

Autonomic Charge Modulation in Attachment Therapy: A Multiple-Case Analysis of the Somatic Attachment Protocol

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Abstract

Attachment-related difficulties present in diverse ways, including relational instability, emotional flattening, and cognitive-emotional disconnection, and may arise from shared underlying mechanisms rather than distinct symptom categories. A proposed mechanism is emotional memory reconsolidation, in which previously encoded emotional learning can be updated when reactivated under specific conditions.

This study examines whether these presentations can be understood and treated through a shared process involving the modulation of autonomic activation, conceptualized here as autonomic charge. A multiple-case analysis (N = 3) was conducted using the Somatic Attachment Protocol (SAP), a process-based framework integrating somatic observation, neural interruption, and relational co-regulation, with cases selected to represent relational instability, emotional flattening, and cognitive-emotional disconnection. Across all cases, therapeutic change followed a similar sequence of activation, sustained somatic observation, reduction in autonomic activation, and subsequent reorganization of emotional and behavioural responses (AORR). Despite differences in presentation, all cases converged toward increased emotional regulation and adaptive relational functioning.

These findings support a process-based view of psychotherapy, in which diverse attachment difficulties may reflect variations in a shared underlying mechanism. SAP is presented as a flexible clinical framework for engaging this process, with limitations and implications for future research discussed.

Keywords: autonomic charge modulation, somatic attachment protocol, process-based psychotherapy, emotional memory reconsolidation.

Introduction

Attachment-related difficulties represent a significant focus within contemporary psychotherapy, yet they manifest in diverse and often contrasting ways. Clinical presentations may include relational instability characterised by repeated conflict, emotional flattening despite functional stability, or strong cognitive insight accompanied by limited emotional access. These variations present challenges for treatment, as interventions are often selected based on observable symptom patterns rather than underlying processes.

Recent developments in psychotherapy research have increasingly emphasised a shift from symptom-based classification toward the identification of core mechanisms of change (Lane et al., 2015; Wampold & Imel, 2015). From this perspective, seemingly distinct clinical presentations may reflect different expressions of shared underlying processes, suggesting that therapeutic effectiveness may depend less on targeting specific symptoms and more on engaging the mechanisms through which emotional and relational patterns are maintained and transformed.

One important idea in this area is emotional memory reconsolidation. This refers to the process where emotional memories can change when they are activated and then updated with new experience (Ecker et al., 2012; Nader et al., 2000). For this to happen, the emotional pattern must first become active. Then, under the right conditions, the brain can revise the original learning.

Emotional memories are not only stored as thoughts or stories. They are also stored in the body as patterns of activation (Craig, 2009). These patterns can show up as tension, pressure, or emotional intensity. In the present framework, this embodied activation is referred to as autonomic charge. Autonomic charge is conceptualised as a clinically derived construct referring to the residual physiological activation associated with unresolved emotional experience. It is grounded in established findings that emotional processes are closely linked to autonomic nervous system activity and interoceptive awareness (Craig, 2009; Damasio, 1999; LeDoux, 2000).

Rather than representing a distinct biological entity, autonomic charge serves as an integrative term to describe how unresolved emotional activation is experienced and maintained within the body. This framing allows for a clinically accessible way of working with processes that are otherwise described across multiple domains of affective neuroscience and psychophysiology. When this charge is repeatedly activated without being resolved, it may lead to persistent patterns in behaviour, emotion, and relationships.

In this framework, therapeutic change depends on working directly with this bodily activation. Rather than focusing only on thoughts or behaviour, the aim is to bring the activation into awareness and allow it to reduce. In the Somatic Attachment Protocol (SAP), this is done through three main processes: somatic observation, neural interruption, and relational co-regulation. Somatic observation involves noticing body sensations without reacting or analysing. Neural interruption helps break fixed emotional patterns. Co-regulation provides safety and stability through the therapist's presence.

SAP is designed as a process-based framework rather than a fixed set of techniques. It focuses on helping clients develop the ability to stay with emotional activation without reacting to it. Over time, this becomes a skill that can be used outside of therapy as well. From this view, different attachment problems may reflect differences in how autonomic charge is activated, accessed, or regulated, rather than entirely different conditions.

The present paper explores this idea through a multiple case analysis of three clients with different attachment-related presentations. The first case involves repeated relational instability and conflict. The second involves emotional flattening despite high functioning. The third involves strong cognitive control with limited emotional access.

The aim of this study is to examine whether these different patterns can be understood through a shared underlying process. Specifically, the paper looks at whether change across these cases follows a common pathway involving a shared process of activation, sustained observation, and subsequent reorganisation. By focusing on process rather than symptoms, this study contributes to a growing shift in psychotherapy toward mechanism-based models of change and offers a preliminary examination of SAP as a flexible framework for working with diverse attachment difficulties.

1. Theoretical Framework

Attachment and Regulation

Attachment theory provides a developmental framework for understanding how patterns of emotional regulation are shaped through early relational experience. Contemporary attachment research emphasises that attachment is not only reflected in relational behaviour, but is fundamentally rooted in the regulation of affective and physiological states (Hindz, 2015; Siegel, 2012).

Conceptually, attachment difficulties can be understood as disruptions in the capacity to regulate autonomic activation in relational contexts. Patterns such as hyperactivation, hypoactivation, and dissociation reflect different regulatory strategies developed in response to early relational environments. These patterns are maintained not only at the level of cognition or behaviour, but within embodied physiological processes.

The present study builds on this view by proposing that changes in attachment patterns may occur through direct engagement with these underlying regulatory processes. Specifically, SAP targets the modulation and resolution of autonomic activation as a pathway through which relational and emotional patterns reorganise over time.

Emotional Memory Reconsolidation

Emotional memory reconsolidation refers to the process by which existing emotional learning can be updated. When an emotional memory is activated, it becomes temporarily unstable, allowing new experience to modify the original pattern before it is stored again (Ecker et al., 2012; Nader et al., 2000). Emotional memory reconsolidation has been identified as a core mechanism underlying durable therapeutic change, whereby previously encoded emotional learnings can be updated when reactivated under specific experiential conditions (Ecker, 2015). Experimental studies have further demonstrated that fear memories can be modified or prevented from returning when reactivated under specific conditions, providing empirical support for reconsolidation processes (Kindt et al., 2009; Schiller et al., 2010).

