

Foundations of the Positive Affect Tolerance Protocol: The Central Role of Interpersonal Positive Affect in Attachment and Self-Regulation

Andrew M. Leeds

Sonoma Psychotherapy Training Institute, Santa Rosa, California, USA

Research has highlighted the negative effects of early neglect and abuse on the development of emotional self-regulation and attachment. Attention has focused more on negative affect states related to past adverse and traumatic experiences than on the deactivating effects of the absence of early shared positive affect states from parent-infant play, warmth, and affection. Treatment strategies for survivors of early neglect and abuse have focused on methods to metabolize memories of traumatic events. Skills development models have emphasized the benefits of distress tolerance, acceptance, and mindfulness training for patients with persistent negative affect states. Research on the benefits of therapeutic interventions intended to increase positive affect indicates they promote prosocial behaviors and creativity, broaden the scope of attention, reduce emotional symptoms and behavioral problems, and improve physical health. Within the field of eye movement desensitization and reprocessing (EMDR) therapy, procedures to increase positive affect have generally focused on resource development and installation procedures intended to increase access to positive affect-related memories and images. A neglected clinical issue is the inability of survivors of early neglect to tolerate and integrate actual positive interpersonal experience into positive emotional states, interpersonal scripts, or self-concepts. These deficiencies, characteristic of those with dismissing insecure attachment, help produce and maintain profound psychological, medical, and social problems that limit the ability of patients with these histories from progressing in psychotherapy. This article explores research supporting the potential benefits of an EMDR-related procedure, the positive affect tolerance (PAT) and integration protocol, along with possible mechanisms by which the PAT protocol in general, and its bilateral stimulation procedures, might produce clinical benefits for survivors of early neglect. Case vignettes illustrate the potential challenges of implementing and the potential impact of the PAT protocol. Research designs and assessment tools are described that could clarify the potential benefits of the PAT protocol compared to other treatments designed to increase positive affect.

Keywords: affect regulation; EMDR therapy; bilateral stimulation; BLS; attachment

Survivors of early childhood emotional and psychological neglect often find adult experiences of shared positive emotional states aversive due to their being unfamiliar—and thus confusing and anxiety-provoking (Kashdan et al., 2013). These individuals lack access to early adaptive memory networks (Solomon & Shapiro, 2008) of shared positive affect linked to a positive model of self and thus they cannot predict a positive

outcome from such interactions (Cotraccia, 2022). These stimulating emotional interactions may also be experienced as aversive due to being associated with early formative experiences of being ignored, shamed, or hurt by caregivers. Adult survivors of neglect may attempt to hide their inner discomfort by offering superficial and socially appropriate acknowledgment or by redirecting others' attention elsewhere. They may also appear blank or frozen as

these poorly tolerated social interactions can evoke states of depersonalization or derealization (Michal et al., 2005; Myers & Llera, 2020).

The Positive Affect Tolerance (PAT) protocol is an eye movement desensitization and reprocessing (EMDR) therapy approach intended to allow survivors of early childhood emotional and psychological neglect to increase their awareness of, tolerance for, and integration of, moments of shared positive emotional states. The aim of the PAT protocol is to help these individuals integrate such experiences into adaptive interpersonal schemas and more resilient and positive self-concepts. The PAT protocol procedures were described in an earlier article (Leeds, 2022). This article comprehensively explores the research foundations for the PAT protocol, offers procedural clarifications, and expands the range of potential clinical benefits with additional case illustrations.

Two Themes Explored in This Article: Effects of Emotional Neglect and EMDR Treatment Strategies

Two primary themes will be considered in this article. The first explores the effects of emotional and psychological neglect on early childhood development and the role of shared positive affect on the brain's development. The second theme explores how for some patients who present with social anxiety disorder (SAD) and/or depersonalization or derealization disorder and who do not yet meet standard readiness criteria (Shapiro, 2018) for reprocessing memories of adverse or traumatic memories, there can be strategic benefits in initially targeting current interpersonal experiences of shared positive affect as part of the preparation phase of treatment.

The Nature of EMDR Therapy

EMDR therapy as an approach to psychotherapy is based on the Adaptive Information Processing (AIP) model and incorporates a general eight-phase model of treatment (Shapiro, 2007, 2018). In Phase 1, a comprehensive history is gathered to delineate the patient's overall life experience, including salient positive, adverse, and traumatic life experience, with a focus on identifying maladaptively encoded experiences that are hypothesized to form the foundation for current symptoms. Identifying positive life experiences is equally essential since successful treatment outcomes depend on the synthesis of adaptive memory networks with pathogenic memories (Hase

et al., 2017; Solomon & Shapiro, 2008). This delineated client history leads to an AIP-informed case conceptualization and a proposed optimal sequence for reprocessing target memories.

In Phase 2, the patient is offered the type and extent of preparation needed before reprocessing memories for adverse and traumatic experiences. This includes informed consent to the general risks and benefits of EMDR therapy and can include skills-building interventions to enhance affective, cognitive, and behavioral self-regulation. It is essential that patients develop a working therapeutic alliance with sufficient mutual trust to tolerate an interpersonal connection and collaboration with the clinician (Cotraccia, 2022; Hase, 2021; Hase & Brisch, 2022). In some cases—such as where there are significant affect phobias (McCullough, 2003) or dissociative phobias (Van der Hart et al., 2010)—extended preparation may be needed before and during the gathering of a comprehensive history and the development of the treatment plan. Sessions that involve reprocessing begin with Phase 3 deliberate activation and assessment of a specific memory to be reprocessed and continue with three phases of reprocessing known as Phase 4 (Desensitization), Phase 5 (Installation), and Phase 6 (Body Scan). These three phases incorporate rapid bilateral stimulation with alternating left–right tracking eye movements, kinesthetic stimulation, or sounds. Each reprocessing session ends with an organized Closure (Phase 7). Subsequent sessions open with Phase 8, Reevaluation of general functioning, symptoms, and the previous target(s) of reprocessing.

Applying EMDR Therapy to Attachment-Related Problems in Living

Various authors have proposed EMDR-related strategies to modify attachment organization and the early developing attachment circuit (Burgdorf & Panksepp, 2006; Panksepp, 2011). This includes both the use of resource development and installation (RDI) strategies (Korn & Leeds, 2002; Leeds & Shapiro, 2000; Schmidt, 2004; Steele, 2003) in an extended Preparation phase and the standard EMDR Posttraumatic Stress Disorder (PTSD) protocol (Shapiro, 2018) to reprocess adverse memories of early childhood attachment experiences (Wesselmann & Potter, 2009; Wesselmann et al., 2012). Early attempts to directly modify memories associated with attachment experiences with standard EMDR therapy can prove challenging due to either minimization/idealization defenses that prevent activation of these memories or

to hyperactivating defensive reactions that can lead to states of anxiety or depersonalization (Knipe, 2018) that are beyond the patient's window of tolerance (Siegel, 1999).

Avoidant and Dismissing Insecure Attachment (Deactivating Strategies)

The role of minimization defenses has not been widely explored in the EMDR therapy literature. This should not be surprising. As reported by Carl et al. (2013) and others, the role of deactivating strategies and, in particular, their effects on positive mood states tends to go underrecognized in most clinical settings. Furthermore, as Seligman et al. (2006) comment, "Indeed, therapies that attend explicitly to the positives of clients are few and far between." Mikulincer and Shaver (2005, p. 151) delineate the multifaceted problems that evolve from the deactivating strategies of insecure attachment:

Appraising proximity seeking as unlikely to alleviate distress results in inhibition of the quest for support and active attempts to handle distress alone. These secondary approaches to affect regulation are called deactivating strategies (Cassidy & Kobak, 1988) because their primary goal is to keep the attachment system deactivated in order to avoid frustration and further distress caused by attachment-figure unavailability. **These strategies involve denial of attachment needs and avoidance of emotional involvement, intimacy, and dependence in close relationships** [emphasis added] (Mikulincer & Shaver, 2005, p. 151).

One seldom recognized consequence of deactivation strategies is the extent to which the severity of mental health issues experienced by those who rely on these strategies go underrecognized and undertreated. In a classic article, Shedler et al. (1993) delineated the tendency of those with this type of psychological defense to appear healthier than they truly are on standardized mental health scales. They point out, "Psychological defense has physiological costs. It is associated with autonomic reactivity and may be a risk factor for medical illness." Stänicke and McLeod (2021) explored the role of deactivating strategies (defenses) in paradoxical treatment outcomes such as patients who appear to get worse on standard measures as they become more willing and able to acknowledge the extent of their suffering and unmet needs.

The Positive Affective Tolerance Approach to Addressing Attachment-Related Issues and Deactivating Strategies

In contrast to attempts to reprocess memories of the perceived unavailability of one or more childhood attachment figures, the PAT protocol is generally initially directed at modifying the later developing sociability circuit (Burgdorf & Panksepp, 2006; Panksepp, 2011). The PAT protocol localizes the focus of therapeutic work on normally positive but poorly tolerated *current experiences* of shared positive affect. The later developing sociability circuit may be less encumbered with associations to defensive reactions that resulted from noncontingent, unpredictable, frightened, or frightening early caregiver behaviors (Liotti, 2017). It may therefore be less likely to elicit minimization defenses or hyperactivating defensive reactions than attempts to reprocess memories of early attachment-related experiences (Knipe, 2018). In the PAT protocol, the work to lessen deactivating strategies and increase the ability to tolerate and assimilate positive interpersonal experiences is localized in the present.

Research Support for the Benefits of Bilateral Stimulation on Positive Memory Networks

Laboratory research supports a beneficial role for incorporating bilateral stimulation procedures in EMDR-based procedures focused on positive memories such as the RDI procedure and the PAT protocol.

