



From Dysregulation to Co-Regulation: A Mixed-Methods Exploratory Case Series of Remote ReAttach for Functional Neurological Disorder

**LeElla Call¹, Steven Painter², Paula Zeestraten-Bartholomeus³,
and Aida Mehrad⁴**

¹LeElla Call, Functional With FND, West Haven, Utah, USA

²Neurolog, United Kingdom

³ReAttach Academy, The Netherlands

⁴Universitat Internacional de Catalunya, Barcelona, Spain

***Corresponding author:** Ella Call, LeElla Call Functional With FND, West Haven, Utah, USA,
E-mail: functionalwithfnd@gmail.com

Abstract

Functional Neurological Disorder (FND) involves ongoing problems with autonomic, sensory, cognitive, and emotional regulation. People with FND often struggle to manage these symptoms on their own, especially during times of high stress, dissociation, increased movement symptoms, or mental overload. Short, remote, and personalized interventions that help with both self-regulation and co-regulation could be useful. This mixed-methods case series looks at remote ReAttach interventions provided to adults with FND and Functional Movement Disorder (FMD) between 2025 and 2026.

Participants took part in remote sessions tailored to their needs, using methods like W.A.R.A. (Wiring Affect with ReAttach), Forgive & Forget Hood, ConFusion, Identifications, and a new technique called the Safety Override Technique (SOT) that focuses on hypervigilance. Data came from participant stories, written feedback, clinical notes, and available Neurolog symptom logs. One participant also shared a series of time-stamped transcripts, which allowed for detailed language analysis.

Participants reported several important benefits, such as feeling less overwhelmed, better emotional regulation, clearer thinking, less dissociation or movement symptoms, and more sense of control. Co-regulation was a key part of the therapy, helping people reach states of regulation they could not achieve on their own. These early results suggest that remote ReAttach could be an accessible and responsive option for people with FND or FMD, especially for those whose needs are not fully met by current treatments. The findings lay the foundation for future research using the Neurolog Symptom Amplification Module (SAM).

Keywords: Functional Neurological Disorder, ReAttach, self-regulation, co-regulation, Neurolog

Introduction

Functional Neurological Disorder (FND) is diagnosed using positive clinical features and examination signs that demonstrate altered neurological functioning, rather than solely through the absence of structural neurological disease. People with FND may experience non-epileptic seizures, movement problems, changes in sensation, trouble walking, weakness, fatigue, memory or thinking issues, and big changes in how they function day to day. Functional Movement Disorder (FMD), which is often seen as part of FND, brings extra difficulties like involuntary movements, instability, and symptoms that can suddenly get worse (Hallett et al., 2022).

Even though the symptoms are real and often severe, many people with FND or FMD not only struggle physically but also lose hope. Some have seen many healthcare providers without lasting improvement. Others feel misunderstood, dismissed, or labeled as too complex or difficult to treat. Over time, this can add another layer of difficulty, as hopelessness becomes part of what they experience.

Emerging longitudinal patient-reported data suggest that hopelessness may be more than an understandable response to prolonged illness. In a wider exploratory NeuroLog analysis, 585 daily entries from 224 people containing the emotion “hopeless” had a mean overall symptom severity of 7.31/10, compared with 6.01/10 in other entries; 72.5% were high-severity logs

($\geq 7/10$), compared with 40.6% of other entries. Among 147 people with both types of entry, severity was on average 0.97 points higher within the same person when hopelessness was recorded. Hopelessness also co-occurred with higher physical symptom burden. This does not establish that hopelessness causes or predicts symptom escalation; rather, it suggests that it may function as a clinically meaningful marker of a high-burden state in which distress, symptoms, and perceived capacity are converging. Recognising this state may help clinicians offer support before it is misread as disengagement, resistance, or lack of motivation

This situation makes us rethink what it means when patients are called difficult to treat. Sometimes, this label reflects not just the complexity of the condition, but also a mismatch between what the patient needs and the treatment being offered. New ideas, like fixed autonomic states, the Emotional Symptom Regulation Model (ESRM), and ReAttach M.I.S.T., suggest that some people with FND or FMD may be stuck in certain patterns that limit their attention, body regulation, emotions, relationships, and ability to seek help (Painter et al., 2025a, 2026a, 2026b; Zeestraten-Bartholomeus et al., 2026a). Here, regulatory capacity refers to the person's moment-to-moment ability to remain oriented and engaged, access attention and working memory, and tolerate the therapeutic task without becoming overwhelmed, shut down, or dissociated.

Seen this way, a person might not be disengaged because they are unwilling or unmotivated. Instead, they could be in a state where it is harder for them to regulate themselves. This difference matters in clinical care, as it changes the question from 'Why is this person not responding?' to 'What kind of support can help them in their current state?'

Remote ReAttach-based approaches may be helpful here because they offer a simple, personalized, and possibly affordable way to support self-regulation and co-regulation. This can be especially useful for people who cannot take part in longer or more demanding therapy due to fatigue, changing symptoms, mobility issues, financial challenges, or feeling overwhelmed. Early studies on remote W.A.R.A. show that remote sessions are possible and may have positive short-term effects (Weerkamp-Bartholomeus et al., 2020, 2021). Related ReAttach work on New Mind Creation (NMC) has described how structured, state-based methods can encourage a growth mindset and adaptive thinking. This background helps explain the idea behind the Safety Override Technique, which is a brief method designed to shift hypervigilance toward safer regulation (Zeestraten-Bartholomeus et al., 2026b).

The present article reports preliminary field-based observations from remote ReAttach work with a small group of people who have FND or FMD. It brings together participant stories, clinical observations, and symptom logs from Neurolog. In one case, a series of time-stamped session transcripts allowed for a detailed language analysis, and two other transcripts focused on hypervigilance were used to analyze the new Safety

Override Technique (SOT). The goal is not to prove effectiveness, but to offer useful clinical insights, highlight participant experiences, and lay the groundwork for future research using the Neurolog Symptom Amplification Module (SAM) protocol (Painter et al., 2025b).