This process differs from suppression or cognitive control. Rather than managing or avoiding emotional responses, reconsolidation involves changing the underlying learning that drives those responses. For this to occur, the emotional pattern must be both activated and experienced under conditions that allow new information to be integrated (Lane et al., 2015). From this perspective, therapeutic change is not primarily about reducing symptoms directly. Instead, it involves altering the emotional memory structures that produce those symptoms.

Within the present framework, the moment of sustained somatic observation, where emotional activation is experienced without the expected reactive, avoidant, or regulatory response, may function as a mismatch experience. The individual remains in contact with the activated emotional state while the anticipated behavioural or cognitive response does not occur. This divergence between expected and actual response conditions is consistent with reconsolidation models, in which prediction error or mismatch enables the updating of previously encoded emotional learning (Ecker et al., 2012; Lane et al., 2015). In this framework, somatic observation is not merely a regulatory strategy, but may constitute the critical condition under which reconsolidation becomes possible.

Emerging practice-based approaches have begun to operationalize memory updating through structured sensory and attentional interventions. Approaches such as Multichannel Eye Movement Integration (MEMI) (Deninger, 2021) utilize guided eye movements and multi-sensory processing to facilitate changes in distressing memories without requiring detailed verbal recounting. Within this framework, experience is understood as organized across multiple channels, including sensory representations, physiological responses, and cognitive elements, which can be accessed and modified through targeted pattern interruption. This approach offers a preliminary clinical illustration of how reconsolidation principles might be operationalized in practice, though empirical validation remains at an early stage.

Clinical descriptions of these approaches suggest that when habitual sensory, perceptual, and affective patterns are disrupted, emotional and cognitive responses reorganize spontaneously. This process is consistent with broader theoretical accounts of memory reconsolidation, in which reactivated emotional learning becomes labile and subject to modification under specific conditions. While empirical validation remains in early stages, this approach offers clinically relevant models for understanding how sensory-based interventions may facilitate rapid shifts in emotional experience.

By examining three clinically distinct cases through a shared theoretical lens, this paper offers an initial contribution toward mechanism-based understanding of attachment change processes, and provides a foundation for future controlled investigation of autonomic charge modulation as a therapeutic pathway.

Autonomic Charge

Emotional memories are not stored only as thoughts or narratives. They are also encoded as patterns of physiological activation within the body (Craig, 2009). These patterns can be experienced as tension, pressure, restlessness, or emotional intensity.

In the present framework, this embodied activation is referred to as *autonomic charge*. Autonomic charge refers to the residual physiological activation linked to unresolved emotional experience, as defined earlier. When this charge remains unresolved, it can be repeatedly triggered in current situations, leading to persistent emotional and behavioural patterns.

Operationally, autonomic charge is inferred from observable physiological, behavioural, and self-reported indicators during the therapeutic session, including respiratory pattern (e.g., a shift from shallow to deeper, more regulated breathing), facial muscular tension, client-reported bodily tension or its resolution, the intensity of distress-related affect (e.g., anger, sadness, grief), and incidental self-regulatory behaviours (e.g., cessation of cuticle-picking or hyperventilation, spontaneous yawning as a marker of parasympathetic release). Reductions in autonomic charge are further evidenced when clients report a marked decrease in subjective

activation upon recalling a previously distressing trigger, relative to their activation earlier in treatment.

Different individuals may show different patterns of autonomic charge. Some may experience high levels of activation, such as anxiety or emotional reactivity. Others may show reduced activation, such as emotional flattening or disconnection. In some cases, there may be a split between cognitive awareness and bodily experience, resulting in suppression or dissociation from emotional states.

Despite these differences, the underlying issue can be understood as a difficulty in resolving autonomic charge once it has been activated.

Core Change Processes in SAP

The Somatic Attachment Protocol (SAP) is designed to work directly with autonomic charge through three core processes: somatic observation, neural interruption, and relational co-regulation. Across cases, this mechanism follows a consistent four-stage sequence - AORR which recurs throughout the analysis below.

Somatic observation involves sustained attention to bodily sensations without attempting to change, interpret, or avoid them. The purpose is to allow autonomic activation to be experienced without reinforcing the original emotional pattern. This creates the conditions for the activation to naturally reduce over time.

Neural interruption may be understood as a form of attentional and perceptual disruption, consistent with research on orienting responses and dual-attention mechanisms, which have been shown to modulate emotional intensity and disrupt fixed patterns of processing. This refers to techniques that disrupt established emotional and perceptual patterns and may include shifts in attention, sensory input, or eye movements. These interventions introduce variability into the system, helping to loosen fixed responses and create opportunities for new learning. From a neurocognitive perspective, such interruptions may function by engaging orienting responses and shifting attentional networks, thereby disrupting ongoing predictive and emotional processing patterns. This may reduce the stability of previously learned responses, creating conditions for updating.

Relational co-regulation involves the therapist providing a stable and attuned presence that supports the client's nervous system during emotional activation. In practice, this involves the therapist actively regulating their own physiological and attentional state to maintain a calm, steady presence. This may include slowing speech, maintaining consistent pacing, minimising abrupt shifts in tone or focus, and using simple, non-directive prompts to guide attention toward bodily sensations. The therapist monitors the client's level of activation moment-to-moment, adjusting proximity, tone, and pacing to support engagement without overwhelming or disengagement. These micro-adjustments function to stabilise the relational field, allowing the client to remain within a tolerable range of activation while engaging with internal experience. This is particularly important when working with higher levels of charge, where independent regulation may not yet be possible. The therapist functions as a regulatory scaffold, helping the client remain within a tolerable range of activation. This aligns with polyvagal perspectives on safety and ventral vagal regulation (Porges, 2011).

