; Teicher et al 1997.

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Insecure attachment and endogenous opioids

- A variety of human and animal studies indicate endogenous opioids and dopamine play a central role in maternal-infant attachment.
 - Depue & Morrone-Strupinsky (2005); Graves, Wallen & Maestripieri (2002); Kalin et al., 1995; Moles, Kieffer & D'Amato (2004); Nelson & Panksepp (1998); Weller, & Feldman (2003).

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Early shared positive affect is essential to the development of emotional self-regulation.

- Shared maternal-infant positive interpersonal affect most typically involving mutual gaze and episodes of play and associated with the formation of secure attachment in the first two years of life triggers elevated levels of endogenous opioids and dopamine in both mother and child and appears to be essential to the development of right prefrontal orbital mediated capacities for emotional self-regulation (Schore, 2003a, 2003b).

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Recognizing patients with dismissing insecure attachment

- Partial list of criteria include (Main, 1996):
 - difficulty describing their relationships to their parents;
 - difficulty remembering events from their childhood to justify their description of happy memories;
 - tendency to minimize the importance of early parental relationships;
 - tendency to idealize or devalue (or both) early relationships;
 - lack of awareness of emotional and physiological responses to perceived abandonment or threat of abandonment until it reaches the point of crisis.

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Deactivating and minimizing in dismissing insecure attachment

- Free expression of (especially negative) affect is minimal.
- Structures for regulating, controlling and suppressing affect are rigid and highly organized.
- Affects, memories and cognitions relevant to attachment are overregulated.
 - See: Cassidy, 1994; Kobak & Seery, 1988; Main, 1990.

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Narrative style in dismissing attachment organization

- They constrict rather than contain emotional experience.
- They are strangers to feelings, motivations or inner life.
- When clinicians suggest such patients may be feeling sad, longing or angry they tend to respond: "I guess so. I suppose so." "Maybe I do but I really don't feel it right now." (Slade, 1999)
- When describing (their often few remembered) traumatic childhood events or abandonments their narratives gloss over the bare surface of events with no references to the inner emotional impact of these experiences in the past or overt expression of affect about them in the present.

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Case 1 - "home alone" - (i)

- A 48 year old divorced woman had persistent emotional and physical neglect in childhood. She had no lifetime relationships with genuine emotional closeness (dismissing insecure attachment).
- She was referred for treatment with EMDR with presenting complaints of major depression (severe) and suicidal ideation (with a lethal plan) with onset after her husband abandoned her for a younger woman. She had noted no sign of his infidelity during the prior 2 years of the affair.
- She minimized the significance and impact of witnessing her parents' alcoholism and domestic violence.

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Case 1 - "home alone" - (ii)

- Her primary memory of her father was of regularly walking late at night by herself to the bar (ages 9-11) to retrieve her father so that he would find his way home.
- She had no memories of her mother other than of her mother's conflicts with her father.
- She never spoke of negative affect states, but spoke only in behavioral terms such as nights when she played computer solitaire for more than 6 hours.

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Discrete Behavioral States model

- Putnam (1997) in *Dissociation in children and adolescents* refers to "discrete states of consciousness" after the fashion of Tart (1972, 1975), and "behavioral states" after the fashion of Wolff (1987).
- These discrete behavioral states involve physiological, affective, and behavioral variables.

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Watkins's Ego States model contrasted with Putnam's Discrete Behavioral States model

- Watkins' (1997) Ego States:
 - Are not referenced to underlying psychophysiological states;
 - Are organized around social roles and mental functions rather than being grounded in internal state defining variables.

