ACADEMIA
MENTAL HEALTH &
WELL-BEING

Review Article
Published: 2024-12-09
https://doi.org/10.20935/MHealthWellB7427

The impacts of neglecting neglect in psychotherapy research and practice and a role for positive affect in repair

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Academic Editor: Birgitta Dresp-Langley

Abstract

Childhood emotional neglect (CEN) and childhood physical neglect (CPN) are often overlooked in research due to challenges in defining and detecting these forms of maltreatment. Despite being identified through standardized intake forms, CEN and CPN are often overlooked in organized clinical settings. CEN has been shown to significantly impact subsequent mental health issues in both prospective and retrospective studies. Sensitive periods have been identified during which CEN and CPN have greater impacts on later symptoms of post-traumatic stress disorder, depression, and shutdown dissociation. Notably, CEN has been identified as a more specific predictive factor for shutdown dissociation in adults than early-childhood maltreatment. To address these issues, clinicians must gain a greater awareness of the role of CEN and CPN and develop effective strategies for identifying and treating their long-term effects. Survivors of CEN can enhance their self-concept and their interpersonal interactions through clinical interventions aimed at enhancing their capacity to tolerate and assimilate positive emotional states.

Keywords: *childhood adversity*, *sensitive periods*, *shutdown dissociation*, *depersonalization*, *positive affect, narrative review*

Citation: Leeds LM. The impacts of neglecting neglect in psychotherapy research and practice and a role for positive affect in repair. *Academia Mental Health and Well-Being* 2024;1. https://doi.org/10.20935/MHealthWellB7427

1. Introduction

1.1. Challenges in the study and treatment of childhood emotional neglect

Since the 1993 National Research Council (NRC) report on child abuse and neglect was issued, significant advances have been made in understanding the causes and consequences of these issues [1]. However, over the last three decades, research on childhood abuse has consistently predominated, while the study of childhood neglect has remained comparatively overlooked. Two recent PubMed searches illustrate this disparity: only 17% as many search results for childhood neglect were retrieved compared to those for childhood abuse. The PubMed search (treatment for adults abused as children) OR (psychotherapy for adults abused as children) returned 17,628 results, while the similar PubMed search (treatment for adults neglected as children) OR (psychotherapy for adults neglected as children) returned 2,970 results.

This disparity in research efforts may partly reflect the greater challenges involved in studying the impacts of childhood neglect compared to the study of childhood abuse. For example, Xiao et al. [2] state, "Childhood emotional abuse (CEA) and childhood emotional neglect (CEN) are the least well-studied forms of childhood maltreatment due to challenges in their definition and in detection".

This narrative review provides a qualitative and brief summary of the literature on the impacts of childhood emotional abuse (CEA) and childhood emotional neglect (CEN), including sensitive periods related to the range of adverse childhood experiences (ACEs) and the role of CEN in shutdown dissociation, and explores potential clinical interventions that may merit further investigation as ways to enhance survivors' self-concept and interpersonal interactions.

1.2. The amplifying effects of childhood emotional neglect on mental health issues

Both CEA and CEN amplify mental health issues. However, CEN has amplifying effects beyond those of CEA. Xiao et al. reviewed 79 English and 11 Chinese studies and found that CEA and CEN were associated with increases in adult mental health issues, including depression, anxiety, substance abuse, suicidal ideation or attempts, personality disorders, and eating disorders. Compared with nonclinical populations, they found individuals in clinical populations were more likely to have experienced both emotional abuse and neglect during childhood [2].

In an online survey of adults in Hong Kong, when controlling for childhood experiences of both physical and sexual abuse, researchers found the highest scores for mental health problems in

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individuals who experienced both CEA and CEN, including depression, anxiety, borderline personality disorder, post-traumatic stress disorder (PTSD), and somatoform dissociation [3].

1.3. Reported failures to inquire about childhood emotional neglect in clinical settings

Given the amplifying effects of CEN on subsequent mental health problems, it is concerning that issues related to childhood neglect are overlooked in clinical settings. Published studies in the United States and the United Kingdom found that most users of adult mental health services are not asked about childhood abuse or neglect. Rates of inquiring about emotional neglect were far lower than those for asking about abuse. These failures occurred despite sections in standardized intake questionnaires explicitly calling for gathering information about early abuse and neglect [4].

A study in New Zealand found that the identification of emotional and physical neglect was poor, despite these being the two most common of the five types of childhood adversity. A comparison with an earlier study in Ireland suggests that clinicians identify less than one-third of their adult clients' histories of CEN. Histories of physical neglect were identified even less often [5]. See **Table 1**.

