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

Andrew M. Leeds

Director of Training, Sonoma Psychotherapy Training Institute, Santa Rosa, California

Survivors of early neglect and other adverse childhood experiences often struggle with general and social anxiety, depressive states, and negative self-concept. Trauma-informed treatment strategies for survivors, such as EMDR therapy, exposure therapy, and cognitive processing therapy, tend to focus on resolving memories of adverse and traumatic experiences. Coping skills development models, such as Dialectical Behavior Therapy and Skills Training in Affective and Interpersonal Regulation (STAIR), emphasize training in mindfulness, assertiveness, or self-soothing skills for patients with persistent negative affect states. In the era of trauma-informed psychotherapy, an often-overlooked clinical issue is the impaired ability of survivors of early neglect to tolerate and integrate moments of shared positive interpersonal experience into positive emotional states and positive self-concepts. Survivors of neglect tend to make use of overt or covert avoidance strategies and minimization responses to avoid the discomfort, anxiety, or confusion they experience in what others find to be pleasurable and enriching social interactions. The Positive Affect Tolerance and Integration (PAT) protocol focuses on helping survivors of early emotional neglect to learn to tolerate and assimilate moments of appreciation, praise, and affection. This paper offers principles and a specific series of interventions that incorporate standard EMDR therapy procedures with minor adaptations. In addition to a summary of the PAT protocol, three case examples are described to illustrate selection criteria and potential clinical responses.

Keywords: positive affect; affect tolerance; EMDR therapy; bilateral stimulation; dismissing attachment; neglect

Although healthy individuals enjoy and benefit from sharing positive interpersonal emotions (Fredrickson, 1998), survivors of profound early childhood emotional and psychological neglect and abuse often find such experiences aversive due to their being unfamiliar states—and thus confusing and anxiety-provoking (Kashdan et al., 2013)—and to their being associated with early aversive formative experiences of being ignored, shamed, or hurt. The inability of survivors of profound emotional neglect to tolerate and assimilate moments of shared positive emotional states may help explain their observed atypical responses to standard EMDR reprocessing (Shapiro, 2001, 2018) of disturbing memories as well as to Resource Development and Installation procedures (RDI; Korn & Leeds, 2002; Leeds, 2001, Leeds & Shapiro, 2000). Concepts from attachment theory regarding dismissing (avoidant) attachment classification (Main, 1996), Putnam's (1997) discrete behavioral states model, and McCullough's (1997, 2003) model of short-term dynamic psychotherapy for affect phobia provide a scholarly foundation for applying EMDR procedural steps to increasing the awareness of, tolerance for, and integration of shared positive emotional states into adaptive interpersonal schemas and the development of more resilient and positive self-concepts. These theoretical models and relevant neurobiological research will be examined in a second paper. In this article, the focus is on describing criteria for when to consider applying the Positive Affect Tolerance and Integration (PAT) Protocol, a description of principles, a summary of the procedural steps, and a listing of the minor differences and essential congruences with the standard EMDR therapy procedural steps (Shapiro, 2018, pp. 446–448). Three case examples illustrate case selection and potential

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clinical responses in using this approach with the aim of encouraging research into this novel application of EMDR therapy.

The Standard EMDR Model and Procedures

EMDR therapy is a widely recognized, empirically supported psychotherapy for posttraumatic stress disorder (PTSD; Bisson et al., 2019; World Health Organization, 2013) with applications to a broad range of other conditions (Matthijssen et al., 2020). Francine Shapiro (1989) initially developed EMDR therapy on purely heuristic, observational grounds. She then proposed the Adaptive Information Processing model (AIP; Shapiro, 1991, 2001; Shapiro & Laliotis, 2010) to explain EMDR's observed treatment effects and guide clinical application. The AIP model, while distinctive in its principles, is consistent in broad terms with earlier models for emotional information processing (Bower, 1981; Foa & Kozak, 1986; Lang, 1977, 1979; Rachman, 1980). The AIP model also provides a basis for applying EMDR procedures to address clinical populations that do not meet readiness criteria for standard EMDR or that have adverse or atypical responses to standard EMDR (Gonzalez et al., 2012; Knipe, 2018; Mosquera, 2014, 2018).