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For Putnam Discrete Behavioral States define variable responsiveness

- “State-dependent stimulus responsiveness produces differential responses to the same stimulus, depending upon the state the individual is in at the time.” (Putnam, 1997, p.153)
- “State-defining variables may be continuous or dichotomous. For example, respiratory rate is a continuous variable, whereas eyes open or closed is a dichotomous variable.” (Putnam, 1997, p.154)

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Discrete Behavioral States model: Putnam, 1997

- “The creation of new discrete states, together with the evolution and elaboration of existing states, contributes to the increasingly complex behavioral repertoire of the growing child. . .
- . . . These two interconnected processes of state creation and pathway development are ways in which the developmental web continues to expand throughout the life span.” (Putnam, 1997, p. 160)

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Development of behavioral state space

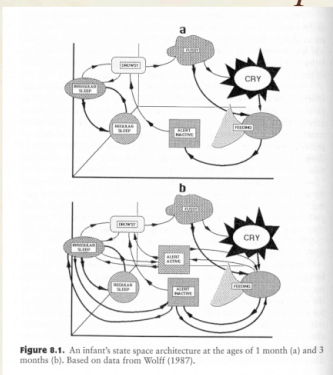


Figure 8.1. An infant's state space architecture at the ages of 1 month (a) and 3 months (b). Based on data from Wolff (1987).

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Predictable sequences between discrete states define an individual's personality

- In total, this behavioral architecture defines an individual's personality by encompassing both the range of the behavioral states available to the individual and the sum of prior experiences that have created distinct, stable states of mind.
- This architecture can be traversed in multiple ways, but individuals tend to follow roughly predictable sequences.” (Putnam, 1997, p. 157)

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Unfamiliar shared positive affect states are highly unstable and poorly tolerated

- Patients with dismissing insecure attachment had insufficient exposure to the state defining variables in shared positive affective states generated through interpersonal experiences of mutual gaze and positive voice tones needed to create stable discrete states.
- As a result they continue to employ overt (behavioral) and covert (dissociative) strategies to avoid these states.
- If triggered into these states they become overwhelmed with anxiety or show dissociative responses.

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Case 1 - “home alone” - (iii)

- Given the persistent depression, emotional anguish and suicidal ideation of this 48 year old divorced woman, her clinician offered her RDI to help stabilize her mood.
- The potential impact of her dismissive insecure attachment on her response to RDI was not considered in advance.
- An attempt to install a singular memory of a kind, soothing other from childhood led initially to a report of increased calm. Then she became distraught and fled the office.
- She cancelled several of her next scheduled appointments on short notice. When she resumed sessions, she refused further RDI or EMDR insisting on talk therapy only.
- This response to RDI was later recognized as reflective of her inability to tolerate states of shared positive affect.

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Fostering new discrete behavioral states and a new sense of self

- Patients with intolerance for shared positive affect states have a need to:
 - First, understand what is missing and why it would be helpful to change.
 - Second, be guided to develop new, stable, discrete behavioral states of shared positive affect.
 - Third, integrate these new discrete behavioral states into new interpersonal behaviors and a new sense of self.

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A short-term model of psychotherapy for treating character disorders as affect phobias

- McCullough (1997, 2003) has described a short-term anxiety-regulating model of psychotherapy.
- She lists five major facets of defense and affect restructuring which are sequentially addressed over the course of psychotherapy:
 - Defense recognition
 - Defense relinquishment
 - Affect experiencing
 - Affect expression
 - Self and other restructuring

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Adaptive versus defensive forms of Interest-Excitement

(from McCullough, 1997, table 7.4)

- | | |
|--|---|
| <ul style="list-style-type: none">○ <i>Adaptive interest-excitement</i><ul style="list-style-type: none">□ A cared-about person or product□ Relaxed but deep involvement□ Energizing, vitalizing□ Deeply satisfying and lasting | <ul style="list-style-type: none">○ <i>Defensive interest-excitement</i><ul style="list-style-type: none">□ A compulsive attraction, endeavor or repetitive ritual□ Intense and driven involvement□ Ultimately tiring, draining□ Excessive repetition is required for satisfaction |
|--|---|

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Purposes of the Positive Affect Tolerance and Integration Protocol

- To assess the patient's capacity and
- To help the patient learn
 - to tolerate and
 - to integrate discrete behavioral states with *shared* positive affect (interest-excitement and enjoyment-joy)
 - *into a shared positive experience of self.*

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Patients for whom PAT should be considered

- Patient's history reflects absence of early shared positive affect or significant emotional neglect.
- Positive affect phobia (uses defensive strategies to avoid experiencing shared positive affect).
- Does not meet standard EMDR readiness criteria or has persistently blocked reprocessing.
- May show dismissing (avoidant) insecure or disorganized attachment.
- May show co-morbid DSM IV-TR Cluster C Axis II symptoms (Avoidant, Dependent, or Obsessive-Compulsive Personality Disorder).

