

PSYCHOTHERAPEUTIC
INTERVENTIONS FOR
EMOTION REGULATION

A NORTON PROFESSIONAL BOOK

PSYCHOTHERAPEUTIC INTERVENTIONS FOR EMOTION REGULATION

*EMDR and Bilateral Stimulation
for Affect Management*

John Omaha



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Dedication

for
Reina
1966–2001

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Ultimately, the responsibility for every word in this book is mine. I take responsibility or blame for the book's organization, its style, and for any errors of fact, misstatement, misrepresentation, or omission.

In a very real sense, this volume is my child. As a parent, I take pride in my offspring. Like any parent, I hope my progeny adds some measure to the expanding body of human knowledge and acumen and that it contributes some good to the world. Now it is time to separate from my creation and let it find its place in the world. I give it my blessings as I give it to you.

PSYCHOTHERAPEUTIC
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I n t r o d u c t i o n

Toward an Affect Centered Therapy

The present work represents a new phase in a profound revolution in psychotherapy, in which affects take their rightful place of equality with cognitions, drives, and behavior among the modalities that must be interpreted by theory and embraced by therapy in understanding both normal and pathological personality development (Cicchetti, Ackerman, & Izard, 1995). The book synthesizes experimental and theoretical advances regarding the primacy of affect in both human psychological health and dysfunction. These advances are translated into practical clinical applications the clinician can immediately utilize. The clinical interventions presented here are solidly grounded in recent experimental advances in understanding the developmental neurobiology of affect (Schore, 1994). These skills and concepts lay the foundation for a new approach to treating psychopathology that begins with the affects.

The four chapters of Part I assemble current empirical and theoretical information into a coherent picture of how self structure emerges in the context of the infant–caregiver dyad as the child is socialized for affect regulation within the dyad. When the dyad functions optimally, the child learns good affect regulation skills and at the same time an adaptive, positively functioning self structure organizes itself. When the dyad is impaired for whatever reason, adequate affect regulation skills are not transmitted to a greater or lesser degree resulting in the emergence of a more or less maladaptive, impaired, and negatively functioning self structure. Research and theory presented in Part I are thematically united by the principle that affect regulation and self structure are intimately interrelated and arise conjointly. The first four chapters point toward the clinical skills presented in Part II, the psychotherapeutic interventions for affect regulation that are the focus of this book. Theory and research are presented to support the practice of these interventions, referred to collectively as affect management skills training (AMST). The seven

basic and several ancillary AMST interventions presented in Chapters 5 through 11 are designed to remediate deficits in affect regulation and conjunctively promote the emergence of a more adaptive, positively functioning self. The theoretical and empirical justifications of the first four chapters and the AMST clinical interventions transmitted in the next six chapters, lay the foundation for a new school of therapy, affect centered therapy (ACT). Chapter 12 presents some of the principles of ACT and illustrates how affect dysregulation and impaired self structure may present in certain disorders. Three authors who have also created therapies oriented toward affect are Fosha (2000), Greenberg (2001), and Johnson (2002).

AFFECT CENTERED THERAPY AND THE AFFECT MANAGEMENT SKILLS TRAINING PROTOCOL

Affect Centered Therapy is a psychotherapeutic orientation constituting a theory for the origin of the patient's problems and a treatment for those problems that is derived from its theoretical principles. The patient's current problems are believed to originate in impairments of affect and emotion regulation. Affect Management Skills Training is a protocol that remediates impairment of affect and emotion regulation. The protocol consists of seven fundamental skills and a number of ancillary skills. AMST constitutes the first phase of ACT. Theory, supported by clinical impressions, suggests that clients must be provided with the tools to recognize, tolerate, and regulate both comfortable and distressing affects and emotions *before* they can safely and productively proceed to the second phase of ACT in which the causes of the current problems are uncovered and resolved. The skills of AMST provide for containment of disturbing material, establishment of an internal image of safety, affect recognition, affect tolerance, detachment from affect, and affect regulation. There are seven fundamental skills.

Skill I, *containment*, addresses the fact that many clients come to therapy burdened with intrusive thoughts and memories that are assembled with painful emotions. Therefore, at the outset of therapy, a container is created to separate and enclose this disturbing material. The containment skill employs a client-generated image of a "container sufficient to hold every disturbing thing" so as to wall off memories of adverse experience and the distressing emotions associated with them. Moving this material into the container is facilitated by tactile alternating bilateral stimulation (TABS) which can be provided manually by tapping on the client's knees or by the battery powered TheraTapper™. With this material contained, the client receives immediate relief and can more easily learn the rest of the skill set. During Phase II of ACT, this material can be removed from containment for processing. For example, a bulimic patient's bingeing and purging behaviors and their antecedent causes would be among the "disturbing things" her unconscious would place in containment. After completing the AMST protocol in Phase I of therapy for her bulimia, the client would be assisted in removing "bulimia and everything associated with it" from her container as the initial step in uncovering and treating the causes of the disorder.

Skill II, *safe place*, develops an internal image of safety and security, elaborating it in visual, auditory, olfactory, and tactile perceptual modes. Many clients

have never before developed such an internal image. The safe place image can be used to self-soothe in stressful daily life situations or in session when processing distressing material. AMST skill II extends Shapiro's (1995, 2001) use of sensations in her 8-step safe place exercise. Skill II explicitly focuses on four sensory modalities: sight, hearing, smell, and touch. Skill II also assembles the safe place image with cognitions of safety and the emotion safety, and it teaches the client to identify sensations accompanying the emotion of safety. In skill II and throughout the protocol, TABS facilitates effective, efficient skills acquisition. Both containment and safe place establish a foundation for the remainder of AMST, skills III to VII, which focus on recognizing, tolerating, and regulating specific affects.

Affect management consists of affect recognition, affect tolerance, and affect regulation. In setting up skills III to VII, the client selects a target affect, usually beginning with fear affect, that will be the protocol's first focus. A rating scale is introduced that allows the client to differentiate between high and low levels of fear and to avoid potentially overwhelming levels of fear arousal. She is asked to retrieve a memory of a time she felt fear at a low, manageable intensity. Of course, the client is in fact recalling fear emotion, but at its core is the fear affect she will be learning to recognize, tolerate, and regulate. Her remembered experience is named the target scene and functions as the focus for skills III to VII.

Skill III, *sensation-affect-identification*, transmits the ability to recognize an affect by the physical sensations the client experiences as he holds the image of the target scene. These physical sensations constitute the qualia for the affect. Once he has acquired skill III enabling him to recognize fear affect, he is in a position to learn how to tolerate it.

Skill IV, *sensation as signal*, links deployment of an image for affect tolerance to the appearance of the qualia for the target affect. Tolerance for fear affect is transmitted through the image of a grounding resource, which is client generated and may take many forms; for example, a grounding cord, grounding roots, magnetic boots, or other images enable the client to feel connected to the ground. The grounding resource assists the client in staying grounded and present while she experiences the target affect in the target scene. Skill IV, facilitated by TABS, links deployment of the grounding resource to the qualia accompanying fear affect so that its utilization becomes automatic.

Skill V, *grounded and present*, completes the affect tolerance component of AMST by linking the index affect as experienced in the target scene with the grounding resource image and with a cognition, "I can stay grounded and present while I am feeling fear." Again, TABS facilitates this assembly process. The affect tolerance skills transmitted by the grounding resource and skills IV and V provide the client with the tools to intervene in acting out behaviors such as bingeing or purging, substance abuse, and verbal or physical violence.

Skill VI, *noticing*, imparts to the client the ability to detach from images, memories, thoughts, and sensations that accompany the index affect in the target scene. Previously clients were identified with these affect-assembled modalities. Skill VI builds on skills III, IV, and V. When the client has deployed the skill IV grounding resource and has affirmed with skill V his ability to stay grounded and present while he experiences the affect target, he can then "just notice" the

thoughts, memories, and affects assembled with the target affect. The noticing skill promotes disidentification from the remembered material; the skill allows the client to step outside her problem and observe it and thereby creates a larger context for the problem. The creation of a larger context expands the client's self structure.

Skill VII, *regulation*, provides images for regulating affects. There are two regulatory resources, one for down-regulating distressing affect and a separate one for up-regulating comfortable affects. Down-regulation is accomplished by the disposal resource; up-regulation is facilitated by the gauge resource. The image of a disposal resource, which may be a garbage chute, a sink disposal, or a bottomless pit, is created to facilitate the client's attenuation of distressing affect. With TABS facilitation the client learns to decrease a negative affect like fear. A companion image, the gauge resource is developed to help the client increase positive affects like interest and joy. Utilization of the regulatory images is facilitated by TABS.