The Eight-Phase Framework for EMDR Therapy

The standard EMDR procedural steps (Leeds, 2016, pp. 377–379; Shapiro, 2018, pp. 446–448) are used within an eight-phase framework that starts with obtaining a complete history of the person and their symptoms (phase 1) and preparing the person for reprocessing (phase 2) until they meet readiness criteria (Shapiro, 2018, pp. 86–97). After developing an AIP-informed case conceptualization and a target sequence based on a complete history of the person and their symptoms, memories of adverse and traumatic experiences are reprocessed to resolution. There are five phases focused on resolving disturbing experiences. These start with an assessment and activation of the target experience (phase 3). Next follow three reprocessing phases, each of which incorporates bilateral sensory stimulation, most commonly with eye movements. In the desensitization phase (phase 4) the experience becomes less vivid and less emotionally charged as it is integrated into a broader framework of adaptive life experiences. In the installation phase (phase 5), this integration is extended and enhanced with a focus on a positive statement of self-appraisal. In the body scan phase (phase 6), these gains are confirmed by verifying only neutral or positive physical sensations remain associated with the experience. Each reprocessing session ends with the closure phase (phase 7) to confirm current stability and present orientation. An eighth re-evaluation phase begins subsequent sessions. The standard EMDR approach to resolving PTSD, called the PTSD protocol (Shapiro, 2001, 2018) is used to resolve symptoms of PTSD that are believed to be caused by an identifiable, discrete conditioning adverse experience or a series of such experiences. However, other specialized protocols have been developed and researched to resolve symptoms in individuals after a wide range of experiences and conditions, such as after recent events (Becker et al., 2021) and for those with major depressive disorders (Carletto et al., 2021).

The Standard Three-Pronged Protocol for PTSD

The standard EMDR PTSD protocol is based on Shapiro's (2018) general treatment planning principle of a three-pronged approach addressing targets from the past, present, and future. In this approach, the standard EMDR procedural steps are first used to reprocess one or more adverse memories from the past. Later, these steps are used to reprocess current external or internal cues that still evoke maladaptive responses. Finally, they are applied to imaginal rehearsal of more adaptive responses in the future. Variations in the sequencing of addressing targets have been successfully used to help individuals with histories of pervasive developmental trauma, such as in the Inverted Protocol (Hofmann, 2010), in which future goals and current triggers are addressed with EMDR reprocessing in an extended preparation phase that begins reprocessing on current difficulties before targets from the past are directly addressed. Data from many randomized clinical trials and meta-analyses (De Jongh et al., 2020; Shapiro, 2018) indicate the standard PTSD protocol and standard EMDR procedural steps provide an effective and efficient treatment for posttraumatic stress disorder.

Insecure Attachment and Atypical Responses to EMDR

Among patients who fail to meet standard EMDR readiness criteria or who show atypical responses—such as depersonalization—to standard EMDR, many have histories that reflect significant early childhood emotional neglect and adversity, and may present with comorbid DSM-5 (American Psychiatric Association, 2013) Cluster C symptoms (avoidant, dependent, or obsessive-compulsive personality disorder). These individuals may show superficial characteristics of competence, interpersonal skills, or emotional stability, but on closer examination they prove to be more fragile or may even collapse in the

face of social stressors. Such vulnerabilities are characteristic of those with dismissing and disorganized insecure attachment (Cassidy, 1994; Cassidy & Shaver, 1999; Dagan et al., 2021). Careful clinical assessment reveals these patients have low tolerance for positive interpersonal emotions and engage in overt or covert defensive strategies to dismiss, minimize, deny, or subtly avoid experiencing and assimilating shared positive emotional states into their internal models of self-identity or self-worth (Shedler et al., 1993; Werner-Seidler et al., 2013). This defensive avoidance of shared positive emotional experiences may significantly contribute to symptom maintenance. (Carl et al., 2013; Kashdan, 2013) Thus, finding ways to incorporate an EMDR treatment strategy to initially address this defensive avoidance could serve as an important addition to the EMDR approach to psychotherapy.

Brief History of the Positive Affect Tolerance Protocol

Resource Development and Installation (RDI: Korn & Leeds, 2002; Leeds, 2001; Leeds & Shapiro, 2000) has become a standard part of training in EMDR therapy and can be used in the preparation phase of EMDR therapy to assist individuals to develop capacities for self-soothing and self-regulation. It is widely considered to be a safe and supportive intervention (Amano & Toichi, 2016).

However, despite being credited with being the developer of the RDI procedure, the author had a disturbing clinical experience when attempting to use RDI with a suicidally depressed patient. The intention was to strengthen this patient's self-soothing skills by installing a resource of a positive memory of a supportive other from her childhood. The patient initially responded positively, but quickly became distraught and fled the office, not to return for several weeks. This experience demonstrated that prototypical use of RDI could not only fail to meet the clinical needs for certain patients but suggested that the experienced of shared positive emotion could be so poorly tolerated by some individuals as to create a clinical crisis.