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EMDR treatment responses that suggest PAT should be considered

- When the patient:
 - Shows anxiety, confusion or other negative responses to RDI procedures.
 - Shows depersonalization or chronic blocked responses during attempts to use standard EMDR procedure on disturbing memories.

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Overview of PAT treatment phase

- 1. Clinical determination of patient inability to tolerate and assimilate shared positive affect.
- 2. Psychoeducation on value of shared positive affect and informed consent to investigational use of EMDR.
- 3. Teach standard 3 step exercise to accept praise with homework to practice and report back.
- 4. Apply the Positive Affect Tolerance and Integration Protocol to a current experience of shared positive affect.
- 5. Repeat over several sessions until patient shows clinical gains with a positive experience of shared positive affect.
- 6. Apply standard EMDR as indicated to memories of adverse events.

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Psychoeducation

- a) The role of shared positive interpersonal affect in infancy and childhood for the development of:
 - Essential brain systems (and discrete behavioral states) for tolerating and integrating shared positive affect as a positive dimension of life.
 - Adaptive models (schemas) for selecting and regulating attachment relationships that include shared positive affect.
- b) Information from research studies for the health and stress protective characteristics of shared positive affect.

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Metaphors for learning to tolerate and incorporate shared positive affect

- Metaphors for understanding how shared positive affect can be initially experienced as distressing, yet lead to later positive, enjoyable experiences.
 - i. After being on a starvation diet, the need to start carefully and gradually as the digestive system rebuilds its capacity to assimilate nutrition from richer, more nutritious foods.
 - ii. After a prolonged absence from exercise, how initial exercise can easily lead to muscle or ligament injury, how soreness is normal with appropriate increases in exercise, how nerve supply takes weeks to develop before new blood supply gradually forms, before new muscle tissue slowly develops.

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Teach 3 step exercise actively receiving appreciation, compliments, and praise

- When offered appreciation, compliments or praise:
 - 1. Make and maintain eye contact
 - 2. Take a deeper breath into the upper chest to expand a space around the heart and make room for positive feelings.
 - 3. While maintaining eye contact say, "Thank you. I appreciate you saying that."

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Start with reversed roles

- After explaining 3 step exercise, start with reversed roles.
- Ask patient to offer two compliments that can be real or made up.
 - Explain first you will demonstrate rejecting the compliment. "Notice how that feels." Then you will demonstrate actively accepting the compliment. "Notice if that feels different."
 - Demonstrate both and have patient comment on the difference.
- Then have patient practice first actively rejecting a compliment and second actively accepting. Have patient comment on the difference when actively receiving.
- Assign homework practice actively accepting appreciation, compliments and praise during the week and keep a log.

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Selecting targets for PAT

- The target for the Positive Affect Tolerance and Integration Protocol is always the "internal feeling state" (discrete behavioral state) associated with a specific experience of positive affect.
- The selected event is the "lens" that allows the patient to focus on the positive feeling state and any associated defensive emotions or beliefs.
- In most cases the target will be a recent, poorly tolerated moment of shared positive affect.

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7 differences in clinical application of EMDR procedural steps to PAT (i)

- 1) The target is the “feeling state” from a recent experience (not an old memory);
- 2) The target is conceptualized as the poorly tolerated *discrete behavioral state* of shared positive emotion (not the event itself);
- 3) Initial clinical goal is to lower 2-3 SUD levels (not necessarily to achieve a “0” SUD); a limited number (3-5) of sets of eye movement are applied.
- 4) The SUD scale may be replaced with a bi-valued “feeling thermometer” scale that comprises both negative and positive ratings.

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7 differences in clinical application of EMDR procedural steps to PAT (ii)

- 5) If early associated disturbing memories are recalled, they are acknowledged and noted for future reprocessing but are not reprocessed until later treatment phases; reprocessing is refocused to the original target (recent experience);
- 6) Installation of a Positive Cognition is offered with goal to raise VoC modestly (2-3 points) even if the SUD remains above a 2;
- 7) The closure phase may be extended and multi-stage for patients with tendencies to disorganize during a focus on shared positive affect.