AFFECT AND EMOTION

Affects are the genetically hard-wired, physiological building blocks from which feeling, emotion, and mood are constructed. A distinction must be drawn among them to establish a solid foundation from the outset. Because affect is the primordium, it will be introduced first. The human genome codes for a limited number of unique responses, affects, which are elicited by changes in environmental stimulus patterns and are discriminated from one another by physiological and behavioral criteria. The nine basic affects are excitement, joy, startle, fear, anger, anguish, shame, disgust, and dissmell (Nathanson, 1992). (*Dissmell* refers to the pattern of actions produced by a noxious odor. The pattern includes wrinkling the nose, raising the upper lip, and avoidant behavior.) The neurobiology of fear has been well researched, and based on these findings it appears that each affect has a unique neurophysiological expression that is genetically encoded. The nervous system transmits signals to various effector sites where affects are translated into physiological responses such as change in heart rate, alteration in smooth or striated muscle tension, or perspiration. Affects are universal, and although no person can truly know another's experience, it is in our shared affective life that we humans most closely approach commonality simply because we are all similarly hard-wired for the experience of affects.

An affect becomes a feeling when the organism becomes aware of the affect. The physiological signals generated by an affect are called *qualia*. The qualia accompanying an affect constitute the organism's experience of the affect. Thus, a person becomes aware of an affect when she notices the qualia of the affect, and at that moment the affect becomes a feeling. In common usage, people use the word *feeling* when referring to their emotions and affects, and they refer to their experience of affects through the associated qualia when they say, for example, "I *feel* angry," or "I *feel* sad."

Emotion manifests a higher level of complexity in the affective system, because emotion involves memory. Affects are experienced in particular situations, and the events and the affects assembled with them are stored in memory and

retrieved again and again in new situations. Affects modified by experience become emotions. In emotion, affects are assembled with images, memories, cognitions, introjects, and other affects. Affects are often experienced in combinations, and these assemblages of affects also contribute to the more complex phenomenon of emotion. The basic building blocks, the affects, assemble into complex neural networks that grow more elaborate over time. Complexity does not always equate with order, however. In childhood, if affects are experienced too intensely, as, for example, during traumatic events, the system can be overwhelmed, and chaos rather than order results. Emotion is the complex experience of affect alloyed by memory, thought, and image. As Nathanson (1992) wrote, “affect is biology, emotion is biography” (p. 50).

Emotions are as diverse, nearly as numerous, and every bit as unique as the people who experience them. While there are only a small number of affects, the emotions number in the hundreds. Where affect is relatively straightforward, emotion is convoluted. Emotion is also idiosyncratic. Because emotion is amalgamated from affects modified by an individual’s unique history, emotion experience entails far less mutuality than affective experience. For example, what any one client means by the word *relief* is unique to that person. For one individual, the emotion of relief may be assembled with childhood memories of termination of physical abuse; for another person, relief may be accompanied by images of slaking intense thirst with a cold glass of water.

Throughout the book, I have attempted to adhere to a consistent usage of the words *affect* and *emotion*. I will use the word *affect* when I am specifically referring to one of the limited number of discrete, hard-wired, genetically determined human biological responses. Use of the word *affect* will indicate that I intend to reduce an emotional phenomenon to its neurophysiological basis. I will use the word *emotion* in all other instances. Thus, when I mean to indicate the fully nuanced phenomenon in which affects are assembled with each other, with experience, with images, with memories, with other emotions, or with cognitions, then I will use the word *emotion*. When I am referring to a client’s experience, I will use the word *emotion*, except when a client reports awareness of affect or emotion, and then the word *feeling* will be used.

Complication arises because the word for an affect is the same as the word for an emotion. The term *fear*, for example, applies to both the affect fear and the emotion fear. The same words are used to describe the basic affects as are used to describe the corresponding emotion. Fear affect becomes fear emotion when it is assembled with idiosyncratic experience, idiosyncratic images, and unique combinations of other affects and other emotions in the individual. For example, a particular client may fear the affect fear. She may go to extremes to avoid feeling fear, because it so rapidly compounds itself, cycling ever deeper into anxiety, and then panic. This avoidance may lead her to stay indoors, avoid people, and restrict her contact with the world. For her, fear affect is assembled with memories of times she felt fear, images of people who caused fear, cognitions such as “I am a fraidy-cat” or “If I go there I’ll get scared.” In this case fear affect has become fear emotion. For other clients, fear affect may be assembled with images of a school bully, a punitive parent, a snake, or with an image of not getting homework

done on time. For still others, fear affect may be assembled with other affects. For example, in the daredevil, fear may assemble with excitement; in the spousal abuser it may assemble with shame and elicit anger. In each of these examples, fear affect has become fear emotion. Throughout the book, when I mean to describe a discrete affect such as the affect fear, and intend to distinguish it from the emotion of the same name, the words *fear affect* will be used; when the emotion, qua emotion, is discussed, this will be indicated by the words *fear emotion*. The same language will be used in other instances where an affect and an emotion share the same name. Thus, *sadness affect* and *sadness emotion* will discriminate the different usages.

The term *mood* refers to affective states or processes that consume the organism and alter normal patterns of responding, perceiving, and thinking over a more extended time frame. For example, the *Diagnostic and Statistical Manual* (American Psychiatric Association, 1994, DSM-IV) specifies a two-week period for a major depressive episode. While affects and emotions are focused on an immediate object or situation, moods are characterized by diffuseness and globality (Fridja, 1993). Moods lack the object orientation that is a distinctive feature of emotions. As Fridja wrote, “Moods are thus affective states without an object” (1993, p. 381). Whereas affects and emotions play out over a relatively brief time span, moods last longer—Lewis (2000) called them “extended affective states” (p. 46). Moods are pervasive, changing social, occupational, and relationship functioning. The person in a joyful mood will relate joyously to a variety of elements in the environment, while the person in an angry mood will respond with irritation to the same elements. Cognition and emotion interact in mood in a complex manner. For example, a depressed mood may originate from persistent beliefs about the self or others. A person in a depressed mood may hold unrealistic negative attributions toward the self. In an anxious mood, a person may feel the whole world is endangering the self. The emotion associations in mood may activate cognitive networks with the result that learning, judgment, and memory may be biased over time. Lewis (2000) notes that the stable mood state appears to be sustained in some way by affect and favors a self-sustaining feedback mechanism. ACT proposes that, at least in the case of depressed moods, the self-sustaining process may consist of an intrapsychic conflict between two affects; for example, anger and disgust.

Emotion derives from autobiography, and therefore it is what we experience. However, because affect derives from physiology and neurophysiology, affect is what we regulate. The client who comes for help controlling his “temper” is speaking of an emotion. For this client, anger affect has assembled with memories, images, thoughts, and sensations to form the emotion that he names temper. The term *temper* is a common usage. Clients and clinicians use the common language of emotion to communicate with each other. The client may call his temper an emotion or a feeling. Clients rarely reduce emotion words to their affective roots. Yet, after you have taught your client the AMST protocol you will learn from this book, and he has learned to “control his temper,” what he will in fact be doing is regulating anger affect, which, like all affects, is generated neurophysiologically and expressed in physiological terms. AMST employs images, sensations, and

cognitions to build regulatory skills in the client that enable him to attenuate or arouse affects. AMST uses the client's images and memories to deconstruct the client's emotion and tease out the underlying affect or affects. It is these underlying affects that are regulated. This book teaches *affect* management skills, not *emotion* management skills, because it is the affect at the core of the emotion that is being regulated. When the client has mastered the skills of affect management, he will be able to regulate his emotions because affects are the building blocks of emotions. This introduction to affect and emotion leads naturally to an overview of the book's subject, training in skills for affect management.

AFFECT MANAGEMENT SKILLS TRAINING

AMST is the first system to provide for direct regulation of affects at their inception. Affect expression originates with neural activity. AMST employs images to modify the neurophysiological process of affect expression. By intervening in affect expression at its neurophysiological origin through the use of regulatory imagery, AMST modifies the cascade of processes that begin with affective arousal. Chapter 1 explains how affective arousal motivates physiological change, cognition, and behavior. Neurophysiological activity is the primary process engendering physiological, cognitive, and behavioral processes, and AMST alters these derivative processes by altering arousal levels for the primary affective process. Other systems of emotion regulation, as we will see, have attempted to alter affective arousal by altering physiology, thought process, or behavior. These are derivative or secondary processes, and therefore I refer to these methods as indirect emotion regulation protocols. AMST provides for direct regulation of affects, because AMST employs images to alter the primary neurophysiological processes that generate the secondary processes of physiology, cognition, and behavior. In using images to repair affect dysregulation, AMST makes use of the same imagistic mechanisms by which affect regulation is acquired during childhood. Chapter 2 describes the development of affect regulation from birth through adolescence, demonstrating how representations of caregivers form in the context of the infant-caregiver dyad and become the basis for both affect arousal and affect attenuation in the child. The chapter emphasizes the conceptual identity between the normal process of affective socialization occurring in childhood in the context of the infant-caregiver dyad and the psychotherapeutic process occurring in adulthood in the context of the client-therapist dyad.