Recent studies have started to build a broader framework for understanding regulation problems in psychobiosocial conditions like FND. The ReAttach M.I.S.T. framework, the Emotional Symptom Regulation Model (ESRM), and research on fixed autonomic states all suggest that symptoms may not just fit into single disorder categories. Instead, they may show ongoing patterns in arousal, sensory integration, cognitive bias, emotional processing, and how people relate to others (Painter et al., 2026a, 2026b; Zeestraten-Bartholomeus et al., 2026a).

In this framework, FND/FMD symptoms are seen not just as problems to stop, but as signs of a system that is out of balance. This idea fits with larger models of stress and defense that focus on adaptation, patterns in the nervous system, and the effects of ongoing stress (Bracha, 2004; Cannon, 1932; McEwen, 1998). It also matches what clinicians often see: brief, targeted interventions can sometimes make a real difference, even in complicated cases.

The Safety Override Technique (SOT) was developed in this clinical setting as a short, ReAttach-based method for people who struggle with hypervigilance, sensory overload, or constant threat monitoring. In the cases reviewed here, SOT used quick tapping, therapist cues, confusion to interrupt hypervigilant thinking, and guidance to help participants move toward a safer or more positive state. According to the therapist, this approach was most helpful when participants could not calm themselves directly. The method seems to borrow ideas from the Confusion Technique and from approaches like New Mind Creation, which use state-based activation to help people develop better coping patterns (Zeestraten-Bartholomeus et al., 2026b).

The Neurolog Symptom Amplification Module (SAM) protocol is important here because it links therapy with participants' own long-term symptom tracking, emotional notes, and real-life changes (Painter et al., 2025b). This paper does not replace that protocol. Instead, it offers early, practice-based insights that could help improve it, especially around participant feedback, state-sensitive methods, ongoing hypervigilance, partner roles, and the challenges of incomplete real-world records. This exploratory article describes early mixed-methods findings from remote ReAttach-based support for people with FND/FMD. We use participant stories, practice observations, and naturalistic Neurolog symptom logs to look at perceived benefits, shifts from hopelessness to agency, changes in self- and co-regulation, the impact of brief remote interventions, the possible value of tools like the Safety Override Technique (SOT), and clinical signals that could guide future Neurolog SAM-based research. A second aim was to carry out qualitative process analyses for participants with time-stamped session transcripts. We used these analyses to see if changes over time appeared

not just in symptoms and functioning, but also in language, communication, how participants described their experiences, and how teachable and logical the Safety Override Technique seemed.

Method

Design

This study uses a mixed-methods exploratory case series approach, drawing on field observations from practice. It brings together qualitative narratives and descriptive data from natural symptom logs. The aim is to describe and generate hypotheses, not to confirm them. When this draft was written, the study group included about five participants from a practice-based group of Neurolog users with FND or FMD conditions. Both women and men were represented, with at least one participant also having post-traumatic stress disorder (PTSD). Two participants were involved in training, peer support, or lived-experience collaborations, which made their cases especially useful for exploring self-regulation, co-regulation, and participation.

For this manuscript, the participants are described as follows:

- Participant 1: Male, 42 years old, with FMD and experience in lived-experience collaborations.
- Participant 2: Male, 52 years old, with FND and involved in training contexts.
- Participant 3: Male, 43 years old, with FND and PTSD.
- Participant 4: Female, 19 years old, with FMD. A transcript series was available for qualitative language analysis.
- Participant 5: Female, 23 years old. Her transcript, focused on hypervigilance, contributed to the qualitative analysis of SOT.

Final participant numbers, case descriptions, and demographic details will be confirmed in the final submission.

Clinical Context and Setting

All participants were users of Neurolog and received remote ReAttach-based support between October 2025 and June 2026. The work was carried out on a non-fee basis in a real-world clinical context rather than within a formal controlled trial. Participants were invited to share reflections on their experiences and to permit anonymized use of their material for exploratory publication.

The group was clinically relevant because the participants represented people living with persistent dysregulation, substantial symptom burden, and varying degrees of hopelessness, repeated disappointment, or felt lack of therapeutic fit. In this sense, the sample was not selected for simplicity, but for complexity.

Intervention Procedures

Sessions were individualized and state-sensitive, adapting to

the participant's clinical presentation, momentary needs, and regulatory capacity rather than following a fixed, manualized experimental protocol. Sessions were generally brief—typically lasting approximately 30 minutes—and relational co-regulation formed a central, guiding component of all sessions. The intervention was individualized rather than delivered as an identical set of procedures to every participant. Across the available case accounts, the procedures described included sensory grounding, structured tapping, tactile pressing, the Forgive & Forget Hood, guided conceptualization and reframing tasks, and the emerging Safety Override Technique (SOT). The manuscript does not establish that every participant received each procedure, and no physiological measures were collected to determine whether any procedure produced a specific sympathetic, parasympathetic, or other biological response. An emerging brief intervention for hypervigilance was also developed and applied in this work, provisionally termed the Safety Override Technique (SOT). Conceptualized as a mixed ReAttach-derived intervention, the SOT combines elements of the ConFusion Technique, Cognitive Bias Modification 1 (within ReAttach), and New Mind Creation-related state-shifting logic. In the present material, SOT was used as a brief, guided procedure for interrupting hypervigilant threat dominance and facilitating a rapid shift toward a safer regulatory state when direct access to calmer regulation was otherwise difficult. The SOT utilized rapid tapping, pressing cues, brief confusion-based sequencing, and the deliberate evocation or amplification of a safer or more positive felt state. In several instances, the method was rehearsed collaboratively so that participants and their close others could later use aspects of it outside the immediate session. Because hypervigilance may re-emerge episodically in individuals with FND/FMD even after meaningful therapeutic progress, the SOT is considered a promising and practical addition to the Affect Coach Online Program.