Bilateral Stimulation Reduces Startle Response to Negative Images and Increases Attention to Positive Images

Reichel et al. (2021) investigated the effects of bilateral tactile stimulation on startle reflex and skin conductance response (SCR) in nonclinical subjects who were focusing in turn on negative, neutral, and positive scripts.

The results clearly demonstrate that bilateral tactile stimulation has benefits compared to no stimulation: Startle reflex during negative imagination was reduced, and skin conductance response (i.e., attention) for positive imagination was increased. These findings correlated with a reduced level of distress for negative scripts and an increased arousal for positive scripts. (p. 1)

The results also demonstrate for the first time, that bilateral stimulation increases subjective arousal and integrated SCR (i.e., attention) for positive mental scenes. It might thus also be suitable for reinforcing positive emotions during therapy. (p. 20)

Reichel's findings provide a neurophysiological explanation for observed effects of bilateral stimulation (BLS) during the PAT protocol as reported subjective units of disturbance (SUD) disturbance decreases and then Validity of Cognition (VoC) ratings increase when focusing on poorly tolerated positive social interactions. See Cotraccia (2022) for an extended discussion of attention schema theory (Graziano, 2021) as well as Hase and Brisch (2022) on the central role of an attuned therapeutic relationship in promoting heightened states of self/other consciousness as a pathway to reworking the attachment system in EMDR therapy. Cotraccia also discusses the role of the superior temporal sulcus (STS) in social cognition and attention as revealed by the research of Amano and Toichi (2016) on BLS.

Bilateral Stimulation Enhances Positive Feelings About Positive Memories by Increasing Activation of Right Superior Temporal Sulcus

Amano and Toichi (2016) used multichannel near-infrared spectroscopy during a script-assisted recall of a pleasant memory in laboratory subjects with or without tactile BLS. Fifteen nonclinical subjects were asked to think about personally meaningful positive memories associated with a sense of well-being by listening to a script they had prepared in advance. They were randomized in the order in which they experienced thinking about their positive memory with or without BLS. The authors focused on the potential applicability of their investigation to the RDI procedure or the Installation phase focusing on positive self-statements. However, their findings seem equally relevant to the PAT protocol.

The results showed that, compared with non-BLS conditions, accessibility was increased and subjects were more relaxed under BLS conditions. A significant increase in [oxygenated hemoglobin concentration: oxy-Hb] was detected in the right superior temporal sulcus (STS), and a decrease in the wide bilateral areas of the prefrontal cortex was observed in response to BLS...These results indicate

an important neural mechanism [when using BLS with positive memories] that emotional processing occurred rather than higher cognitive processing. (p. 1)

It is a noteworthy finding that higher cognitive processes (e.g., activity in the prefrontal cortex) were not required for the benefits in the BLS condition on positive memories as these positive effects occurred in the STS, a lower brain region that is important for social cognition, empathy, trustworthiness, and intention (Lehner et al., 2016, p. 345–364).

In this study, the right STS was significantly activated by BLS (using alternately bilateral tactile stimulation) during recall of pleasant memories. Interestingly, our previous study of unpleasant memories showed significantly reduced activity in the right STS during recall with BLS (using eye movement). The seemingly contradictory findings regarding the response of the STS may be attributable to differences in the nature of pleasant and unpleasant memories, considering that the right STS is associated with memory representation. The increase in [oxy-Hb] due to BLS may reflect the reported “increased accessibility” and “increased vividness” in the subjective questions (Amano & Toichi, 2016, p. 8). Considering the neuroscientific evidence to date, BLS [when focusing on positive memories] may enhance comfortable feelings about pleasant memories (Amano & Toichi, 2016, p. 1).

The Effects of Positive Affect During Early Development

The origins of contemporary attachment theory are found in the works of John Bowlby (1969, 1973, 1980, 1988) who was the first to propose that infants possess an essential need to seek proximity from attachment figures. This human desire for proximity is essential to survival during the period of helplessness immediately after birth and has been conserved over the long course of human evolution. Infants who experience consistent, sensitive caregiving form a secure base for developing a cohesive sense of self and for moving into the world with resilience. Subsequent neurobiological research has clarified the specific sensory and neurohormonal systems involved in the development of essential capacities for self-regulation. Allan Schore

has described how shared maternal-infant positive interpersonal affect typically involves mutual gaze during episodes of play and is associated with the formation of secure attachment in the first two years of life. These episodes of play trigger elevated levels of endogenous opioids and dopamine in both mother and child, and appear to be essential to the development of right prefrontal orbital mediated capacities for emotional self-regulation (Schoore, 2003a, 2003b). Mutual gaze during shared states of positive affect is central to this process.

High-intensity events of face-to-face dyadic gaze transactions are “central moments” of the growing infant’s day and are “formative in their effect far out of proportion to their mere temporal duration (Pine, 1981, p. 25; Schoore, 1994, p. 80).

These research findings provide one of the key foundational elements underpinning the role of mutual gaze in the PAT protocol.

Psychological and Neurobiological Effects

Recurring early childhood experiences of shared positive affect through mutual play and caregiver affection produce an array of specific neurobiological effects including increased secretion of specific neuropeptides—endogenous opioids and dopamine—that increase the rate of development of neural circuits in the right prefrontal orbital cortex involved with tolerating interpersonal upregulation of arousal (Depue & Morrone-Strupinsky, 2005; Schoore, 2003a, 2003b). Those interested in the impacts of the infant or parental blindness on the emotional development of the child are referred to discussions in Loots et al. (2003) and Pérez-Pereira and Conti-Ramsden (2019). With the growing recognition of neuroplasticity across the human lifespan (Barsaglini et al., 2014; Simpkins & Simpkins, 2013) there is evidence that positive neuropsychological effects continue to be produced when adults increase their ability to tolerate and assimilate these moments of positive emotional interaction (Koban et al., 2021).

In this co-created dialogue, the “good enough” mother and her infant co-construct multiple cycles of both “affect synchrony” that up-regulates positive affect (e.g., joy-elation, interest-excitement) and “rupture and repair” that down-regulates negative affect (e.g.,

fear-terror, sadness-depression, shame). Internal representations of attachment experiences are imprinted in right-lateralized implicit-procedural memory as an internal working model that encodes non-conscious strategies of affect regulation (Schoore, 2014).

The relative paucity or, indeed, the complete absence of early experiences of upregulating shared positive affect can lead adolescent and adult survivors of neglect to experience anxiety, mistrust, and confusion when even respected peers, mentors, and advisors offer compliments, praise, and affection. They may even suspect that the praise is somehow motivated by an intention to manipulate, deceive, or trick them. They minimize or deflect these positive comments and change the subject. Affection, especially when accompanied by mutual gaze, rather than inducing pleasant feelings, can create a rising sense of anxiety and even panic leading to withdrawal from this poorly tolerate contact.

Specific Effects of the Absence of Shared Positive Affect States in Childhood

Neurobiological Effects

Extensive work has been done to describe age-sensitive periods for the effects of various forms of child abuse on development (Teicher et al., 2018). However, 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 (Alexander, 1992, 1993; Fonagy et al., 2002; Schoore, 1996, 1997, 2000, 2001; Siegel, 2012; Teicher et al., 1993, 1997; Teicher, 2000). The specific effects of abuse and neglect differ, for example, on perceptual development. Childhood physical abuse leads to less accuracy in recognizing neutral pictures which instead are viewed as angry. Both early neglect and childhood sexual abuse lead to less accuracy in recognizing positive pictures which instead are viewed as neutral. (Young & Widom, 2014). Survivors of childhood emotional neglect with adult SAD compared with healthy controls show “less neurological activity, slower reaction times, and poorer memory for accepting happy faces” (Kashdan, 2007, p. 359). Therefore, Kashdan et al. (2013)

suggest “Clinicians might consider expanding the explicit target of interventions for SAD to include the reduction of experiential avoidance and increase of positive experiences.” (p. 653)

Vulnerability to States of Depersonalization

The risk of experiencing states of depersonalization and derealization in young adults—as measured by the Dissociative Experiences Scale (DES-II)—was found by Ogawa et al. (1997) to be far more strongly linked to early experiences of neglect than to early childhood physical or sexual abuse. As summarized by Dutra et al. (2009)

Support for the role of early attachment processes in pathways to dissociation has been provided by a 20-year longitudinal study from infancy of 126 children from low-income families. Ogawa et al. (1997) found that disorganized attachment and psychological unavailability of the caregiver during the first two years of life were the strongest predictors of clinical levels of dissociation as measured by the DES in young adulthood. These two variables alone accounted for one-quarter of the variance in dissociation. **Psychological unavailability of the caregiver was the single strongest predictor of dissociation at age 19, accounting for 19% of the variance in dissociation** [Emphasis added]. Surprisingly, occurrence of prospectively assessed physical or sexual abuse during childhood was not associated with dissociation scores.

Subsequent longitudinal research carried out by Dutra, Bianchi, et al. (2009, p. 87) confirmed that early childhood maltreatment did not predict adolescent DES-II scores. Instead, the strongest predictors of depersonalization and derealization in young adults were early childhood lack of positive maternal affective involvement, maternal flatness of affect, and overall disrupted maternal communication. While the development of complex dissociative disorders, such as dissociative identity disorder (DID), has been clearly linked to chronic exposure to early childhood physical and/or sexual abuse (Dorahy et al., 2014), the longitudinal research by Dutra, Bianchi, et al. (2009) and by Ogawa et al. (1997) has demonstrated that the absence of shared positive affect along with psychological neglect creates the essential

vulnerability to adult states of depersonalization and derealization. With this etiology, there is a rationale for considering specific EMDR interventions organized to teach survivors of neglect to attend to, learn better to tolerate, and assimilate experiences of shared positive affect. This etiology provides a rationale for predicting that increasing capacities to tolerate and enjoy shared affect could lead to decreases in vulnerability to states of depersonalization or derealization.