This experience of clinical rupture is described in detail in a subsequent article on the conceptual background to the development of the PAT protocol. This unusual yet profoundly adverse response to the RDI procedure focused on a memory of a supportive other instigated a search for theoretical frameworks with which to understand the intolerance for such shared positive affective states and ultimately to a deeper appreciation of the role of insecure attachment in case conceptualization. This research eventually led to an alternate EMDR strategy for helping patients with intolerance for shared positive interpersonal emotion, the PAT protocol.

The conceptual framework and a detailed PAT protocol also grew out of discussions with Carol York between 1997 and 2004 exploring how EMDR procedures could be adapted to meet the needs of survivors of early emotional and psychological neglect who had not learned to tolerate the full range of adaptive human emotions and who showed atypical responses during attempts to use the standard EMDR procedural steps. A preliminary version of the Positive Affect Tolerance and Integration Protocol was initially presented at EMDR national conferences (Leeds, 2006, 2007). In subsequent presentations (Leeds, 2015, 2017), the PAT procedural steps were simplified to the form summarized in this article. A detailed procedural script from the 2015 presentation is available as listed in the references.

Purposes of the Positive Affect Tolerance and Integration Protocol

The purpose of the PAT protocol is both to assess the patient's capacity and to help the patient learn 1) to tolerate and 2) to integrate current experiences of shared positive affect-mediated discrete behavioral states into a positive experience of self. (See Putnam [1997] for a description of the discrete behavioral states model.)

Patient Selection for PAT

Patients for whom PAT could be considered include those where: 1) the patient's history reflects significant (or extensive) early emotional neglect; 2) there is a dismissing (avoidant) insecure attachment; 3) there are characteristics associated with co-morbid avoidant, dependent, or obsessive-compulsive personality disorder; 4) there is positive affect phobia (i.e., the patient admits to the use of covert or overt defensive strategies to avoid experiencing shared positive affect); and 5) the patient does not meet standard readiness criteria for EMDR therapy (Shapiro, 2018). Note that patients seldom spontaneously disclose their use of covert or overt defensive avoidance strategies to avoid experienced shared positive affect. Clinicians need to be prepared to actively inquire about this issue when patients report histories suggestive of emotional and psychological neglect and with anxiety disorder presentations.

With experience, EMDR-trained clinicians may recognize cases in which a PAT-informed approach could be initiated at early phases of intake and treatment planning. The case summaries that follow are intended to assist in this regard. In addition, EMDR treatment responses may suggest PAT should be considered. For example, a PAT approach should be considered when the patient has a history of early emotional neglect and: 1) shows anxiety, confusion, or other negative responses to RDI procedures; or 2) shows depersonalization during attempts to use standard EMDR procedure on disturbing memories.

Overview of PAT Protocol

After a clinical determination of a patient's current inability to tolerate and assimilate shared positive affect, the clinician would start the PAT protocol by offering psychoeducation on the potential value of shared positive affect and then proceed to obtaining informed consent to an investigational use of EMDR therapy. Since patients with these issues actively avoid, minimize, or deflect moments of shared positive affect, the author has found it helpful to teach a standard 3-step behavioral exercise for accepting praise, compliments, or warmth. After in-session practice, patients are given the assignment to practice this exercise as homework and to report back on their experiences. The PAT reprocessing procedural steps can then be applied to a current experience of having been offered shared positive affect. This is repeated over several sessions until the patient reports clinical gains with improved mood and reduced anxiety and describes positive current experiences of accepting shared positive affect. After such gains appear to be stable, standard EMDR reprocessing can be applied as indicated to memories of adverse events that are sources of other symptoms.

Psychoeducation

To help patients learn to recognize the potential benefits to be obtained from work on learning to tolerate and to assimilate shared positive affect, clinicians can describe the central role of positive interpersonal affect through shared caregiver–infant affection, warmth, and play in infancy and childhood for the development of essential brain circuits for tolerating and integrating shared positive affect as a positive dimension of life (Schore, 2014). Clinicians can describe the normative role these early experiences play in developing adaptive models for selecting and regulating attachment relationships that include shared positive affect. Clinicians can also share information from research studies on the health and stress-protective characteristics of shared positive affect (Carl et al., 2013; Horwitz, 1982; Salovey et al., 2000; Timoney & Wood, 2020).