Co-Regulation and Systemic Involvement

Co-regulation was an important part of the clinical process. In some cases, partners were present during sessions. In at least one case, a partner applied ReAttach techniques under instruction. These observations suggest that regulation in this group may not be exclusively individual, but often relational and systemic. This issue is especially relevant in a population in which isolation, fear, dysregulation, and instability can affect close relationships as well as individual functioning.

Data Sources

Four forms of material informed the present study: participant narratives and written reflections, practice-based clinical observations from remote sessions, available naturalistic Neurolog symptom logs, and longitudinal, anonymized, time-stamped transcripts (specifically from Participants 4 and 5).

Participant narratives and written reflections were central to the study, as the intention was to understand therapeutic change not only through symptom description but also

through lived meaning. Practice-based clinical observations contributed a vital contextual understanding of state shifts, relational factors, intervention fit, and recovery processes. Where available, naturalistic Neurolog logs served as a complementary longitudinal data source. Finally, the transcript material enabled an embedded qualitative process analysis of both communicative language change and the application of the emerging Safety Override Technique (SOT). All participants were users of Neurolog. Symptom logging was included as a naturalistic source of longitudinal self-report data rather than as a fully standardized research dataset. Variability in logging behavior was expected. Some participants may have logged consistently, some intermittently, and some may have forgotten or stopped logging during the process. Incomplete or interrupted logging was not treated as failure of participation, but as part of the real-world context of this patient group, in which fatigue, cognitive overload, avoidance, emotional fluctuation, symptom escalation, and changing functional capacity may all affect adherence to self-monitoring. Available logs were therefore used descriptively to identify symptom patterns, recurrence, fluctuation, and possible change over time, without requiring complete uniformity across cases. The analytic procedure for the narrative, transcript, and descriptive materials is outlined below.

Qualitative Analytic Procedure

The overall study was exploratory and mixed-methods in nature. Participant narratives and written reflections were reviewed qualitatively to examine perceived benefit, lived meaning, changes in self-regulation, changes in hope and agency, and the role of relational support. Clinical observations were used to support contextual interpretation. Neurolog logs were examined descriptively where available to explore symptom intensity, variability, persistence, recurrence, and possible change over time. The purpose of the quantitative and descriptive material was triangulation rather than formal outcome modeling. Within this broader design, the transcript analysis followed an iterative qualitative procedure focused on changes over time in how participants described bodily sensations, emotions, self-observation, daily functioning, and agency. All transcripts were read several times in chronological order, first within each case and then across cases, so that linguistic changes could be understood in relation to the sequence of the intervention rather than as isolated statements. The analysis was theory-informed but not based on a fixed coding scheme in advance. In the first round, meaningful utterances and short interactional fragments were marked and described closely. In the second round, these fragments were compared within and across cases and grouped into broader interpretive categories. This process resulted in four recurring domains: somatic/affective language, metacognitive differentiation, functional self-description, and agency-oriented language. These domains were used to structure the comparison while allowing overlap where utterances reflected more than one process at the same time.

Embedded qualitative longitudinal analyses were also conducted for selected transcript subsamples. One focused on Participant 4, for whom a series of time-stamped transcripts from remote sessions was available. A second focused on two hypervigilance-related transcripts involving a young female participant, a male participant with partner involvement, and a small supervision-group context involving a peer helper or trainee participant. These analyses were interpretive and transcript-based, with attention to language content, language form, interactional organization, metalinguistic reflection, textual indicators of affect, temporal organization, and, in the hypervigilance material, the procedural structure and apparent therapeutic logic of SOT. This approach was informed by discourse analysis, conversation analysis, and longitudinal process-oriented psychotherapy research (Avdi et al., 2015; Goodman, 2017; McLeod & Balamoutsou, 2019; Muntigl et al., 2020; Salvatore et al., 2020; Voutilainen et al., 2011). Interpretation focused on how utterances functioned in context and how they reflected change during the ReAttach process. Excerpts were therefore read in relation to the surrounding interaction, the timing within the intervention, and the participants' own evaluations of stress, relaxation, safety, overarousal, and functioning. Because source audio analysis was not undertaken for the embedded studies, no conclusions were drawn about prosody, pitch, or fine-grained vocal affect. The transcript-based time stamps did, however, allow cautious examination of pauses, hesitation sequences, response timing, and guided procedural sequencing as interactional rather than purely acoustic phenomena. As an exploratory qualitative case analysis, the purpose was interpretive depth and pattern identification rather than formal inter-rater reliability or formal linguistic modeling. To strengthen trustworthiness, patterns identified within the separate training cases were compared with the longitudinal FND case. The final analytic model was developed through repeated reading and comparison across the full dataset rather than imposed beforehand. Ethical considerations relevant to the use of anonymized practice-based material are outlined below.

Ethical Considerations

This article reports anonymized practice-based observations collected with participant permission. It was not designed as a formal controlled clinical trial. No identifying personal details are included in the manuscript. Participants were invited to contribute voluntarily and to allow use of their reflections and case material in anonymized form.

Results

Overview of Findings

All participants entered the process from a condition marked by persistent dysregulation and a subjective sense of being stuck. Clinically, these starting points were conceptualized as consistent with fixed or recurrent dysregulated states rather than isolated transient symptoms. Several participants also

appeared to have reached a level of discouragement in which hope for meaningful change had been reduced.

Within this exploratory mixed-methods case series, all participants described some degree of meaningful benefit from the remote ReAttach process. Because the present study is intentionally qualitative and practice-based in orientation, the findings are not framed primarily through uniform standardized outcome scores. Instead, they are presented through participant narratives, supported where possible by descriptive observations from Neurolog symptom logs.

Participant Narratives

Participant 1

Participant 1 was an adult diagnosed with Functional Movement Disorder (FMD) within the broader Functional Neurological Disorder (FND) spectrum. At baseline, the participant presented with persistent motor instability, involuntary movements, and difficulty modulating arousal during stress. Their symptom profile included fluctuating tics, episodic motor intensification, and heightened sensitivity to both emotional and sensory triggers. These features were consistent with a recurrent dysregulated autonomic state, rather than isolated motor events. The participant reported a long history of treatment fatigue and limited benefit from prior interventions, particularly those requiring sustained cognitive effort or prolonged emotional exposure. This pattern suggested reduced regulatory access and diminished therapeutic hope at the outset of intervention.