Table 1 • Comparison of clinician-identified childhood neglect cases in adult clients: 2016 New Zealand study vs. 2015 Irish study

	Irish study (2015)		**New Zealand study (2016)**
	Actual	**Clinical notes**	**Clinical notes**
Any child abuse or neglect	77%	38%	56%
Sexual abuse	25%	8%	32%
Physical abuse	28%	20%	36%
Emotional abuse	40%	25%	35%
Physical neglect	**48%**	**5%**	**7%**
Emotional neglect	**62%**	**13%**	**21%**

The bold font highlights the much lower rate for clinical notes identifying physical and emotional neglect compared to clinical notes for several forms of abuse. Adapted with permission from Sampson and Read [5] (see Table 5, emphasis added).

1.4. Hidden stories of neglect in the pathogenesis of shutdown dissociation

While CEN itself is relatively neglected both in research studies and in clinical settings, the recognition of the impact of CEN in the pathogenesis of shutdown dissociation has also been largely ignored in favor of focusing attention on the impacts of physical, sexual, and emotional abuse. For example, in the history of the evolution of attachment theory and research, the recognition of secure, insecure avoidant, and insecure preoccupied attachment in 1978 [6] emerged a decade before the recognition of the disorganized–disoriented pattern in 1992 by Liotti [7]. When the disorganized–disoriented attachment pattern was identified, it was proposed that the causes were to be found in frightening or frightened parental behaviors, such as CEA.

Building on the earlier work by Barach [8] and Main and Hesse [9], Liotti [7, 10] emphasized that the *precursors* to the development of severe dissociative disorders were found in insecure disorganized (type D) attachment and the early formation of multiple internal working models of the self and others, due to attachment to a *frightened* or *frightening* parent suffering from unresolved mourning or PTSD. Data to support this theory came from Strange Situation research by Main and Hesse [9], replicated by Ainsworth and Eichberg [11].

The development of Attachment Theory and its assessment in infants using the Strange Situation paradigm and in adults through the Adult Attachment Interview (AAI) are summarized in Section 2.5. This is followed by a discussion of the impact of CEN on attachment deactivation.

1.5. Evidence for the presence of two distinct developmental pathways to dissociation

Years of research on the neurobiological basis of post-traumatic stress has placed dissociation along a hierarchy of defensive responses to threat. Schauer and Elbert [12] provide an extended discussion of the "defense cascade" evolutionary theory of shutdown dissociation, which emphasizes responses to physical threat. Based on this evolutionary theory, Schalinski et al. [13] describe the development of the brief structured interview known as the Shutdown Dissociation Scale (Shut-D), which has significant convergent validity with subscales for amnesia, absorption, and derealization of the Dissociative Experiences Scale-II (DES-II) [14].

Despite the construct validity and potential clinical benefits to be derived from an evolutionary theory of shutdown dissociation, reviews of the developmental literature on dissociation suggest that there are "dual developmental pathways to dissociation". One pathway follows from infants' defensive reactions to frightening or fearful states in the caregiver, which are consistent with the evolutionary theory of dissociation. However, a second pathway involves different intersubjective and attachment-related aspects of mother–child interactions, based on maternal neglect [15] and the absence of shared positive affect and play.

1.6. Two longitudinal studies of high-risk mother–infant interactions highlight neglect

Many clinicians are surprised to learn that two separate longitudinal studies of high-risk mother–infant dyads found that clinically significant dissociative symptoms—as measured by the DES-II [14]—at age 19 are best predicted by the quality of the mother–infant interaction, specifically, by a lack of positive affective involvement and maternal flatness of affect. "These studies found that early hostile and intrusive maternal behavior were not significantly related to later dissociation" [15]. These authors emphasized different forms of "dissociation" at different stages in the development of the child. They cite scholars who believe that dissociative behaviors in younger children may be more normative than similar behaviors in older children. Young children may exhibit dissociative behaviors as normative responses to stress because they are more prone to resolving conflict through fantasy play. "A splitting of self is thus more natural in early childhood, and it is only later, with the appearance of more advanced modes of thought, that dissociation becomes more clearly pathological" [16]. Taylor et al. [17] showed that 65% of children up to age seven had imaginary companions at some point, and those who did scored higher on emotional understanding and theory of mind.

1.6.1. The Ogawa et al. study

The team of Ogawa et al. [18] at the Institute of Child Development, University of Minnesota, investigated whether trauma, sense of self, quality of early mother–child relationships, temperament, and intelligence were related to dissociative symptomatology measured at four times across 19 years. They found that both avoidant and disorganized patterns of attachment were strong predictors of dissociation. They reported strong support for the perspective of Waller et al. [19] that psychopathological dissociation should not be viewed as the top end of a continuum of dissociative symptomatology but rather as a separate taxon that represents an extreme deviation from normal development. Only psychological unavailability in infancy predicted dissociation at age 19; psychological unavailability (emotional neglect) accounted for 19% of the variance by itself.