Metaphors for Learning to Tolerate and Incorporate Shared Positive Affect. Metaphors can play a crucial role in helping patients to understand how learning to tolerate and assimilate shared positive affect might be initially experienced as disturbing, yet lead to later, subjectively enjoyable experiences. For example, after being on a starvation diet because of a natural disaster or a severe case of diarrhea, a person needs to start carefully and gradually as the digestive system rebuilds its capacity to assimilate nutrition from richer, more nutritious foods. Too much rich food or even a "normal" diet can overwhelm the weakened digestive system, which in the face of illness or starvation had sloughed off the villi that support normal digestion and waited for sufficient nutrients to be present before rebuilding the villi (Adams, 2021).

Another example is a fitness metaphor. After a prolonged absence from exercise, excessive initial exercise can easily lead to muscle or ligament injury. Soreness is normal with appropriate increases in exercise. New nerve supply takes weeks to develop before new blood supply gradually forms. Only then can new muscle tissue slowly develop. During early phases of a new exercise program people often feel winded, sore, or fatigued. Only after people have progressed in their new fitness program will they feel "better" after each exercise period (Haywood & Getchell, 2021).

A Three-Step Exercise for Actively Receiving Appreciation, Compliments, and Praise

To overcome well-established behavioral patterns of avoiding, minimizing, or deflecting shared positive affect, clinicians may find the following three-step exercise provides a simple means to teach patients how to begin to experience shared positive affect. Patients are instructed that when they notice they are offered appreciation, compliments, or praise they are first to make and maintain eye contact. Second, while maintaining eye contact, they are to take a deeper, diaphragmatic breath from the belly all the way into the upper chest area "to expand a space around the heart and make room for positive feelings." Third, while still maintaining eye contact, the patient is instructed to say, "Thank you. I appreciate you saying that" or an equivalent affirmative expression of acceptance and appreciation.

After Instruction, Begin the Role-Play Exercise With Reversed Roles. A role-play exercise can help motivate patients to begin to practice this exercise as homework and help them understand the impact on others of their historical habits of covert or overt avoidance. After explaining the three-step exercise, start with reversed roles. Ask the patient to offer two compliments to the therapist that can be sincere or made up. These compliments do not have to be about the therapy or the person of the therapist. They can be about some object in the therapy office or how the therapist is dressed. Explain that first you will demonstrate how to reject the compliment and "instruct the patient to "notice how that feels" when you do." Then add that during the second compliment you will demonstrate taking a deeper breath, maintaining eye contact, and actively accepting the compliment. Instruct the patient to again "notice if that feels different" when their offered compliment is actively accepted. Demonstrate each response in turn and then have the patient comment on what they noticed about the difference. Patient comments at this stage can often reflect a recognition that it feels much less pleasant when the clinician ignores or overtly rejects the compliment than when the clinician actively acknowledges and accepts the compliment. This can increase patient motivation to make the effort to actively acknowledge compliments in the exercise and in the days that follow. Then reverse roles and have the patient practice first actively minimizing or rejecting a compliment and second actively accepting and taking in the compliment. Ask the patient to comment on any differences noted when actively receiving the compliment.

Assign the Three-Step Exercise as Homework. Then assign the patient as homework practicing the three-step exercise. Ask the patient to notice between sessions when they are offered appreciation, compliments, praise, or affection. When they notice this, the patient is instructed to practice the three-step exercise. If they protest that they are unlikely to have any opportunities to practice the exercise, indicate that if they have few opportunities, just to notice that and report back. Also explain, that they also may discover times when they miss the opportunity to practice the exercise in the moment until after the fact and to make note of that delayed awareness. Also, it will be helpful to notice if they feel uncomfortable practicing the exercise or if they find it pleasant to practice the exercise. Whatever they notice, it will be helpful to keep a written log of what they notice about their awareness and their felt responses and thoughts. These experiences will serve as targets for future PAT reprocessing using slightly modified EMDR therapy procedural steps.

Selecting Targets for PAT

The target for the PAT protocol is always the "*internal feeling state*" (Putnam, 1997) associated with a specific (current) experience of shared positive affect. In this way the target for PAT is always in the present facet of the three-pronged framework. The selected event is the "lens" that allows the patient to focus on the internal experience that arises during a shared positive feeling state. Reprocessing with the EMDR procedural steps for phases 3–6 allows the patient to lessen any associated defensive emotions or beliefs and to learn to experience receiving compliments, praise and warmth as a positive inner experience associated with a positive self-statement.

Eight Differences in Clinical Application of EMDR Procedural Steps for the PAT Protocol

While the PAT protocol makes use of the standard EMDR procedural steps as its foundation, there are eight minor differences from the standard EMDR procedural steps as employed in the PTSD protocol (Shapiro, 2018).