Research on Therapeutic Interventions to Increase Positive Affect

A comprehensive transdiagnostic review of the role of positive emotional regulation in emotional disorders by Carl et al. (2013) summarized standardized assessment tools and 12 interventions including mindfulness-based cognitive therapy, loving-kindness meditation, positive psychology interventions, and acceptance and commitment therapy. They highlighted two important areas that are explicitly addressed in the PAT protocol. First, they described a need for “psychoeducation regarding the nature and function of positive emotions...” (p. 355). Relevant to the background of the PAT protocol, they explicitly discussed “controlled up regulatory response modulation strategies for positive emotion” such as “savoring” (Eisner et al., 2009).

A more recent review by Miguel-Alvaro et al. (2021) summarized the literature on interventions that focus on positive memories including techniques to increase the accessibility of positive memories and to enhance self-esteem or emotional regulation. However, none of the techniques reviewed by Miguel-Alvaro et al. (2021) involved prospectively modifying current experiences of positive interpersonal interactions, reducing defensive avoidance of shared positive affect, or increasing positive self-statements about accepting positive interpersonal interactions as is done in the PAT protocol.

Two Theoretical Frameworks for Understanding the Process of Resolving Deactivating Strategies

Given the general lack of recognition of and the limited use of active treatments to address deactivating strategies in psychotherapy, two relevant theoretical models will be briefly considered: the discrete behavioral states model of Putnam (1997) and short-term dynamic psychotherapy developed by McCullough (1997, 2003).

The Discrete Behavioral States Model

Putnam's Discrete Behavioral States Model Differs From Ego States and Internal Family System Models. Putnam (1997) in *Dissociation in Children and Adolescents* refers to "discrete states of consciousness" based on the work of Tart (1972, 1975), and Wolff (1987). These discrete behavioral states involve physiological, affective, and behavioral variables. The discrete behavioral states model differs significantly from both the dualistic, ego states model of Watkins and Watkins (1997) derived from the work of Janet, Freud, Jung, and Federn, and the internal family systems model of Schwartz (1995) derived from the Bowenian School of Family Therapy and Schwartz's theory that the human personality is formed from "an ecology of relatively discrete minds" (Schwartz, n.d.).

Discrete Behavioral States Are Referenced to Psychophysiological States. For Putnam, discrete behavioral states are referenced to underlying psychophysiological states and define variable responsiveness of the individual while in different states (Putnam, 1997, p. 153). As Wolff (1987) described in his infant observations, individuals are born with a limited number of discrete behavioral states and a limited number of pathways connecting these states. With development, the number of discrete behavioral states and the architecture of their associated pathways expand.

Changes in State Space Architecture in Infants from 1 to 3 Months of Age. Putnam (1997, p. 156) describes changes in state space architecture that occur according to Wolff (1987) from age 1–3 months. In the one-month-old infant, there are only seven possible states: "regular sleep," "irregular sleep," "drowsy," "fussy," "cry," "feeding," and "alert inactive." The only pathway to "alert inactive" is from "feeding." At three months, due to increases in energy reserves, the number of possible states increases from seven to eight with the additional state of "alert active." In addition, there are new pathways to this state from states of "drowsy," "irregular sleep," or "feeding".

Survivors of Early Neglect Lack Stable Discrete States for Shared Positive Affect. A potential implication of the discrete behavior states the model is that survivors of persistent early neglect may have profound deficits in the development of discrete states associated with shared positive affect. Their discrete states of shared positive affect, if they exist at all, may only be partially developed and are highly unstable.

Theoretically, state space may be vast, but one can only regularly visit those regions in which one has created stable, discrete states. ... 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).

Survivors' Behavioral and Dissociative Strategies to Avoid Shared Positive Affect States. Patients who experienced persistent early psychological neglect—who present with dismissing insecure or unresolved attachment—had insufficient exposure in early childhood to the state-defining variables of shared positive affective states generated through interpersonal experiences of mutual gaze and positive voice tones needed to create stable discrete states that could support tolerance of shared positive affect. As a result, they make use of overt (behavioral) and covert (dissociative) strategies to avoid these states. When offered genuine compliments, they often change the subject or minimize their contributions. When unable to overtly avoid being triggered into these states, they can easily become overwhelmed with anxiety or have dissociative responses with depersonalization and may experience psychogenic amnesia for aspects of these experiences.

Horizontal Vs. Vertical Planes of Dissociative Defenses. While patients meeting criteria for DID or other specified dissociative disorder (OSDD; American Psychiatric Association, 2013) can be viewed as having complex vertical planes of dissociative defenses between self-states with some degree of the separate, first-person perspective, survivors of persistent early neglect who do not meet criteria for DID or OSDD may instead be viewed as suffering from a form of horizontal dissociation¹ that diminishes their capacity to detect and distinguish between various emotional and psychophysiological states. They tend to describe their inner experiences only in terms of alterations in their observable behaviors. Indeed, they appear to have developed a social persona by imitating observed interpersonal behaviors, but they generally do not experience an authentic sense of self-anchored in distinct emotional states.

Three Key Steps to Fostering New Discrete Behavioral States and a New Sense of Self

From the perspective of the discrete behavioral states model, patients with dismissing insecure or unresolved attachment and intolerance for shared positive affect states can approach learning to tolerate and assimilate discrete states of shared positive affect in three initial stages. First, they need to understand what is missing and why it would be helpful to change. Second, they need to be guided to develop and tolerate new, stable, discrete behavioral states of shared positive affect. Third, they need to integrate these discrete behavioral states into new interpersonal behaviors and a new sense of self. Clearly, addressing these dramatic developmental deficits is a major challenge. We should not expect such reparative work to be rapid or without potential complications. To help guide their trajectory of change, let us next consider a model with demonstrated success in addressing avoidance of emotional states.

A Short-Term Model of Psychotherapy for Treating Personality Disorders as Affect Phobias

McCullough (1997, 2003) described a short-term anxiety-regulating model of psychotherapy with 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, and self and other restructuring. The pace at which the therapy progresses through these major facets depends on the amount of anxiety generated at each step. The therapy does not advance to the next phase until the patient can tolerate it. These principles can be applied to the challenge of working with individuals with deficits in tolerating states of shared positive affect.

Two critical concepts elaborated by McCullough are that affects can serve adaptive or defensive purposes and that one affect can serve as a defense against another. For example, McCullough contrasts adaptive versus defensive forms of interest–excitement (from McCullough, 1997, p. 254). In adaptive interest–excitement, the experience involves a cared-about person or product, a relaxed but deep involvement, that is energizing, vitalizing, deeply satisfying, and lasting. In defensive interest–excitement, the experience involves compulsive attraction, repetitive ritual,

intense and driven involvement, and is ultimately tiring and draining, and excessive repetition is required for satisfaction. In many individuals with dismissing insecure attachment, interest–excitement and enjoyment–joy may be observed primarily or only in their defensive functions.

In the PAT protocol, the phase of psychoeducation (Leeds, 2022) precedes the defense recognition phase. In the defense recognition phase, the patient can be asked to notice or to acknowledge defensive avoidance of moments of shared positive affect. In defense relinquishment and affect experiencing, the patient can be invited to experiment behaviorally and emotionally and to allow small moments of genuine (adaptive) shared positive affect. These moments of shared positive affect are likely to be poorly tolerated and to generate anxiety (sometimes noticed), avoidance impulses, and internalized negative self-appraisals. Over a series of sessions, recent memories of these small moments of shared positive affect can then be addressed with the PAT-modified EMDR procedural steps to further facilitate defense relinquishment, affect experiencing, affect expression, and self and other restructuring.

How the Positive Affect Tolerance Protocol Is Organized to Increase Attentional Resources, Behavioral Activation, Positive Affect Tolerance, and the Restructuring of Self-Other Relatedness

Despite the limitations of its name that might suggest the procedure focuses on the solitary experience of certain emotional states, the essence of the PAT protocol is organized around self–other relatedness. Targets for the PAT protocol are selected from contemporary, interpersonal experiences of being seen in positive ways by a respected, appreciative other. These moments involve the receiving of appreciation, praise, or affection and can be engaging or even playful. The patient needs to have made a good faith commitment to practicing the three-step behavioral exercise—steady eye contact, deep breath expanding space around the heart in which to let in the good feelings, and saying “Thank you. I appreciate you saying that.”—(see Leeds, 2022) when being offered compliments, praise, or affection. When the intention to carry out these steps has not been made, potential targets are not yet ready for reprocessing with the PAT protocol.

Case Illustrations of the Positive Affect Tolerance Protocol and Its Impact on Self-Concept and States of Depersonalization

Two case illustrations drawn from the clinical work of consultees are provided to further clarify aspects of the PAT protocol, areas of confusion, and potential benefits. The work of consultees was selected to illustrate common challenges and their resolution in learning to apply the PAT protocol.

Isolating While Being Offered Praise— Consultation on the Case of “Roger”

Kelly is an EMDR-trained clinician who had studied the handouts from a conference presentation on the PAT protocol (Leeds, 2015). Kelly requested feedback on the use of the PAT protocol with “Roger,” a 50-year-old male working in social services with issues of oppression. Kelly described how Roger discounted his contributions, which have been widely praised by others. He believes he has “never amounted to anything” and minimizes his accomplishments. He has well-developed manners growing up in a home with “old money.” He appears to take in compliments, but this is at most a surface acceptance. Kelly explained to Roger the value of learning to tolerate shared positive affect, taught him the three-step exercise, and gave him homework to practice and report back. While teaching him the three-step exercise, Kelly observed that Roger displayed ambivalence about taking in positive compliments from others but hoped for the best. When Roger came to the next session, he reported the following experience, which Kelly decided to target with the PAT protocol.