1.6.2. The Dutra et al. study

A second longitudinal study by Dutra et al. [20] of a high-risk sample from birth to age 19 investigated what predicts the development of adolescent dissociative symptoms as measured on the DES-II [14]. They found that early-childhood maltreatment did not predict adolescent dissociative symptoms. Similarly, maternal psychiatric symptoms, including anxiety, depressive, dissociative, and PTSD symptoms, did not predict adolescent dissociative symptoms. Instead, the strongest predictors of dissociation in young adulthood were an early-childhood lack of positive maternal affective involvement, maternal flatness of affect, and overall disrupted maternal communication [20, p. 87]. Thus, emotional neglect was the strongest single predictor for shutdown dissociation, e.g., depersonalization and derealization. For an extended discussion, see *Developmental Pathways to Dissociation* by Leeds:

> These findings challenge us to rework our views of what lies at the root of the multiple, complex problems of patients with severe, adult dissociative disorders. Perhaps the implications of these findings will help clinicians broaden what has, at times, become an overly narrow focus on uncovering and metabolizing the content of autobiographical memories of "what happened", and support a shift to a consideration of the intersubjective and affective clinical "dialogue" between client and clinician, and to deeper, neuroaffective strategies that facilitate activation, development and integration of neurobiologically mediated systems for social engagement with higher cortical systems for self-representation, such as advanced EMDR interventions [21].

2. Discussion

2.1. Implications for clinical practice

The findings from these two longitudinal studies and the research demonstrating the neglect of neglect in clinical settings challenge us in three domains. The first domain is the need to increase our awareness of the centrality of CEN as both a causative agent and a maintenance factor in anxiety, depression, and dissociative disorders. The second domain is the need to adapt our clinical practices for history-taking to incorporate strategies for recognizing histories of CEN and childhood physical neglect and implementing assessment procedures to evaluate the specific impacts of emotional neglect. The third domain is the compelling need to incorporate clinical interventions for individuals who experienced CEN, specifically designed to help them learn to tolerate positive emotional states in interpersonal interactions and integrate these positively valenced experiences into new models of self and other.

2.2. Maltreatment and Abuse Chronology of Exposure findings on the timing of adverse childhood experiences on later symptoms

In recent decades, there has been increasing research on the effects of ACEs on brain development and adult symptoms. Many of these studies provide evidence for sensitive periods during which specific forms of childhood maltreatment are more likely to produce particular effects on later symptoms [22, 23]. Among the most cited of these reports is the 2015 study by Teicher and Parigger [24]. They carried out a retrospective assessment of abuse and neglect during development using the Maltreatment and Abuse Chronology of Exposure (MACE) scale.

The MACE scale is more comprehensive than the earlier ACE scale [25], in which only one item addressed physical neglect and one item addressed emotional neglect. Fifteen MACE items assess emotional and physical neglect. Each of the 52 MACE questions includes 18 checkboxes to indicate ages of exposure from 1 to 18 years. This detailed information on the timing of exposure is crucial in relation to sensitive periods. The MACE scale investigates 10 types of maltreatment: emotional neglect, nonverbal emotional abuse, parental physical maltreatment, parental verbal abuse, peer emotional abuse, peer physical bullying, physical neglect, sexual abuse, witnessing interparental violence, and witnessing violence toward siblings.

Using data from the MACE, Schalinski et al. [26] found support for the sensitive period exposure model and determined that the impacts of physical and emotional neglect were greatest during preschool (ages 4–5) and preadolescent (ages 8–9) periods. They emphasize, "Regarding type of experience, the present results emphasize the importance of emotional and physical neglect, which may have been underestimated when focusing exclusively on sexual abuse and traumata. Regarding timing of experience, the present results emphasize sensitive developmental periods between age 5 and 14, thus preschool age and early adolescence" (p. 12). Using retrospective reports from the MACE, Schalinski et al. [26] found that PTSD symptoms were best predicted by overall ACE severity, followed by physical neglect at ages 5–6. Symptoms of shutdown dissociation increased due to physical neglect at age 5 and emotional neglect at ages 4–5. Symptoms of depression increased due to emotional neglect at ages 8–9.

