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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."

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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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 & Maestriperi (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' (1997) Ego States model

- Watkins' Ego States model is based on:
 - Dualistic "mental states"
 - Concepts of "mental energies" from Janet, Freud, Jung, and Federn
 - Subconscious personalities
 - Personality as multiplicity
 - Ellenberger's "divided personality"
 - Hilgard's neodissociation theory of hypnosis and the concept of the "hidden observer."

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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-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)
- "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)

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Discrete Behavioral States model: discontinuous jumps in state space

- “Individual behavioral states exist within a larger multidimensional framework or space defined by a chosen set of variables.
- Individual behavioral states occupy discrete volumes of state space, centered around the intersections of the state-defining variables. (See figure 8.3)
- An individual’s behavior traverses state space in a series of discontinuous jumps or “switches” from one state to another.” (Putnam, 1997, p. 156)

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Switches among discrete behavioral states

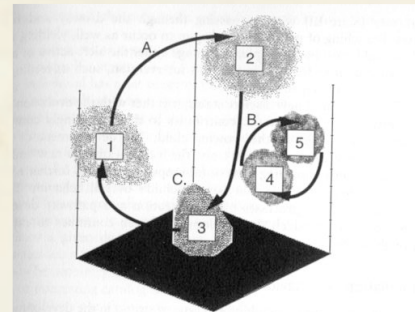


Figure 8.3. Switches among discrete behavioral states.

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States as self-organizing and self-stabilizing

- “Discrete states are transitory behavioral structures. Within time limits, states are self-organizing and self-stabilizing. (Wolff, 1987).
- When a state is newly activated -- for instance, when a sleeping infant wakes up the newly activated state progressively organizes and stabilizes itself. . .
- Eventually a state is destabilized in some fashion, and the locus of organization for cognition and behavior shifts to another region of state space.” (Putnam, 1997, p. 157)

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One can only regularly visit regions in state space with stable discrete states

- “Theoretically, state space may be vast, but one can only regularly visit those regions in which one has created stable, discrete states.
- Discrete states are linked together by directional pathways forming a behavioral architecture (see Figure 8.2).
- Movement along these pathways occurs in a probabilistic fashion, which lends some degree of predictability to human behavior.” (Putnam, 1997, p. 157)

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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

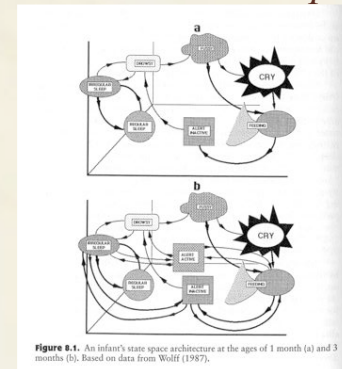


Figure 8.4. An infant's state space architecture at the ages of 1 month (a) and 3 months (b). Based on data from Wolff (1987).

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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 dismissing insecure attachment and 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)

- | | |
|---------------------------------------|----------------------------------------------------------|
| ○ <i>Adaptive interest-excitement</i> | ○ <i>Defensive interest-excitement</i> |
| □ A cared-about person or product | □ A compulsive attraction, endeavor or repetitive ritual |
| □ Relaxed but deep involvement | □ Intense and driven involvement |
| □ Energizing, vitalizing | □ Ultimately tiring, draining |
| □ Deeply satisfying and lasting | □ 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 positive affect (interest-excitement and enjoyment-joy) mediated discrete behavioral states
 - into a positive experience of self.

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Patients for whom PAT should be considered

- The patient's history reflects significant (or extensive) emotional neglect.
- Dismissing (avoidant) insecure attachment.
- Co-morbid DSM IV-TR Cluster C Axis II symptoms (Avoidant, Dependent, or Obsessive-Compulsive Personality Disorder).
- Positive affect phobia (uses defensive strategies to avoid experiencing and expressing shared positive affect).
- Does not meet standard EMDR readiness criteria.

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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 during attempts to use standard EMDR procedure on disturbing memories.
 - Does not meet criteria for Dissociative Identity Disorder or DDNOS.

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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 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 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 positive emotional state (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 (or a modified Positive Cognition) is done 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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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
 - Co-morbid PTSD and Cluster C Axis II symptoms
 - Histories of limited or no exposure to shared positive affect in the first two years of life
 - 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.

Positive Affect Tolerance and Integration Protocol
Forging a foundation for change with positive affect scripts

1. **“Tell me about the most recent time when you had a good feeling and the good feeling that you had then.”**

2. **“What picture represents that situation?”**

3. **“When you focus on that picture, how do you feel now?”**

4. **“When you focus on that picture and notice that _____ feeling, (from step 3), what thought or belief do you have about yourself now?”**

If the statement in step 4 is positive skip step 5 and go to step 6. If the statement in step 4 is negative, go to step 5.