Intervention Exposure and Engagement

Remote ReAttach sessions emphasized multimodal sensory grounding, fast tapping sequences, and parasympathetic-oriented pressing procedures. The participant engaged readily with these techniques and demonstrated early responsiveness to co-regulation, indicating that the intervention successfully lowered the cognitive load typically associated with trauma-focused therapies.

The participant described the tapping and fingertip-based grounding techniques as an accessible “extra tool” for interrupting escalating arousal. They reported that self-applied tapping on the collarbone or shoulders produced a “distraction calming” effect during stressful moments, suggesting rapid engagement of sensory-motor pathways that support down-regulation.

Observed Changes Across Sessions

Across sessions, the participant reported:

- Reduction in tic intensity, including fewer abrupt motor surges during high-arousal periods
- Increased familiarity with high-arousal bodily sensations, indicating improved interoceptive tolerance
- Reduced overwhelm during emotionally evocative procedures

- Improved regulatory confidence, reflected in greater willingness to use techniques independently

The Forgive & Forget Hood elicited strong emotional activation but was described as “less overwhelming” than prior trauma-focused therapies such as EMDR. This suggests that ReAttach’s structured, multisensory format may buffer against excessive autonomic activation while still enabling emotional processing. During down regulation procedures, the participant exhibited visible motor relaxation, including spontaneous shoulder release, and reported decreased fear. These observations are consistent with rapid shifts toward parasympathetic dominance, a key therapeutic target in FND.

Naturalistic Symptom Data

Where available, Neurolog logs provided descriptive, time-stamped symptom data. Although symptom intensity continued to fluctuate, logs indicated modest reductions in motor escalation during periods when the participant practiced ReAttach techniques independently. These naturalistic data support the participant’s subjective reports and suggest emerging regulatory stability.

Summary of Clinical Benefit

Overall, Participant 1 demonstrated meaningful benefit from brief remote ReAttach sessions. Improvements were most notable in:

- Motor symptom modulation
- Reduction of overwhelm during arousal spikes
- Increased regulatory confidence
- Enhanced ability to interrupt escalating autonomic states

These findings indicate that ReAttach may offer a low-threshold, accessible regulatory intervention for individuals with FMD who have previously struggled with cognitively demanding or emotionally intensive therapies.

Participant 2

Participant 2 was an adult diagnosed with Functional Neurological Disorder (FND) who also participated in training-related contexts connected to ReAttach and peer-support environments. At baseline, the participant presented with a dissociative symptom profile characterized by cognitive fog, emotional overwhelm, and stress-linked functional instability. They reported difficulty sustaining emotional presence during triggering events and described a tendency to “close off” or disconnect from internal experience—consistent with autonomic hypo-arousal and dissociative withdrawal patterns commonly observed in FND.

Intervention Exposure and Engagement

Remote ReAttach sessions emphasized sensory grounding, fast tapping, and guided conceptualization tasks designed to enhance emotional accessibility and cognitive integration.

The participant engaged actively and demonstrated strong responsiveness to co-regulation, suggesting intact capacity for relational attunement despite baseline dissociative tendencies. They described ReAttach as “more welcoming” than trauma-focused therapies such as Eye Movement Desensitization and Reprocessing (EMDR) or Cognitive Processing Therapy (CPT), noting that ReAttach targeted the “whole emotional state” rather than requiring explicit trauma disclosure. This distinction highlights ReAttach’s non-exposure-based mechanism, which may reduce avoidance and facilitate broader affective integration. Fast tapping was reported to increase present-moment awareness and cognitive focus, while the Forgive & Forget Hood procedure facilitated a shift from agitation and frustration toward sadness—a transition the participant interpreted as deeper emotional processing rather than destabilization. This emotional reorganization suggests activation of limbic-cortical integration pathways, supporting adaptive affect regulation.

Observed Changes Across Sessions

Over the course of intervention, the participant reported:

- Increased emotional accessibility, including greater self-kindness and compassion
- Improved relational connection with their spouse, reflecting enhanced interpersonal regulation
- Strengthened identity coherence, describing reconciliation between their pre-FND self and current lived reality
- Reduced frequency of dissociative episodes, with improved ability to “catch symptoms early” using ReAttach techniques

These outcomes indicate enhanced metacognitive awareness and early interception of dysregulation, consistent with improved top-down modulation of autonomic responses.

Naturalistic Symptom Data

Where available, Neurolog logs provided descriptive corroboration. Data reflected reduced frequency of dissociative episodes but continued variability in intensity—consistent with the participant’s report that symptoms were “less disruptive” even when present. This pattern suggests partial stabilization of autonomic reactivity and improved recovery trajectories following stress exposure.

Summary of Clinical Benefit

Overall, Participant 2 demonstrated meaningful benefit in:

- Emotional regulation, evidenced by increased affective range and reduced avoidance
- Cognitive flexibility, reflected in improved clarity and conceptual integration
- Early symptom interception, indicating enhanced self-monitoring and regulatory access

These findings support ReAttach’s potential as a multimodal, relationally anchored intervention capable of improving emotional and cognitive regulation in FND presentations marked by dissociation and stress-linked instability.

Participant 3

Participant 3 was an adult diagnosed with Functional Neurological Disorder (FND) and comorbid Post-Traumatic Stress Disorder (PTSD), presenting with a prominent hypervigilance profile. Their symptom constellation included functional seizures, dissociation, sensory overload, and rapid escalation into threat-linked high-arousal states. At baseline, the participant described difficulty achieving a subjectively calmer state independently and reported that trauma-linked arousal dominated daily functioning, consistent with chronic sympathetic overactivation and impaired parasympathetic recovery.