2.3. The Traumatic Antecedents Questionnaire as alternative instrument for in-depth developmental assessment of adverse childhood experiences

Clinicians seeking a somewhat simpler instrument that still assesses developmental periods may consider the Traumatic Antecedents Questionnaire (TAQ). The TAQ is a 42-item self-report measure, originally developed by Bessel van der Kolk in 1997 as an unpublished instrument and now maintained by Spinazzola [27]. The TAQ gathers information on the frequency and severity of exposure to traumatic and adaptive experiences during four developmental periods: birth to age 6, ages 7–12, ages 13–18, and adulthood. The TAQ examines 11 domains of experience: (1) competence, (2) safety, (3) neglect, (4) separation, (5) family secrets, (6) emotional abuse, (7) physical abuse, (8) sexual abuse, (9) witnessing trauma, (10) other traumas (e.g., natural disaster, serious accident, and traumatic loss of intimates), and (11) exposure to drugs and alcohol. The TAQ has been validated by Park et al. [28]. For clinicians and researchers interested in the amplifying effects of childhood adversity during sensitive periods, the MACE offers the greatest specificity. However, with 12 fewer items in the TAQ than in the MACE and only four developmental windows instead of 18 checkboxes, clinicians may choose the instrument that best suits their research or clinical needs.

2.4. Obtaining clinical histories that go beyond vague statements like "my parents loved me"

When obtaining a clinical history, clinicians need to recognize that vague and superficial client statements about their childhood experiences often bear little relationship to their actual experiences due to a range of factors.

2.4.1. Stigma, shame, minimization, and idealization defenses

ACEs can carry significant stigma and sense of shame, which may lead adult clients to downplay or minimize their early-childhood experiences. Recalling and discussing traumatic childhood events can be extremely difficult and painful for adults. There may be an unconscious tendency to minimize the severity of these events as a coping mechanism to avoid reexperiencing the trauma. Some adults may not fully realize the long-term impacts ACEs can have on mental and physical health. Without this awareness, they may inadvertently downplay the significance of their childhood adversities. Additionally, adults may worry about being judged negatively if they fully disclose details of childhood abuse or neglect. Adults with insecure attachment may present minimization or idealization defenses, leading them to make misleading statements about their ACEs [29, 30].

For these reasons, clinicians are encouraged to go beyond accepting overly general and vague statements like "my parents loved me". Those with dismissing, cannot classify, and unresolved attachment may focus on superficial parental behaviors, such as providing for basic physical needs, ensuring regular medical care, and attending parent–teacher conferences or children's school or sports activities. They may minimize or fail to report experiences of feeling invisible or unnoticed, as well as the absence of physical affection, warmth, or praise. Clinicians can consider exploring these issues more explicitly.

2.4.2. Exploring the presence or absence of parental play, affection, warmth, or praise

Clinicians can consider exploring more directly and explicitly early experiences of warmth, play, affection, and praise. Instead of open-ended questions, specific inquiries about who offered these positive experiences can be used. Clinicians can ask: "When you were a small child at home…"

- "Who held you, hugged you, kissed you, or gently stroked you?"
- "Who used a gentle voice with you and said loving words?"
- "Who smiled at you, laughed with you, or played with you?"
- "Who greeted you with smiles and enthusiasm?"
- "Who followed your lead when playing with you?"
- "Who spent time just focused on your interests?"
- "Who listened to you with full attention?"
- "Who gave you praise and encouragement?"
- "Who read to you?"

2.4.3. Assessing capacity to accept positive affect

Without early-life experiences to help individual learn to tolerate and assimilate the emotional intensity of mutual gaze, play, affection, and praise in childhood, adult survivors of neglect tend to find these experiences aversive and therefore, engage in a variety of overt (behavioral) and covert (attentional) strategies to minimize their discomfort. These avoidance strategies contribute to the maintenance of both physical and psychological health problems [31].

As early as 1982, Horwitz [32] reported, "People who infrequently accepted positive stroking reported statistically more obsessive-compulsive patterns of behavior, greater symptoms of clinical depression, greater levels of manifest anxiety, more disordered thinking, and more indications of interpersonal alienation, as compared to those individuals who responded as frequent positive stroke acquirers" (p. 220).

Defensive avoidance—or acceptance—of shared positive affect can be assessed through direct clinical inquiry as well as by using McKenna's Stroking Profile [33] to assess the capacity to actively accept compliments, praise, and warmth from others. The Stroking Profile inventory has been found to have good reliability and validity [34].

2.4.4. Health benefits from accepting positive interpersonal affect

A variety of studies support the health- and stress-protective characteristics of accepting positive interpersonal affect [35–37]:

> There are two ways in which social support can affect health (Cohen & Syme, 1985; Cohen & Wills, 1985; Stroebe & Stroebe, 1996). The buffering hypothesis argues that people benefit from social support only when they experience a stressful life event, whereas the direct effect hypothesis argues that social relationships promote health and well-being regardless of the individual's stress level [31].

> …sociability was associated with greater resistance to developing colds when persons were experimentally exposed to a cold virus. [Lack of] sociability is an important predictor of illness [36].