Roger described receiving positive feedback from his supervisor during a recent meeting. Roger shared the written evaluation with Kelly, which was overwhelmingly positive. Roger reported dismissing the positive aspects of the evaluation, interpreting it as patronizing and a waste of his time—because if he really was doing a good job, he wouldn’t be stuck in what he considers an entry-level job. Instead, he focused on the small amount of negative feedback because “it is the only way I’ll ever become competent.” He reported experiencing no positive emotions in response to the positive feedback but rather experienced a degree of interest in hearing the negative comments. He made no effort to practice taking in the praise during the meeting nor did

it occur to him afterward that he had missed an opportunity.

During the assessment of the target, they identified the following elements. Image: Sitting in a room with supervisor receiving feedback and writing notes while the supervisor spoke. Negative cognition: I have no value. Positive cognition: I can learn to do better so that I have something to contribute. VoC: 2; Emotion: irritation and impatience; SUDS: 5; Body: jaw tight, otherwise “empty.”

When Kelly began reprocessing this target with bilateral eye movements, Roger had only negative associations. He kept comparing himself to others who have achieved “more” than him. Kelly was surprised by this and continued with sets of bilateral stimulation down a long channel not following the PAT protocol to limit the length of channels to only 3–5 total sets of 24 eye movements and not following channels with negative associations. Having gone off the rails, Kelly abandoned the PAT protocol, and the session shifted into a conversation about Roger’s value. Kelly closed the session with extended closure techniques.

In reviewing Kelly’s summary report, it was clear that Roger had not made a good faith effort to attempt to assimilate the positive aspects of the feedback from his supervisor. Although in the previous session, he seemed somewhat willing to work toward the goal of increasing his tolerance of positive shared affect, he had remained skeptical. The experience of overwhelmingly positive feedback from his supervisor led to such a degree of anxiety, confusion, and depersonalization that Roger lost any sense of comfort and shifted his attention to looking down at the notes he was making and carefully avoided any eye contact. He narrowed his attention to the few areas of negative feedback in his supervisor’s praise. Roger made eye contact only when his supervisor offered him criticism.

Since Roger did not make a good faith attempt to actively assimilate the positive aspects of the interaction, it was not possible to start PAT reprocessing. It should also be noted that Roger’s negative and positive self-statements did not relate to the acceptance of positive feelings offered by his supervisor at all but only to his internalized beliefs in the inadequacy of his functioning. The focus of the target and Roger’s attention were not on learning to assimilate another’s praise but rather on a subjective appraisal that freed him from the need to learn how to take in good feelings from others. This is not a well-selected target for PAT. The identified material

had not progressed to the stage of defense recognition (McCullough, 2003), and thus attempting to work on restructuring positive affect and self-other relations was premature.

Learning in Small Steps—Consultation on the Case of “Liz”

After reflecting on lessons learned from consulting on the case of Roger, Kelly requested guidance on the use of PAT reprocessing with another patient. “Liz” was a bright, likable, 57-year-old female who, despite multiple advanced degrees, was working in a modest public sector job due to procrastination, disorganization, rebellion against authority, depression, and periods of overwhelming fatigue that keep her from getting to work. She believed the only reason that she had not been fired was because she was physically disabled, and her employer was afraid of a lawsuit. She described herself as a failure in work and in relationships but presented in the session as affable and intelligent. She reported persistent emotional neglect in childhood with early parental pressures to become self-supporting. She reported numerous failed relationships and had given up on trying to have a relationship with a man. She saw herself as faking not only confidence and connection but also merely pretending to do a good job or be a caring friend.

Kelly explained to Liz the value of learning to tolerate shared positive affect and helped her see how her intolerance of these experiences interfered with her success in relationships and work. After further psychoeducation, Kelly taught Liz the three steps for actively accepting positive feedback. She was curious about proceeding and committed to practicing the homework. She returned and reported a couple of experiences in which she had attempted, but poorly tolerated, positive shared affect. Kelly chose the following PAT target. At her birthday party, a friend told Liz how much she enjoyed her company. Liz initially felt some interest and enjoyment with a sense of fullness receiving the positive feedback, but then felt uncomfortable and ashamed and deflected her friend’s attention with humor. Image: Friends around the table at dinner, enjoying laughter together—one friend complimenting her in front of the rest of the group. NC: I don’t deserve the attention. I’m selfish if I accept it. PC: It is okay to accept this. VoC: 3; Emotion: shame; SUDS: 8; Body: collapsing feeling in chest.

Kelly began reprocessing the feeling state associated with this poorly tolerated experience of shared positive affect, using sets of 24 eye movements. Liz’s verbal reports were at first positive. She reported an expanding sense of fullness in her heart during the first three sets of eye movements. But then Liz reported negative material, including a memory of being labeled “manipulative and undeserving” by her older siblings whenever she accomplished goals. Despite standard instructions in the PAT protocol to limit the number of sets and to return to target after any negative associations, Kelly shifted into standard reprocessing strategies and attempted to use interweaves on the emerging negative memories. Kelly then closed the session with the extended closure techniques.

I gave Kelly positive feedback on the target selection and assessment phase. Liz’s NC and PC did relate to the process of learning to let in and assimilate the shared positive feelings. This was a well-selected target for PAT. The three-step exercise created a behavioral framework for learning to assimilate shared positive affect and an emotional “space” to allow the positive feelings to be perceived, even if briefly, as in this clinical vignette. However, as Kelly discovered, it is important not to offer too many sets of bilateral eye movements. Each set of BLS should be the standard length of about 24 bilateral sweeps. Instead of continuing down long channels of association, in the PAT protocol, we offer perhaps just three sets and then return to the target. The more we follow spontaneous associations, the more we risk the patient associating to negative material, especially in early sessions of PAT. If early negative memories arise, the patient should be thanked for sharing these memories and told they will be addressed in future sessions. Then attention should be brought back to the PAT target situation as noted in number five of the seven differences in the PAT procedure from standard reprocessing (Leeds, 2022, p. 6).

The goal for initial PAT reprocessing is to achieve modest reductions in the SUD rating. A decrease of just two points in the SUDS scale is reasonable. We are asking patient’s brains to learn to tolerate unfamiliar feeling states and building a new discrete state space. EMDR-trained clinicians have the habit of attempting to lower the SUD rating to a zero in every session. However, during PAT reprocessing, small gains are better than overshooting the patient’s current affect tolerance. Clinicians need to be cautious and not get overconfident when the

initial reports during reprocessing are positive. After modest gains, where the SUD decreases two to three levels, it is appropriate to shift to the installation phase and strengthen positive self-acceptance with modest gains in the VoC.

A Case Illustrating Possible Benefits of the Positive Affect Tolerance Protocol on Decreasing the Vulnerability to States of Depersonalization and Increasing Tolerance for Activating Prosocial and Intimate Interactions and the Basis for a New Sense of Self

“Nadine” was an approved consultant who regularly reported consistent benefits to the author from the use of the PAT protocol with selected patients with histories of pervasive childhood emotional neglect. She provided an extensive written case report of her work with her patient “Lucy” from which this summary is drawn. Part of the inspiration for Nadine preparing her case report was the significant clinical gains Lucy made in the early phases of her treatment through work on current issues before applying the standard EMDR protocol to adverse memories from the past.

Patient’s Early Life Experiences

Lucy was born and raised in Western Europe in an upper-class home. Class distinctions were emphasized by her parents. She was only allowed to spend time with children from other upper-class homes. Her mother and father were emotionally distant and cold toward her, and she developed an avoidant attachment orientation toward both. In addition, Lucy’s mother was a chronic alcoholic; however, this was never acknowledged until her mother entered rehab when Lucy was an older child. Lucy was cared for by a series of nannies and housekeepers. Lucy explained that her mother’s severe drinking may have been a response to extremely harsh treatment by Lucy’s grandmother when growing up. This maternal grandmother was threatened by Lucy’s mother attaching to anyone and forbade any more contact with the nanny that she had hired to raise Lucy’s mother the day she began primary school.

Presentation at Intake

Lucy entered treatment with Nadine at age 55 with symptoms of dysthymia and generalized anxiety disorder (GAD). She was a married homemaker with

teenage children. She presented for treatment after experiencing panic symptoms when her husband insisted after many years of marriage that when he said he loved her, he wanted her to look at him and say that she loved him as well. She could not do this and instead froze and felt “terror.” Lucy had obtained a master’s degree in social work after moving to the United States but did not go on to work in the field after the birth of her children. Once her children were in school, Lucy volunteered to help care for the elderly and infirm at a local hospital providing pet therapy and hospice support.

Despite the impacts of early emotional neglect, Lucy achieved success in her first professional career in the legal field and had external and internal resources. She exercised regularly. She was a competent and well-organized homemaker and an active volunteer. She had good friends with whom she met regularly. Some of them were aware of her issues with closeness and with them she was able to talk about these issues and be understood.

Depersonalization, Freeze Responses, and Dysthymia

Nadine’s attempts to obtain a complete history from Lucy had to be set aside as Lucy had major amnesic gaps in her childhood memories. With current episodes of depersonalization, freeze responses, and extensive childhood amnesia, Nadine administered the Multidimensional Inventory of Dissociation (MID; Dell, 2006) which yielded a mean MID score of 9.5, indicating an absence of pathological dissociation, with clinically significant elevations in subscales for depersonalization and memory problems and subclinical elevations in somatization and general posttraumatic stress symptoms. She positively endorsed four items on the Adverse Childhood Experiences scale (ACE; Felitti et al., 1998)—mentally ill parent, parent was a problem drinker, parents divorced, often felt that no one in the family loved her or thought she was important. However, she stated that she had experienced no overt physical abuse, sexual assaults, or criterion-A-type events. Her initial depression score on the Patient Health Questionnaire (PHQ-9) (Kroenke et al., 2001) was three with a response of “not at all difficult” to cope with daily activities. However, her GAD-7 (Spitzer et al., 2006) total score was 10 indicating “moderate anxiety” and GAD with a functional impairment rating of “somewhat difficult.” Lucy

was taking Wellbutrin 300 mg for anxiety and dysthymia.