Intervention Exposure and Engagement

Remote ReAttach sessions targeted arousal modulation, sensory grounding, and guided cognitive-emotional reframing. Given the participant’s pronounced hypervigilance, the Safety Override Technique (SOT) was introduced as a brief, structured method for interrupting threat dominance and restoring regulatory access. The participant demonstrated strong responsiveness to SOT, describing it as a rapid and accessible way to shift out of hypervigilant states when traditional calming strategies were ineffective. This responsiveness suggests effective engagement of bottom-up sensory pathways and top-down inhibitory control, both critical for trauma-linked autonomic dysregulation.

Observed Changes Across Sessions

During sessions, the participant exhibited:

- Improved tolerance of emotional material without escalation into dissociation or seizure activity
- Increased cognitive clarity and reduced overwhelm during guided tasks
- Enhanced ability to remain present, indicating improved integration of sensory and emotional processing
- Effective partner-supported co-regulation, with the partner learning tapping and pressing sequences to assist outside therapy

This relational scaffolding appeared to strengthen the participant’s capacity for regulation during hypervigilant spirals, though available case material did not permit quantification of frequency changes. The observed improvements align with polyvagal-informed mechanisms, wherein social engagement and tactile co-regulation support vagal activation and threat de-escalation.

Naturalistic Symptom Data

Where available, Neurolog logs reflected episodic but

reduced severity of hypervigilance-linked symptoms during periods when SOT was practiced. Entries indicated shorter duration of high-arousal episodes and faster recovery times. The participant described SOT as “interrupting the loop,” enabling a perceptible shift toward safer internal states—a qualitative marker of successful autonomic rebalancing.

Summary of Clinical Benefit

Overall, Participant 3 demonstrated meaningful benefit from remote ReAttach intervention, particularly in:

- Trauma-linked dysregulation reduction, evidenced by improved arousal modulation
- Hypervigilance interruption, through rapid engagement of sensory-motor regulatory techniques
- Relational co-regulation, enhancing access to safety and emotional presence

These findings suggest that ReAttach, supplemented by SOT, may provide an efficient, trauma-informed framework for stabilizing autonomic hyperarousal and improving relational regulation in FND presentations complicated by PTSD.

Participant 4

Participant 4 presented with Functional Movement Disorder (FMD) within a broader pattern of FND-related regulatory instability. A longitudinal series of anonymized, time-stamped transcripts provided a unique opportunity to examine communicative and regulatory change across sessions. This case offered insight into the linguistic and metacognitive correlates of regulation, allowing qualitative tracking of therapeutic movement through expressive patterns.

Baseline Communicative Profile

Early transcripts were characterized by fragmented, state-bound descriptions of experience, marked hesitation, and global experiential language (e.g., “foggy,” “weird,” “slow”). These early contributions suggested limited reflective capacity and a tendency to speak from within immediate embodied states rather than from an observational or metacognitive stance. The participant’s discourse reflected low differentiation of internal states, minimal temporal referencing, and reduced ability to link sensations to contextual triggers—features consistent with autonomic dysregulation and diminished cognitive integration.

Progressive Linguistic and Regulatory Shifts

Across subsequent sessions, the participant demonstrated a gradual shift toward differentiated and function-linked accounts of internal experience. Their language increasingly reflected the ability to:

- Discriminate among internal states (e.g., distinguishing fatigue from emotional heaviness)
- Identify fluctuations over time, suggesting improved temporal organization

- Articulate mixed outcomes within a single report, indicating cognitive flexibility

Cognitive clarity improved, and descriptions began to incorporate contextual elements such as daily functioning, triggers, and recovery patterns. This evolution from global experiential phrasing to contextually anchored self-report represents a measurable increase in metareflective capacity—a key qualitative marker of regulatory progress.

Emergence of Agency and Self-Regulation

By later sessions, the participant’s contributions showed emerging agency, including references to managing symptoms, noticing changes proactively, and linking internal states to specific activities or environmental demands. This linguistic shift from passive observation (“it happens to me”) to active engagement (“I notice when it starts and can slow it down”) reflects enhanced self-efficacy and integration of regulatory strategies. The participant’s discourse demonstrated greater coherence, reduced fragmentation, and increased narrative continuity, all of which correspond to improved executive and interoceptive functioning.

Interpretive Analysis

This communicative evolution—from fragmented, state-bound expression to organized, reflective, and contextually anchored descriptions—suggests meaningful regulatory change. The pattern aligns with theoretical models proposing that improved articulability of internal states and increased metareflective capacity serve as early qualitative markers of therapeutic movement in FND/FMD. Linguistic differentiation and temporal coherence may thus represent non-invasive indicators of neural integration, paralleling physiological stabilization observed in other participants.

Summary of Clinical Benefit

Participant 4 demonstrated progressive improvement in cognitive clarity, emotional articulation, and self-regulatory agency. The longitudinal transcript analysis supports the hypothesis that language-based markers of differentiation and contextualization can reflect underlying autonomic and cognitive stabilization. These findings contribute to emerging evidence that ReAttach-facilitated co-regulation may enhance both expressive organization and functional regulation in FND presentations characterized by communicative fragmentation.

Embedded Longitudinal Qualitative Language Analysis of Participant 4

Early Sessions

In the earlier transcripts, the participant’s contributions were often brief, hesitant, and closely tied to immediate bodily or affective states. Descriptions tended to be experiential rather than elaborative, with formulations centered on immediate internal shifts such as feeling peace, calm, or clearer, and at other times feeling weird or slowed down. Speech frequently

contained hesitation markers, restarts, and softening devices, suggesting that the participant was often speaking from within experience rather than from a settled reflective position. At this stage, the discourse was characterized by short response units and a relatively narrow descriptive range, with symptom and affect language closely intertwined.

These early formulations suggest that the participant could register change, but that such change was initially expressed in momentary and globally framed terms. Relief was described, but not yet extensively contextualized. Distress was also described in immediate experiential language rather than integrated into a broader account of fluctuation, trigger, or recovery.