2.5. Attachment theory overview and the impact of neglect on attachment deactivation

2.5.1. Attachment theory history

Sir Bowlby [38–40] was the first to theorize about the impact of early attachment experiences on adult functioning. Carlson and Sroufe [41], Demos [42], and others have shown the persistence of childhood attachment patterns (at 12 months) into adolescence and adulthood.

2.5.2. Attachment status: the Strange Situation

The Strange Situation is a research paradigm first investigated by Salter Ainsworth et al. [6]. Researchers observed and video-recorded infant–mother pairs through one-way glass as they reacted to an unfamiliar environment and people. First, the infant responded to a strange laboratory room, then to the entrance of a strange person, and finally, to two different separations from its mother. This initially led to the identification of three primary infant attachment classifications.

Secure (B): The majority of babies (69%) played and explored happily prior to separation; showed signs of missing the parent during separation, such as crying and calling; sought proximity immediately upon the parent's return; and then quickly returned to play and exploration, being "secure" once again in the parent's presence.

Insecure: avoidant (A): Thirty percent of babies showed little or no apparent distress at being left alone in the unfamiliar environment. Upon the mother's return, they avoided and ignored her. In-home observations revealed that their mothers actively rejected their babies' attachment-seeking behavior. Infants classified as avoidant (A) represented a puzzle in the early 1970s because they did not show distress during separation. Ainsworth and Bell [43] theorized this outward lack of protest masked significant distress. Later studies with heart rate monitors revealed that these "avoidant" babies were, in fact, in great distress and remained so for prolonged periods of time.

Insecure: resistant–ambivalent (C): Other babies (8%) were "ambivalent". They showed great distress when the mother left. Upon her return, they alternated between frantic clinging and avoiding her, and they did not calm down. In-home observations revealed that their mothers were unpredictably available and tended to overly intrude on their babies' attempts at exploration.

Insecure attachment (D): Liotti [7], building in part on earlier work by Barach [8], subsequently proposed a fourth attachment classification for infants—disorganized–disoriented.

Insecure: disorganized–disoriented (D): A subset of insecure–avoidant infants displayed odd and conflicting behavior patterns in the parent's presence. For example, they would approach a parent with their head averted—suggestive of contradictions in intention—or they would show sudden immobility accompanied by a dazed expression, indicating a lack of orientation to the present environment. Such infants might show another—more oriented and organized—pattern in the same situation at the same period in life with the other parent.

Barach [8] had earlier proposed that clinicians treating individuals with dissociative disorders give greater attention to the role of attachment failures in the development of problems in living and treatment strategies, compared to previous authors in the dissociative disorders field who tended to focus on the role of traumatic experiences. Barach emphasized the role of emotional neglect by the non-offending caregiver. Nevertheless, Liotti [7, 10] proposed that the disorganized–disoriented pattern results from frightened or frightening parental behavior, which he hypothesized could be due to unresolved parental grief or parental PTSD. He proposed that the child's attempts to adapt to this inconsistent range of parental behaviors give rise to "multiple working models of self", which he suggested are a necessary precursor to the development of a complex dissociative disorder.

2.5.3. Infrequent recognition of deactivating strategies

Attachment deactivation refers to the inhibition and exclusion of the proximity-seeking functions of the innate attachment system. As Bowlby [40] commented:

> …when a child's attachment behaviour is strongly aroused and when, for any reason, it is not responded to… the child protests more or less violently and is much distressed. Should the situation recur frequently and for long periods, not only is distress prolonged but it seems that the systems controlling the behaviours ultimately become deactivated.
>
> The deactivation of systems mediating attachment behaviour, thought and feeling, appears to be achieved by the defensive exclusion, more or less complete, of sensory inflow of any and every kind that might activate attachment behaviour and feeling. The resulting state is one of emotional detachment which can be either partial or complete.

Blizard comments [44]:

> Deactivation is typical of avoidant attachment, with the child focusing on the environment to the exclusion of the attachment figure.

As reported by Carl et al. [45] and others, the role of deactivating strategies, and in particular their effects on positive mood states, tends to go underrecognized in most clinical settings. As previously discussed, not only are early histories of emotional neglect often unrecognized and unexplored in clinical settings [4], but the lasting effects of deactivating strategies on limiting the ability to reach out for and accept social support also tend to go unnoticed.

Mikulincer and Shaver [46] delineate the multifaceted problems that evolve from the deactivating strategies of insecure attachment:

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

One seldom-recognized consequence of deactivation strategies is the extent to which the severity of mental health issues experienced by those who rely on these strategies goes underrecognized and undertreated. In a classic article, Shedler et al. [47] delineated the tendency of those with this type of psychological defense to appear healthier than they truly are on standardized mental health scales. They point out, "Psychological defense has physiological costs. It is associated with autonomic reactivity and may be a risk factor for medical illness". Stänicke and McLeod [48] explored the role of deactivating strategies (defenses) in paradoxical treatment outcomes, such as patients who appear to get worse on standard measures as they become more willing and able to acknowledge the extent of their suffering and unmet needs.

