RELATIONAL AFFECT REGULATION (R.A.R.) PROTOCOL

- EMDR preparation phase protocol that installs the therapeutic relationship as a resource to help complex trauma survivor clients regulate and tolerate affect, both during and in-between sessions.

- EMDR resource based on attachment theory, that incorporates concepts from Stress Inoculation Training (SIT) and Accelerated Experiential Dynamic Psychotherapy (AEDP).

INITIAL DILEMMA

- Many experiences of finally earning the hard-won trust of complex trauma survivor clients only to have them revert back to their distrust by the very next session

- Goal: develop ways to enhance, reinforce, and help client retain the experience of feeling safe in the therapeutic relationship.
SECOND DILEMMA

- After basic trust is established, many complex trauma survivor clients were more able to tolerate previously intolerable affect during sessions, but whenever new material was activated in-between sessions, they would feel helpless to handle it without the therapist.

- Goal: To help client develop resources that replaced the need for frequent contacts in-between sessions.

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TODAY’S AGENDA

Complex trauma
- Introduction
- Complex Trauma
- Attachment theory

Stabilization Strategies
- Building Safety & Dyadic Regulation
- Resource development
- Stress inoculation

R.A.R. Protocol
- Protocol procedural steps
- Case example
- Intrapersonal protocol variation
- Experiential exercise

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CONSENSUS MODEL FOR TREATMENT OF COMPLEX TRAUMA

Phase 1: Safety and stabilization

Phase 2: Memory processing and reconsolidation

Phase 3: Re-integration
- self and relational growth
- resolving developmental deficits
- enhanced regulatory and reflective functioning


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EMDR Therapy for Complex Trauma

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Our Focus: Stabilization & Preparation Phase Tasks
Goal: Safety and stabilization

- Development of treatment alliance
- Establishing safety
- Increasing capacity for affect tolerance and emotional regulation
- Enhancing coping resources
- Expanded EMDR preparation phase needed to accomplish all of these tasks


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Complex Trauma: Definition
The result of exposure to chronic or recurrent interpersonal trauma, often without means of escape, due to one or more of the following constraints:
- physical
- psychological
- developmental/maturational
- family/environmental
- social

Herman (1992); van der Kolk, et al. (2005); Cloitre, et al. (2012)

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Complex Trauma: Complex Symptoms

1. History of prolonged, recurrent trauma, typically involving betrayal of trust
2. Emotional dysregulation
3. Alterations in consciousness and attention— including intrusive memories, numbing, amnesia
4. Impairment in sense of self
5. Impaired relationships and perception of others
6. Somatic complaints
7. Loss of sustaining beliefs, sense of meaning

Herman (1992); van der Kolk, et al. (2005); Cloitre, et al. (2012)

Complex Trauma: Response to Recurrent Threat

- preoccupation with survival and defense
- avoiding (or combating) danger is primary
- constant state of fear, often not explicitly acknowledged
- hypervigilant state of alert
- fight-flight-freeze response activation
- reflexive emotional and behavioral reactions, activated by trauma cues
- avoidance of intolerable affect, causing disengagement/disconnection/dissociation
- collapse, "feigned death," conservation of energy in response to immediate life threat
- interferes with healthy autonomic nervous system function, activities of daily living, social engagement, and higher order thinking needed for adaptive learning.

Porges (2009)

Complex Trauma: Dissociation

"separation of an idea or thought process from the main stream of consciousness"

—Braun (1988)
Relational Affect Regulation for Complex Trauma Survivors

**COMPLEX TRAUMA: THE BASK MODEL OF DISSOCIATION**

- **Behavior**
  - threat-based actions
  - action urges
- **Affect**
  - narrow window of tolerance (Siegel, 2001, 2012)
  - emotional dysregulation
- **Sensation**
  - body memories
  - somatization
- **Knowledge**
  - state-dependent, implicit memories
  - somatization

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**COMPLEX TRAUMA: STRUCTURAL DISSOCIATION**

Complex traumatic stress disorders prevent integration of discrete behavioral states, which are organized into two categories of dissociative parts (i.e., ego states):

- One or more ego state(s) that avoid internal and external trauma cues and only engage in action systems for adaptation to daily living (caretaking, exploration, play, socialization, sexuality, etc.)
- Two or more ego states fixated in trauma and solely engaged in action systems of physical defense (fight, flight, freeze, and collapse) and attachment cry.