5. PC - **“When you focus on that picture and notice the _____ feeling you get now (from step 3), what more positive thought or belief would you like to be able to have about yourself now?” (PC)**

6. VoC - **“When you focus on that picture, and notice the _____ feeling you get now (from step 3), and those the words, _____(restate the client’s PC), how true do those words feel to you now from 1 to 7, with 1 being completely false and 7 being completely true?”**

VoC: 1 2 3 4 5 6 7

7. Emotion - **“When you focus on that picture, that _____ feeling you get now (from step 3), and those words _____ (repeat the words from step 4) what emotion goes with it?”**

8. Emotional valence - **“Using a feeling thermometer scale (FT) from 0 to 100 where 0 is the most disturbing you can imagine, 50 is neutral, and 100 is the most positive you can imagine, how would you rate that emotion now?”**

Mark the FT level: 0 10 20 30 40 50 60 70 80 90 100

9. Body location - **“Where do you feel it?”**

10. Titration. **When the FT is above 30 skip step 10 and go to step 11.** When the FT is below 30, the clinician should attempt to lessen the intensity of the reactive negative affect to the target situation before processing, with one of the options in 10 A:

“It seems very uncomfortable for you to be focusing so closely on a moment of positive emotion. So what I’d like to offer is:”

10 A. i) **“Instead of actually focusing on that memory where you had the positive feeling, I’d like you to just think about thinking about that situation.”**
(York, 1999)

10 A. ii) **“Instead of actually focusing on that memory where you had the positive feeling, I’d like you to imagine that a movie about that situation with the positive feeling is being shown in an empty theatre and you are outside the movie theatre where know that the movie is playing. You can’t hear or see or feel it, but you can just think about it.”**

10 A. iii) **“Instead of actually focusing on that memory where you had the positive feeling, I’d like you to think of someone you know and like and who you would like to be more like in the way they let in positive feelings like those. I’d like you to imagine this other person being in the situation where you had the positive feelings. Notice anything about how this other person shows how it’s ok for them to have this positive feeling.**

10 B. Rechecking the FT on the reactive emotion. Select the matching phrase:

i) **“And now as you just think about thinking about it,”**

ii) **“And now as you just think about the movie,”**

ii) **“And now as you imagine noticing it being ok for this other person to have and show that feeling,”**

. . . how is that for you now?

10 C. Emotional valence - **“Using a feeling thermometer scale (FT) from 0 to 100 where 0 is the most disturbing you can imagine, 50 is neutral, and 100 is the most positive you can imagine, how would you rate that now?”**

Mark the FT level: **0 10 20 30 40 50 60 70 80 90 100**

10 D. Body location - **“Where do you feel it?”**

11. Desensitization - **“Focus on where you feel that, and those the words, _____(from step 4). Now follow my fingers (or tones, lights, taps, etc.)”** Do a set of 24-40 eye movements (SEM)

1st SEM

11 A: **“What are you feeling or noticing now?”**

If the client reports more positive feelings or less distress say:

“Notice that and follow again.” Then go to the 2nd SEM.

If the client reports more negative feelings or associates to a negative memory, return to target by saying: **“I understand more about how it is difficult to allow yourself to feel positive feelings. Even with such negative feelings (or memories), you can begin to learn to tolerate positive feelings today.”**

(if NOT using titration).

Focus again on the recent situation where you had the good feelings.” Pause.

“What do you feel or sense when you focus on it now?”

(if using titration).

i) **“And now as you just think about thinking about it,”**

ii) **“And now as you just think about the movie,”**

ii) **“And now as you imagine noticing it being ok for this other person to have and show that feeling,”**

“. . . what do you notice now?”

“Where do you feel that?” Location: _____ . **“Focus on that.”**

2nd SEM

11 B: **“What are you feeling or noticing now?”**

Use response options from above again.

3rd SEM

11 C: **“What are you feeling or noticing now?”**

12 A. Return to Target (if NOT using titration). After about 3 SEM ask: **“Focus again on the recent situation where you had that good feeling. What do you notice when you focus on it now?”**

12 B. Return to Target (if using titration). After about 3 SEM ask:

i) **“And now as you just think about thinking about it,”**

ii) **“And now as you just think about the movie,”**

ii) **“And now as you imagine noticing it being ok for this other person to have and show that feeling,”**

“. . . what do you notice now?”

13. Emotional valence - **“Using a feeling thermometer scale (FT) from 0 to 100 where 0 is the most disturbing you can imagine, 50 is neutral, and 100 is the most positive you can imagine, how would you rate the feelings connected to that positive emotion now?”**

Mark the FT scale: **0 10 20 30 40 50 60 70 80 90 100**

14. Installation.

If the FT scale is 50 or above say:

“Do the words _____ (repeat PC) still fit, or is there another more suitable positive statement that you would like to be able to make about allowing yourself to feel those positive feelings?”

If the FT scale is below 50, say,

“As you focus on the memory of the positive feeling that went with this situation, even with the disturbance that remains, what is the most positive thing you can say or believe about allowing yourself to have that positive emotion now?”