2.5.4. Assessing adult attachment classification

While there are many "relationship questionnaires", their results do not correspond to those of the AAI [49], which remains the only instrument shown to produce results in adults that parallel the findings from the Strange Situation classifications of infants 18 years later [41, 42]. The AAI provides an in-depth and nuanced understanding of attachment, while relationship questionnaires offer a more superficial assessment. However, the AAI requires specialized training and is complex and time-consuming to administer and score, whereas relationship questionnaires are simpler and quickly administered. Relationship questionnaires focus on self-reported behaviors and attitudes, while the AAI focuses on the narrative coherence and emotional tone of interview responses, which appear to reflect differences in the development of prefrontal organization [50].

2.5.5. Adult attachment interview

The AAI is a research instrument that assigns adults to one of the four attachment categories by analyzing the content and narrative style of a transcript from a structured interview [51, 52]. AAI results do not correlate with measures of adult personality. This supports the hypothesis that adult attachment status is based primarily on early and some adult experiences, more than on genetic contributions to temperament. The AAI is not normed for clinical use. However, questions from the AAI can be incorporated into clinical interviews. Clinicians can attend to both narrative structure and content in these interviews.

Attachment classifications used in the Strange Situation (secure, insecure avoidant, insecure resistant, and disorganized) and the AAI (secure, dismissing, insecure preoccupied, and unresolved or cannot classify) are generally parallel in their characteristics. The AAI classification "cannot classify" refers to adults who engage, at various times, in a mixture of insecure dismissing and insecure preoccupied attachment strategies. The "unresolved" classification refers to confusion or incoherence during the recall of childhood experiences involving loss or abuse. Deactivating strategies, including the aversion to experiencing shared positive affect, can be observed in adults classified as insecure dismissing or unresolved or cannot classify [53]. Adults in these AAI classifications would likely have experienced CEN during the critical periods described in Schalinski et al. [26] and insufficient experiences of early maternal warmth, play, and affection as described in the Ogawa [18] and Dutra et al. studies [20].

2.5.6. Narrative style in dismissing attachment organization

Individuals with dismissing attachment organization constrict rather than contain emotional experiences. They are disconnected from their feelings, motivations, or inner life. When clinicians suggest that such patients may be feeling sad, longing, or angry, they tend to respond with statements like "I guess so. I suppose so" or "Maybe I do, but I really don't feel it right now" [54]. When describing their often-limited recollections of traumatic childhood events or abandonments, their narratives gloss over the bare surface of these events, without referencing the inner emotional impact they may have had in the past or expressing any overt affect about them in the present.

Descriptive criteria for individuals with a dismissing attachment organization include [55]:

- difficulty describing their relationships to their parents,
- difficulty remembering events from their childhood that justify their descriptions of happy memories,
- a tendency to minimize the importance of early parental relationships,
- a tendency to idealize or devalue (or both) early relationships, and
- lack of awareness of emotional and physiological responses to perceived abandonment or the threat of abandonment until it reaches the point of crisis.

2.5.7. Narrative style in unresolved attachment

Individuals with an unresolved attachment organization struggle to coherently discuss their past experiences of loss or abuse, in part due to a tendency to enter dissociative, trance-like states when attempting to reflect on these experiences. Technically, the unresolved classification is not a formal fourth adult classification but rather a breakdown in patterns of discourse [56].

- A struggle to support their narratives with examples or explanations.
- A failure to consider others' past intentions.
- Leaving the listener uncertain about the point of their discourse.
- Glaringly omitting the consequences of their experiences.
- Interrupting their narratives midway through.

2.6. Techniques for working with positive memories

Earlier evidence has shown that histories of CEN tend to be neglected in clinical settings and that clinicians often fail to recognize deactivating strategies in adults with avoidant insecure attachment. It should not be surprising that most therapeutic interventions focus on the negative thoughts and emotions of patients [57], failing to explicitly address ways to enhance positive emotional interactions. In exploring "positive psychology", Seligman et al. [58] comment, "Indeed, therapies that attend explicitly to the positives of clients are few and far between" (p. 275).