The therapeutic relationship itself plays an important role in facilitating change, with relational factors such as attunement, alliance, and co-regulation consistently identified as key contributors to therapeutic outcome (Norcross & Lambert, 2018). Together, these processes support the AORR sequence in a controlled and safe manner.

2. Somatic Attachment Protocol as a Process-Based Clinical Framework

Somatic Attachment Protocol (SAP) is conceptualised as a process-based framework rather than a fixed set of techniques. The focus is on the sequence of internal processes that lead to change, rather than on specific interventions alone.

Within this framework, the key therapeutic task is to support the client in developing the capacity to remain present with autonomic activation without reactive interpretation. This capacity, referred to as somatic charge regulation, can be learned over time and applied outside of therapy contexts.

SAP can be applied in two main contexts. In lower-intensity situations, individuals may use somatic observation independently to work through everyday emotional experiences. In higher-intensity situations, the therapist provides co-regulation and guidance to support the process. In both cases, the underlying mechanism remains the same: activation of autonomic charge, sustained observation, reduction of activation, and updating of the associated emotional memory.

Conceptually, different attachment-related difficulties can be understood as variations in how autonomic charge is activated, accessed, or regulated. The role of therapy is not to target each presentation separately, but to facilitate the same underlying process across different forms of expression.

3. Research Methodology

This study used a multiple case analysis design ($N = 3$) to examine whether different attachment-related presentations can be understood through a shared therapeutic process. Rather than testing treatment outcomes, the focus was on identifying patterns in how change occurred within each case. A case-based approach was chosen because it allows close examination of therapy processes as they unfold over time. This is especially useful when studying mechanisms of change, where the sequence and quality of internal experience are central to understanding how transformation takes place. This approach is consistent with established case study methodologies, which are particularly suited to examining complex processes of change within real-world clinical contexts (Stake, 1995; Yin, 2018).

Case Selection

Three cases were selected to represent different forms of attachment-related difficulty. The selection was intentional and aimed to capture variation in how emotional and relational problems can present in clinical settings. Cases were selected to represent three distinct clinical patterns: a client presenting with repeated relational instability and conflict, a client with emotional flattening in the context of high functioning, and a client characterised by strong cognitive awareness alongside limited emotional integration. These cases were not chosen to represent diagnostic categories, but to reflect differences in how autonomic charge may be expressed, accessed, or regulated across individuals.

Cases were purposively selected (Stake, 1995; Yin, 2018) rather than drawn consecutively from clinical intake, in order to capture theoretically meaningful variation across presentations. Full session-level procedural detail for each case, including treatment duration, session counts, and timing of outcome measurement, is provided in Appendix A

Intervention Framework

All cases were treated using the Somatic Attachment Protocol (SAP), a process-based clinical framework that focuses on working with autonomic charge through somatic observation, neural interruption, and relational co-regulation. The intervention was not applied

as a fixed set of steps. Instead, it was adapted based on each client's level of activation, access to bodily experience, and capacity for regulation.

Across all cases, the therapeutic process followed a general sequence involving the activation of relevant emotional experience, guided attention to bodily sensations, support for remaining present without reactive interpretation, the use of interruption techniques when needed, and the gradual reduction of autonomic activation.

The therapist provided co-regulation throughout the process, particularly during periods of higher emotional intensity.

Relational co-regulation, as a foundational element of SAP, was present from the outset of the therapeutic relationship in all three cases, rather than being introduced at a discrete point in treatment. References elsewhere in this paper to the onset of SAP denote the point at which somatic observation and/or neural interruption were deliberately introduced as adjuncts to this ongoing co-regulatory foundation.

While SAP is applied flexibly, the consistency of its core processes - activation, somatic observation, interruption, and reduction - provides a stable structure that can be observed across cases.

Data Sources

Data for this study were drawn from clinical practice, including therapist observations during sessions, process notes recorded after sessions, and client-reported experiences and changes. The focus was on capturing shifts in emotional experience, bodily awareness, behaviour, and relational patterns over the course of therapy. In two of the cases, subjective units of distress (SUDS) ratings were used during sessions to track within-session changes in perceived distress. In the remaining case, change was tracked using a global wellbeing scale (1–10, with higher scores reflecting greater emotional access and functioning) at select sessions, alongside SUDS ratings at points where a discrete neural interruption technique was applied. This measurement difference reflects the differing clinical presentations across cases (see Appendix A) rather than inconsistent application of a single instrument. No standardised measures were used, as the study prioritised detailed process observation over quantitative outcomes.

Analytical Approach

The analysis followed a process-oriented approach, examining each case in terms of presenting pattern, underlying autonomic dynamics, therapeutic process, and observed changes over time. The aim was to identify how autonomic charge was activated, how it was worked with during therapy, and how it changed across sessions.

After analysing each case individually, a cross-case comparison was conducted. This comparison focused on identifying common patterns across cases, particularly in relation to how different presentations relate to underlying autonomic processes, how SAP was applied across different starting points, and whether therapeutic change followed a similar sequence. The analysis prioritised identifying shared mechanisms rather than differences in symptom expression.

Epistemological Position and Researcher Role

This study adopts an exploratory, process-oriented case analysis approach. The aim is not to independently validate the Somatic Attachment Protocol (SAP) as a treatment model, but to examine whether observed therapeutic change can be meaningfully described using its proposed framework.

The therapist delivering the intervention is also the developer of SAP. This dual role introduces the possibility of interpretive bias in both data collection and analysis. To address this, the study focuses on transparent description of therapeutic processes and observed changes, allowing readers to evaluate the coherence and plausibility of the proposed mechanisms.

The cases were selected to represent variation in clinical presentation rather than to provide a representative or random sample. As such, findings should be understood as exploratory and illustrative rather than generalisable.

Ethical Considerations

All case material was anonymised prior to analysis and publication. Identifying information was removed or modified to ensure that individual clients could not be recognised from the descriptions provided. The cases were presented only to the level of clinical detail necessary to illustrate the therapeutic processes under examination. All clients provided informed consent for the use of their anonymised clinical material for research and publication purposes.