Middle Sessions

Across subsequent sessions, the participant appeared increasingly able to describe not only states, but also variation between states. Expressions such as less foggy, references to a rough day, and contrasts between difficult and clearer periods suggested an emerging capacity to observe fluctuation rather than only report distress or relief in the moment. This represented an important qualitative shift. The discourse no longer conveyed solely whether the participant felt better or worse, but increasingly how experience changed, when it changed, and in what domains it changed.

At the level of language form, this phase still included frequent hedging and self-repair, but these occurred alongside a broader descriptive repertoire. The participant began to compare states across time and to articulate mixed outcomes within the same report. Improvement in one domain could be described alongside continuing difficulty in another. This increased differentiation is clinically important in FND/FMD contexts, where progress may first emerge as improved discrimination of internal states rather than as immediate and stable symptom resolution.

Later Sessions

In later sessions, the participant's language more often linked internal experience to activity and functioning. The participant described walking, shopping independently, and managing specific everyday situations. Such descriptions suggest that speech increasingly moved beyond raw symptom description toward functional self-observation. The linguistic shift was not simply from negative to positive wording, but from global experiential statements toward more contextualized accounts of capability, variability, and recovery.

A related shift was visible in the participant's metalinguistic and reflective language. Later formulations suggested greater ability to notice, compare, and label internal states. Expressions describing brain fog as having lifted, or characterizing experience as more unstable rather than merely bad, indicate not only symptom reporting but interpretive refinement. In this sense, the participant appeared increasingly able to speak about bodily and affective experience as an observed process rather than only as an overwhelming condition.

The participant's language also showed signs of partial agency, particularly in formulations referring to managing, doing, or noticing. These were modest rather than absolute claims, which is clinically appropriate in a fluctuating condition. The significance of this pattern lies not in any suggestion of full recovery, but in movement from a predominantly passive linguistic position toward a more active and observant stance in relation to symptoms and functioning.

Interactional and Temporal Features

Across the transcripts, hesitation, pauses, and delayed starts remained common. These features should not be interpreted simply as communicative deficit. In therapeutic contexts involving difficult-to-name embodied experience, such phenomena may indicate searching, monitoring, or closer contact with internal states (Muntigl et al., 2020; Voutilainen et al., 2011). The participant's responses appeared, over time, to become more sustained and more self-generated, even when hesitations remained present. Thus, continuity of hesitation did not preclude change; rather, the transcripts suggested that reflective capacity expanded within an interactional style that remained effortful.

The time-stamped structure of the transcripts also made it possible to observe pauses and delayed response onset as part of the therapeutic process. Although transcript-based timing cannot substitute for acoustic analysis, the pattern suggested that moments of self-observation and emotionally complex material were often accompanied by delayed verbal onset. In context, these pauses appeared compatible with reflective work rather than simple breakdown.

Interpretive Summary of the Case

Taken together, the embedded language analysis of Participant 4 suggested a gradual communicative shift from brief, state-bound, and relatively undifferentiated symptom descriptions toward more differentiated, function-linked, and metareflective accounts of experience. The most meaningful pattern was not a simple decrease in symptom language, but an increase in the participant's ability to articulate internal change, track fluctuation, connect symptoms to functioning, and adopt a more observant stance toward experience.

Within the context of remote ReAttach-informed work, this pattern may be clinically significant. It suggests that therapeutic benefit may become visible not only through reduced symptom burden, but also through greater articulability of embodied states, increased discrimination between conditions, and the emergence of language that reflects partial agency and regulatory flexibility. In this sense, communicative change may function as an early qualitative marker of therapeutic movement in FND/FMD.

Participant 5 and Hypervigilance-Focused Material

A further transcript subsample concerned the emerging Safety Override Technique. One transcript involved a young

female participant who appeared to be learning and rehearsing the procedure in relation to hypervigilance and sensory overload. A second transcript involved a male participant with partner involvement and a small supervision-group context in which the procedure was explored collaboratively, including the presence of a participant interested in learning how to help regulate other people with FND. Taken together, these transcripts made it possible to examine the SOT not only as a therapeutic event, but also as an emerging method being explained, demonstrated, and relationally scaffolded.

Embedded Qualitative Analysis of the Safety Override Technique Procedural Description and Apparent Mechanism

Across both hypervigilance transcripts, the therapist repeatedly framed the intervention around high arousal, sensory overload, and the difficulty of reaching a calmer state directly. In one transcript, the sequence was introduced by referring back to high arousal and fast tapping, followed by explicit reference to a middle range in which the participant could notice sensory overload. The procedure then centred on guided rapid tapping and pressing cues. In the second transcript, the therapist narrated the collaborative development of the method and guided the participant into fast tapping with eyes closed, followed by pressing cues and deliberate amplification of a good or safer feeling. This pattern suggests that SOT was being used as a practical interruption-and-reorientation procedure, engaging the participant's reported high-arousal state before attempting to support a safer or calmer felt state. It does not establish the underlying biological mechanism.

Qualitatively, the material is consistent with the interpretation that SOT uses ConFusion-based interruption to support access to a subjectively calmer state for participants who find this difficult through direct instruction. In the context of the present field material, the therapist's guidance did not simply ask the participant to calm down. The procedure instead used rhythm, speed, and sensory-motor engagement, followed by a short sequence linked to safety, positive felt sense, or enhanced regulation. These observations describe the procedure and reported experience, not a demonstrated physiological mechanism. This is conceptually consistent with the use of Confusion Technique as a bridge when direct regulation is not accessible, and it also shows family resemblance to New Mind Creation procedures that attempt to stimulate more adaptive schemas through guided state-dependent activation (Zeestraten-Bartholomeus et al., 2026b).

Teachability and Guided Rehearsal

The SOT transcripts also suggested a teaching and rehearsal component. In one transcript, the participant was invited to show, rehearse, and recognise what happened during fast tapping and pressing. Similarly, the supervision-group transcript indicates that the procedure could be described, practised, and adapted in a multi-person setting involving a participant,

a partner-caregiver, and a peer helper or trainee. These observations suggest that SOT was being treated as a teachable clinical procedure within the available material, but they do not establish effectiveness, generalisability, or biological mechanism.