1. The target for PAT is the internal "feeling state" from a *current* experience, not an old memory.
2. The target is conceptualized as the poorly tolerated interoceptive, positive *emotional state,* not the external event itself.
3. The initial clinical goal (for one treatment session) is to lower the reported Subjective Units of Disturbance (SUD) associated with the target experience by 2–3 SUD levels. It is not necessary to attempt to achieve a "0" SUD in a single session before doing an installation of a preferred (positive) cognition. Smaller increments of change may be better tolerated when learning to accept shared positive affect, while other patients will easily reach a SUD of 0. A limited number (3–5) of sets of eye movement are applied, in which each set of eye movements includes the standard number of 24–30 repetitions per set and at the standard fast pace used for memory reprocessing.
4. The standard SUD scale may be used or the SUD scale may be replaced with a bi-valued "feeling thermometer" scale that comprises both negative and positive ratings. The author has used the following script for the Feeling Thermometer (FT) scale: "Using a feeling thermometer scale from 0 to

100 where 0 is the most *disturbing* you can imagine, 50 is neutral, and 100 is the most *positive* you can imagine, how would you rate that emotion now?"

5. If during the "Desensitization phase" early disturbing memories or negative associations arise, they are acknowledged and *noted for future reprocessing,* but these are *not reprocessed* until later treatment phases. Reprocessing during the PAT protocol is refocused to the original target—the recent experience of shared positive affect. If necessary, the early memory can be set aside in an imaginal container.
6. The phase 5 installation of a Positive Cognition (or a modified Positive Cognition) may be performed after modest decreases in SUD level even if the SUD remains above a 2. The intention is to help build a positive self-appraisal even when there still may be some defensive (negative) affect or anxiety associated with the experience of shared positive affect. The Validity of Cognition scale (VoC) does not have to rise to a 6 or 7. Even an increase of 2 or 3 VoC ratings is sufficient to represent gains in positive self-appraisal. Smaller increments of change on both the SUD and VoC scales in early PAT reprocessing sessions may be better tolerated by some patients.
7. The "body scan phase" is skipped over. Identification and reprocessing of residual unpleasant body sensations with bilateral stimulation is not done in the PAT protocol to avoid the risk of the patient accessing unresolved dysfunctionally stored material from the past.
8. The closure phase may optionally be extended with multiple stages for patients with tendencies to disorganize during PAT reprocessing. The author has on occasion used a three-stage closure procedure when needed to help organize and refocus patients at the end of the PAT procedure including: i) the calm place exercise (Shapiro, 2018); followed by the ii) "light stream" exercise (Shapiro, 2018); and iii) a presentification exercise, such as asking the patient to engage in current sensory orientation by noticing objects in the external environment that can be seen or heard such as "an object that is red" or "the sound that seems to come from furthest away."

Five Essential Congruencies with Standard EMDR Procedural Steps

The PAT protocol incorporates the standard EMDR procedural steps in most essential ways.

1. The target involves a discrete experience rather than a free-floating or generalized positive affect state.
2. The assessment phase includes the standard elements in the standard sequence of picture, NC, PC, VoC, specific emotion, SUD, and body location.
3. The number of back-and-forth eye movements (tones or taps) is the standard 24–30 per set at the same fast speed used for standard EMDR reprocessing.
4. There are desensitization, installation and closure phases.
5. Feedback from the patient log during the re-evaluation phase helps align future PAT target selection.

Case Examples Illustrating Use of the PAT Protocol

The following three case summaries illustrate client selection issues and potential clinical responses to the PAT protocol. In each of these cases, initial attempts at reprocessing were ineffective with all three patients experiencing marked depersonalization during reprocessing. Use of the PAT protocol led to both reported clinical gains in self-concept and mood, and decreased anxiety, but also to the subsequent ability to have effective and completed reprocessing of highly disturbing old memories. Considering these case illustrations, EMDR-trained clinicians could consider offering the PAT protocol as part of the preparation phase even before they attempt standard memory confrontation for patients who meet the patient selection criteria described above.

Case 1—"Everyone Victimizes Me"

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

History taking and treatment planning were initially limited by her tendency to lapse into vague, self-critical statements when asked to describe stressful social interactions or specific traumatic memories. She reported moderate levels of depersonalization in stressful social interactions. She was the only and adopted child of two teachers at an exclusive prep school. She reported both parents had narcissistic personality traits. She was expected to look and be "perfect." She said her parents were preoccupied with her

social presentation and showed no interest in her feelings, insecurities, problems, hopes, or ambitions. Her mother was chronically depressed. Her father focused on academic interests and school politics.