4. Case Studies Presentations

Case 1 – Relational Instability (Hyperactivation Pattern)

The client was a woman in her mid-30s who reported ongoing difficulty maintaining stable romantic relationships. She described a pattern of intense emotional involvement followed by conflict and eventual breakdown. Her partners were often emotionally unavailable or not ready for commitment. She reported frequent arguments, strong emotional reactions, and repeated experiences of betrayal. Despite recognising the pattern, she found herself returning to similar types of relationships. She described feeling “pulled in” quickly and struggling to regulate her emotional responses once engaged.

Mechanistic Formulation

From a process perspective, the client presented with high levels of autonomic activation linked to attachment. Emotional experiences were intense and easily triggered, particularly in relational contexts.

This pattern can be understood as persistent activation of autonomic charge without successful resolution. The charge appeared to drive both emotional reactivity and behavioural repetition. Relational situations served as triggers that activated underlying emotional patterns, which then reinforced themselves through repeated cycles of conflict and distress. Although the client had some awareness of her patterns, this awareness did not lead to change, suggesting that the underlying issue was not cognitive, but related to dysregulated autonomic activation.

SAP Intervention Process

Prior to the period described here, the client had engaged in 11 sessions of EMDR and CBT (June 2023–February 2024) without sustained stabilization of her emotional dysregulation. She discontinued therapy and returned in June 2025, at which point SAP was introduced. Therapy focused on working directly with emotional activation as it emerged in session. When relational themes were discussed, the therapist guided the client to shift attention from narrative to bodily sensations.

The client was supported to notice areas of tension, pressure, and intensity without attempting to analyse or change them. Due to the high level of activation, relational co-regulation was central. The therapist maintained a steady presence and helped the client remain within a tolerable range of experience.

At points where the client became overwhelmed or repetitive in her responses, neural interruption techniques were used. These included shifts in attention and structured changes in focus to disrupt the ongoing emotional loop. Over time, the client was able to remain with emotional activation for longer periods without escalating. This allowed the intensity of the activation to gradually reduce.

Observed Changes

As therapy progressed, the client showed reduced emotional reactivity in both session and real-life situations. She reported being less overwhelmed during conflict and more able to pause before responding.

There was also a shift in relational behaviour. The client began to show increased awareness of her attraction patterns and was less likely to engage quickly with emotionally unavailable partners. These changes were not driven by new beliefs alone, but were accompanied by a noticeable reduction in the intensity of emotional activation during relational situations.

In-session subjective units of distress (SUDS) ratings indicated a reduction in perceived emotional intensity of approximately 50% or more within a single session.

Case 2 – Emotional Flattening (Hypoactivation Pattern)

The client was a woman in her mid-30s who was high functioning in her professional and social life. She described herself as capable and engaged in daily activities, with a stable job and a supportive partner. Despite this, she reported feeling emotionally flat and disconnected. She described a lack of enjoyment and a general sense of distance from her own experience. She did not report high distress, but rather a persistent absence of emotional engagement.

Mechanistic Formulation

In contrast to Case 1, this client showed low levels of observable autonomic activation. Emotional experiences appeared dampened, and access to bodily sensations was limited.

This pattern can be understood as reduced access to autonomic charge rather than excessive activation. Emotional responses may have been suppressed or inhibited over time, leading to a state of hypoactivation. The difficulty in this case was not overwhelming emotion, but limited contact with emotional experience. This reduced the opportunity for activation and subsequent updating of emotional patterns.

SAP Intervention Process

The client had prior therapy experience before beginning treatment with the present therapist in July 2022. Co-regulation and progressive training in somatic and interoceptive observation were present from the start of treatment, with neural interruption techniques (EMDR, then MEMI) introduced at specific points across the course of therapy. Therapy focused on gradually increasing the client's awareness of bodily sensations. Initial work involved directing attention to subtle physical experiences, such as temperature, pressure, or small shifts in tension.

During this phase of treatment, the client accessed previously repressed material related to earlier traumatic experience. This was approached within an established framework of safety and stabilization, consistent with standard trauma-informed practice, and the pacing of further processing was adjusted in response to the client's regulatory capacity. Rather than attempting to generate strong emotion, the aim was to build sensitivity to low-level activation. The therapist provided consistent co-regulation to support a sense of safety during this process.

As the client's awareness increased, moments of emotional activation began to emerge. These were approached through the same process of somatic observation, allowing the client to remain with the experience without analysis or avoidance. Neural interruption was used sparingly, primarily to shift the client out of habitual cognitive processing when it interfered with direct experience.

Observed Changes

Over time, the client reported increased access to emotional experience. She described a broader range of feelings and a greater sense of connection to her daily life. There was also a shift in how she related to her internal state. Rather than feeling distant or neutral, she reported moments of engagement, interest, and emotional presence. These changes were gradual and appeared to follow increased access to and resolution of previously dampened autonomic activation.

Case 3 – Cognitive Suppression (Dissociative Pattern)

The client began therapy in August 2024. Following an initial intake and brief assessment period, a specific injunction - "don't be a problem to others" was identified early in treatment as central to his presentation. The client was a man in his late 30s who presented as highly articulate and psychologically informed. He was able to describe his patterns in detail and demonstrated strong cognitive understanding of his behaviour.

Despite this, he reported difficulty experiencing and expressing emotion. His affect was often incongruent with the content of discussion, including the use of humour when describing distressing experiences. He also reported several near-accident incidents as a pedestrian, suggesting reduced situational awareness in real-world contexts. These incidents were understood as reflecting lapses in attentional awareness associated with dissociative disengagement from present-moment sensory experience, as reported by the client.

Mechanistic Formulation

This case was characterised by a disconnect between cognitive processing and autonomic experience. Emotional activation appeared to be present but not fully accessible to conscious awareness. This pattern can be understood as suppression or dissociation from autonomic charge. Cognitive processing remained active, but did not lead to integration or change, as it was not connected to the underlying physiological activation. The client's use of humour and minimisation functioned as avoidance strategies that prevented sustained contact with emotional experience.