Co-Regulation, Partner Involvement, and Generalisation Potential

The second SOT transcript also highlighted the relational dimension of regulation. The presence of a partner-caregiver and an additional participant interested in learning to help regulate others suggests that the technique may have value beyond individual self-application. In this material, regulation was not represented as a purely solitary capacity. Rather, it appeared as something that could be scaffolded by another person, demonstrated in interaction, and potentially generalised to supportive others after guided learning. This is especially relevant in FND/FMD populations, where periods of overload or hypervigilance may reduce the person's momentary capacity for autonomous self-regulation.

From a practice perspective, the SOT therefore appears to have at least three potential uses: as a therapist-guided acute regulation strategy, as a participant-rehearsed self-help sequence, and as a co-regulatory support tool that close others may help facilitate after appropriate instruction. These observations remain preliminary, but they help explain why the method may be practically relevant in daily life, especially for recurring episodes of overload.

Interpretive Summary of the SOT Material

Taken together, the hypervigilance transcripts suggest that the Safety Override Technique functioned as a brief, guided, state-sensitive method for interrupting hypervigilant dominance and supporting access to a safer regulatory state. The material further suggests that the method was teachable, repeatable, and relationally adaptable. Unlike approaches that rely on verbal reassurance alone, SOT appeared to use a structured sensory-motor and confusion-based sequence to meet participants at the level of activated arousal before attempting to redirect them toward safety. In the present material, this logic seemed particularly relevant for participants who could not simply choose or imagine calm on demand.

Because no prior formal publication has yet focused specifically on SOT, these findings should be understood as descriptive and hypothesis-generating. Nonetheless, they provide an initial manuscript basis for naming the method, describing its apparent mechanism, and identifying its potential role within remote ReAttach-based care for FND/FMD and related hypervigilance presentations.

Cross-Case Themes

Movement From Hopelessness Toward Agency

Across the case material, hopelessness appeared less as a static belief than as a clinically relevant marker of reduced

perceived capacity. Participants did not begin from a neutral position. They described prolonged struggle, repeated difficulty, and in some cases a diminished belief that meaningful change was still possible. The wider exploratory NeuroLog finding that hopelessness clustered with higher symptom burden supports treating hopelessness as a high-burden state signal rather than as disengagement, resistance, or lack of motivation. In these cases, reported movement toward agency and renewed engagement should therefore be interpreted cautiously as an early process-level shift, not as proof of symptom resolution or treatment efficacy.

Increased Regulatory Flexibility

All participants appeared to begin from rigid patterns of dysregulation. Reported benefit was not best understood as simple cure language. More often, participants described increased flexibility: quicker recovery after destabilisation, less domination by hypervigilance or overwhelm, improved access to regulation, reduced persistence of distress states, or the experience that symptoms no longer completely determined the shape of the day.

Meaningful Value of Brief Remote Sessions

The brief remote format appeared to matter in itself. For participants with fluctuating function, fatigue, stress reactivity, mobility limitations, or overload, a 30-minute remote intervention could be both manageable and meaningful. This suggests that low-threshold remote work may be particularly relevant for populations who struggle to tolerate or access standard treatment formats.

Importance of Tailoring

The value of the intervention appeared strongly linked to its individualised nature. Sessions were not experienced as a rigid protocol applied identically to everyone, but as responsive work adapted to the participant's actual state. This is consistent with a state-based clinical framework in which different forms of dysregulation require different entry points.

Co-Regulation as a Therapeutic Pathway

The material suggests that change often occurred through co-regulation as much as through self-regulation alone. This included the therapeutic relationship itself, partner presence during sessions, and partner-assisted application of techniques. This same principle was visible in the SOT material, where hypervigilance-related regulation appeared learnable not only by the participant, but also through partner and group-supported rehearsal. In this group, self-regulation may be best understood not as an isolated internal skill, but as something that can develop through repeated experiences of safe and effective co-regulation.

Benefit Beyond Symptoms Alone

Participant benefit was not limited to symptom description. The emerging material also points toward changes in hope, trust, safety, confidence, relational engagement, and participation. These domains are clinically important in a population that is often defined by symptom complexity and therapeutic disappointment.

Practical Value of Accessible Tools

An important cross-case theme was the value of tools that could be used beyond the formal session. This was already visible in the remote ReAttach-based work and became especially relevant in relation to the emerging Safety Override Technique. For individuals in whom hypervigilance may recur intermittently, a brief self-applied or co-regulated tool may offer important practical support in daily life.

Neurolog Symptom Log Observations

Neurolog logs were available as a complementary source of descriptive data. Logging frequency appeared to differ between participants. Some participants may have logged more consistently than others, whereas others may have logged intermittently, forgotten to log, or stopped logging during the process.

This variability was treated as part of the ecological reality of FND/FMD care rather than as a reason for exclusion. Where available, the logs may help illustrate symptom fluctuation over time, shifts in severity or recurrence, periods of relative stability or destabilization, patterns associated with hypervigilance, and possible correspondence between narrative accounts and logged experience. In the present exploratory paper, the logs are therefore best understood as naturalistic supportive data, not as a complete uniform measurement system.

Discussion

Taken together, the case material suggests that hopelessness may be an important clinical context in which to understand changes reported during remote ReAttach-based work. The title phrase from hopelessness to self- and co-regulation should therefore be read as a process-level description rather than an efficacy claim. In these cases, the early clinically meaningful change was not necessarily symptom resolution, but renewed perceived possibility, increased engagement, and greater access to self- or relational support. This interpretation remains preliminary and requires prospective testing with defined outcome measures.

The findings fit with a state-based understanding of dysregulation. If people are functioning from fixed autonomic or defensive states, then limited benefit from conventional approaches may not indicate unwillingness or resistance. It may instead reflect a mismatch between the offered intervention and the person's current regulatory capacity. From that perspective, brief, individualized, remote ReAttach-based work may help

create the conditions under which further therapeutic progress becomes possible.