An Absence of Early Maternal Warmth, Praise, and Affection

Lucy admitted that she had experienced no affection or praise from either parent, especially her mother, despite her steadfast efforts to be a good daughter and an excellent student. For example, her acceptance into one of the preeminent universities in her home country went unacknowledged by her parents. Lucy's sole source of warmth and affection in childhood was the family dogs that provided her a sense of being welcome in the family home. After her parents separated when she was a teen, the dogs were all given away. She then moved from their country home to a big city where without the dogs there was no longer any sense of love.

Positive Affect Tolerance as an Explicit Patient Treatment Goal

At intake, Lucy complained of little to no libido, disliking physical touch, and dreading sensitive or vulnerable conversations. She reported a history of shallow relationships and life-long discomfort with attempts by others to connect. In her 20s, she had worked in the relentless, fast-paced legal field which allowed her to avoid connecting to others while achieving external success. She had previously been in therapy for social anxiety. She now experienced GAD and dysthymia with irritability and emptiness but without acute sadness, despondency, or hopelessness. Her primary coping strategy continued to be being constantly active, thereby avoiding opportunities to pause and reflect. She explained she had been unaware of not experiencing love and closeness until she had children and described how they "broke her open." Despite these pervasive issues, Lucy stated her goals for therapy were to feel safe and open to receiving love and affection. She wanted to feel safe in relationships and to connect on a deeper level in personal relationships. She wanted to be able to feel and return love genuinely to others beyond just her children.

Responses to Early Preparation Activities

Lucy was able to connect to and report pleasant body sensations, but she started to freeze and panic when she began to label them as "positive." She was unable to identify or connect with positive scenes in the calm place exercise (Leeds, 2016; Shapiro,

2018). She selected the image of being at the beach with her dog and soon became emotionally overwhelmed and felt panic. Nadine then asked her to imagine the imagery as just a "movie" on a screen, and she then gradually became calm. Nadine followed this exercise with grounding and presentification exercises until Lucy was again fully calm and reoriented to the therapy office. Lucy did not find the light stream visualization exercise helpful (Shapiro, 2018). She consistently found grounding and presentification exercises helpful in managing her tendency to go into states of depersonalization, including the bean bag toss (Leeds, 2016) and returning attention to the here-and-now with the Constant Installation of Present Orientation and Safety exercise (CIPOS; Knipe, 2018, p. 235-246). She was also able to make effective use of the container exercise. For this, she selected the image of an extremely heavy cooking pan with a heavy lid as a way of setting aside disturbing thoughts, feelings, and memories.

Working Case Conceptualization and Decision to Initially Focus on the Positive Affect Tolerance Protocol

Nadine recognized that Lucy had a lifelong history of emotional distance in all relationships and relied on an avoidant attachment orientation. Her extreme discomfort with positive interpersonal attention consistently led her to feel a lack of safety followed by either fear or defensive anger in response to the attempts of others to gently touch or otherwise connect with her positively. She dreaded sensitive conversations with her children. Nadine hypothesized that Lucy had limited to no opportunity to learn to associate positive attention and interpersonal connection with safety and positivity due to poorly attuned or absent caregiving by an alcoholic and traumatized mother. Her upbringing in a household that prized only external representations of worth, value (politeness, tidiness, and performance), and paths to dignity (class, achievement, etc.) robbed Lucy of the opportunity to develop a sense of her inherent worthiness and lovability.

This combination of significant depersonalization, dysthymia, and generalized anxiety combined with an identified history of a lack of maternal warmth and avoidant attachment led Nadine to propose that work with the PAT protocol should be a central element of the initial phases of Lucy's therapy. This strategy was consistent with Lucy's stated treatment goals to address her panic

response to intimate connections and sense of dread with emotional intimacy, without confronting early traumatic memories. They agreed to pursue a focus on the PAT protocol and to reevaluate Lucy's readiness to address childhood material after progress with PAT treatment.

Psychoeducation, Homework, and Work With Current Triggers

Nadine provided Lucy with basic information about the essential role of parental warmth, play, praise, and affection in learning to experience close connection as a positive dimension of life as well as metaphors for how this could be gradually corrected. Lucy experienced a sense of normalization of how her symptoms of depersonalization and panic had developed. She came to believe she was not "broken" or defective but merely needed to reeducate her brain by reprocessing current defensive reactions to moments of positive connection. Lucy agreed to practice the three-step exercise (Leeds, 2022) of actively accepting proffered warmth, affection, and praise and report current triggers to Nadine.

Initial Positive Affect Tolerance Reprocessing

The first target selected for PAT reprocessing was the experience of a friend thanking Lucy for bringing her homemade granola. Lucy had shared with the friend about Lucy's PAT homework. Lucy protested with a laugh, "So she deliberately thanked me effusively!" Lucy admitted her friend's thanks led to significant discomfort. During PAT reprocessing, her SUD (scale 0–10) on this target significantly reduced from 7 to 3. Lucy was then able to focus on and accept the positive self-statement, "I deserve to feel good when a friend offers me appreciation and thanks." The VoC (scale 1–7) rating rose from 2 to 5.

Subsequent Positive Affect Tolerance Targets Build on the Sociability Network Before Moving to Attachment Triggers

At their next session, Lucy reported a hospice patient thanking Lucy for helping her. Following the previous session's reprocessing results, Lucy found it surprisingly comfortable to accept this woman's appreciation. They applied PAT reprocessing and reduced the SUD to one and raised the VoC to six with the same positive self-statement. The session after this, Lucy reported her friends telling her about how hard they worked with preparations for Lucy's birthday party. Lucy smiled and told them how much

their efforts and friendship meant to her; however, inside, she was feeling extremely anxious. With PAT reprocessing, Lucy's SUD lowered to a zero, and for the first time, she was able to get her VoC to a seven with the statement, "I deserve to feel good when friends show me kindness and appreciation." One day not long after this session, Lucy reported receiving a delivery of flowers from a friend. Her first impulse was to hide them, as she didn't want her family to know. "I felt embarrassed that someone liked me enough to give me flowers." Again, PAT reprocessing led to a SUD of zero and the VoC rose to a seven.

At the next session, Lucy asked to work on her husband's recent attempt to hug Lucy. His simple spontaneous acts of affection and warmth triggered intense anxiety and physical stiffening in Lucy. Lucy worked on current experiences of her husband's offering her hugs over a series of three separate PAT reprocessing sessions before her SUD reduced fully to zero or one and the VoC rose to a six or seven with the statement, "I deserve to enjoy receiving warmth and affection from my husband."

Despite these gains focused on tolerating shared positive affect, there were indications that some current triggers were associated with childhood experiences of parental rejection of any display of strong emotion, including protest behaviors. For example, Lucy reported that one evening her daughter got extremely upset after being told to wash the dishes. Lucy could not tolerate the intensity of her daughter's emotion. She reported feeling panic and had to practice her presentification skills to cope with an involuntary tendency to go into a state of depersonalization. Nadine and Lucy discussed the need to eventually reprocess childhood experiences of being ignored or shamed whenever she was not immediately compliant with parental demands.

At one of their next sessions, Nadine offered Lucy a compliment about her volunteer work with sick kids at the hospital. The first time this occurred, Lucy experienced significant panic with depersonalization. Nadine helped Lucy to reorient with sensory presentification exercises including the bean bag toss and CIPOS. Despite or perhaps because of Lucy's strong, positive transference relationship with Nadine, the experience of being seen by her therapist and receiving praise for an activity that meant so much to Lucy stood in stark contrast to her childhood experiences of never being praised. As a result, it evoked intense discomfort. They used

short sessions of PAT reprocessing on this compliment intermittently over several sessions as Lucy's SUD rating reduced only slightly at each of the PAT sessions. In each of these sessions, it was necessary to contain childhood associations in the heavy cooking pot and to return to target after only two sets of BLS.

Treatment Gains and Work That Remains

Nadine reported that over several months of therapy, Lucy learned to tolerate and even enjoy compliments from friends. She now tolerates receiving praise from Nadine without panic as well as hugs offered by her husband, yet these experiences remain mildly uncomfortable. She has yet to be able to look him in the eyes and say, "I love you." Lucy has realized the significance of her defensive anger and her difficulties with irritability during PAT reprocessing. Interestingly, she has reported significantly reduced reactivity to intense emotions in her children and others. She also reports an increased ability to stay present and calm through a range of triggering experiences and no longer goes into states of depersonalization.

At the time of preparing this case summary, Lucy stated she was now ready to begin reprocessing disturbing childhood memories which had been prioritized into a proposed targeting sequence. Nadine had agreed that Lucy was ready based on the progress she had achieved in the preparation phase of the therapy. Lucy was progressing well in these reprocessing sessions and had demonstrated the ability to remain present and grounded while successfully reprocessing disturbing early childhood memories of her mother. Lucy achieved large reductions in self-blame and shame about these previously highly disturbing memories as well as an ability to offer the same kind of compassion and acceptance toward herself as she had toward her young children. Nadine reported being highly moved by witnessing the dramatic progress Lucy had made following their initial work with the PAT protocol.

Future Directions for Research

The case reports of PAT outcomes described in Leeds (2022) and this article suggest several specific kinds of benefits for survivors of childhood neglect who present with (a) social phobia or general anxiety, (b) mild to moderate depression, and (c) vulnerability to states of depersonalization and avoidant attachment. Despite the potential for PAT procedures to activate memories of childhood adversity

and some short-term increases in anxiety, no negative outcomes have been reported to date from the use of this protocol. In these case reports, no objective measures were used to track the patient's experiences of tolerating negative or positive emotions, nor to assess changes in frequency or severity of states of depression, anxiety, or depersonalization. Future case reports and case series could make use of repeated assessments with standardized tests and behavioral measures as was done in the paper introducing RDI (Korn & Leeds, 2002). Controlled studies could also be conducted to clarify the relative benefits and duration of treatment needed in comparison to previously studied interventions to increase positive affect and specifically shared positive affect from accepting praise, warmth, and affection.