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Essential congruencies with standard EMDR procedural steps

- The target involves a discrete event rather than a free floating or generalized positive affect state.
- The assessment phase includes: picture, NC, PC, VoC, specific emotion, SUD and body location.
- The number of eye movement cycles (tone or taps) is the standard 24-30 per set.
- There are Desensitization, Installation and Closure phases.
- Feedback from the patient log helps align future PAT target selection.

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Extended, multi-stage closure for patients who disorganize during PAT

- A. Safe or calm place.
 - Access and enhance without BLS (Shapiro, 2001, pp 125-127).
- B. Light stream.
 - (Shapiro, 2001, pp 244-246).
- C. Whole and complete self.
 - *“As I count upwards from one to five, I’d like you to bring your whole and complete self back here to this room. (Pause.) So, bringing your whole and complete self back into the room now, one, two, (rising intonation), three, four and five.”* (York, personal communication.)
- D. Present sensory awareness.

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Case 2 - “everyone victimizes me” (i)

- A 54 year old divorced grandmother who worked part-time as a fitness instructor presented for EMDR treatment for a life-long series of victimization experiences.
- She had been teased and sexually abused or exploited in primary school, high school and college by other students and teachers. She had been exploited sexually by her sadomasochistic accountant for many years.
- She had numerous cosmetic surgeries (only some medically indicated). She was in long-term stable recovery from alcohol abuse and was active in AA.

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Case 2 - “everyone victimizes me” (ii)

- History taking and treatment planning were initially limited by her tendency to lapse into vague, self-critical statements when asked to describe stressful social interactions or specific traumatic memories. She reported depersonalization in stressful social interactions.
- She was the only and adopted child of two teachers at an exclusive prep school. She reported both parents had narcissistic personality traits. She was expected to look and be “perfect”. She said her parents were preoccupied with her social presentation and showed no interest in her feelings, insecurities, problems, hopes or ambitions.
- Her mother was chronically depressed. Her father focused on academic interests and school politics.

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Case 2 - “everyone victimizes me” (iii)

- Initial attempts to apply EMDR to her earliest memories of parental neglect, parental conflict and sexual abuse in elementary school all led to blocked responses with severe depersonalization.
- Attention then shifted to psychoeducation on the role of positive affect and role playing shared positive affect. The next week her mood brightened. She reported taking in praise and appreciation at her AA meetings and from her fitness students.
- She was completely surprised at the difference in her internal state when she actively took in these compliments and at the sheer number compliments she was being offered each week.

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Case 2 - “everyone victimizes me” (iv)

- One of these positive experiences was then selected each week for a series of PAT procedures. After 5 sessions of psychoeducation and PAT, EMDR was again attempted on a memory of sexual abuse from the sixth grade.
- This time (and subsequently) the patient had a completed session with no blockage due to depersonalization.
- She did report a period of “brain fog” in the middle of EMDR sessions. (i.e. moments of confusion during initial reorganization of memories). The brain fog passed within 2-4 sets of eye movements followed by a sense of resolution and tremendous well-being. This became a hallmark sign that effective reprocessing was taking place.

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Case 3 - “hollow inside” (i)

- A 37 year old talented musician requested treatment on learning that his girl friend was leaving him. He said that he just felt “hollow inside” and couldn’t imagine going on now that this familiar feeling had returned again.
- He reported his mother had been ill with cancer when he was a child and died when he was 9 years old. His father remarried a younger woman who was only interested in her biological children.
- He won scholarships to a music conservatory and awards in the music industry. He was respected and appreciated by his peers, but tended to be dismissive of his achievements.

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Case 3 - “hollow inside” (ii)

- His EMDR clinician reported he seemed puzzled by the safe place exercise. “What’s the point,” he said. Trauma focused reprocessing of his mother’s lingering death and his step-mother’s rejections led to depersonalization and confusion that made him suspicious of EMDR.
- After consultation, the EMDR clinician refocused to psychoeducation on the role of positive affect and role playing on shared positive affect.
- Then they used recent experiences of accepting praise and warmth from peers in a series of six PAT sessions. The extended, multi-layered closure was used for the first three of these sessions due to mild depersonalization.