Other therapeutic systems provide indirect approaches to affect regulation. Some systems attempt to modify the primary affective process by altering a secondary process that may be a sensation, cognition, behavior, or some combination of these. Several therapies that target stress and anger attempt to change affective responding by changing the client's physiological state through deep breathing and progressive muscle tension and relaxation. Rational-emotive therapy (RET) attempts to alter dysfunctional affective responding by changing the client's cognitive structures, that is, his thoughts and beliefs. Cognitive-behavioral therapy (CBT) combines behavioral change strategies with cognitive change strategies to alter maladaptive affective responding. Another therapeutic school, family systems

therapy, attempts to influence affect by manipulating the internal representations of developmentally important persons from the family of origin. Still other therapies make use of the therapeutic dyad as a change agent. Psychoanalysis, greatly simplified, believes that the client's distress—which we define as emotion dysregulation—can be resolved by analyzing and working through the transference. Person centered therapy teaches that the client's distress can be resolved by the supportive, attuned relationship with the therapist. These therapeutic schools appear to believe that affect dysregulation is a symptom of the client's maladjustment. In contradistinction, AMST and ACT believe the client's physiological, cognitive, and behavioral maladjustments are manifestations of affect dysregulation. According to ACT, the first step in helping the client to achieve a more positive functioning is to repair the deficits in affect regulation. AMST provides the client with skills to regulate affects adaptively.

AMST is a brief intervention that can be taught to every client at the beginning of therapy and then integrated into any clinician's practice. The protocol can provide immediate relief for the client's suffering, because it transmits affect regulation skills from the outset of therapy. It can quickly assist the client to more adaptive functioning in both the short and long term, because it is designed to remediate deficits in affect regulation. In my own practice, I teach the skill set to every client so as to establish a baseline of adaptive affect and emotion functioning. Clinicians reading this book will come from diverse theoretical backgrounds and should realize that the skills taught here are meant to enhance outcomes from their established method of practice. AMST can be integrated with family systems, cognitive-behavioral, rational-emotive, psychoanalytic, or person centered therapies. While the protocol can be used in conjunction with other therapeutic approaches, it does constitute the initial phase of ACT.

The affect management skill set is multidimensional and directive and also highly interactive. The AMST skills have been carefully crafted to assemble images, affects, sensations, and cognitions into unified constructs. Each of these dimensions is essential to assuring positive outcomes, and no modality can be separated out from the others. In this respect, AMST is a coordinated protocol. The clinician takes a directive stance as the coach who knows more about affects and their regulation than the client. The clinician has the responsibility to transmit skills to the client that were not transmitted in the client's childhood. Through teaching these skills, the clinician begins the process of repairing deficits in the client's self structure. The need for directiveness in the therapeutic dyad, which may be uncomfortable for some clinicians, derives from the theoretical basis of a psychotherapy focused on affect. In part the interactivity of AMST arises from its use of ideomotor signaling to bypass the client's cognitive defenses. The term *ideomotor signaling* refers to a technique for getting information from the unconscious mind. As used by AMST it consists of asking the client to raise her index finger when she has completed an affective task. Ideomotor signaling facilitates a more direct communication between the therapist and the client's unconscious. The interactivity of AMST also stems from its use of client self-report. The protocol adapts appraisal scales from eye movement desensitization and processing (EMDR; Shapiro, 2001), expands them, and adapts them to suit the protocol's

goals. The two appraisal scales allow the clinician and client to assess client stress or discomfort and to assess client progress in attaining protocol goals.

AMST is unique in that it employs an affect to facilitate acquisition of affect management skills. The protocol uses alternating bilateral stimulation in the tactile mode to elicit surprise–startle affect at a subthreshold level, which is beneath the client’s conscious awareness. Elicitation of surprise affect can be accomplished by tapping on the client’s knees or hands, or it can be supplied by a battery powered device, the TheraTapper™*, that delivers a slight, tactile “buzzing” sensation to the palms of the hands. Tactile alternating bilateral stimulation (TABS) by means of tapping or use of the TheraTapper™ supplies an important element of the coordinated, multidimensional AMST protocol. Using an affect to promote effective, efficient skills acquisition is called *affect mediation*. Subthreshold startle affect mediates the skills acquisition in the AMST protocol.

EMDR

For readers unfamiliar with EMDR, the present section presents an overview of this powerful therapy. AMST originally emerged within the environment of EMDR as an adjunct to using EMDR in treatment of alcoholism, addictions, nicotine dependency, and eating disorders (Omaha, 1998, 1999, 2000). AMST utilizes some of the tools created by Shapiro (2001). EMDR is an active, multidimensional, coordinated, empirically validated psychological protocol for resolving the sequelae of traumatic events and for treating clinical disorders caused by trauma. EMDR employs side-to-side eye movements or forms of alternating bilateral stimulation as one component of its integrated protocol. The eye movements appear to be an active treatment component (Kavanagh, Freese, Andrade, & May, 2001; Lohr, Tolin, & Kleinknecht, 1996; Montgomery & Ayllon, 1994).

The EMDR procedure consists of eight phases (Shapiro, 2001). In phase one, a careful client history identifies the client’s dysfunctional behaviors and symptoms that will be targeted in EMDR therapy, and a treatment plan is created. Client suitability is assessed during this phase: “A major criterion of the suitability of clients for EMDR is their ability to deal with the high levels of disturbance potentially precipitated by the processing of dysfunctional information” (Shapiro, 1995, p. 68). A primary thrust of AMST is to improve the client’s ability to withstand high levels of emotional disturbance so that he can successfully engage his adverse and traumatic material and process it adaptively and effectively. AMST was created with the intention of improving client suitability for EMDR.

EMDR’s second phase prepares clients for the therapy by explaining its theory and protocol. In the preparation phase, clients are also provided with relaxation and visualization techniques. In the third EMDR phase, assessment, clients are helped to identify and refine a distressing memory or event constituting the target for processing. A negative belief about the self associated with the target,

*TheraTappers (Patent No. 6,001,073) can be ordered from: DNMS Institute, LLC (<http://www.theratapper.com>, sales@theratapper.com, Phone: 1-210-561-7881, FAX: 1-210-561-7806) or John Omaha Enterprises, LLC (<http://www.johnomahaenterprises.com>, Phone: 1-530-899-7719).

an emotion assembled with the target, and physical sensations accompanying the target are all identified. A positive cognition about the self in relation to the target is also identified for later installation, once the distressing material has been processed. The level of distress caused by the material is assessed using a subjective scale.

Desensitization is the fourth phase of EMDR. The client is asked to hold in awareness the target image, the negative cognition, emotion, and physical sensations, and sets of eye movements are initiated. These sets continue until the level of disturbance associated with the target has decreased to neutrality or near it. Once the target has been adaptively processed and desensitized, the positive cognition is installed, replacing the previously held negative belief about the self. Installation of the positive cognition constitutes the fifth phase. The client holds the target image in mind and brings up the new, positive, self-referential belief, and with sets of eye movements, this belief is installed. "I am okay just the way I am" is an example of a positive belief that might be installed, replacing, for example, the negative belief "I am flawed."

In the sixth phase, the client is asked to scan his or her body for remaining tension, and any residual physiological distress is then targeted in additional sets of eye movements. Closure is the seventh phase of the EMDR treatment protocol. Instructions are given to help the client cognitively distance herself from the target material. The goal of this phase is to restore a state of emotional balance in the client by the end of the session. Reevaluation, the eighth phase takes place at the beginning of the next session following a session of target processing. The client is asked to reassess the previous target to ascertain if treatment effects have persisted. Further processing is instituted as required.

Perkins and Rouanzoin (2002) have recently evaluated current views regarding EMDR while summarizing the extensive literature empirically supporting it. This therapy is an effective treatment for either civilian or combat-related PTSD. EMDR is a more rapid treatment than exposure therapy. A 15-month follow up study demonstrated that treatment gains persisted over that time period. Results with EMDR are not due to a placebo effect. EMDR differs from exposure therapy by using brief, interrupted periods of attention to traumatic memories followed by free association. Stickgold (2002) has proposed that EMDR operates by repetitively redirecting attention, thus creating a neurobiological state in which traumatic memories can be cortically integrated. Cortical integration is believed to reduce the strength of episodic, traumatic memories. Furthermore, EMDR-facilitated cortical integration is also proposed to decrease the amygdala-dependent negative affect associated with the traumatic memory.

USING AMST

This book is written for all clinicians working in the field of mental health including psychiatrists, psychologists, psychotherapists, marriage and family counselors, and social workers. Familiarity with or training in EMDR (Shapiro, 2001) is not a prerequisite for learning the skills taught here. The book teaches clinicians skills that can be effectively and efficiently transmitted to clients to help them

immediately begin to move toward a happier, freer, less fear-driven, less shame-based life. These skills are simple. Once developed, they may operate in the client with conscious awareness, or unconsciously, or in a mixture. The skills persist. Positive changes in the client's traditional responses to emotion-laden experience accumulate, gaining momentum. Theory tells us that affect regulation is a central factor in the self-organization of a client's personality (Izard, Ackerman, Schoff, & Fine, 2000). The skills presented here begin the process of remediating the client's defects of affect regulation, and as a result, the client's personality begins to reorganize around a functional core of adaptive skills.

AMST is a recent development. I compiled the first version in November 2000. In February 2001, I presented the initial AMST workshop to a group of EMDR-trained clinicians in New York City, and in July that year I presented a workshop at EMDR International with Cindy Browning (Browning & Omaha, 2001). Since that time, many EMDR-trained clinicians have learned and used the AMST protocol.