Measures to Be Considered

Standardized instruments are available to assess symptoms to be addressed with the PAT protocol. The Positive and Negative Affect Scales (PANAS; Watson et al., 1988) can be used to assess individual positive and negative mood states and were found to be highly internally consistent, largely uncorrelated, and stable over a two-month period. The Savoring Beliefs Inventory (Bryant, 2003) can assess individuals' perceptions of their ability to savor positive moments and was found to be positively correlated with affect intensity, extraversion, optimism, internal locus of control, life satisfaction, self-esteem, and negatively correlated with neuroticism, guilt, physical and social anhedonia, hopelessness, and depression. The PHQ-9 (Kroenke et al., 2001) has been found to be a reliable and valid measure of depression severity. The GAD-7 (Spitzer et al., 2006) is reported to be a valid and efficient tool for screening for GAD and assessing its severity in clinical practice and research. The Cambridge Depersonalization Scale (Sierra & Berrios, 2000) is widely used to assess individuals' experiences of depersonalization and derealization and has shown high internal consistency and good reliability. When screening individuals for their childhood experiences, a standardized scale for retrospective assessment of neglect and abuse such as the Maltreatment and Abuse Chronology of Exposure scale (MACE; Teicher et al., 2015) can clarify the nature of childhood adversity. The MACE scores have shown greater correlations with symptom measures than the ACE scores (Felitti et al., 1998) across all symptom domains

and good to very good test–retest reliability. In addition, subjects’ defensive avoidance of shared positive affect could be assessed using McKenna’s (1974, p. 20) stroking profile to assess their capacity to actively accept compliments, praise, and warmth from others. The stroking profile inventory was found to have good reliability and validity (Koorankot & Mukherjee, 2022). As Horwitz (1982) reported,

people who infrequently accepted positive stroking reported statistically more obsessive–compulsive patterns of behavior, greater symptoms of clinical depression, greater levels of manifest anxiety, more disordered thinking, and more indications of interpersonal alienation, as compared to those individuals who responded as frequent positive stroke acquirers. (p. 220)

Research Questions

Carl et al. (2013) raised essential questions, which have yet to be adequately addressed in the literature, on increasing positive affect through treatment interventions.

Who stands to benefit from treatment strategies targeting positive emotion regulation versus who does not? When should positive emotion regulation disturbances be addressed in the course of treatment? Should they be addressed in acute or posttreatment phases? (p. 355)

In this and the previous article on the PAT protocol (Leeds, 2022), the emphasis has been on the use of PAT procedures in the early or preparation phase of treatment with individuals who experienced chronic emotional neglect in childhood and who respond with increased anxiety and/or depersonalization when offered compliments, praise, warmth, or affection in their current lives or who go into states of depersonalization when attempting to use standard EMDR reprocessing on memories of childhood or adolescent trauma. However, PAT can also be of potential benefit for individuals who experienced chronic but less severe forms of emotional neglect who present for treatment with adult-onset PTSD. When their memories for “criterion A” adult experiences have been resolved, they could benefit from enhanced quality of life by offering them PAT in the traditional second prong of the standard PTSD protocol (Shapiro, 2018)

focused on current triggers to address their impaired ability to take in and assimilate positive interpersonal experiences and to establish a more positive self-image.

Controlled Research Designs

Individuals to be selected for controlled PAT research would present with primary symptoms of (a) GAD or occasional panic, (b) dysthymia or mild to moderate depression, and (c) regular and significant episodes of depersonalization. They should not have primary complaints of acute PTSD from adult experiences as these symptoms might merit immediate treatment with standard EMDR therapy procedures. Potential subjects should be screened to verify they do not meet the threshold criteria for a complex dissociative disorder using the MID-60 (Kate et al., 2020). Their childhood experiences of neglect should be identified with standard tools such as the neglect subscale of the MACE (Teicher et al., 2015). They should be free of psychotic symptoms and active substance abuse.

Individuals would be randomly assigned to a specific number of treatment sessions of either the PAT protocol or an alternate treatment. For PAT, the minimum number of treatment sessions would be four. Six to eight sessions would be optimal. Fidelity in the application of the PAT protocol (and the alternate treatment) would need to be assessed using fidelity ratings by an independent fidelity rater familiar with the treatment protocols.

Alternate Treatment Conditions

Several candidates could be considered as the alternate intervention. These include a daily imaginal review of a positive personal memory which Bryant et al. (2005) found increased the perceived ability of young adults to enjoy life. Another option would be mood-regulation focused cognitive behavioral therapy which Högberg and Hällström (2018) reported improved emotional regulation through counterconditioning. “Sharing positive narratives with a partner” was investigated by Lambert et al. (2013) who reported “the perks of sharing positive experiences” led to gains in positive affect, happiness, and life satisfaction only when participants shared their positive experiences and when the partner provided an active-constructive response. None of these alternate interventions directly address dysfunctionally stored information (Gonzalez et al., 2012) related to internal phobias for shared positive

emotional states as does the PAT protocol of EMDR therapy.

Conclusion

The first article on the PAT protocol (Leeds, 2022) explored selection criteria for when and how to use the PAT protocol. This article explored potential challenges and benefits in its application. Neurodevelopmental foundations for how shared positive affect can become aversive were described. Theoretical foundations were provided to give clinicians a strong conceptual framework to support case selection and to organize their use of the PAT protocol. Case illustrations delineated common clinical misunderstandings, challenges, and potential benefits. Finally, assessment tools and instruments were identified to support the assessment of clinical outcomes for therapeutic settings, case series reports, and controlled research. Selection criteria and alternate treatment conditions were described for future randomized studies.

Extensive research has been published in recent decades exploring the pervasive impacts of adverse and traumatic life experiences across the developmental life span as well as various therapeutic interventions intended to alleviate the symptoms of acute and chronic traumatic stress. Far less work has been published on the enduring impacts of childhood emotional neglect or of treatments that seek to ameliorate its specific effects. This article proposes that not only are there highly specific lifetime effects of profound early childhood emotional neglect, but that these effects can be ameliorated with interventions developed from an understanding not of what did happen but rather of what did not happen. Survivors of neglect can benefit from specific interventions intended to build on the neuroplasticity of the human brain (Doidge, 2007) and to learn to tolerate and feel good about shared positive feelings.

Note

1. This use of the terms horizontal dissociation and vertical dissociation involves the author's own idiosyncratic terminology. These two planes of dissociation are rarely cited in psychology. See brief mentions in Orbendorf (1941) and Berrios (2018).

References

- Alexander, P. C. (1992). Application of attachment theory to the study of sexual abuse. *Journal of Consulting and Clinical Psychology, 60*(2), 185–195. <https://doi.org/10.1037/0022-006X.60.2.185>
- Alexander, P. C. (1993). The differential effects of abuse characteristics and attachment in the prediction of long-term effects of sexual abuse. *Journal of Interpersonal Violence, 8*, 346–362. <https://doi.org/10.1177/088626093008003004>
- Amano, T., & Toichi, M. (2016). The role of alternating bilateral stimulation in establishing positive cognition in EMDR therapy: A multi-channel near-infrared spectroscopy study. *PLoS One, 11*(10), e0162735. <https://doi.org/10.1371/journal.pone.0162735>
- Barsaglini, A., Sartori, G., Benetti, S., Pettersson-Yeo, W., & Mechelli, A. (2014). The effects of psychotherapy on brain function: A systematic and critical review. *Progress in Neurobiology, 114*, 1–14. <https://doi.org/10.1016/j.pneurobio.2013.10.006>
- Berrios, G. E. (2018). The concept of dissociation in psychiatry. In *Rivista sperimentale di freniatria: La rivista dei servizi di salute mentale* (Vol. CXLII, pp. 29–50). Franco Angeli. <http://digital.casalini.it/10.3280/RSF2018-001003>
- Bowlby, J. (1969). *Attachment and loss: Vol. 1: Attachment*. Basic Books.
- Bowlby, J. (1973). *Attachment and loss: Vol. 2: Separation: Anxiety and anger*. Penguin Books.
- Bowlby, J. (1980). *Attachment and loss: Vol. 3: loss: Sadness and depression*. Penguin Books.
- Bowlby, J. (1988). *Parent-child attachment and healthy human development*. Basic Books.
- Bryant, F. (2003). Savoring beliefs inventory (SBI): A scale for measuring beliefs about savouring. *Journal of Mental Health, 12*(2), 175–196. <https://doi.org/10.1080/0963823031000103489>
- Bryant, F. B., Smart, C. M., & King, S. P. (2005). Using the past to enhance the present: Boosting Happiness through positive reminiscence. *Journal of Happiness Studies, 6*(3), 227–260. <https://doi.org/10.1007/s10902-005-3889-4>
- Burgdorf, J., & Panksepp, J. (2006). The neurobiology of positive emotions. *Neuroscience and Biobehavioral Reviews, 30*(2), 173–187. <https://doi.org/10.1016/j.neubiorev.2005.06.001>
- Carl, J. R., Soskin, D. P., Kerns, C., & Barlow, D. H. (2013). Positive emotion regulation in emotional disorders: A theoretical review. *Clinical Psychology Review, 33*(3), 343–360. <https://doi.org/10.1016/j.cpr.2013.01.003>
- Cotraccia, A. J. (2022). Trauma as absence: A biopsychosocial-AIP definition of trauma and its treatment in EMDR therapy. *Journal of EMDR Practice and Research, 16*(3), 145–155. <https://doi.org/10.1891/EMDR-2022-0011>