"Since 2000, research within positive psychology has exploded, as reflected in dozens of meta-analyses of different interventions and targeted processes, including strength spotting, positive affect, meaning in life, mindfulness, gratitude, hope, and passion" [59]. A 2022 *Frontiers* research topic featured 20 articles related to positive psychology interventions (PPIs) [60]. Few of these PPIs are specifically directed at increasing the interpersonal sharing of positive emotional states, positive memories, or positive emotional interactions in patients. A recent systemic review of randomized controlled trials (RCTs) or trials involving matched pairs with randomization by Carr et al. [61] identified 441 separate PPIs with a single intervention and 133 multielement programs. Few were specifically focused on positive emotion per se, such as writing about positive experiences (N = 13) or recalling funny things (N = 11). Recent systemic reviews and meta-analyses of PPI interventions, such as Carr et al. [61], are available. Additional PPIs are listed in Ciarrochi et al. [59]. None of these RCTs or trials with matched pairs with randomization involve interventions where patients are asked to practice receiving warmth, praise, or affection. PPIs involving the active acceptance of moments of shared positive emotion most closely recreate the early-childhood developmental sequence of learning to tolerate shared positive emotions and foster an interpersonally grounded positive view of identity and self-worth.

What follows is a brief exploration of potential therapeutic interventions that have been proposed or investigated to enhance positive emotional states, positive memories, or positive emotional interactions in patients. They were located using the search parameters "interventions to increase or enhance positive emotional states", "interventions to increase or enhance positive memories", and "interventions to increase or enhance positive emotional interactions in patients". Most search results were not directly related to potential clinical interventions. What follows is not meant to be an exhaustive review but rather an exploration of PPIs that most directly involve enhancing positive emotional states, positive memories, or positive emotional interactions in patients. All the selected studies were published in high-quality journals.

Some are clinical trials, while the others are merely experimental studies. They were selected not for their scientific rigor but because they explored interventions aimed at directly enhancing positive emotions. They illustrate possibilities for clinical interventions, and they highlight the need for further research specific to the needs of survivors of CEN.

2.6.1. The benefits of positive reminiscence

Bryant et al. [62] list a series of potential benefits of positive reminiscence, as proposed by previous authors, including:

- helping establish and maintain personal identity,
- bolstering self-esteem,
- serving as a mechanism for coping with negative experiences,
- providing comfort,
- reducing negative affect, and
- helping resolve problems and conflicts.

2.6.2. Using positive reminiscing imagery or mementos to access positive memories

In a nonclinical, experimental study of college students, Bryant et al. [62] found that a cognitive imagery task focused on positive reminiscing produced greater gains in feeling happy than merely examining mementos. They found that the vividness of recalled memories, but not the amount of recalled detail, led to a greater impact from cognitive imagery. Students who reminisced twice daily for a week about positive memories using either cognitive imagery or memorabilia reported greater increases in happiness, compared to students who merely thought about their present life situation twice daily for a week.

Notably, Bryant et al. point out that "unless one finds some pleasure in the moment, there will be no positive details to memorize and no pleasant memories to recall. In this sense, savoring the moment is truly a necessary precondition for savoring the past" [62, p. 254]. They cite no studies or suggestions for enhancing the capacity to tolerate or enjoy positive emotional states.

2.6.3. Treating depression with counterconditioning

In the plus-minus-plus method of Mood Regulation–Focused Cognitive Behavioral Therapy (MR-CBT), Högberg and Hällström [63] studied MR-CBT (counterconditioning) in suicidal youth. Using a model based on reconsolidation, they studied the effects of training in keeping positive affect and letting go of negative affect, compared with treatment as usual (TAU), on adolescents with depression and suicidal ideation. They employed mood mapping, with the person at the center and their various moods circling around them. The basic sequence in MR-CBT is to establish positive affect, activate and process the negative affect, and finally, aim for positive, future-oriented affect. They reported greater reductions in suicidality after MR-CBT compared to TAU, with equal improvements in depression and well-being in both groups.

2.6.4. Eye movement desensitization and reprocessing therapy with resource development and installation shows parallels to reconsolidation in Mood Regulation–Focused Cognitive Behavioral Therapy

There are similarities between the plus-minus-plus of MR-CBT (2018) and the earlier use of reconsolidation principles in EMDR therapy with resource development and installation (RDI) [64] (see also Leeds and Shapiro [65] and Korn and Leeds [66]).

For the "plus" phase, begin by installing adaptive memories (RDI). For the "minus" phase, reprocess a specific maladaptive memory ("desensitization") using phase four of EMDR therapy. Finally, for the "plus", link the resolved memory with a positive self-statement during the "installation" phase (phase five of EMDR therapy). This same sequence has been studied extensively, including in more than a dozen RCTs on the DeprEnd©–EMDR therapy protocol for treating depressive disorders [67, 68] and acute suicidality [69].