SAP Intervention Process

SAP was applied across two distinct episodes of treatment. In the first (September 2024), a single session of neural interruption addressed the identified injunction, producing a marked shift in the client's self-concept ("I'm not a problem"). Follow-up sessions confirmed the change had stabilized, and the client discontinued therapy having reported that his goals were met. He

returned approximately thirteen months later, presenting with a structurally similar pattern in a new form - repeated near-miss incidents accompanied by passive ideation about their outcome. This prompted a direct risk assessment at the time, which did not indicate acute risk requiring escalation beyond the ongoing therapeutic relationship; this was monitored throughout the subsequent phase of treatment, which was addressed through a second, brief episode of SAP-focused work. The recurrence of a related pattern in a different manifestation is considered further in the Discussion.

Therapy focused on redirecting attention from cognitive analysis to direct bodily experience. When the client began to explain or interpret, the therapist guided him back to noticing physical sensations. This required repeated interruption of cognitive loops. Neural interruption techniques were used to shift attention and disrupt habitual patterns of intellectualisation. Relational co-regulation was important in maintaining engagement, as the client showed a tendency to disengage from emotional material. Gradually, the client began to identify and stay with bodily sensations linked to emotional content. This created opportunities for direct processing rather than cognitive avoidance.

Observed Changes

The client showed increased awareness of his emotional and bodily states over time. His responses became more congruent, with less reliance on humour or minimisation. He also reported improved presence in daily situations, including increased awareness of his surroundings. The frequency of near-accident incidents, as reported by the client, reduced over time. These changes appeared alongside improved ability to remain with emotional activation without shifting into cognitive avoidance.

Similar reductions in SUDS ratings were observed within session, suggesting a marked decrease in subjective distress alongside the observed shift in autonomic activation.

5. Cross-Case Analysis

Divergent Presentations of Attachment Difficulty

The three cases presented different forms of attachment-related difficulty. At a surface level, they appeared to reflect distinct problems.

Case 1 showed high emotional reactivity, with repeated relational conflict and instability. Emotional responses were intense and difficult to regulate.

Case 2 showed low emotional engagement, with a sense of flatness and disconnection despite stable functioning. Emotional responses were muted and difficult to access.

Case 3 showed strong cognitive awareness but limited emotional integration. The client relied on thinking, humour, and minimisation, with reduced connection to emotional experience.

These patterns are often treated as separate clinical issues. However, when viewed through a process-based lens, they can be understood as different expressions of how autonomic activation is organised and regulated. In cases where subjective units of distress were recorded, reductions in perceived emotional intensity were observed within session, providing additional support for the proposed process of activation and resolution.

Underlying Autonomic Patterns

Across the three cases, differences in presentation corresponded to differences in autonomic activation.

Case 1 was characterised by *hyperactivation*, where emotional charge was strong, easily triggered, and difficult to regulate.

Case 2 showed *hypoactivation*, where emotional charge was dampened, with reduced access to bodily sensation and emotional experience.

Case 3 reflected a *disconnection from activation*, where emotional charge was present but not fully accessible due to suppression or dissociation.

Despite these differences, all three cases involved difficulty in working with autonomic charge once it was activated. The core issue was not the level of activation alone, but the capacity to remain with and resolve that activation.

Convergent Therapeutic Process

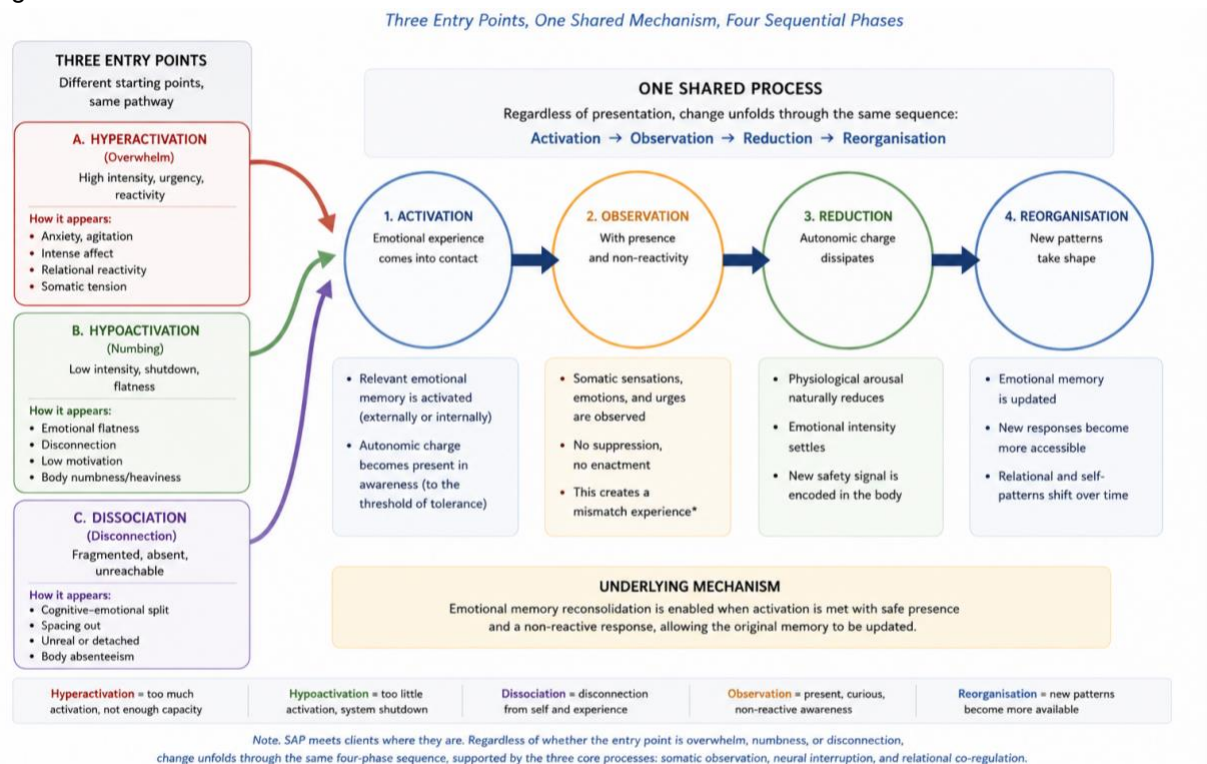
Although the cases differed in how they presented, the therapeutic process followed a similar pattern across all three.