Empirical support and empirical validation are the touchstones of modern psychotherapy. Clinical impressions for a new protocol are usually gathered before the protocol is subjected to rigorous empirical test. In this book you will read case reports from 17 clients who experienced AMST in their therapies. These clinical impressions provide support for the protocol. Many therapists have supplied their own clinical impressions of the effectiveness of AMST through the on-line discussion group I moderate for therapists who have taken an AMST workshop, and some of these will be cited in the book's narrative. The first empirical research on AMST is beginning to appear. AMST was a component of a therapy for eating disorders that also employed EMDR and showed promising outcomes in a single case design study (Omaha, 2000). Waltner-Toews (2002) has reported promising results in a small single case design pilot study with obsessive-compulsive disorder that used AMST in a group setting. Brown and Gilman (S. Brown, personal communication, February 17, 2003) showed that "AMST was an important component in providing positive outcomes" in a small multiple single case design study with dual diagnosis (PTSD and substance abuse) participants from a court ordered drug program in which AMST was used in conjunction with the EMDR standard protocol (Brown & Gilman, 2003). A major objective in writing this book is to stimulate further empirical outcome research on AMST.

ACT AND AMST

ACT is an overarching construct of which AMST constitutes the first phase. ACT is a complete therapy in that it proposes a theory for the origin of the patient's problems and provides a treatment for those problems derived from its theoretical principles. ACT is based on a developmental model that relates the patient's current difficulties to antecedent experiences. The emerging ACT therapy provides tools and techniques for identifying and then resolving the affect-laden experiences and internal affective conflicts believed to operate in many Axis I and II disorders. Other ACT interventions promote the emergence of more adaptive self structures in clients.

Three Principles of Affect Centered Therapy

Three principles guide the ACT approach to psychotherapy. The first principle of ACT asserts that affects are primary determinants of human behavior and cognition. Affective primacy originates from the developmental fact that the affects come on-line first and that behavior, thought, neurological structure, the self, and consciousness all emerge from and are structured by affective transactions between the organism and the environment, including, of course, the people in it. Behavior, cognition, and experience are viewed as secondary determinants because their influence depends on the affects with which they are assembled.

A second principle states that the self is structured during and by the process of affective socialization across a succession of milieus beginning with the infant-caregiver dyad, continuing with the family, and expanding to include school and society. The same principles of this developmental model apply to the emergence of an adaptive, positively functioning self as to the emergence of a maladaptive, negatively functioning self. Maladaptive, negatively functioning self structures are formed in response to and as a means of managing affects arising as a result of the vicissitudes, adversities, and traumas that are experienced across the developmental domains. ACT is grounded in theories advanced by Bowlby (1969), Schore (1994), and Sroufe (1996, 1997).

The third principle derives from these first two and structures and organizes the ACT approach to therapy itself. The principle asserts that in order to treat psychopathology, deficits in affect regulation must be remediated and then past experiences that have caused affect dysregulation must be uncovered and resolved. Affect dysregulation is believed to originate from one or both of two sources. The first source consists of failures to transmit skills for adaptive affect regulation, which is termed *childhood deficit experience*. The second source is adverse or traumatic childhood experience. A corollary to the third principle states that the maladaptive organization of self must be restructured, and ACT teaches a number of techniques for accomplishing this. ACT continues to develop new techniques for restructuring the self.

ACT therapy consists of two phases. In phase 1, the AMST skill set is transmitted to the client. When the client can recognize, tolerate, and regulate the range of emotions, therapy can proceed to the second phase in which he can uncover and resolve the adversities and traumas that have contributed to his emotion dysregulation and deficient self structure. In this second phase, therapeutic interventions facilitate the emergence of a more adaptive self structure. To reiterate, the AMST skill set conveyed in this book constitutes the essential first phase of ACT. While AMST can stand alone and provide benefit to the client in and of itself, and while it can also be incorporated into other therapeutic approaches, AMST is solidly embedded in the larger theoretical and therapeutic milieu of ACT. Just as, for example, a clinician can incorporate Gestalt techniques into a family systems approach to therapy, so too can a clinician adapt AMST techniques to the same family systems—or any other—approach to therapy.

AMST, ACT, EMDR, and Other Psychotherapies

AMST is compatible with all psychotherapeutic orientations. The skills and tools of the protocol can be integrated into psychoanalysis (e.g., Goldman & Milman, 1978), self psychology (Kohut & Wolf, 1978), rational–emotive therapy (Ellis & Dryden, 1987), cognitive therapy (Beck, 1976), dialectical behavioral therapy (Linehan, 1993), and family systems therapy (Bowen, 1978). Furthermore, ACT’s affect orientation has the potential to complement the theory and practice and improve the outcomes of these other schools.

AMST can be integrated into the practice of EMDR (Shapiro, 2001). AMST is a protocol that teaches affect regulation, and because EMDR treats disorders characterized by affect dysregulation, the AMST skills can improve the effectiveness of EMDR therapy. AMST was originally created within the environment of EMDR and has now moved to a position of independence. The theoretical framework of ACT has the potential to provide an etiological and ontological foundation for EMDR. ACT incorporates some EMDR techniques into its expanding assemblage of therapeutic interventions. ACT, AMST, and EMDR all make use of alternating bilateral stimulation. ACT and AMST use *tactile* alternating bilateral stimulation supplied by a TheraTapper™, which delivers a gentle vibrating stimulus alternating from side to side through hand-held probes. EMDR employs side to side eye movements postulated to induce a dual attention stimulation condition (Shapiro, 2001). It must be emphasized that this book teaches AMST employing TABS. This book does *not* teach EMDR; only trainers or instructors approved by the EMDR International Association can legitimately teach EMDR.

ACT and EMDR are significantly different therapeutic orientations characterized by divergent points of view in four crucial areas. ACT has a fundamentally different conception of how a personality system moves from dysfunction towards adaptive, positive functioning. ACT has a significantly different view of the primacy of affect and emotion. ACT’s theory of personality is different from the theory upon which EMDR is based. ACT and EMDR propose different theories to explain the effectiveness of bilateral stimulation, whether supplied by eye movements or TABS, in producing positive therapeutic outcomes.

How Healing Occurs

ACT and EMDR propose different hypotheses for the process by which a personality system moves from maladaptation to positive adaptation. EMDR is founded on Shapiro’s hypothesis of an innate adaptive information processing system (AIPS) that is proposed to move automatically towards healing (Shapiro, 2001, 2002). Shapiro wrote that “inherent in all of us is a physiological information-processing system that integrates the perceptions of sensory input and the cognitive components of experience into an associated internal memory network to allow for ecological, healthful, balanced functioning” (2000, p. 9). According to Shapiro, the AIPS automatically moves toward healthy functioning. The EMDR model proposes that trauma prevents or blocks the automatic movement toward healing and

that once trauma-induced blockage is removed, the AIPS again will automatically restore the system to adaptive functioning.

ACT proposes that movement in therapy from dysfunction toward positively adaptive functioning depends upon the quality of the therapeutic dyad and the internal representation the client forms of the therapist. Movement towards positive functioning also depends upon the nature of the client's internal representations of self and others and the relations among them. The therapeutic change process consists of transformations in the client's internal representations of developmentally important others as well as transformations of internal representations of self. For these transformations to occur, the client must be provided with an internal image of an important other person—usually the therapist is the model for this image—who is emotionally attuned, accepting, and sensitively responding. The image of the therapist functions as a template against which the client compares the internal images of persons who were developmentally important as well as self representations. A mismatch between images of therapist and images of self and others elicits affects that may include disgust, anger, sadness, shame, and fear. Healing occurs when arousal of disgust, anger, sadness, shame, and fear affects is attenuated as the therapist guides the client's personality system towards a resolution of representations of developmentally important others and a transformation of the self representation.

This process of change in the direction of positive functioning relies on the propensity of the central nervous system (CNS) for synthesis—the capacity to assimilate, accommodate, organize, and integrate its experiences from the beginning of life. The synthetic function is the innate (i.e., genetically determined) property of the CNS, as the object relations theorists recognized (Horner, 1984). Siegel (2002a) defined integration as the “functional coupling of distinct and differentiated elements into a coherent process or functional whole” (p. 100). Assimilation, accommodation, organization, and integration are the basic functions of the CNS constituting Shapiro's “physiological information-processing system that integrates the perceptions of sensory input and the cognitive components of experience into an associated internal memory network” (2002, p. 9). ACT postulates that EMDR's AIPS is in fact a construct that is acquired during the course of early socialization. This construct develops in the context of the dyads that are operative during childhood, in particular the dyads involving the infant and maternal caregiver and the infant and paternal caregiver. Whereas EMDR proposes that the AIPS moves toward healthy functioning, ACT posits that the system moves toward adaptive functioning, not necessarily healthy functioning. The nature of adaptive functioning is determined by the context structured by the currently operative dyads and by the nature and quality of the current internal representations the client possesses. During childhood, the client's synthetic function promoted the child's survival by facilitating adaptation within his or her developmental environment. When the early environment was deficient, the attachment was negatively impacted, and a distressed personality structure emerged, a situation made worse if the environment included adversity and trauma as well. A personality structured by deficit experience and adverse and traumatic experience, while it may have been adaptive in its developmental environment, will

experience maladaptation in the social environments of adolescence and adulthood. The stress entailed by maladaptation or the consequences resulting from negative functioning will bring the individual to therapy.