Steele, van der Hart, & Nijenhuis (2005); van der Hart, Nijenhuis, & Steele, 2006

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**DISSOCIATION IN AIP TERMS**

“The active prevention of adaptive information processing and the creation of state dependent memory networks that are compartmentalized from part(s) of consciousness, via amnestic barriers, in response to threat.” (Goldberg, 2009)

Memories are stored in compartmentalized, isolated neural networks due to high arousal at the time of trauma. Ego states are configurations of these dissociated memory networks. (Forgash, 2014)

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**RELATIONAL AFFECT REGULATION for Complex Trauma Survivors**

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**COMPLEX TRAUMA: IMPACT ON RELATIONSHIPS**

- Impaired trust—implicit internal working model of relationships involves lack of safety, security (Bowlby, 1988; Bretherton & Munholland, 2008)

- Phobia of attachment/attachment loss (van der Hart, Nijenhuis, & Steele, 2006)
  - Isolation/avoidance/detachment (flight)
  - Desperate attempts to get others to meet needs—external locus of control, fear of abandonment (fight)
  - Counterphobic involvement in dysfunctional relationships (freeze)

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**ADULT ATTACHMENT STYLES: SECURE**

Secure/Autonomous

- coherent narrative; collaborative discourse
- possess range of internal working models of different types of attachment relationships
- values rewarding emotional connections
- able to accurately perceive and evaluate both positive and negative aspects of relationships, as well as their impact
- flexible planning and behavioral reactions

Bowlby (1988); Wallin (2007); Siegel (2012)

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**ADULT ATTACHMENT STYLES: INSECURE**

Dismissing

- incoherent narrative
- neglectful, rejecting, or disconnected childhood relationships
- denial and normalization of childhood experiences
- minimizes value of attachment relationships

Preoccupied

- incoherent narrative
- inconsistent early relationships
- preoccupation with nature of past attachment relationships intrudes on present life
- hostility, passivity or fearfulness about current relationships

Wallin (2007); Siegel (2012)

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**ADULT ATTACHMENT STYLES: INSECURE–DISORGANIZED**

Unresolved/Disorganized

- Incoherent narrative: lapses in rational thought process during discussion of loss or abuse.
- Lapses are dissociative in nature, e.g. “spacing out,” talking in the present tense about past traumatic events (Barach, 1991, 2010).
- Prolonged silences, attempts to block out thoughts about past trauma or inability to put experience into words.
- Occurs in conjunction with both dismissive and preoccupied attachment styles.

Wallin (2007)

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**AFFECT REGULATION CAPACITY BASED ON ATTACHMENT STATUS**

- **Interactive affect regulation** – occurs between the securely attached infant and the primary caregiver and then develops into the ability to flexibly regulate emotional states with other humans in interconnected contexts.
- **Auto regulation of affect** – securely attached adults have the adaptive capacity to regulate their own emotional states in autonomous contexts.
- **Affective dysregulation** – lack of ability to regulate one’s own emotional states that is a result of insecure attachment.

Schore (2009)

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**EMDR APPROACH TO INTERACTIVE AFFECT REGULATION**

The relational approach to EMDR (Dworkin, 2005, 2009, Dworkin & Errebo, 2010) emphasizes the importance of the intersubjective and making relational repairs of ruptures in attunement to therapeutic relatedness and mental state resonance (Norcross, 2011; Siegel, 2001).

Through reattunement, intersubjective repair is achieved and client and clinician are brought back into a shared state of resonance and interactive affect regulation.

Dworkin, 2005, 2009; Dworkin & Errebo, 2010; Goldberg & Dworkin (2013)

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AEDP APPROACH TO INTERACTIVE AFFECT REGULATION

- Psychotherapy method developed by Diana Fosha that includes relational, experiential and integrative techniques, based on attachment theory, emotion theory, affective neuroscience and transformational studies.
- AEDP theory states that "trauma survivors possess core bioaffective resources that can be activated therapeutically -- in the right, safe facilitating environment..."
- The development of a co-created safe therapeutic relationship is essential to achieve dyadic regulation of affect and for providing a safe container for experiencing deep, painful emotions previously avoided due to dissociation of unbearable affect.