In each case, therapy involved bringing relevant emotional activation into awareness. This was followed by guiding the client to observe bodily sensations without reacting, analysing, or avoiding the experience.

As clients were able to remain with this activation, the intensity of the autonomic response began to reduce. This reduction was not forced, but occurred gradually through sustained observation.

Following this shift, changes were observed in emotional responses, behaviour, and relational patterns. This sequence can be summarised as activation of emotional experience, somatic observation, reduction of autonomic charge, and reorganisation of response. This process was consistent across all cases, despite differences in starting point and presentation. See figure 1 below for the process model of SAP illustrating the three points of entry.

Figure 1: Process Model of Somatic Attachment Protocol



Source: Author's conceptualization based on the Somatic Attachment Protocol (SAP) framework developed in this study.

While the overall pattern of change was consistent across cases, the process did not unfold in a strictly linear manner. Periods of difficulty were observed, including initial resistance to sustained somatic observation, fluctuations in the client's capacity to remain with activation, and moments where cognitive or behavioural avoidance re-emerged. These variations highlight the iterative and non-linear nature of engaging with autonomic processes in therapy. In some instances, progress was slower or temporarily stalled, particularly when clients experienced difficulty sustaining attention on bodily sensations or reverted to habitual cognitive or behavioural patterns.

6. Role of Therapist as Regulatory Scaffold

The therapist played a central role in supporting this process across all cases. Through relational co-regulation, the therapist provided a stable and attuned presence that helped clients remain within a tolerable range of activation. This was particularly important in cases of high activation, where emotional intensity could become overwhelming, and in cases of low or disconnected activation, where engagement with experience needed to be supported.

The therapist also guided attention, helping clients shift from narrative or cognitive processing to direct bodily awareness. At key points, neural interruption techniques were used to disrupt repetitive patterns and support flexibility in experience.

In this way, the therapist functioned as a regulatory scaffold, supporting the client's ability to engage with and process autonomic activation.

Different Entry Points, Shared Mechanism

While the underlying process was consistent, the entry point into therapy differed across cases.

In Case 1, the focus was on regulating excessive activation and helping the client remain with intense emotional states without escalation.

In Case 2, the focus was on increasing access to activation by building awareness of subtle bodily sensations and supporting engagement with emotional experience.

In Case 3, the focus was on reconnecting cognitive processing with bodily experience by interrupting avoidance patterns and redirecting attention to somatic awareness.

These differences highlight that while the mechanism of change may be shared, the path into that mechanism varies depending on the individual's pattern of regulation. Despite these variations, all cases converged on the same process of working with autonomic charge through the AORR stages.

Across all three cases, different attachment-related difficulties were associated with different patterns of autonomic activation. However, therapeutic change did not depend on targeting each presentation separately.

Instead, change occurred through engagement with a shared underlying process: the reduction of autonomic charge under conditions of sustained somatic observation and co-regulation. This is consistent with the possibility that diverse attachment presentations may reflect variations in the expression of a common mechanism, rather than fundamentally distinct problems.

7. Discussion

Mechanism Over Symptom

This study examined three cases presenting with distinct attachment-related difficulties, including relational instability, emotional flattening, and cognitive-emotional disconnection.

Although these presentations differed at the level of observable symptoms, analysis across cases revealed a consistent underlying process through which change occurred.

Across all cases, therapeutic change followed a similar sequence: activation of emotional experience, sustained somatic observation, reduction in autonomic activation, and subsequent reorganisation of emotional and behavioural responses. This convergence suggests that diverse attachment-related difficulties may reflect variations in a shared underlying regulatory process, rather than fundamentally distinct conditions.

These findings support a process-based perspective on psychotherapy, in which the focus shifts from categorising symptoms to understanding how emotional experience is organised, activated, and resolved within the nervous system. Therapeutic change then involves working with this activation directly, rather than targeting symptoms alone.

The construct of autonomic charge is not intended to represent a novel physiological entity, but rather a clinically integrative term that synthesises existing constructs across affective neuroscience and psychophysiology. It overlaps with concepts such as autonomic arousal, the window of tolerance (Ogden & Minton, 2000), and the polyvagal hierarchy (Porges, 2011), while emphasising the experiential and process-oriented dimension of unresolved activation as it is encountered in clinical practice. In this sense, autonomic charge functions as a bridge construct, linking subjective somatic experience with underlying regulatory dynamics, rather than competing with established theoretical models. As such, autonomic charge is best understood as a clinically useful, theoretically grounded construct rather than a directly measurable biological entity in the present study.

The findings of this study can be summarised in a central proposition: therapeutic change may occur through the reduction of autonomic charge under conditions of sustained somatic observation and relational co-regulation, enabling the reconsolidation of previously encoded emotional patterns.

The present study does not establish SAP as an empirically validated treatment model. Rather, it offers a theoretically coherent and clinically grounded account of how change may occur, based on observed therapeutic processes. The value of this contribution lies in articulating a process model that can be further tested, refined, and evaluated in future research.

Implications for Attachment-Oriented Therapy

The findings suggest that attachment work may benefit from a shift in focus from symptom categories to underlying processes.

In traditional approaches, different attachment patterns are often addressed using different strategies. For example, high reactivity may be treated through regulation techniques, while emotional disconnection may be addressed through activation or engagement strategies.

While these distinctions remain useful, the present findings suggest that these patterns can also be understood as different entry points into the same process. In all cases, the central task is to support the client in engaging with autonomic activation in a way that allows it to resolve.