In the context of a therapeutic dyad, the client's personality system will move toward adaptive functioning as it is defined in the dyad. In the therapeutic dyad, one partner is designated the *client*, and this partner is presumed to be less healthfully and less adaptively functioning than the therapist partner. The therapist is present to help, to guide, and to model healthful and adaptive functioning. The therapeutic dyad functions to remediate the impairments in the client's self structure that originated in the client's developmental dyad of childhood. The client forms an internal representation of the therapist. This representation serves as a template for the client's restructuring of his or her schemas. For the most part, therapists model healthful, adaptive functioning. For that reason, most clients experience a change in functioning toward adaptivity and health in the course of EMDR therapy. Shapiro (2001, 2002) ascribed to the putative self-healing mechanism of the AIPS the qualities that are actually inherent in the therapeutic dyad. Siegel (2002a) affirmed the ACT approach when he wrote:

In general, psychotherapy can be seen as the basis for a form of attachment relationship, one in which the patient seeks proximity to (i.e., wants to have a physical and emotional closeness with) the therapist, has a safe haven (is soothed when upset), and achieves an internal working model of security (called a "secure base") derived from the patterns of communication between therapist and patient." (p. 106)

In the therapeutic dyad, the therapist models trust in her own perceptions, acceptance of the emotional states of the client, bonding, experience of joy and intimacy, achievement of a sense of greater purpose, commitment to service, and interpersonal connection, and the client incorporates these qualities because the therapist models them. Because the therapist embodies these qualities, the client is able to integrate them and as a result is able to "enter terrifying states and process information" from unresolved trauma (Siegel, 2002a, p. 107). As Siegel wrote, "This interpersonal communicative experience may cause these rigidly constrained or disorganized states, which are at the core of unresolved trauma, to be dramatically—and permanently—altered" (p. 107).

Viewpoint Toward Affects

ACT and EMDR are similar in one respect and fundamentally different in another in regard to affects. The similarity pertains to their shared viewpoint that trauma is determined by the unresolved affect bound with experience and stored physiologically. The difference arises from ACT's greater emphasis on the determining influence of early social context on affective responding across the life span.

ACT proposes that beginning from the first months of life the emerging human personality is both conditioned by and responding to the demands of its social context for affect regulation. The personality may be viewed as the means by which the organism regulates its affects within that social context. From ACT's viewpoint, the personality is primarily an assemblage of the organism's behavioral,

structural, cognitive, sensational, and affective transactional schemas for managing affects and emotions. Attainment of higher human capacities like service to humanity and spirituality depend almost entirely upon the prior establishment of a well-organized, integrated, differentiated self system capable of functional affect regulation.

EMDR focuses upon the organism's traumatic experiences, while ACT focuses on the emergence of structure in the organism's self system. Shapiro (2002) wrote that "any of the ubiquitous experiences of childhood can qualify as a 'Small t' trauma" (pp. 14–15). From EMDR's perspective, childhood development appears to be the cumulative record of 'Small t' and 'Big T' traumas, all of which are assembled with unresolved affects. Apparently, according to EMDR, the lesser traumas to a lesser extent and the greater traumas to a greater extent overwhelm the AIPS and prevent its spontaneous restoration of the system to healthy functioning.

From ACT's perspective, the organism's early experiences in the developmental dyad set the basic personality structure and determine therefore what its subsequent responding will be. Whether an event arouses distressing levels of affect or not will depend upon the organism's attachment status and affective socialization. If the maternal caregiver is sensitive, appropriately responsive, soothing, and caring, the toddler will form an internal representation of her that embodies these qualities and then will rely on that representation for self-soothing in times of stress. For this child, the vicissitudes of life will be less likely to arouse distressing levels of affect because the child can self soothe. This child's early affective socialization engendered a resilient self structure. In contrast, an infant whose maternal caregiver is absent or neglectful, insensitive or unresponsive, will form an internal representation of the caregiver embodying her qualities. This child will lack a self structure that includes an internal locus of soothing, and as a result, many of life's vicissitudes will be distressing.

Because of its theoretical orientation toward affect, ACT is able to understand and directly and effectively intervene for the client's benefit in the area of self-worth. ACT proposes that negative self-reflective cognitions about the self—i.e., statements of impaired self-worth such as "I am flawed," "I am a failure," and "I am unworthy"—are driven by affects, in particular, disgust affect, directed at the self. A client's statement of self-directed negative attribution will have a history across that client's developmental time span, and will have originated in part in negative affects broadcast at the client in childhood by important attachment figures. Developmentally, the client's present negative self attributions may also have originated in negative affects elicited in the client in childhood by inappropriate experiences forced on the client. ACT has adopted and then expanded a central technique from EMDR called *cognitive interweave*. In cognitive interweave, the therapist deliberately elicits from the client useful information in the form of imagery, movement or verbalizations "that would have been expected to associate spontaneously in unimpeded processing" (Shapiro, 2002, p. 43). ACT, as has already been explained, does not support the notion of *spontaneous processing*. From the ACT perspective, processing is largely guided through therapist modeling or through the therapist's directives. ACT's intervention could be called

an *affective interweave*, because the therapist directs the client to notice what affects are being broadcast at the client by a parent in the childhood scene being processed. ACT is different from EMDR, because ACT accords early affective socialization a position of primacy in determining how the self is structured and as a result how the organism responds to life's vicissitudes across the life span.

Theory of Personality

EMDR and ACT differ in the theory of personality upon which each one is based. EMDR defines personality in terms of experiences. Shapiro (2002) wrote that personality is “an accumulation of characteristic internal patterns and responses” that are believed to result from an interaction between genetic predisposition and experiences (p. 10). For EMDR, the accumulation of responses and patterns characterizing an adaptive personality is “considered to be engendered by adequately processed childhood experiences that have laid the groundwork for adaptive behaviors” (p. 10). The adequate processing of childhood experience lays the foundation for appropriate responding to current situations. Shapiro wrote further that dysfunctional processing of current distress is “engendered by inadequately processed [childhood] experiences that are activated by current conditions” (p. 10). Apparently for EMDR, the locus of adequate processing lies entirely within the organism and is manifested in the putative AIPS.

In contradistinction to EMDR, ACT stresses the central importance of structure—i.e., representations of self and others—in defining personality. The personality is more than the sum of its patterns and responses. According to ACT, experience in the developmental dyad during the early years determines how the brain structures itself, which in turn determines how the organism tolerates later experiences of adversity and trauma. ACT separates the experiences that determine personality into two categories, attachment, which refers to experiences from birth to three or four years of life, and childhood socioemotional history, which lasts through adolescence. Referring to early experience, Siegel (2002a) wrote:

[T]he early years of life—during establishment of the basic brain circuits that mediate such processes as emotional and behavioral regulation, interpersonal relatedness, language, and memory—are the most crucial for people to receive the kinds of experiences that enable proper development to occur. (p. 88)

Separating attachment from subsequent history stresses the centrality of the developmental dyad in determining the basic structure of the personality. Personality is socially constructed, first within the context of the developmental infant–maternal caregiver dyad, then within the context of an expanding array of other dyads. The personality system that emerges out of this socialization process is primarily an affect regulating entity. If there were deficiencies in the caregiver's affective contribution to the dyad, the child's personality structure and hence its capability to manage affect will be conditioned by those deficiencies. If there was adversity or trauma in the dyad and subsequent socioemotional history, the individual's personality structure will be determined by the affects experienced and the organism's efforts to regulate them.

The quality of the socially-organized personality structure, emerging from interactions in the developmental dyad, determines how successfully the organism will resolve the vicissitudes of the subsequent developmental periods. ACT emphasizes the social construction of the organism's mechanisms for participating in pleasant experiences and processing stressful experiences, and thus ACT differs from EMDR's focus on whether childhood events were adaptively processed or not. ACT stresses the representations of self and others that are formed early in life and that determine current functioning. Personality is crafted from the internal working models, which are also called representations of self and other, that are formed beginning in the first months of life. These representations are assembled with affects, memories, sensations, and thoughts. These complex constructs determine the self's current functioning in present circumstances.

These considerations have important therapeutic consequences. ACT begins therapy with AMST which is structured to remediate the deficits in affect regulation from the client's childhood that have determined the client's personality structure and consequently his or her current maladaptation and negative functioning. Reflecting its focus on internal representations, AMST seeks to uncover affect regulating ego states. Affect regulating ego states are parts of the self that may have formed to protect the self system by dissociating sensations or affects out of awareness, or that manifest hypervigilant perspectives that protect the system by preventing it from trusting itself or the social context. In Phase II of ACT, where the causal antecedent experiences of current problems are uncovered, ACT focuses on child ego states, symptom-expressing ego states, introjected parents that function as ego states, and false self identities that are another form of ego state. ACT also facilitates maturation of the authentic self, a nascent ego state that is brought up to currency on the client's developmental time line. ACT's focus on ego states, their affect-managing functions, and the affective transactions among them, as well as its focus on the experiences that engendered the ego states distinguishes it from EMDR which focuses solely on experience.