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RELATIONAL FOCUS

Therapist emotional engagement – active and explicit empathic, caring, and affirming stance (Fosha, 2000, 2012)
Therapist emotional transparency – genuine reactions to patients are shared and countertransference errors are explicitly acknowledged (Prenn, 2011, 2013)
Tracking patients' receptive affective experiences on a moment-to-moment basis
- the patient's subjective, body-based sense of the therapist
- explicitly mindful of moments of attunement, disruption, and repair


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GOALS OF RELATIONAL FOCUS

- to undo unbearable aloneness
- to help patients know and feel that they exist in the heart and mind of the therapist
- overcome fear and impaired trust from relational trauma and neglect
- build patient hope for a therapeutic connection that feels safe, comforting and healing
- establish a “secure base” (Bowlby, 1988)
- fosters interactive affect regulation


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**RELATIONAL AFFECT REGULATION**

Focus on relatedness from day one:

- overcomes defenses that foster social isolation and facilitates initial trust
- facilitates interactive affect regulation within an attachment-based therapeutic relationship
- results in a shift from defense mode to a more reflective state in which the client has more tolerance for affective experience and is more prepared for processing trauma.


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**AEDP TRIANGLE OF EXPERIENCE**

![AEDP Triangle Diagram](image)

Defenses Red Signal Affects Green Signal Affects

Pathogenic Affect Unbearable States of Aloneness Maladaptive Core Affective Experience

Categorical Emotions Core Relational Experience Adaptive Core Affective Experience

Fosha (2000, 2013); Prenn (2013)

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**EMDR ADAPTIVE INFORMATION PROCESSING**

- Francine Shapiro theorized that we have an adaptive information processing (AIP) system built into our nervous system to help us digest our experiences, determining what is useful and necessary and discarding the thoughts, feelings, sensations and physiological arousal that are no longer needed.
- When our AIP system is functioning optimally, experiences can be put in perspective.


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Optimal AIP Function

- Behavior
- Affect
  - Achieving adaptive resolution involves the integration of all aspects of experience—including all BASK elements
- Sensation
- Knowledge

AIP Theory

- According to AIP theory, much of emotional and behavioral disturbance is due to traumatic experiences and distressing life events that are so overwhelming that the ability to process and gain perspective is blocked.


State-Dependent Memory Networks

- "a particularly distressing incident may become stored in state specific form, meaning frozen in time in its own neural network, unable to connect with other memory networks that hold adaptive information."

  --Francine Shapiro (2001)
AIP AND DISSOCIATION

Dissociation inhibits AIP because the state of negative arousal is far greater than the brain’s capacity to productively make new associations, forge new linkages, and learn from experience.

State-dependent encoding of memory is functional as a survival mechanism at the time of trauma. Its only later that what was functional is outdated once the threat is over. Avoidance prevents new learning, so dissociation continues along one or more dimensions of experience. Processing and gaining perspective needed for optimal functioning remains stalled.

AIP & COMPLEX TRAUMA

Hyper-arousal

Avoidance

Flashbacks/Flooding (Intrusion Symptoms)

Numbing/Detachment (Dissociation)

Stuck Processing/Looping

EXTENDED EMDR PREPARATION PHASE

Needed to reduce intrusion and avoidance symptoms and address all four aspects of stabilization phase of complex trauma treatment:

- Development of treatment alliance
- Establishing Safety
- Development of capacity for affect regulation
- Skill building

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EMDR RESOURCE DEVELOPMENT AND INSTALLATION (RDI)

Purpose:

- strengthen self capacities before trauma work
- need accessible resources, as well as affective and behavioral stability, before proceeding to history taking, identification of targets and active reprocessing phases of EMDR treatment for clients with complex trauma histories

Leeds (2001)

RDI STRATEGIES

- Identify positive memories that can strengthen self capacities (if adaptive memories exist).
- Implement strategic interventions designed to increase positive resources, utilizing imagery, stories, metaphors, humor, play, structured skill building, etc.
- As mastery and attachment experiences accrue, install them with BLS to increase their accessibility.
- Maintain focus on positive memories: utilize short sets of BLS to prevent stimulating dysfunctional memory networks.

Leeds (2001)

RDI PROTOCOL

1. Resource
2. Image
3. Emotions and Sensations
4. Enhancement
5. Bilateral stimulation (BLS)
6. Cue word – with BLS

Shapiro (2012a)
THE THERAPIST AS RDI RESOURCE

Purpose: to enhance the experience of feeling connected to the therapist and install it as a resource able to be used between sessions.

- The relational approach to EMDR emphasizes the importance of the intersubjective and repairing of ruptures to therapeutic relatedness.
- The therapist is installed as an RDI resource each time there is an intersubjective repair of a rupture.