- Dell, P. F. (2006). The multidimensional inventory of dissociation (MID): A comprehensive measure of pathological dissociation. *Journal of Trauma & Dissociation*, 7(2), 77–106. https://doi.org/10.1300/J229v07n02_06
- Doidge, N. (2007). *The brain that changes itself: Stories of personal triumph from the frontiers of brain science*. Viking.
- Dorahy, M. J., Brand, B. L., Sar, V., Krüger, C., Stavropoulos, P., Martínez-Taboas, A., Lewis-Fernández, R., & Middleton, W. (2014). Dissociative identity disorder: An empirical overview. *The Australian and New Zealand Journal of Psychiatry*, 48(5), 402–417. <https://doi.org/10.1177/0004867414527523>
- Dutra, L., Bianchi, I., Siegel, D., & Lyons-Ruth, K. (2009). The relational context of dissociative phenomena. In P. Dell & J. A. J. O'Neil (Eds.), *Dissociation and the Dissociative disorders: DSM-V and beyond* (pp. 83–92). Routledge.
- Eisner, L. R., Johnson, S. L., & Carver, C. S. (2009). Positive affect regulation in anxiety disorders. *Journal of Anxiety Disorders*, 23(5), 645–649. <https://doi.org/10.1016/j.janxdis.2009.02.001>
- Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., Koss, M. P., & Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The adverse childhood experiences (ACE) study. *American Journal of Preventive Medicine*, 14(4), 245–258. [https://doi.org/10.1016/s0749-3797\(98\)00017-8](https://doi.org/10.1016/s0749-3797(98)00017-8)
- Fonagy, P., Gergely, G., Jurist, E. L., & Target, M. (2002). *Affect regulation, mentalization, and the development of the self*. Other Press.
- Gonzalez, A., Mosquera, D., Leeds, A., Knipe, J., & Solomon, R. (2012). The AIP model and structural dissociation: A proposal to extend the framework. In A. Gonzalez & D. Mosquera (Eds.), *EMDR and dissociation: The progressive approach* (pp. 31–50). Amazon Imprint.
- Graziano, M. S. A. (2021). Understanding consciousness. *Brain*, 144(5), 1281–1283. <https://doi.org/10.1093/brain/awab046>
- Hase, M. (2021). The structure of EMDR therapy: A guide for the therapist. *Frontiers in Psychology*, 12, 660753. <https://doi.org/10.3389/fpsyg.2021.660753>
- Hase, M., & Brisch, K. H. (2022). The therapeutic relationship in EMDR therapy. *Frontiers in Psychology*, 13, 835470. <https://doi.org/10.3389/fpsyg.2022.835470>
- Hase, M., Balmaceda, U. M., Ostacoli, L., Liebermann, P., & Hofmann, A. (2017). The AIP model of EMDR therapy and pathogenic memories. *Frontiers in Psychology*, 8, 1578. <https://doi.org/10.3389/fpsyg.2017.01578>
- Högberg, G., & Hällström, T. (2018). Mood regulation focused CBT based on memory reconsolidation, reduced suicidal ideation and depression in youth in a randomised controlled study. *International Journal of Environmental Research and Public Health*, 15(5), 921. <https://doi.org/10.3390/ijerph15050921>
- Horwitz, A. (1982). The relationship between positive stroking and self-perceived symptoms of distress. *Transactional Analysis Journal*, 12(3), 218–222. <https://doi.org/10.1177/036215378201200312>
- Kashdan, T. B. (2007). Social anxiety spectrum and diminished positive experiences: Theoretical synthesis and meta-analysis. *Clinical Psychology Review*, 27(3), 348–365. <https://doi.org/10.1016/j.cpr.2006.12.003>
- Kashdan, T. B., Farmer, A. S., Adams, L. M., Ferssizidis, P., McKnight, P. E., & Nezlek, J. B. (2013). Distinguishing healthy adults from people with social anxiety disorder: Evidence for the value of experiential avoidance and positive emotions in everyday social interactions. *Journal of Abnormal Psychology*, 122(3), 645–655. <https://doi.org/10.1037/a0032733>
- Kate, M.-A., Jamieson, G., Dorahy, M. J., & Middleton, W. (2020). Measuring dissociative symptoms and experiences in an Australian college sample using a short version of the multidimensional inventory of dissociation. *Journal of Trauma & Dissociation*, 22(3), 265–287. <https://doi.org/10.1080/15299732.2020.1792024>
- Knipe, J. (2018). *EMDR toolbox*. <https://doi.org/10.1891/9780826172563>
- Koban, L., Gianaros, P. J., Kober, H., & Wager, T. D. (2021). The self in context: Brain systems linking mental and physical health. *Nature Reviews Neuroscience*, 22(5), 309–322. <https://doi.org/10.1038/s41583-021-00446-8>
- Koorankot, J., & Mukherjee, T. (2022). Development of the stroke pattern inventory in a clinical population. *Transactional Analysis Journal*, 52(2), 148–158. <https://doi.org/10.1080/03621537.2022.2044626>
- Korn, D. L., & Leeds, A. M. (2002). Preliminary evidence of efficacy for EMDR resource development and installation in the stabilization phase of treatment of complex posttraumatic stress disorder. *Journal of Clinical Psychology*, 58(12), 1465–1487. <https://doi.org/10.1002/jclp.10099>
- Kroenke, K., Spitzer, R. L., & Williams, J. B. (2001). The PHQ-9: Validity of a brief depression severity measure. *Journal of General Internal Medicine*, 16(9), 606–613. <https://doi.org/10.1046/j.1525-1497.2001.016009606.x>
- Lambert, N. M., Gwinn, A. M., Baumeister, R. F., Strachman, A., Washburn, I. J., Gable, S. L., & Fincham, F. D. (2013). A boost of positive affect: The perks of sharing positive experiences. *Journal of Social and Personal Relationships*, 30(1), 24–43. <https://doi.org/10.1177/0265407512449400>
- Leeds, A. M. (2015). Learning to feel good sharing positive emotion: The positive affect tolerance protocol. In *EMDRIA Conference Session 432*.
- Leeds, A. M. (2016). *A guide to the standard EMDR therapy protocols for Clinicians, supervisors, and consultants* (2nd ed). Springer Publishing Company. <https://doi.org/10.1891/9780826131171>
- Leeds, A. M. (2022). The positive affect tolerance and integration protocol: A novel application of EMDR

- therapy procedures to help survivors of early emotional neglect learn to tolerate and assimilate moments of appreciation, praise, and affection. *Journal of EMDR Practice and Research*. <https://doi.org/10.1891/EMDR-2022-0015>
- Leeds, A. M., & Shapiro, F. (2000). EMDR and resource installation: Principles and procedures for enhancing current functioning and resolving traumatic experiences. In J. Carlson & L. Sperry (Eds.), *Brief therapy strategies with individuals and couples* (pp. 469–534). Zeig, Tucker, Theisen, Inc.
- Lehner, T., Miller, B. L., & State, M. W. (2016). *Genomics, circuits, and pathways in clinical neuropsychiatry*. Elsevier.
- Liotti, G. (2017). Conflicts between motivational systems related to attachment trauma: Key to understanding the intra-family relationship between abused children and their abusers. *Journal of Trauma & Dissociation*, 18(3), 304–318. <https://doi.org/10.1080/15299732.2017.1295392>
- Loots, G., Devise, I., & Sermijn, J. (2003). The interaction between mothers and their visually impaired infants: An intersubjective developmental perspective. *Journal of Visual Impairment & Blindness*, 97(7), 403–417. <https://doi.org/10.1177/0145482X0309700703>
- McCullough, L. (1997). *Changing character: Short-term anxiety-regulating psychotherapy for restructuring defenses, affects, and attachment*. Basic Books.
- McCullough, L. (2003). *Treating affect phobia: A manual for short-term dynamic psychotherapy*. Guilford Press.
- McKenna, J. (1974). Stroking profile: Application to script analysis. *Transactional Analysis Bulletin*, 4(4), 20–24. <https://doi.org/10.1177/036215377400400408>
- Michal, M., Kaufhold, J., Grabhorn, R., Krakow, K., Overbeck, G., & Heidenreich, T. (2005). Depersonalization and social anxiety. *The Journal of Nervous and Mental Disease*, 193(9), 629–632. <https://doi.org/10.1097/01.nmd.0000178038.87332.ec>
- Miguel-Alvaro, A., Guillén, A. I., Contractor, A. A., & Crespo, M. (2021). Positive memory intervention techniques: A scoping review. *Memory*, 29(6), 793–810. <https://doi.org/10.1080/09658211.2021.1937655>
- Mikulincer, M., & Shaver, P. R. (2005). Attachment theory and emotions in close relationships: Exploring the attachment-related dynamics of emotional reactions to relational events. *Personal Relationships*, 12(2), 149–168. <https://doi.org/10.1111/j.1350-4126.2005.00108.x>
- Myers, N. S., & Llera, S. J. (2020). The role of childhood maltreatment in the relationship between social anxiety and dissociation: A novel link. *Journal of Trauma & Dissociation*, 21(3), 319–336. <https://doi.org/10.1080/15299732.2020.1719265>
- Ogawa, J. R., Sroufe, L. A., Weinfield, N. S., Carlson, E. A., & Egeland, B. (1997). Development and the fragmented self: Longitudinal study of dissociative symptomatology in a nonclinical sample. *Development and Psychopathology*, 9(4), 855–879. <https://doi.org/10.1017/s0954579497001478>
- Panksepp, J. (2011). The basic emotional circuits of mammalian brains: Do animals have affective lives? *Neuroscience and Biobehavioral Reviews*, 35(9), 1791–1804. <https://doi.org/10.1016/j.neubiorev.2011.08.003>
- Pérez-Pereira, M., & Conti-Ramsden, G. (2019). *Language development and social interaction in blind children*. Routledge. <https://doi.org/10.4324/9781003019756>
- Putnam, F. W. (1997). *Dissociation in children and adolescents: A developmental perspective*. Guilford Press.
- Putnam, F. W. (2016). *The way we are: How states of mind influence our identities personality and potential for change*. Ipbooks.
- Reichel, V., Sammer, G., Gruppe, H., Hanewald, B., Garder, R., Bloß, C., & Stingl, M. (2021). Good vibrations: Bilateral tactile stimulation decreases startle magnitude during negative imagination and increases skin conductance response for positive imagination in an affective startle reflex paradigm. *European Journal of Trauma & Dissociation*, 5(3), 100197. <https://doi.org/10.1016/j.ejtd.2020.100197>
- Schmidt, S. J. (2004). Developmental needs meeting strategy: A new treatment approach applied to dissociative identity disorder. *Journal of Trauma & Dissociation*, 5(4), 55–78. https://doi.org/10.1300/J229v05n04_04
- Schore, A. N. (1994). *Affect regulation and the origin of the self: The neurobiology of emotional development*. Lawrence Erlbaum Associates, Publishers.
- Schore, A. N. (1996). The experience-dependent maturation of a regulatory system in the orbital prefrontal cortex and the origin of developmental psychopathology. *Development and Psychopathology*, 8(1), 59–87. <https://doi.org/10.1017/S0954579400006970>
- Schore, A. N. (1997). Early organization of the nonlinear right brain and development of a predisposition to psychiatric disorders. *Development and Psychopathology*, 9(4), 595–631. <https://doi.org/10.1017/s0954579497001363>
- Schore, A. N. (2000). Attachment and the regulation of the right brain. *Attachment & Human Development*, 2(1), 23–47. <https://doi.org/10.1080/146167300361309>
- Schore, A. N. (2001). The effects of early relational trauma on right brain development, affect regulation, and infant mental health. *Infant Mental Health Journal*, 22(1–2), 201–269. [https://doi.org/10.1002/1097-0355\(200101/04\)22:1<201::AID-IMHJ8>3.0.CO;2-9](https://doi.org/10.1002/1097-0355(200101/04)22:1<201::AID-IMHJ8>3.0.CO;2-9)
- Schore, A. N. (2003a). *Affect dysregulation and disorders of the self* (1st ed.). W.W. Norton.
- Schore, A. N. (2003b). *Affect regulation and the repair of the self* (1st ed.). W.W. Norton.
- Schore, A. N. (2014). The right brain is dominant in psychotherapy. *Psychotherapy*, 51(3), 388–397. <https://doi.org/10.1037/a0037083>