Initial attempts to apply standard EMDR reprocessing to her earliest memories of parental neglect, parental conflict, and sexual abuse in elementary school all led to blocked responses with moderate to severe depersonalization and emotional numbing. It had become clear in clinical discussions that she was well-liked by her fitness students and that she tended to minimize receiving compliments or appreciation from them. Attention then shifted to psychoeducation on the role of shared positive affect and practicing the three-step role-playing exercise of actively accepting shared positive affect. The next week her mood had brightened. She reported actively accepting praise and appreciation offered to her at her AA meetings and from her fitness students. She was completely surprised at the difference in her internal state when she actively took in these compliments and at the sheer number of compliments she was being offered each week.

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

Over the next few months, using the standard EMDR PTSD protocol and standard EMDR procedural steps, she was able to reprocess the complete series of experiences of childhood and adolescent sexual abuse and the sexually exploitive sadomasochistic relationship with the accountant. Attention then turned to reprocessing her issues with body image and self-concept that had led to some medically unnecessary cosmetic surgeries and a lifelong preoccupation with unrelenting, perfectionistic standards of physical appearance. She continued to improve her skills in socializing and became more accepting of compliments and closeness. She lost her fear that men would only want to exploit her sexually and financially and had a few non-sexual dates with sympathetic and supportive men. Her treatment ended when she left the area to be able to spend more time with her grandchildren out of state.

Case 2—"Hollow Inside"

This case vignette is based on several discussions with an EMDR-trained clinician during advanced case consultation. A 37-year-old talented musician requested treatment on learning that his girlfriend was leaving him. He said that he just felt "hollow inside" and couldn't imagine going on now that this familiar feeling had returned again. He reported his mother had been ill with cancer when he was a child and died when he was 9 years old. His father remarried a younger woman who was only interested in her biological children. He had won scholarships to a music conservatory and awards in the music industry. He was respected and appreciated by his peers, but tended to be dismissive of his achievements.

His EMDR clinician reported he seemed puzzled by the calm place exercise. "What's the point?" he said. Trauma-focused reprocessing of his mother's lingering death and his stepmother's rejections led to episodes of depersonalization and confusion that made him suspicious of EMDR.

After consultation, the EMDR clinician refocused to psychoeducation on the role of positive affect and then taught him the three-step role-playing exercise for actively accepting shared positive affect. In subsequent sessions, they then used recent experiences of accepting praise and warmth from peers in a series of six PAT sessions. The extended, multi-layered closure was used for the first three of these sessions due to mild depersonalization.

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

Case 3—"The Real Me"

A 46-year-old divorced woman sought treatment for PTSD with EMDR therapy on referral from her Employee Assistance Program. She presented with a range of symptoms, including anxiety, depression, insomnia, nightmares, and somatic problems, including frequent migraines, temporo-mandibular joint pain, and fibromyalgia. History taking revealed that symptoms of PTSD developed during her divorce when her husband of 21 years progressed from being extremely controlling during the marriage to stalking, harassment, and indirect threats of violence.

Chronic Childhood Emotional Neglect and Marital Isolation. She was the younger of two daughters of narcissistic parents who provided her with no interest in her feelings or emotional needs. She reported that both her parents responded with emotional and psychological punishment when she tried to express her needs to them. Her father showed frequent signs of paranoid ideation. She described her parents as socially isolated and self-contained. When she married, she believed she had found a loving and supportive husband, but as she began to mature and to develop her own interests and gain recognition in their community, he became increasingly controlling and demeaning toward her. After years of this, she believed she had no alternative but to divorce. He then became abusive to a sociopathic degree. After the worst of the traumas of her divorce came to an end, she became active in a church choir, but unfortunately she was eventually sexually exploited and then abandoned by the choirmaster after her had appeared to befriend her.

Current Depersonalization, Alexithymia, and Social Isolation. When she presented for treatment, it gradually emerged that she frequently became confused in social situations, experiencing depersonalization and alexithymia and then became withdrawn. At intake, she was unable to sleep through the night. She tried to sleep in a different room each night in the house where she lived alone with the idea that she might escape the terrifying nightmares and anxiety attacks that disrupted her sleep. Although she worked full-time and appeared to be fully functional, she lived an inner life of desperation with no friends and no support system, and frequent emotional and physical pain. She had great difficulty managing work-related interpersonal stressors. Her only other social contacts were her physician and her adult children.

Her treatment was complicated by her inability to know what she was feeling and further complicated by inaccurate facial displays of affect. She reported she could seldom cry. She never showed negative affect facial displays and her positive affect expressions seldom reflected her true feeling state. She often smiled when she felt frightened, anxious, or hurt.