This has practical implications for therapy. Rather than applying fixed interventions based on presentation, therapists may benefit from tracking the client's level of activation and adjusting their approach accordingly. This includes recognising when to support regulation, when to increase activation, and when to redirect attention from cognitive processing to embodied experience.

Relation to Existing Literature

Positioning of SAP Within Existing Therapeutic Approaches

While SAP shares common ground with existing somatic and experiential therapies, it differs in its emphasis on the primary mechanism through which change is facilitated.

Approaches such as those developed by Peter Levine emphasise the discharge and completion of autonomic responses as a pathway to resolving trauma-related activation. Similarly, experiential therapies, including those developed by Greenberg (2011), focus on the transformation of emotional experience through expression, processing, and meaning-making within a therapeutic context.

SAP aligns with these approaches in recognising the importance of embodied emotional processes. However, it diverges in its central emphasis on sustained, non-interventionist observation of autonomic activation as the primary driver of change. Rather than facilitating discharge or emotional transformation directly, SAP prioritises the client's capacity to remain in contact with activation without reactive engagement. In this framework, reduction of autonomic charge occurs through the stabilisation of attention and the absence of reinforcing responses, rather than through active resolution strategies.

In contrast to models that rely more heavily on emotional expression or cathartic processes, SAP conceptualises change as emerging from the gradual dissolution of activation under conditions of sustained awareness and relational safety. Neural interruption techniques are used not as primary interventions, but as supportive mechanisms to disrupt rigid patterns and enable continued observation.

This positioning suggests that SAP may represent a distinct process-based pathway within the broader landscape of somatic and experiential therapies. Rather than focusing on what clients do with emotional experience, SAP emphasises how they relate to it at the level of sustained attention and regulation.

Emerging and as yet pre-empirical modalities such as Multichannel Eye Movement Integration (MEMI) offer a preliminary clinical account of memory updating through structured sensory and attentional interventions. These approaches share with SAP a provisional focus on non-cognitive, bottom-up processing, though their empirical status remains limited and their inclusion here is illustrative rather than comparative.

However, SAP differs in its central emphasis on sustained, non-directive somatic observation as the primary mechanism of change. Whereas MEMI employ structured procedural interventions to actively disrupt and reorganise sensory and perceptual patterns, SAP prioritises the dissolution of autonomic activation through stabilised attention and relational co-regulation. From this perspective, reorganisation is not directly induced, but emerges as a consequence of reduced autonomic charge under conditions of sustained awareness.

The findings are consistent with existing work on emotional memory reconsolidation, which suggests that emotional learning can be updated when activated under conditions that allow for new experience (Ecker et al., 2012; Lane et al., 2015). These findings are also consistent with clinical reconsolidation models suggesting that symptom transformation occurs when emotional schemas are destabilised and revised through new experiential input (Ecker & Bridges 2020).

The emphasis on bodily experience also aligns with research on interoception, which highlights the role of the body in emotional awareness and regulation (Craig, 2009). Somatic approaches to therapy have similarly emphasised the importance of attending to bodily sensations as part of emotional processing (Levine, 2010; Gendlin, 1996).

At the same time, the present study contributes to this literature by offering a clearer articulation of the process through which change may occur. Specifically, it highlights the role of reducing autonomic charge through sustained observation, supported by relational co-regulation and targeted interruption of habitual patterns.

In this way, the Somatic Attachment Protocol (SAP) can be understood as an applied framework that integrates these elements into a coherent clinical process.

Contribution of the Somatic Attachment Protocol (SAP)

The contribution of SAP lies not in introducing entirely new techniques, but in offering a more precise articulation of the process through which therapeutic change may occur. Specifically, SAP organises existing insights from memory reconsolidation, somatic awareness, and relational regulation into a coherent, process-based model centred on the modulation and resolution of autonomic activation.

SAP provides a structured account of how therapeutic change unfolds across different clinical presentations. In addition, SAP emphasises the development of a transferable skill. Clients are supported in learning how to remain with emotional activation without reactive interpretation. Over time, this skill can be applied outside of therapy, allowing individuals to engage with emotional experience in a more regulated and adaptive way. This focus on skill acquisition extends the relevance of the approach beyond individual sessions and supports generalisation into everyday life.

Clinical Implications

The findings suggest several implications for clinical practice.

First, therapists may benefit from focusing on the client's level of autonomic activation rather than relying solely on symptom categories. This includes recognising whether the client is in a state of high activation, low activation, or disconnection from experience.

Second, intervention can be guided by the client's current state. For clients with high activation, the focus may be on stabilisation and supporting tolerance of experience. For clients with low activation, the focus may be on increasing access to bodily sensations. For clients with cognitive dominance, the focus may be on redirecting attention from thinking to embodied awareness.

Third, the therapist's role as a source of co-regulation remains central. Providing a stable and attuned presence allows clients to engage with emotional activation in a way that would not be possible independently, particularly in the early stages of therapy.

Finally, the emphasis on somatic observation highlights the importance of developing the client's capacity to remain with internal experience without avoidance or over-interpretation.

8. Limitations

This study has several limitations that should be considered when interpreting the findings.

First, the sample size was small. The analysis was based on three cases, which limits the ability to generalise the findings. The purpose of this study was to explore process rather than to establish effectiveness across a wider population.

Second, the data were drawn from clinical observation and therapist notes. While this allows for detailed tracking of internal processes, it does not provide objective or standardised measurement. The absence of quantitative data limits the ability to compare results across cases or with other studies.

Third, all cases were treated by a single therapist. The outcomes may therefore be influenced by the therapist's skill in guiding somatic observation, providing co-regulation, and applying neural interruption. This raises questions about how easily the approach can be replicated across practitioners with different levels of experience.

Fourth, the study did not include physiological measures of autonomic activation. As a result, changes in autonomic charge were inferred from subjective experience and observed behaviour rather than directly measured.

Finally, the analysis focused on short- to medium-term changes within the course of therapy. Long-term outcomes and the stability of change over time were not assessed.