2.6.5. A boost in positive affect is greatest with an "active–constructive" response by a partner

"Sharing Positive Narratives with a Partner" was investigated by Lambert et al. [70] in a series of laboratory experiments. They reported that "the perks of sharing positive experiences" with a partner resulted in the largest gains in positive affect, happiness, and life satisfaction only when participants shared their positive experiences, and the partner provided an enthusiastic, "active–constructive" response. For example, "Great job!!!! I heard you got in the top 10%. I'm so proud of you". However, these laboratory experiments do not provide a direct technique for individuals to enhance positive affect. They may be useful in couples counseling. When one partner shares a positive experience, the other can be encouraged to provide an enthusiastic "active–constructive" response.

These experimental studies highlight the central role of validating interpersonal responses in enhancing positive affect. These adult validating responses parallel the need for early-childhood experiences of having one's positive achievements and emotional states witnessed and actively acknowledged by a caregiver with "mindsight" [71, 72].

2.7. The limits of individually focused techniques for increasing positive affect

As highlighted by research on stroking profiles [32, 33], a crucial element for individuals with deactivating strategies is their inability to tolerate and actively assimilate positive interactions from others. None of the techniques summarized above for modifying positive affect address the phobic avoidance of accepting shared positive emotional states from others. Transactional analysis can include assessing individuals' stroking profiles and exploring ways to strengthen their ability to accept compliments and praise from others [73]. Additionally, there is also an EMDR procedure intended to directly address internal phobias surrounding shared positive emotional states: the "Positive Affect Tolerance and Integration" (PAT) protocol [74, 75].

2.7.1. An eye movement desensitization and reprocessing intervention for learning to tolerate and assimilate positive interactions

The PAT protocol was introduced by Leeds in 2006 and 2007 and later published with a case series in 2022 and 2023 [74–77].

The published PAT protocol [74] includes selecting individuals with deactivating strategies; providing psychoeducation to help individuals recognize the potential benefits of working on learning to tolerate and assimilate shared positive affect; teaching a three-step behavioral exercise for actively receiving appreciation, compliments, and praise; and conducting EMDR reprocessing sessions focused on current experiences of learning to tolerate and assimilate shared positive affect. After completing a series of PAT reprocessing sessions, clients have described gains in self-concept, the ability to enjoy and benefit from positive social interactions, improved assertiveness, and indications of reorganization in attachment status. Additional reported gains included decreased depersonalization during social interactions [74, 75].

3. Conclusions

The neglect of CEA and CEN is a significant issue often overlooked in research due to the challenges of defining and detecting these forms of maltreatment. Research by Xiao et al. [2] has demonstrated that CEA and CEN are associated with more severe adult mental health problems. Surprisingly, most users of adult mental health services in the United States and the United Kingdom are not questioned about past abuse or neglect, with emotional neglect being particularly overlooked in assessments, even when intake questionnaires include prompts [5].

Two validated tools, the TAQ and the MACE scale, can be helpful for assessing early histories of abuse and neglect. Research using the MACE sheds light on sensitive periods and the lasting impact of childhood experiences on mental health [26]. Survivors of CEN often develop insecure dismissing, cannot classify, or unresolved attachment classifications. Clinical identification of individuals with dismissing, cannot classify, or unresolved attachment organization involves recognizing criteria, such as difficulty describing relationships with parents, minimizing the importance of early relationships, idealizing or devaluing early parental relationships, and lack of awareness of emotional responses until they escalate to the point of crisis.

Contrary to common belief, traumatic experiences and fear states during attachment in early years do not uniquely predict adult dissociation. Research by Dutra et al. [20] found that early-childhood maltreatment and maternal psychiatric symptoms do not predict adolescent dissociative symptoms. Instead, lack of positive maternal affective involvement, maternal flatness of affect, and disrupted maternal communication in early childhood are the strongest predictors of dissociation in young adulthood. It is essential that clinicians gain a greater awareness of the role of CEN in the vulnerability to adult mental health issues and explore the use of interventions that target increasing individuals' capacities to tolerate and assimilate positive emotional states into their self-concept and their interpersonal interactions.

Acknowledgments

An earlier version of this paper was presented orally at the 41st annual conference of the International Society for Trauma and Dissociation on March 24, 2024.

Funding

The author declares no financial support for the research, authorship, or publication of this article.

Author contributions

The author confirms sole responsibility for this work. The author approves of this work and takes responsibility for its integrity.

Conflict of interest

The author declares no conflict of interest.

Data availability statement

Data supporting these findings are available within the article, at https://doi.org/10.20935/MHealthWellB7427, or upon request.

Institutional review board statement

Not applicable.

Informed consent statement

Not applicable.

Additional information

Received: 2024-07-01

Accepted: 2024-11-13

Published: 2024-12-09

Academia Mental Health and Well-Being papers should be cited as *Academia Mental Health and Well-Being 2024*, ISSN 2997-9196, https://doi.org/10.20935/MHealthWellB7427. The journal's official abbreviation is *Acad. Ment. Health WellB.*

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