An Initial Treatment Plan to Focused on Recent Stalking and Violent Threats. While it was clear from her history that some of her issues in self-concept and social adjustment had been present all her life, it was initially decided to offer her EMDR treatment for the PTSD symptoms that had developed in response to the stalking and threats by her ex-husband. The process variable measures of EMDR treatment (i.e., the SUD, Validity of Cognition, and Body Scan) indicated completed treatment sessions for the first three specific traumatic incidents targeted. However, her PTSD symptoms did not begin to improve after these successful EMDR sessions. There were signs that she experienced moderate levels of depersonalization during these EMDR sessions, but not to a degree sufficient to block reported treatment effects during the sessions.

Exploring Hypotheses to Explain Lack of Symptom Gain from Completed Reprocessing. Several hypotheses were considered regarding the initial lack of treatment gain. First, it was considered that, due to the large number of traumatic incidents, more memories might need to be treated. Second, it was considered that pre-existing family-of-origin issues (referred to as "feeder memories" in Shapiro [2018]) were contributing to the maintenance of symptoms. However, attempts to discuss these issues in more depth in order to identify discrete targets to be addressed with EMDR led to increased states of depersonalization, confusion, and a lack of capacity to mentalize about these disorganized states. Finally, positive affect tolerance issues were explored. These discussions led to strengthening a third hypothesis that an inability to tolerate and assimilate positive affect was contributing to states of depersonalization during the EMDR reprocessing and that these states were in part responsible for the apparent lack of treatment gain after the initial three sessions. This led to a decision to apply the PAT protocol before resuming further standard EMDR sessions.

Temporarily Shifting the Treatment Plan to the PAT Protocol. After three sessions in which psychoeducation and metaphors for potential benefits for PAT procedures were introduced, a series of four sessions of PAT procedures were offered interspersed over the next six sessions. Targets for these sessions

included recent experiences of receiving praise from a co-worker, affection and appreciation from two of her adult children, and encouragement from a female friend she had not seen in a long time. The extended closure was needed for the first two sessions to help stabilize and reorient the patient from some moderate states of depersonalization. In the third and fourth PAT procedures, reactive anxiety was notably lower, there were no reports of depersonalization, and no formal interventions were needed for closure.

After a Series of PAT Procedures, Attention Returns to Trauma Reprocessing. Two weeks after the fourth PAT procedure, attention returned to standard EMDR reprocessing of traumatic memories of her ex-husband from the period of her divorce. She requested to work on the most disturbing of these memories in which she had feared for her daughter's safety and her own life. This memory processed to resolution in one session with no indications of depersonalization during or after the session. The following week, the patient reported that she had slept in her bedroom all week (rather than switching rooms each night from fear of nightmares) and had no "major" nightmares or night terrors that week.

In succeeding weeks, trauma memory reprocessing with standard EMDR therapy continued to be used in several sessions with no further episodes of depersonalization in the sessions and with further indications of moderate, but significant, decreased symptom severity. In addition to decreased symptoms of PTSD, the patient also reported increased ability to recognize what she was feeling rather than simply developing increased somatic symptoms over a period of several days after stressful work interactions. On a few occasions, she began to act with increased assertiveness toward co-workers and her supervisor. Following these assertive interactions, she did not display the feelings of guilt and confusion that had accompanied her earlier attempts to stand up for herself at work. Having lived her life as if she were the one-dimensional person she had presented to the world, she expressed these changes most poignantly when she said, "For the first time I feel like I found the real me."

Summary and Findings

Some patients with co-morbid PTSD and Cluster C personality disorder symptoms have histories of limited or no exposure to shared positive affect in the first few years of life and show dismissing or disorganized (unresolved) insecure attachment. They may experience depersonalization when stressed in social situations or during standard EMDR reprocessing or in response to RDI procedures. These patients may benefit from an initial focus in treatment on the effects of neglect and from working on improving their ability to tolerate and to integrate shared positive affect into new discrete behavioral states and new self-schemas, rather than initially attempting to treat their PTSD symptoms.

Patients with co-morbid PTSD, dismissing insecure attachment and cluster C personality disorder symptoms associated with early neglect deserve treatment that addresses both the impacts of inadequate exposure to shared, positive affect from caregiver play, affection, warmth, and praise, as well as treatment for the impacts of discrete adverse and traumatic experiences. The three cases above, selected to illustrate client selection and potential clinical responses to the PAT protocol, describe patients who became able to tolerate and benefit from standard EMDR reprocessing free from depersonalization after a phase of treatment with the PAT protocol. These patients also described gains in self-concept, ability to enjoy and benefit from positive social interaction, improved assertiveness, and narrative and behavioral indications of some reorganization in attachment status.