The Mechanism of Action of Bilateral Stimulation

ACT and EMDR propose different theories to explain the effect of bilateral stimulation. EMDR proposes that the side to side eye movements or other forms of alternating bilateral stimulation induce a dual-attention stimulation that Shapiro believes directly affects cognitive processes. Shapiro (2002) offered several possible mechanisms for the eye movement effects. Shifts in cognitive content and attribution correlated with eye movements could be due to interference with working memory, elicitation of an orienting response, creation of a relaxation response, activation of rapid eye movement responses like those seen in dreaming, distraction, evocation of a reparative physiological state, or cognitive loading. In discussing the dual-attention stimulation that she believes explains EMDR's effectiveness, Shapiro (2002) wrote "there is a good possibility that the primary common denominator is the attentional element" (p. 28).

ACT and AMST propose a mechanism based in affect. The eye movements or other form of alternating bilateral stimulation are hypothesized to elicit

surprise–startle affect, the effect of which is to “blank the mind” briefly. ACT proposes that the common denominator among forms of alternating bilateral stimulation is the affective element. Elicitation of surprise–startle is hypothesized to briefly interrupt ongoing energy flows along established neural pathways. From a biological perspective, surprise–startle functions to prepare the mind to deal with a suddenly appearing novel stimulus. In the context of AMST or ACT, tactile alternating bilateral stimulation (TABS) the usual mode of delivering alternating stimulation, is believed to interrupt established ways of thinking, feeling, sensing, and behaving, and thereby to allow new modes to emerge. Surprise–startle interrupts established connections between thoughts and allows new connections to form; it breaks up established connections between images and internal representations of self and other, and thereby allows new relationships to emerge. Very importantly, as AMST is being transmitted to the client, TABS facilitated surprise–startle breaks up old patterns of emotion responding and allows new, more adaptive patterns to organize.

THE CENTRALITY OF AFFECT AND EMOTION

Clinicians know that clients who come to the counseling office are often suffering because of difficulty in managing their emotions. Affect and its dysregulation cause most of the problems for people that bring them to therapy. No matter what the diagnosis, it is the problem of affect and the maladaptive defenses and self structures that have emerged to manage it that have impelled the client to seek professional help. The client may act out his or her emotions—a behavioral management script—with consequences for the client in the sphere of interpersonal relations. The client may regulate his emotions with a substance—alcohol, drugs, nicotine, food—with social, legal, medical, and career consequences. In other clients, a repressive emotion management self-structure may have emerged, and this client presents with depression. Still others may find their way to therapy because they are troubled by process addictions in areas of gambling, pornography, or sex. In these addictions the process of gambling or sex serves to facilitate emotion regulation. Finally, in some clients the maturation of the affect regulation process was derailed at such an early developmental stage that a disordered or severely fragmented personality emerged, as, for example, with clients suffering from borderline personality disorder, narcissistic personality disorder, or dissociative identity disorder. For each of these classes of clients, the skills taught in this book can provide immediate relief. Clients present with emotional distress, and by teaching them to manage the affects that are the building blocks of their emotions, the clinician can help them achieve improvements in mood, attitude, thinking, and functioning.

The Dialectic between Affect and Cognition

In part, the history of psychology over the past hundred years is the record of swings between thesis and antithesis in a grand dialectical disputation regarding the primacy of affect versus cognition. William James, Charles Darwin, and Sigmund

Freud (Damasio, 1999; LeDoux, 1996, for a summary) introduced the thesis that emotion is a central causal element in human behavior (Zajonc, 1984). Lazarus (1982) was the most cogent advocate for the antithesis to James, Darwin, and Freud, asserting that cognitive appraisal is the central construct in determining behavior. In the nature of the dialectic, thesis and antithesis are followed by synthesis. By 1984, Lazarus and Folkman were proposing that causality between emotion and cognition was “bidirectional” (1984, p. 274). Nearly a decade later, newly formulated theory (e.g., Izard, 1993) suggested both cognitive *and* noncognitive causation for emotion. That synthesis immediately became the polar opposite of yet another antithesis, one expounded by Freeman (2000) and Lewis (2000) among others, suggesting that cognitions and affects coemerge as affective–cognitive structures. Emotions—and the affects that are their building blocks—have cycled from being viewed as the cause of thought to being viewed as causing thought, to being viewed as coadjunctively arising together with thought.

Affects and emotions influence the substance of perceptions, the content of thought, and the type of actions undertaken. Affects motivate, and the affect a person is experiencing will determine what behaviors get motivated. How people appraise a situation and the decisions they make are swayed by affect and emotion. Even moral judgments—once believed to be the exclusive bastion of thought—turn out to be motivated in part by affect. Consciousness itself, humanity’s most prized quality, arises from affective experience. Children learn affect regulation almost from birth, and the effects of adaptive and less than adaptive affect and emotion socialization have observable effects in several domains as early as preschool age. AMST teaches affect and emotion regulation, and when affects and emotions are adaptively regulated, perceptions, thoughts, appraisals, motivation, judgments, and consciousness itself can change in the direction of positive functioning.

Emotion and Perception

Affective state alters how people perceive others. A client feeling shame will see and hear the clinician differently from a client feeling anger. Emotion influences perception (Izard, 1991), and the neural pathways through which it does so are now known. LeDoux (1996) discussed the projections from the affect-processing amygdala to the cortical sensory areas and cortical sensory processing areas. Reciprocal connections between sensory receiving and processing areas of the brain provide a means by which the amygdala can exert affective influence on cortical areas that are processing the stimuli that have activated the amygdala. Knowing about these anatomical connections helps explain results from an early experiment on emotion influence of perception (Izard, 1991). Subjects were either treated discourteously and made angry by an experimenter, or they were made happy by friendly treatment. The happy subjects perceived significantly more happy faces in pictures of emotion expression shown them, while the hostile subjects saw more anger expressions. Social psychologists have demonstrated that affective state alters how people are perceived (Forgas, 1995). It influences attitudes, impacts language use and intergroup behavior, and affects stereotyping, survey research, and self-perception. Forgas’s affect infusion model (1995) demonstrates how affectively

loaded information “exerts an influence on and becomes incorporated into the judgmental process . . . eventually coloring the judgmental outcome” (p. 39).

Emotion and Thought

An angry person’s thoughts will be different from those of a calm person. Normal human cognitive functioning is impacted by affect and emotion (Forgas, 1995; Lazarus, 1982). Lazarus (1982) believed that thought precedes affect, and he has defined affect in such a way that it is a cognitive function. He wrote: “Emotion results from an evaluative perception . . . between a person (or animal) and the environment” (p. 1023). In Lazarus’s view, there is never a situation in which an affect or emotion precedes a cognition. Zajonc (1984) mounted an exhaustive criticism of Lazarus’s position. Zajonc argued that the cognitive and affective systems are independent, that there are some situations in which affect is primary, and that for the most part the two systems operate interdependently. In the earliest stages of development, as we will discuss in more detail in Chapter 1, the affect system is sufficient for affective arousal, and as Zajonc notes in discussing the neonate, “no cognitive appraisal is necessary (or even possible)” (p. 119). Neuroanatomy supports a direct connection between perception and affect that is not subject to appraisal. All mammalian brains apparently have a direct link from the retina to the hypothalamus that provides for generation of an affective reaction on the basis of purely sensory input. Izard has synthesized these points of view into a proposal for four systems for affect and emotion activation, three of which provide for noncognitive information processing (Izard, 1993). In infancy affects are the primary motivators of behavior, and as cognition develops, the affective and cognitive systems become interdependent.

Emotion, Appraisal, and Judgment

How the adolescent client “sizes up” the therapy situation will be strongly affected by his or her affective state. Affect influences the cognitive process of appraisal (Forgas, 1995). Mood affects judgment about or appraisal of the self. Happy people make greater attributions to stable, internal causes for their successes, and sad people make fewer such attributions (Forgas, 1995). Punitive judgments about the self form a basis for depression in both adolescents and adults (Blumberg & Izard, 1985; Fridja, 1993). Blumberg and Izard (1985) showed that depressed children, like depressed adults, endorse sadness, and Forgas (1995) demonstrated that in normal adults, sadness influences the quality of judgments made by the self about the self. The interaction of cognition and affect clearly creates the preconditions for the downward spiral of depression.

Mood also conditions the judgments made by partners regarding a relationship conflict (Forgas, 1995). Sad partners attributed more globality, stability, and internality to causes of conflict than did happy partners. These attributions were far more pronounced when the conflict was serious than when it was simple.