Outcome tracking also differed across cases in ways that should be noted. SUDS ratings were recorded in all three cases and indicated substantial within-session reductions in perceived distress at points where a discrete intervention technique was applied. In one case, an additional global wellbeing scale was used alongside SUDS to track broader change over the course of a longer treatment arc, reflecting that case's hypoactivation presentation, where the clinical concern was diminished emotional access over time rather than acute distress alone. These measures were not standardized instruments and were not applied with consistent frequency across cases, so they provide supportive but limited evidence of change. Additionally, in two cases the SAP-specific intervention phase was brief (one to three sessions), which limits conclusions about the durability of change beyond the periods of follow-up contact described. Finally, in all three cases, clients had an existing therapeutic relationship with the same therapist prior to the introduction of SAP; the contribution of this pre-existing alliance cannot be fully disentangled from the specific contribution of SAP itself.

Future research may address these limitations by including larger samples, multiple therapists, and the use of physiological or behavioural measures. Comparative studies with other therapeutic approaches may also help clarify the specific contribution of the processes described in this paper.

In addition, the contribution of non-specific therapeutic factors cannot be ruled out. Elements such as therapeutic alliance, expectancy effects, repeated attention to emotional material, and the passage of time may have contributed to observed changes. As the present design does not include comparison conditions or independent measures, it is not possible to attribute change specifically to SAP processes. Future research incorporating controlled comparisons or independent outcome measures would be required to clarify the specificity of the proposed mechanisms.

Conclusion

This study examined three cases with different attachment-related presentations, including relational instability, emotional flattening, and cognitive-emotional disconnection. Although these cases appeared different at the level of symptoms, the analysis showed that change followed a similar process across all three.

In each case, emotional activation was brought into awareness and observed without reactive interpretation. Over time, this allowed autonomic activation to reduce, followed by changes in emotional response, behaviour, and relational patterns.

These findings support the view that different attachment difficulties may reflect variations in the expression of a shared underlying mechanism. Rather than treating each presentation as a separate condition, therapy can focus on how autonomic charge is activated, accessed, and resolved.

The Somatic Attachment Protocol (SAP) provides a structured way of working with this process. By integrating somatic observation, neural interruption, and relational co-regulation, it offers a flexible framework that can be applied across different clinical presentations.

Importantly, the approach also supports the development of a transferable skill. As clients learn to remain with emotional activation without reacting to it, they are able to apply this process beyond therapy, supporting ongoing change in daily life. While the findings remain preliminary, they contribute to a growing movement toward process-based models of psychotherapy that prioritise underlying mechanisms over surface-level symptom distinctions. By highlighting the role of autonomic charge and its resolution through sustained somatic observation, this study offers a framework for understanding how diverse emotional and relational patterns may reorganise through a shared pathway of change.

CRediT Authorship Contribution Statement

Nicole S. Y. Tang: Conceptualisation, Methodology, Investigation, Formal Analysis, Writing – Original Draft, Writing – Review & Editing.

Conflict of Interest Statement

The author declares that there are no conflicts of interest regarding the publication of this paper.

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Data Availability Statement

The clinical data supporting the findings of this study are not publicly available due to confidentiality and privacy considerations associated with clinical case material. The analysis is based on anonymised clinical observations, therapist process notes, client-reported experiences, and, where applicable, subjective units of distress (SUDS) recorded during therapy sessions. A de-identified summary may be made available by the corresponding author upon reasonable request, subject to applicable confidentiality and ethical restrictions.

Ethical Approval Statement

This study is based on anonymised clinical case material derived from routine therapeutic practice. All identifying information was removed or modified to protect client confidentiality, and all clients provided informed consent for the use of their anonymised clinical material for research and publication purposes. No experimental intervention was conducted specifically for the purposes of this study.

AI Use Disclosure Statement

The author used ChatGPT, Claude (Anthropic) and Gemini (Google), which are AI language models, to assist with structural editing, academic language refinement, and the identification of coherence issues during the preparation of this manuscript. All theoretical content, clinical material, case formulations, and intellectual contributions are the original work of the author. The process figure (Figure 1) was created by the author with the help of AI tools. The author takes full responsibility for the integrity, accuracy, and originality of all content presented in this manuscript.

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Appendix A

Session-Level Procedural Detail by Case

The following table summarizes session-level procedural detail for each case, including treatment duration, session counts, and timing of outcome measurement, as referenced in the Method and Limitations sections.

	Case 1	Case 2	Case 3
Total time in therapy	Jun 2023–present, gap Feb 2024–Jun 2025	Jul 2022–Jul 2026 (40 sessions)	Aug 2024–Jul 2026, two episodes
Pre-SAP history	11 sessions (Jun 2023–Feb 2024): EMDR, CBT	Prior therapy elsewhere before treatment start; co-regulation present from session 1 with this therapist	Sessions 1–3 (Aug–Sep 2024): intake and initial talk therapy
SAP structure	Sessions 14–16 (11 Jul–7 Aug 2025)	EMDR sessions 18–23 (Oct–Dec 2023); MEMI sessions 30 (4 Aug 2024), 34 (16 Mar 2025)	Episode 1: session 4 (Sep 2024) + follow-up sessions 5–6; Episode 2: sessions 9–10 (6, 22 Nov 2025) + consolidation sessions 11–12 (22 May, 3 Jul 2026)
SAP-phase session count	3 sessions over ~4 weeks	Neural interruption applied across 8 discrete sessions within a 40-session continuous arc	Episode 1: 1 SAP session (+2 follow-up); Episode 2: 2 SAP sessions (+2 consolidation)
Outcome measure	SUDS: 100%→50% (session 14)	SUDS: session 30, 100%→15%; session 34, 100%→30%. Global wellbeing scale (1–10): baseline 5 → session 40, 8	SUDS: Episode 1 (session 4), 100%→50%→25%; Episode 2, session 9 –20%, session 10 further –50%
Case status	Discontinued after session 16; informal follow-up contacts Dec 2025	Closed/maintenance-stable at session 40	Closed as of session 12 (Jul 2026)