These observations also have implications for accessibility and affordability. For many people living with FND/FMD, barriers such as fatigue, practical limitations, cost, symptom unpredictability, and limited specialist access interfere with consistent treatment engagement. A low-threshold remote intervention model may therefore be clinically meaningful not only because of what it does, but because of the help it makes possible.

The present material also highlights the importance of co-regulation. Therapeutic benefit in these cases cannot be reduced to individual skill acquisition alone. Partner involvement, relational safety, and supported regulation appeared clinically significant in several cases. This suggests that future research should examine not only self-regulation, but also systemic and relational pathways of change.

A further contribution of the present study is the embedded qualitative language analysis of one participant across repeated remote sessions. This case suggested that change may become visible in how participants speak before it can be fully captured as symptom reduction alone. In the analyzed transcripts, the participant's discourse appeared to shift from brief and state-bound descriptions toward more differentiated, function-linked, and metareflective accounts of experience. This raises the possibility that communicative change, including increased articulability of internal states and greater use of agency-related formulations, may serve as an early process marker in future FND/FMD research.

The embedded SOT material adds a second process-level contribution. It suggests that hypervigilance-focused regulation may sometimes require a procedure that does not begin with direct calm, but with guided entry into the participant's activated state followed by a structured override toward safety. In the present transcripts, rapid tapping, pressing cues, confusion-based interruption, and amplification of a good or safer feeling appeared to constitute the practical core of this method. The possibility that such a sequence can be taught, rehearsed, and relationally supported is clinically relevant and deserves dedicated prospective study.

The emerging Safety Override Technique deserves special attention. Hypervigilance appears likely to remain a recurrent challenge in at least some people with FND/FMD, even after significant therapeutic gains. A brief mixed ReAttach-derived intervention that can be self-applied or co-facilitated within minutes may therefore be a useful addition to the Affect Coach Online Program. Based on the present exploratory work, the SOT appears sufficiently promising to justify its inclusion in future observational and protocol-based study.

This article is best understood as preliminary field-based preparation for a future Neurolog SAM study, not as a replacement for it. One of the clearest lessons from this work is that future structured research should allow room for

participant narratives, variable real-world logging adherence, recurring hypervigilance, partner involvement, individualized change trajectories, and qualitative process markers visible in language and procedural learning. These are not noise around the condition. They are part of the condition.

Limitations

This study has several limitations. The sample is small, purposive, and still emerging. The work is naturalistic rather than controlled. The intervention is individualized rather than standardized. Participant narratives are central, which is appropriate for the study aims but introduces interpretive subjectivity. Neurolog logging is potentially informative but naturally incomplete and variable across cases. In addition, the dual roles of some participants as patients, collaborators, trainees, or helpers increase richness but may complicate straightforward generalization.

In the embedded transcript studies, analysis was based on transcripts rather than full acoustic speech analysis, which means that interpretations regarding pauses, interactional pacing, and procedural sequencing are stronger than any claims about prosody, pitch, or fine-grained vocal affect. In addition, the SOT material is especially preliminary because the method is still emerging and has not yet been tested in a standardized prospective design.

These limitations mean that the findings should be interpreted as exploratory and hypothesis-generating rather than confirmatory. At the same time, the real-world messiness of the data is not incidental. It reflects the actual ecology of care in a population living with fluctuating symptoms and capacity.

Conclusion

The findings from this mixed-methods exploratory case series suggest that remote ReAttach may offer a clinically meaningful, low-threshold, and potentially affordable intervention for individuals living with Functional Neurological Disorder (FND) and Functional Movement Disorder (FMD) whose needs have often been insufficiently met by existing care pathways. In these early observations, all participants described benefit despite beginning from persistent dysregulated states marked by high complexity and reduced therapeutic hope. Across cases, participants demonstrated improvements in affect regulation, sensory integration, cognitive clarity, emotional accessibility, and functional confidence. This supports a model in which brief, tailored, and remote interventions can help restore regulatory flexibility and create meaningful change that extends beyond symptom reduction alone.

A consistent pattern emerged in which co-regulation served as a foundational mechanism, providing essential relational scaffolding for individuals whose regulatory access is constrained by fixed autonomic states or trauma-linked hypervigilance. ReAttach appears to support rapid shifts in autonomic and affective states through multimodal sensory input and structured pacing.

Importantly, the remote format proved highly feasible, allowing participants to engage despite mobility limitations, fatigue, or symptom variability that often restrict access to traditional care.

The practical, accessible nature of the intervention supports the inclusion of these low-threshold tools within the Affect Coach Online Program. Among these, the emerging Safety Override Technique (SOT), introduced for participants experiencing hypervigilance, demonstrated distinct promise as a brief, teachable procedure capable of interrupting threat-based processing. Future work should systematically examine its role alongside W.A.R.A., the Forgive & Forget Hood, ConFusion, Identifications, New Mind Creation-related procedures, and other mixed ReAttach-derived techniques.

Furthermore, the embedded qualitative analyses reveal that therapeutic movement may be detectable not only in symptoms and functioning, but also in how participants learn to access regulation through guided procedures and how they come to describe, organize, and reflect upon their own embodied experience. The emergence of metareflective capacity and improved articulability of internal states, as observed in the longitudinal transcripts, suggests that communicative change may serve as an early, clinically relevant marker of therapeutic progress in FND/FMD.

While these findings are exploratory and non-confirmatory, they provide field-based groundwork demonstrating that remote ReAttach can effectively offer individualized, state-sensitive support. The Neurolog Symptom Amplification Module (SAM) protocol offers an important next step for studying these processes more systematically in real-world FND/FMD care. Ultimately, this article suggests that the question is not whether these individuals are “untreatable.” The more useful and transformative question is what becomes possible when treatment finally meets them in the state they are actually in.

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Declaration of Interest

Paula Zeestraten-Bartholomeus is the developer of ReAttach. Steven Painter is the developer of Neurolog. These roles should be taken into account when interpreting the perspectives presented in this article.

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