- Schwartz, R. C. (1995). *Internal family systems therapy*. Guilford Press.
- Schwartz, R. C. (n.d.). Evolution of the internal family systems model. IFS Institute. <https://ifs-institute.com/resources/articles/evolution-internal-family-systems-model-dr-richard-schwartz-ph-d>
- Seligman, M. E. P., Rashid, T., & Parks, A. C. (2006). Positive psychotherapy. *Am Psychol*, 61(8), 774–788. <https://doi.org/10.1037/0003-066X.61.8.774>
- Shapiro, F. (2007). EMDR, adaptive information processing, and case conceptualization. *Journal of EMDR Practice and Research*, 1(2), 68–87. <https://doi.org/10.1891/1933-3196.1.2.68>
- Shapiro, F. (2018). *Eye movement desensitization and reprocessing, basic principles, protocols and procedures* (3rd ed.). The Guilford Press.
- Shedler, J., Mayman, M., & Manis, M. (1993). The illusion of mental health. *American Psychologist*, 48(11), 1117–1131. <https://doi.org/10.1037/0003-066X.48.11.1117>
- Siegel, D. J. (1999). *The developing mind: Toward a neurobiology of interpersonal experience*. Guilford.
- Siegel, D. J. (2012). *The developing mind: How relationships and the brain interact to shape who we are* (2nd ed.). Guilford Press.
- Sierra, M., & Berrios, G. E. (2000). The Cambridge depersonalization scale: A new instrument for the measurement of depersonalization. *Psychiatry Research*, 93(2), 153–164. [https://doi.org/10.1016/S0165-1781\(00\)00100-1](https://doi.org/10.1016/S0165-1781(00)00100-1)
- Simpkins, C. A., & Simpkins, A. M. (2013). Neuroplasticity and neurogenesis: Changing moment-by-moment. In *Neuroscience for clinicians* (pp. 165–174). Springer Publishing. <https://doi.org/10.1007/978-1-4614-4842-6>
- Solomon, R. M., & Shapiro, F. (2008). EMDR and the adaptive information processing model—potential mechanisms of change. *Journal of EMDR Practice and Research*, 2(4), 315–325. <https://doi.org/10.1891/1933-3196.2.4.315>
- Spitzer, R. L., Kroenke, K., Williams, J. B. W., & Löwe, B. (2006). A brief measure for assessing generalized anxiety disorder: The GAD-7. *Archives of Internal Medicine*, 166(10), 1092–1097. <https://doi.org/10.1001/archinte.166.10.1092>
- Stänicke, E., & McLeod, J. (2021). Paradoxical outcomes in psychotherapy: Theoretical perspectives, research agenda and practice implications. *European Journal of Psychotherapy & Counselling*, 23(2), 115–138. <https://doi.org/10.1080/13642537.2021.1923050>
- Steele, A. (2003, September). *Imaginal nurturing*. Presentation at the 8th EMDR international association conference. Denver, CO.
- Tart, C. T. (1972). States of consciousness and state-specific sciences. *Science*, 1203–1210.
- Tart, C. T. (1975). *States of consciousness*. Dutton.
- Teicher, M. H. (2000). Wounds that time wo 't heal: the Neurobiology of child abuse. *Cerebrum: The Dana Forum on Brain Science*, 2(4), 50–67. <https://dana.org/article/wounds-that-time-wont-heal/>
- Teicher, M. H. (2002). Scars that won't heal: The neurobiology of child abuse. *Scientific American*, 286(3), 68–75. <https://doi.org/10.1038/scientificamerican0302-68>
- Teicher, M. H., Anderson, C. M., Ohashi, K., Khan, A., McGreenery, C. E., Bolger, E. A., Rohan, M. L., & Vitaliano, G. D. (2018). Differential effects of childhood neglect and abuse during sensitive exposure periods on male and female hippocampus. *NeuroImage*, 169, 443–452. <https://doi.org/10.1016/j.neuroimage.2017.12.055>
- Teicher, M. H., Glod, C. A., Surrey, J., & Swett, C. (1993). Early childhood abuse and limbic system ratings in adult psychiatric outpatients. *The Journal of Neuropsychiatry and Clinical Neurosciences*, 5(3), 301–306. <https://doi.org/10.1176/jnp.5.3.301>
- Teicher, M. H., Ito, Y., Glod, C. A., Andersen, S. L., Dumont, N., & Ackerman, E. (1997). Preliminary evidence for abnormal cortical development in physically and sexually abused children using EEG coherence and MRI (R. Yehuda, , A.C. McFarlane, , & A.O.T.N.Y.A.O. Sciences, Eds.). *Psychobiology of posttraumatic stress disorder*, 821, 160–175. <https://doi.org/10.1111/j.1749-6632.1997.tb48277.x>
- Teicher, M. H., Parigger, A., & Schmahl, C. (2015). The 'Maltreatment and Abuse Chronology of Exposure' (MACE) scale for the retrospective assessment of abuse and neglect during development. *PLOS ONE*, 10(2), e0117423. <https://doi.org/10.1371/journal.pone.0117423>
- Van der Hart, O., Nijenhuis, E. R. S., & Solomon, R. (2010). Dissociation of the personality in complex trauma-related disorders and EMDR: Theoretical considerations. *Journal of EMDR Practice and Research*, 4(2), 76–92. <https://doi.org/10.1891/1933-3196.4.2.76>
- Watkins, J. G., & Watkins, H. H. (1997). *Ego States: theory and therapy*. W.W. Norton.
- Watson, D., Clark, L. A., & Tellegen, A. (1988). Development and validation of brief measures of positive and negative affect: The PANAS scales. *Journal of Personality and Social Psychology*, 54(6), 1063–1070. <https://doi.org/10.1037//0022-3514.54.6.1063>
- Wesselmann, D., Davidson, M., Armstrong, S., Schweitzer, C., Bruckner, D., & Potter, A. E. (2012). EMDR as a treatment for improving attachment status in adults and children. *European Review of Applied Psychology*, 62(4), 223–230. <https://doi.org/10.1016/j.erap.2012.08.008>
- Wesselmann, D., & Potter, A. E. (2009). Change in adult attachment status following treatment with EMDR: Three case studies. *Journal of EMDR Practice and Research*, 3(3), 178–191. <https://doi.org/10.1891/1933-3196.3.3.178>
- Wolff, P. H. (1987). *The development of behavioral States and the expression of emotions in early infancy*. The University of Chicago Press.

Young, J. C., & Widom, C. S. (2014). Long-term effects of child abuse and neglect on emotion processing in adulthood. *Child Abuse & Neglect*, 38(8), 1369–1381. <https://doi.org/10.1016/j.chiabu.2014.03.008>

Disclosure. The author has no relevant financial interest or affiliations with any commercial interests related to the subjects discussed within this article.

Acknowledgments/Author Note. An early version of this material was presented in a paper “Learning to Feel Good Sharing Positive Emotion: The Positive Affect Tolerance Protocol” at the EMDRIA Annual Conference, August 30, 2015, Philadelphia. I am indebted to the clinicians

who obtained permission and shared anonymized case material related to their use of the PAT protocol and those who commented on draft versions of the paper. Names of patients and clinicians used in case summaries are pseudonyms, and case details have been altered to protect the anonymity of patients.

Funding. The author receives fees for providing basic training and workshops in EMDR therapy.

Correspondence regarding this article should be directed to Andrew M. Leeds, 1049 Fourth St., Suite G, Santa Rosa, California, USA. Email: andrewmleeds@gmail.com