Dworkin (2005, 2009); Dworkin and Errebo (2010); Goldberg (2010)

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METAPROCESSING TO ENHANCE POSITIVE EXPERIENCE

Metaprocessing—experiential and reflective techniques for working with in-the-moment positive experiences, therapeutic change and the positive affects that accompany the change. (Fosha, 2013, p.9 in handout)

Positive change is not an end, but a starting point for a round of mindful exploration of the experience:
- to make implicit reactions explicit
- to make explicit reactions experiential and relational
- to facilitate further transformation

Fosha (2013)

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RELATIONAL METAPROCESSING

- “Nonspecific” relationship factors are made specific, through metaprocessing of healing relational moments.
- Facilitates explicit awareness of the differences between the therapeutic relationship and the client’s implicit expectations, stemming from trauma–based working models of relationships.
- Neurons that no longer fire together no longer wire together (Siegel, 2001, 2007, 2012)

Goldberg & Dworkin (2013)

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The first goal in developing the R.A.R. Protocol was to generate some interest and excitement to orient clients to my actual intent instead of their fear-based assumptions about my intent. In order to accomplish this, I wanted to SNAG their attention. SNAG=Stimulate Neuronal Activity and Growth (Siegel, 2007).

Neurogenesis — the creation of new neurons — and neuroplasticity — neural growth and restructuring of neural networks — can be facilitated throughout the lifespan through mindfulness and novel experience (Siegel, 2007).

Doing something novel and unexpected can generate interest and help orient attention, put a client in a more mindful listening state to facilitate new learning.

Therefore, presenting information in new, unexpected ways can facilitate the development of new memory networks.

Stress Inoculation Training (SIT) Scripts

A vehicle to SNAG the complex trauma survivor’s attention and bypass expectations that are based on old mental models of relationships.

Stress Inoculation Training (SIT)

Treatment to help individuals cope with stressful events and "inoculate" themselves to future stressors.

Flexible individually-tailored multifaceted form of cognitive–behavioral therapy.

Goal is to enhance individuals' coping skills and to empower them to use already existing and new coping skills.

Meichenbaum (1985)
THREE PHASES OF SIT

1. Conceptualization Phase
2. Skills Acquisition and Rehearsal Phase
3. Application and Follow-Through Phase

Our focus: Skills acquisition and rehearsal

Meichenbaum (1985)

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FOUR PARTS OF SIT SCRIPT

1. Preparing for the stressor
2. Confronting and handling stressor
3. Coping with feelings of being overwhelmed
4. Evaluation of Coping Efforts and Self-Rewards

Meichenbaum (1985)

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SIT SCRIPT – PART 1

Preparing for Stressor:
- to combat negative thinking
- emphasize planning
- focus on specific ways of preparing for task

Meichenbaum (1985)

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Confronting and Handling Stressor:
- to manage stress reaction
- reassure self of ability to handle it
- remind self to use coping resources
- reinterpret stress as an opportunity to face and overcome difficult challenges

Meichenbaum (1985)

Coping with Feelings of Being Overwhelmed:
- to set up contingency plans in case of becoming extremely distressed and feeling overwhelmed and out of control
- to encourage self to accept and tolerate the emotions, instead of acting impulsively, and wait for emotions to decrease

Meichenbaum (1985)

Evaluation of Coping Efforts and Self-Rewards:
- to praise efforts
- recognize progress in coping
- remind self that all change takes time and each and every small gain is an accomplishment
- to encourage self to keep trying

Meichenbaum (1985)
**RELATIONAL AFFECT REGULATION PROTOCOL**

Step 1: client to develop SIT script of messages 
what the client needs to hear to facilitate affect 
regulation

Step 2: incorporate helpful resources

Step 3: therapist to read script to client, while 
recording it.

Step 4: metaprocessing of client experience of 
therapist relaying message, utilizing AEDP 
relational strategies

Step 5: installing therapist as resource utilizing 
EMDR RDI protocol

Goldberg (2010)

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**R.A.R. PROTOCOL- 1**

Step 1: client to develop SIT script of messages – 
what the client needs to hear to facilitate affect regulation, 
such as:

- You have skills and resources you didn’t have when you were little
- You are not alone; you can ask for help
- You can handle the stress
- You can practice your coping skills
- You can radically accept* and tolerate your emotions
- You can recognize that you are making progress
- You can praise yourself for your efforts to cope
- You can keep doing what you need to do to cope

Goldberg (2010)


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**R.A.R. PROTOCOL- 2**

Step 2: incorporate helpful resources, such as:

- Calm, peaceful place (Shapiro, 2012a, 2012c)
- Container (based on Kluft, 2001)
- Safe State (O’Shea & Paulsen, 2007; O’Shea, 2009)
- Heart Jar (Gomez, 2013)

Add meaningful prayer, poem, meditation, etc. 
such as:

- Serenity prayer (Reinhold Niebuhr)
- Footprints in the sand poem
- Lovingkindness meditation

Goldberg (2010)

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**R.A.R. Protocol – 3**

Step 3: therapist to read script to client

- tape it for client to have as transitional object
- client can use it in between sessions
- decreased need for contact with therapist between sessions

Goldberg (2010)

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**R.A.R. Protocol – 4**

Step 4: metaprocessing of client experience of therapist relaying message, utilizing AEDP relational strategies

Ask client for observations of moment-to-moment interactions during this experience with the therapist

- body-based sensations
- affective experience related to being helped in this way – feeling understood and cared about? special? lovable?