Or (if the FT scale is below 50), say,

“Of all the things you thought and felt while focusing on that positive emotion, what is the most positive thing you can say or believe about yourself or the positive feeling state even as you feel this way now?”

Modified PC: _____

15. Check the VoC:

“As you focus on the memory when you had that positive feeling (repeat client’s description of the feeling state), and the feelings you are having now about that, how true do the words _____ (repeat PC) feel to you now, (optional: even with the disturbance that remains), where 1 is completely false and 7 is completely true?”

VoC: 1 2 3 4 5 6 7

16. First Installation

“Focus again on the memory when you had that positive feeling, notice the feelings you are having now about that, and those words _____ (repeat PC) and follow my fingers (or tones, lights, taps, etc.).”

SEM

17. Check the VoC

“As you focus on the memory when you had that positive feeling (repeat client’s description of the feeling state), and the feelings you are having now about that, how true do the words _____ (repeat PC) feel to you now, (optional: even with the disturbance that remains), where 1 is completely false and 7 is completely true?”

VoC: 1 2 3 4 5 6 7

18. Second Installation

“Focus again on the memory when you had that positive feeling, notice the feelings you are having now about that, and those words _____ (repeat PC) and follow my fingers (or tones, lights, taps, etc.).”

SEM

19. Check the VoC

“As you focus on the memory of the positive feeling (repeat client’s description of the feeling state), that went with this situation, how true do the words _____ (repeat PC) feel to you now, (optional: even with the disturbance that remains), where 1 is completely false and 7 is completely true?”

VoC: 1 2 3 4 5 6 7

20. Skip the “Body Scan.” Identification and processing of residual unpleasant body sensations with stimulation is not done for positive affect tolerance and integration.

21 . Closure – for clients whose final Feeling Thermometer (FT) is 50 or above, a formal closure is generally not needed.

For clients whose final Feeling Thermometer is significantly below 50, some or all of the closure steps below may be needed to calm the client.

A. Safe or calm place.

Say: **“I’d like you to focus on the memory of _____ (remind client of the safe or most calm place identified in the preparation phase).”**

“When you focus on the memory of _____ (the safe or most calm place), what do you see? What do you hear? What do you smell? What sensations do you experience in your body? What emotions do you notice as you focus on this memory? Where do you notice these feelings in your body”

Images: _____

Sounds: _____

Emotions & Sensations: _____

Location of Sensations: _____

Next, enhance the images and feelings of the safe or calm place by repeating the descriptions a few times. The client can keep eyes open or close them as you do this.

“Continue to let yourself be aware of _____ (repeat descriptions of the resource image) and notice the _____ (repeat description of resource feelings, sensations, smells, sounds, etc.).” (Repeat the client’s verbatim sensory descriptions with variations in the sequence of phrases.)

Then ask: **“What do you notice or feel now?”**

B. Light stream.

Say: **"I'd like you to scan your whole body now and to tell me where you notice any unpleasant body sensations or tensions."** _____

Say: **"I'd like you to imagine that those sensations were energy."** Then ask a series of questions. Ask: **"If the energy had a _____ what would it be?"**

a) shape _____

b) size _____

c) color _____

d) temperature _____

e) texture _____

f) sound _____

(high pitched or low)

Ask: **"What favorite color do you most associate with healing?"** _____

Then say: *"Imagine that a light of this color is coming in through the top of your head and directing itself at that shape. Let's pretend that the source of this soothing, healing light is the infinite cosmos, so the more of it you use, the more you have available. Allow the soothing healing light to come in more and more, and direct itself at the shape. As it does so, let the light resonate and vibrate in and around it, more and more. And as it does, what happens to the shape?"*

If the client gives feedback that the shape or tension changed in any way, continue repeating the phrases above portion, asking for feedback about the various characteristics (a-f), until the shape or tension is primarily or completely gone.

Then say: *"Continue to allow the light to flow into your head, neck and shoulders. Let it flow into your chest and down your arms and out your fingertips. Let the soothing, healing light flow through your torso, into your legs and out through your feet. Let the light flow into every part of your body. Then, imagine saying to yourself the positive words you most need to hear right now."* (Pause.)

C. Whole and complete self.

*"Then, as I count upwards from one to five, I'd like you to bring yourself back here in the room, and as you do, I like you to bring **your whole and complete self here**. (Pause.) So, bringing **your whole and complete self** back into the room now, one, two, (rising intonation), three, four and five."*

D. Present sensory awareness.

Say: *"Now as you notice yourself back here in the room, I'd like you to look around the room. Notice a colored object. Notice the shade of this color. Now notice a different colored object. Notice the shade of color of this object. Notice a sound in this room. Notice from what the direction this sound comes. Notice if there is any other sound that comes from farther away. Notice the direction of this other sound. Now look around the room again and notice a shiny or bright object. Notice an object in this room that is the furthest away from you. Notice the size and color of this object. Now notice an object that is close to you. Notice the size and color of this object. Now notice any changes that have been happening in you as you pay attention to what is around you here in this room."*

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