Decreased depersonalization during social interactions and subsequent EMDR reprocessing sessions may have been factors in these gains. It is possible that the PAT procedure can help patients normalize responses to positive affect-mediated states in interpersonal interactions and subsequently when alone. In the framework of discrete behavioral states (Putnam, 1997), it is possible that PAT helps to enlarge a state space in which positive affect states can exist and increases pathways to these states. In the framework of McCullough's (1997, 2003) short-term anxiety-regulating model of psychotherapy, these patients reported rapid defense relinquishment, and improved affect experiencing, together with signs of self and other restructuring.

The gains reported in these illustrative cases suggest that the PAT protocol described in this article warrants more rigorous investigation to determine whether patients with similar clinical features who fail to meet readiness criteria or who have not responded favorably to standard EMDR procedures would benefit from the PAT protocol.

Additional Clinical Issues to be Considered

In other cases where patients meet EMDR readiness criteria at intake and where depersonalization does not block initial effectiveness of EMDR, the potential benefits of the PAT protocol might emerge as

important in later phases of treatment. For patients who are able to make gains through standard EMDR reprocessing and become motivated to explore new social, work, or romantic relationships, limitations in their sense of self and identity may become a focus of attention after trauma symptoms have resolved. While, in this article, the emphasis has been on PAT as an alternate EMDR therapy procedure in the preparation phase to foster innate capacities for tolerating and assimilating shared positive affect, it should also be noted that some patients may also need to be helped to overcome defenses formed against experiencing or expressing shared positive affect benefit by applying standard EMDR reprocess to memories of overt conditioning events in which they were ignored, shamed, or hurt when initially showing or responding to shared positive affect.

Limitations of Illustrative Cases

The cases summarized here, while illustrative of the potential benefits of the PAT protocol, have several obvious limitations. Due to the absence of either standard or structured behavioral measures of attachment status, personality disorder, severity of PTSD symptoms, negative or positive affect tolerance, or structured interviews for diagnosis, it is not yet possible to objectively define parameters of case selection criteria, nor is it possible to quantify the degree of observed improvement in symptoms of depersonalization, PTSD, positive affect tolerance, or severity of personality disorder traits. Due to the absence of a control group, it is not possible to state that the PAT procedure was a unique or essential element in the gains being described. The absence of repeated measures means that it is not possible to differentiate the degree to which the various treatment elements (psychoeducation, use of metaphor, behavioral role play, directed self-monitoring and reporting, and PAT reprocessing) may have contributed to the reported treatment effects. Because the PAT procedures were followed (and generally preceded) in this case series with the standard EMDR procedure as well as some other therapeutic interventions, it is not possible to fully differentiate the various sources of the observed gains. The absence of long-term follow-up data means that it is not possible to state that the observed treatment effects were stable over time.

Future Directions

Work is needed to refine and standardize assessment procedures for identifying cases where an initial focus on tolerating and integrating share positive affect is indicated. McKenna's (1974) Stroking Profile could provide a brief measure of a person's capacity to accept positive comments from others. The Positive and Negative Affect Schedule (PANAS-N: Watson et al., 1988) might be used to assess the presence of positive affect states and the Strengths and Difficulties Questionnaire (SDQ: Goodman et al., 1998; Santos-Lopes-Santos et al., 2018) measure could indicate issues and changes in prosocial behavior. Measures of attachment status such as the Adult Attachment Inventory (AAI; George et al., 1996; Hesse, 1999) and brief measures of personality disorder symptoms such as portions of the Psychotherapy Assessment Checklist (McCullough, 2001) could be helpful in clarifying differential responses in defined populations of patients. Standardized measures of self-concept, depersonalization, and posttraumatic stress disorder would be helpful in clarifying case selection and the degree of treatment gains. Here measures such as the Rosenberg self-esteem scale (Wongpakaran et al., 2012), the Cambridge Depersonalization Scale (Sierra & Berrios, 2000) and the Impact of Events Scale-Revised (Weiss & Marmar, 1997) could be considered. Controlled treatment outcome research with follow-up data is needed to determine whether the PAT protocol is effective in defined populations and whether treatment gains are stable. Controlled research is needed to compare effectiveness of PAT with other potentially effective treatments such as short-term dynamic psychotherapy (McCullough, 1997, 2003), competitive memory training (COMET; Korrelboom et al., 2009) or neurofeedback (Fisher, 2006; Zaehringer et al., 2019).

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Correspondence regarding this article should be directed to Andrew M. Leeds, Director of Training, Sonoma Psychotherapy Training Institute, 1049 Fourth St, Suite G Santa Rosa, CA 95404. E-mail: andrewmleeds@gmail.com