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Case 3 - “hollow inside” (iii)


- By the fourth PAT session he reported days without feeling “hollow inside.” By the sixth session he reported days of “feeling good inside.”
- After a hiatus working out of town, attention shifted to applying EMDR to being “rejected” by his step-mother after a perceived rejection by his agent who appeared to favor another musician. Two memories of step-mother were successfully reprocessed without depersonalization.
- After a dream about his mother, EMDR was successfully applied to memories of his mother’s illness and death. He had significant gains including feeling “connected to my mother for the first time in my life” and insights into his past choices in romantic relationships.

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Summary

- Selected patients with
 - Histories of limited or no exposure to shared positive affect in the first two years of life
 - Co-morbid PTSD and Cluster C Axis II symptoms
 - Dismissing insecure attachment
 - Tendencies for depersonalization
- may benefit from an initial focus on improving their ability to tolerate and integrate shared positive affect into new discrete behavioral states and new self-schemas rather initially attempting to treat their PTSD symptoms.

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Patients deserve treatment for the impacts of both neglect and trauma.

- Patients with co-morbid PTSD, dismissing insecure attachment and Axis II symptoms associated early neglect deserve treatment that addresses both the impacts of lack of exposure to shared positive affect as well as the impacts of discrete traumatic events.
- These cases illustrate patients who became able to tolerate and benefit from standard EMDR without depersonalization after initial treatment focused on the Positive Affect Tolerance and Integration protocol.
- In other cases with EMDR readiness at intake and where depersonalization does not block initial effectiveness of EMDR, the potential benefits of PAT may emerge as important in later phases of treatment.

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Future directions

- Work is needed to refine and standardize assessment procedures for identifying cases where an initial focus on tolerating and integrating shared positive affect is indicated.
- Controlled treatment outcome research is needed to confirm PAT procedures are effective.
- Controlled research is needed to compare effectiveness with other potentially effective treatments such as short-term dynamic psychotherapy (McCullough, 1997, 2003) or neurofeedback (Fisher, 2006).

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Positive Affect Tolerance and Integration Protocol

Forging a foundation for change with positive affect scripts

Overview

The goal of positive affect tolerance processing is to assess the client's capacity and to help the client learn to tolerate and integrate positive affect (interest-excitement and enjoyment-joy) into a positive experience of self. During the processing, the clinician should have the client notice any decreases in anxiety about the experience of positive affect and to link these decreases with a positive self-statement to help create or strengthen positive affect scripts.

Clinicians should have a working model of the client's attachment status and should have screened thoroughly for the presence of a dissociative disorder before offering positive affect tolerance and integration.

For clients whose early development was marked by deeply deficient exposure to shared, interpersonal, positive affect, positive affect tolerance and integration can proceed extremely slowly. For clients who were punished during early childhood for showing positive affect, positive affect tolerance and integration can bring about marked increases in anxiety and even dissociative responses.

When reactive anxiety is high, clinicians may need to titrate exposure to current positive affect inducing experiences and/or accept only slight decreases in reactive negative affect (anxiety, disgust, fear, or sadness) in a given session. A comprehensive, multi-layered closure is provided for those kinds of sessions. In such cases, brief use of the positive affect tolerance and integration protocol may need to be part of nearly every session during the early phases of treatment. In many other cases, negative reactions to positive affect may be mild enough not to need titration, but positive responses may build only gradually over time.

Please note that the purpose of positive affect tolerance and integration is to decrease any negative reactive feelings, thoughts and impulses the client experiences now (in session) while focusing on a recent experience that triggered positive affect. Small decreases in negative reactions are sometimes the best that can be obtained. Linking these modest changes with modified positive self-statements helps build positive affect scripts and a new core sense of self. Other clients will show far fewer negative reactions to positive affect and will need only limited amounts of practice with positive affect tolerance and integration.

Reassessing client responses to positive affect tolerance and integration protocols in subsequent sessions is essential to assure the absence of adverse responses and to confirm progress towards treatment goals.