Goldberg (2010)

---

**R.A.R. Protocol – 5**

Step 5: installing therapist as resource utilizing EMDR RDI protocol

- Client focuses on image, emotions and sensations that best represent the feeling of connectedness with therapist
- Enhanced with bilateral stimulation (BLS)
- Client identifies cue word or phrase for resource
- Installed with BLS

Goldberg (2010)
Relational Affect Regulation for Complex Trauma Survivors

R.A.R. Protocol Used with Diverse Client Populations

Successfully used R.A.R. Protocol with:

- African American, single, Christian female in mid-40s with Complex PTSD and borderline features, from low-income, disenfranchised community
- Irish American, born-again Christian female with C-PTSD and dissociative disorder—50 y. o. divorced grandmother from working class neighborhood
- Jewish American female with C-PTSD and bi-polar—divorced mother in her early 30s from upper middle class community
- German/English/Irish American single female in mid-50s with C-PTSD and dissociative disorder, from middle class neighborhood (raised Catholic, has Native American & Buddhist leanings)

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Case Example

- therapeutic alliance was strengthened
- trust and sense of safety was solidified
- therapist became more solid resource for dyadic regulation of affect
- a more secure base was established
- affect tolerance was increased
- recording was successfully utilized in between sessions as a transitional object
- eliminated the client’s need to call in between sessions to feel connected

Goldberg (2010)

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INTRA-PERSONAL

RELATIONAL AFFECT REGULATION PROTOCOL

- Variation of R.A.R. protocol designed to enhance safety and security between ego states.
- Compassionate, caring communication between ego states is installed as a resource to help complex trauma survivor clients regulate and tolerate affect.

INTRA-RELATIONAL AEDP

Integrative approach to trauma treatment that combines the attachment-based, affect-centered, experiential approach of AEDP with:

- Internalized object relations (Fairbairn, 1952)
- Ego state therapy methodology (Watkins & Watkins, 1997)
- Internal Family Systems (IFS) approaches to fostering compassion and connection between different parts of the self (Schwartz, 2001)

Lamagna & Gleiser (2007); Lamagna (2011)

INTRA-RELATIONAL AEDP TREATMENT

Intra-relational AEDP addresses the patient’s subjective experience of internal fragmentation and conflict and alters’ engrained patterns of intra-psychic conflict and self-punishment by employing AEDP relational strategies to:

- Mobilize internal resources
- Enhance self-compassion
- Build ego strength and affect tolerance
- Enhance self-mentalizing capacity (Fonagy, et al, 2002)
- Resolve internal enactments

Lamagna & Gleiser (2007); Lamagna (2011)
**INTRA-RELATIONAL AEDP**

**TREATMENT OBJECTIVES**

- facilitate authentic, open internal dialogue between self-states previously dissociated from each other
- develop the capacity for reciprocal attunement, resonance and responsiveness
- experientially track the resulting states of shared resonance and recognition
- foster healing affects associated with deep levels of understanding, compassion, and affirmation of self
- develop self-reflective abilities explicitly through "metaprocessing" to deepen, reinforce, and integrate therapeutic changes

Lamagna & Gleiser (2007); Lamagna (2011)

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**INTRAPERSONAL R.A.R. PROTOCOL**

Step 1: help client to develop SIT script of a message that a wounded part (WP) of the self needs to hear from a more adaptive part (AP) of the self, to facilitate affect regulation

Step 2: incorporate resources meaningful to the WP

Step 3: AP reads the script to the WP

Step 4: metaprocess with WP what it was like to hear the AP relaying the message

Step 5: installing AP as a resource for the WP utilizing EMDR RDI protocol

Step 6: metaprocess what it was like for AP to be able to give this message to the WP

Step 7: install AP capacity for compassion towards WP as a resource for the AP utilizing EMDR RDI protocol

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**EXPERIENTIAL EXERCISE**

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