Mood can influence decision making at several stages, because it appears the process of making a decision occurs in a hierarchically structured manner (Isen,

1993). Decision making is not a monolithic process. Isen suggests that command decisions or evaluations may precede actually addressing a problem, and these command decisions are subject to affect intrusion. Affect can enter into—intrude on—the command level decision and derail a decision even before the problem itself is considered. The importance of the task, its utility, control over the outcome, and hedonic consequences—all of which are influenced by affective considerations—may be evaluated before the task itself is addressed, or dismissed. Thus, a person in a depressed mood may fail to make a decision about going to a movie, for example, because his depressed affective state causes him to fail to consider the movie since “I won’t enjoy it anyway.”

Risk taking is a special form of appraisal and decision making. Positive-affect subjects endorsed greater willingness to take, risk on a purely hypothetical task, but when the proposition involved the possibility of real, meaningful loss, the positive-affect subjects were more risk-averse than the negative-affect subjects (Isen, 1993).

Emotion and Decision Making

What a client is feeling will determine what a client will decide. An angry spouse’s decision about the marriage will be different from a fearful or a joyful spouse’s decision. The influence of both positive and negative affect on decision making has been extensively investigated (Isen, 1993). Positive and negative affect have different influences on retrieval from memory. Positive affect can be experimentally induced by watching a few minutes of a comedy film or viewing cartoons. Experimentally induced positive affect has been demonstrated to improve retrieval of positively valenced material from memory. Negative affect is less effective or ineffective in cuing retrieval of negative material. Positive affect influences how material is organized in memory as well as the context for thought. In a positive affect state, subjects produce more associations to neutral material, they categorize more flexibly, they see more similarities between items, and they discriminate more differences between them as well. As a result of these effects, positive-state subjects perform better in an assessment of creativity. They also do better in a test of negotiation performance, and in a positive state, outcomes of negotiation are improved. The influence of positive affect is complex, depending upon variables of task importance, affective valence of subject material, and motive to maintain the positive state. Empirical research supports the commonplace advice to “wait until you calm down before you make a decision.”

Damasio (1994) argued that thought itself, the basis of appraisal, decision making, judgment, and motivation, is inextricably interwoven with and dependent upon brain functions that include body awareness and emotion. Damasio speaks of a “body-minded brain” (pp. 223–244 ff). He argued that “somatic markers” (p. 173), the unpleasant gut feelings that arise when a bad logical outcome appears in mind during cognitive processing, improve the efficiency of the reasoning process. He hypothesized that the body is the frame of reference for mind and that “our very organism rather than some absolute external reality is used as the ground reference for the construction we make of the world around us” (p. xvi). This explains why the spouse dominated by anger affect may not be

able to recognize that he is making a bad choice when he decides to leave the marriage. Alternatively, the spouse influenced by interest affect may be able to access the optimal level of shame affect that apparently helps people recognize when they are making a bad decision.

Emotion and Motivation

Affective state influences motivation, and different affects motivate different behavioral outcomes. The client experiencing excitement affect will be motivated to make different responses toward a behavioral modification plan than the client experiencing fear. Like decision making, motivation has been shown to be influenced by emotion in a complex fashion (Isen, 1993). Positive affect appears to motivate by promoting variety seeking, but only in situations that do not engender thoughts of negative outcomes. Positive affects—interest—excitement and enjoyment—joy—also appear to stimulate “intrinsic motivation,” that is, interest in the task for its own qualities as opposed to “extrinsic motivation,” a monetary reward. Positive affect subjects endorsed more “liking” for a task than did the controls, which also indicates intrinsic motivation. Fear, on the other hand, motivates escape, and anticipation of fear impels avoidance (Izard, 1993). Therefore, the therapist can improve clients’ outcomes on their treatment plans by developing a state where excitement rather than fear is salient.

Emotion and Moral Judgment

The more personally involved one is in a judgment, the stronger is the influence of affect. Being personally involved in any judgment, even a moral judgment, equates with having feelings about the judgment, and the decisions people make about moral issues will be influenced by their emotions. Lawmakers, judges, police and military officers, citizens, therapists, and students are regularly required to make moral judgments. Is it right to cheat on a test? Should I report this person to child protective services? A vote or an opinion on abortion, the death penalty, war, or civil rights implies a moral judgment, and all such judgments have an affective component. A fascinating functional magnetic resonance imaging (fMRI) study has indicated that emotion is involved in formulating moral judgments, an area that rationalists have believed to be purely cognitive (Greene, Sommerville, Nystrom, Darley, & Cohen, 2001). Subjects in the study were administered a 60-item moral dilemma assessment. Items in the assessment were assigned to one of three conditions: moral-personal, moral-impersonal, and non-moral. A moral-personal dilemma is one requiring close contact; for example, *pushing* one person to his death in front of a train in order to save the lives of five persons. This is contrasted with a moral-impersonal dilemma in which *throwing a switch* will cause the train to kill one person thereby saving the lives of five people. Philosophers studying these dilemmas were puzzled by studies showing that subjects would choose to throw a switch, but not push a person, to sacrifice one life in order to save five. The authors captured fMRI data while subjects completed the assessment. The results showed that when making moral-personal judgments,

three areas of subjects' brains known to be associated with emotion processing were activated. These areas—medial frontal gyrus, posterior cingulate gyrus, and angular gyrus, bilateral—were not activated, or were significantly less activated, during the moral-impersonal and nonmoral conditions. In addition, areas associated with working memory, which were activated in the moral-impersonal and nonmoral conditions, were less active during the moral-personal condition. Subjects who concluded that it was “appropriate” to push one person to his death to save five took much longer to reach the decision than to resolve a moral-impersonal dilemma. The authors conclude, “the increased emotional responses generated by the moral-personal dilemmas have an influence on and are not merely incidental to moral judgment” (p. 2107).

Emotion and Consciousness

Damasio (1999) has argued forcefully that consciousness itself is a function of affect and emotion and the sensations generated in the body by affects. Using his observations of individuals with brain lesions, Damasio showed that consciousness, wakefulness, and low-level attention can be separated, but consciousness and emotion cannot be separated. He argued for a core consciousness that is a simple biological phenomenon, that is not exclusively human, and that does not depend upon working memory, conventional memory, reasoning, or language. Extended consciousness is built on this core consciousness and does require both conventional and working memory. This extended consciousness is a complex biological and cultural phenomenon with several levels of organization. It evolves across lifetimes and is language-dependent.

For Damasio, consciousness emerges when the organism becomes aware that its own state has been changed by an encounter with an object in the environment. Objects in the environment are represented by neural patterns in sensory cortices. By a similar process, the organism knows itself as an object represented inside its own brain. Feelings, the somatic sensations accompanying affects and emotions, inform the organism that its state has changed as a result of environmental encounters. Because the human organism holds a representation of itself in mind as an object, the organism is aware of changes in itself as signaled by the feelings accompanying affects and emotions. Self-awareness *is* this process. As Damasio (1999) wrote: “The apparent self emerges as the feeling of a feeling” (p. 31). As we will demonstrate in this book's second section, AMST incorporates Damasio's theoretical framework. AMST develops the client's awareness of sensations and emotions and thereby facilitates the building of self-structure and the elaboration of consciousness.

Emotion Regulation in Childhood

The effects on the child of the caregiver's style of affective socialization can be observed as early as preschool age. The term *affective socialization* refers to the processes taking place between the child and its caretakers and others through which the child comes to feel as it does. An expanding body of empirical research has demonstrated that emotion and its regulation are already playing a crucial

role in the lives of preschool children. Chapter 2 will discuss the development of emotions from birth onward in greater detail. Our central thesis is that a preschooler's problems with affect regulation and with transitioning from family to peer society have their origins in infancy and early childhood. Furthermore, the problems that bring the client to the counseling office today may also be traced to that client's infancy and childhood. The review of the literature in Chapter 2 will support our conclusions that the adverse consequences of impaired affective socialization in the family of origin are observable in preschool social, academic, and psychological functioning and that these consequences may contribute to psychopathology in childhood, adolescence, and adulthood.

A DEVELOPMENTAL HYPOTHESIS

This book proposes that the individuals we see as clients in adulthood are people whose childhoods were characterized in part by failures of emotion learning and socialization. These individuals emerged from the family of infancy and early childhood with impairments in their ability to manage emotions. Emotion management entails emotion recognition (also known as *emotion knowledge*), emotion tolerance, and emotion regulation. Impairments of emotion knowledge, which can already be observed in preschool children, cluster into three categories (Izard, Fine, et al., 2001; Schultz, Izard, Ackerman, & Youngstrom, 2001). The first category is emotion recognition knowledge, the ability to accurately recognize emotions from their displays on another's face. Emotion recognition knowledge is assessed by presenting standardized pictures of facial displays of emotions and asking children to name them. Emotion recognition knowledge implies that the child can recognize emotions in himself as a precondition for recognizing them in another. The second category is emotion situation knowledge, the capacity to correctly name the emotion appropriate to a situation. The child subject is read a brief vignette—for example, a child is given a present—and asked to name the emotion the person would feel. The third aspect of emotion knowledge is emotion role taking: This means that the child can properly identify how a person in a vignette is actually feeling based on their facial and other expressions when that expression is discordant with what the culturally conditioned normative emotion might be in that situation. Children who grow up to become adults with psychopathologies are often people who have difficulties managing their emotions. These difficulties in adulthood arise in part because of problems with emotion socialization in childhood. Problems with emotion socialization can be identified by deficits in preschoolers' emotion recognition knowledge, emotion situation knowledge, and emotion role taking.

Healthy, adaptive emotion education and socialization should be the birthright of all children. Our clients, to a greater or lesser degree, did not receive the “good enough” emotion education and socialization that is every child's due. Things that should happen for every child did not happen for this child. Impairments of emotion learning and socialization contribute to our clients' affect dysregulation.

As a result of impairments in emotion management originating in the family of origin, these individuals experienced more difficulty in preschool peer relationships

and developed less prosocial behaviors and more maladaptive psychological problems. One can begin to recognize the process by which the elements of a distressed personality emerge. I use the word *distressed* to refer to the personality characterized in part by impaired emotion management, because the word connotes being under great stress as well as being in a state of danger. The distressed person is in need of relief from the stress and suffering caused in part by his or her impairments of emotion regulation. Furthermore, affect dysregulation endangers the distressed person in social situations, at work, in relationships, and in relations with the law, because the distressed individual is at risk for the consequences of acting out, inappropriate emotion expression, conflict, and vicarious emotional expression through the abuse of legal or illicit substances.

Emergence of the Distressed Self Structure

An infant's experiences with her caregiver determine the primordial structure of her emerging self. That primordial structure then specifies the nature of her interactions with the environment in the next developmental stage, and in turn that interaction of previous conditioning with current experience directs the further structuring of her personality. The process by which experience and prior conditioning interact to produce further structure in the personality is called *self-organization*. This iterative process occurring over developmental stages results in successively more ordered, more determined personality structure. Principles of self-organization (Izard et al., 2000; Lewis, 2000) describe how early experience guides and directs the spontaneous emergence of more ordered, more determined personality structure. Affective socialization is one of the most potent, early forces acting to determine the structure of the emerging self or personality. Affective socialization in infancy and childhood is critical because it molds the most fundamental qualities of the personality and determines the nature of the developmental pathway upon which the child embarks. When early affective socialization is adequate, the emerging personality is more likely to become adaptive and positively functioning. When early affective socialization is impaired, the emerging self is more likely to develop maladaptively and to function in a less positive way.

The person who appears for therapy today is more likely to be a person who exited the family of infancy and early childhood with impaired emotion management skills. In the preschool social environment, those impairments of emotion management conditioned negative assessments by peers and teachers, entailed less competent academic performance, and predicted internalizing and externalizing behaviors. The accumulating difficulties in peer relationships, with teachers, with academic performance, and with aggressiveness or withdrawal, further determined a self that became increasingly organized around a core of affective-cognitive structures of failure or inadequacy. Affect dysregulation progressed from difficulty with recognizing and managing the core affects of anger, fear, joy, or sadness to difficulty recognizing and managing the more complex constructs of shame affect and disgust affect or the emotions of contempt and loneliness (Lonigan, Carey, & Finch, 1994).

An overarching principle of self-organization theory is that from birth onward at least through adolescence the self is in the process of continuously

self-organizing. This self interacts with a social environment that responds positively or negatively to it (Denham, Zoller, & Couchoud, 1994; Schultz et al., 2001; Youngstrom, Izard, & Ackerman, 1999). A dynamic reciprocity exists. The consequences of positive or negative outcomes in each emotion-laden situation determine the structure across time and experience of the self that is organizing.

This book proposes that three factors combine to influence the emergence of personality. When all three are on balance positive, a positively functioning, well-adapted self emerges. When the balance tilts negatively, then a distressed personality is more likely to form. The first factor is genetics, which will be discussed in Chapter 1 when we learn how inheritance sets the thresholds for affects. The second factor is attachment, and refers to the quality of the relationship between infant and caregiver during the first three to four years of life. When there are failures of affect and emotion socialization in the family of origin during this early period, a developmental pathway is enjoined that can lead to emergence of an increasingly distressed self. Failures of affect and emotion socialization during attachment are termed *deficit experience*, and the effects of deficit experience will be discussed in depth in Chapter 2. The third factor is childhood socioemotional history and refers to the quality of life's vicissitudes in the period from 3 or 4 years through adolescence. When the quality is relatively benign, the developmental outcomes are positive. When there is adverse or traumatic experience during this period, negative outcomes are more probable. I will briefly discuss adverse and traumatic childhood experience in this Introduction and offer a lengthier presentation in Chapter 3.

Adversity: Compounding the Problem

Adverse childhood experience is a large collective grouping that subsumes the full range of stressful childhood events (Anda et al., 1999). Childhood physical and sexual abuse have traditionally been conceptualized as trauma (e.g., Briere & Runtz, 1993; Herman, 1992). In addition to these traumatic events, adverse childhood experiences include experiences of verbal abuse, a battered mother, parental separation or divorce, mental illness in the household, household substance abuse, and incarcerated household members. Adverse and traumatic childhood experiences are things that should never happen to any child and did happen to this child. These lists of acts or actions have traditionally defined traumatic experience, but in recent years theorists have begun to redefine trauma in terms of its effect on the victim. Shapiro (1995) has been a leader in this movement.

When a child is subjected to certain events—being verbally abused, witnessing spousal abuse, being sexually abused, being physically abused—the result is that the nervous system is imbalanced (Shapiro, 1995). Trauma is now defined as experience that imbalances or overwhelms the nervous system. Apparently adverse childhood experiences of all kinds induce imbalance. Shapiro wrote: “the information acquired at the time of the [traumatic] event, including images, sounds, affect, and physical sensations, is maintained neurologically in its disturbing state” (p. 30). When information acquired at the time of trauma is maintained in an excitatory state, it is referred to as “trauma coded” (Schwartz, Galperin, & Masters, 1995a).

In particular, the emotions experienced at the time of the traumatic event become trauma coded. Trauma coded emotions along with trauma coded sensations and thoughts are held in a state-specific, excitatory form in which they are more likely to be elicited subsequently in any situation sharing any valence with the original situation. Trauma coded emotions are unresolved. They may be elicited by internal or external stimuli. Trauma coded emotions are distressing because they recur and because they adversely affect current behavior. They may be assembled with images in the form of nightmares or flashbacks, or they may be elicited in current situations where they appear in an extreme form that is inappropriate to the present situation.

Adverse and traumatic childhood experiences contribute to the emergence of a distressed personality. Emergence of a distressed personality is one of the sequelae of adverse and traumatic childhood experience. A healthy attachment and “good enough” affect and emotion socialization can ameliorate the effects of adverse and traumatic childhood experience. Deficit experience, where present, can worsen the effects of adversity and trauma for the emerging self. The distressed personality of adolescence and adulthood can result from adverse or traumatic childhood experience, from deficit experience, or from a combination of the two.

A VOYAGE OF BOTH THEORY AND PRACTICE

In the course of this book, we will discover how the collectivity of the emotions and their properties and vicissitudes contribute along with other factors to formation of the personality or self, whether adaptive or distressed. The principal objective of this book is practical: the transmission of clinical skills that are immediately applicable. The goal is to transmit AMST skills with sufficient clarity and detail that clinicians can apply the protocol in their psychotherapeutic practice. Theory and research are presented to substantiate the skills and to broaden the reader’s knowledge of affects, emotions, and their vicissitudes.

The book’s journey is divided into two major sections. The first, comprising Chapters 1 through 4, provides the foundation for the very practical skills taught in the second section, Chapters 5 through 11. The final chapter offers the beginnings of an ACT, demonstrating how principles and techniques transmitted in earlier chapters can be integrated into the second phase of therapy. Chapter 1 describes the emotion system, and Chapter 2 lays out the development of emotion regulation from birth through adolescence. Chapter 3 teaches the causes of emotion dysregulation, and Chapter 4 demonstrates how emotion dysregulation presents in psychopathology. The argument constructed through out Part I is that acquisition of affect and emotion regulation skills is the first key to mental health, and failures of their regulation are central to many of the problems that distress people and bring them to our offices. A corollary of this argument is that acquisition of affect and emotion regulation skills will facilitate the deeper work of trauma resolution. Clinicians will come to understand how a client’s working through, deconstruction of defenses, and personality reorganization are all facilitated by first teaching the client the skills to regulate his or her affects.

Part II of the book teaches practical, effective, efficient techniques for affect regulation. Teaching these skills is the principal objective of this book. The clinician will immediately be able to use the techniques and methods presented herein. These skills can form the basis of a brief therapy whose goal can be the immediate improvement of the client's emotion regulation status. The skills presented in Part II can usually be taught to the client in six one hour sessions. The skills may also form the basis of a longer term therapy designed to restructure the client's self system. AMST and ACT assert that learning emotion management remediates deficits in the client's early childhood experience and that acquisition of affect regulation skills is a necessary prerequisite for reorganization of the self toward a more adaptive, more positively functioning state.

