Pain Dynamics: an integrative roadmap for navigating through the experiential process.

by Hans Welling & Netta Ofer

(Hans Welling, Integra, Lisbon, Portugal)
(Neta Ofer, The new school of psychotherapy of the IDC and Geha hospital for mental health, Herzliya, Israel)

Draft version of paper published in 2022: *Person-Centered & Experiential Psychotherapies*

https://www.tandfonline.com/doi/10.1080/14779757.2022.2131605

Abstract

The authors present a theoretical integrative model of *pain-dynamics* for the categorization and transformation of emotional pain in person-centered and experiential psychotherapies. Integrating data from research literature and clinical work, the model distinguishes between three types of emotional pain: basic emotional pain, relational pain, and self-pain. The authors show how each type of emotional pain has not only distinct developmental etiology and evolutionary function, but also how each type requires a fundamentally different transformational process to be healed. Though clients experience all three types of pain in their life, usually one particular pain is dominant in the session. The model provides markers for identifying the active pain in the session, directing the therapist to one of three transformational paths. It thus provides a focus for the work, but also leaves plenty of room for intuitive moment-to-moment tracking of emerging experience. Although this new conceptual model emerged from the integration of the authors' AEDP practice with EFT principles, *pain dynamics* can help to systematically select interventions and techniques from a variety of experiential models. Conceptualizing the active pain in the session combines the advantages of *case conceptualization* (Timulak, 2015) and moment to moment work of *process formulation* (Goldman & Greenberg, 2015)

Introduction

In this article we will argue that psychological pain can be divided into three distinct categories.
Each of these types of pain has been described in the past numerous times by different theorists and therapists in the past, but recognition of the pattern and the systematic distinction between them was still lacking. The separation of these types of pain has important implications for case formulation and treatment selection, as therapeutic change requires three distinct processes for each pain. Identifying the client's active pain in the session can help with mapping the whole transformational path such as: what kind of painful experience needs to be activated, what techniques and resources are most appropriate, what defenses[1] and challenges to expect, and how to structure the work to promote finding new experiences at the right level.
The presented conceptualization of emotional pain is distinct in several ways from many existing models of emotional pain which classify pain according to types of causal events or types of resulting emotions. E.g. Timulak's (2015) model classifies pain according to 3 classes of maladaptive emotions: fear/terror, loneliness/sadness and shame. Other models classify pain according to events such as loss, entrapment, violence (e.g. Levine, 1997; Herman, 1997). Though we will speak about (typical) events and emotions in each pain, these are not the foundation on which the categories are based upon The essence of the model is that it conceptualizes three different functional systems through which pain is registered and processed. Therefore, in our model various emotions like fear, sadness, shame or various events like loss, loneliness or abandonment can play a role in all 3 types of pain systems. Phenomenological research (Bolger, 1999) into the experience of pain found three dimensions (woundedness, disconnection and loss of self) of emotional pain that seem to confirm our three categories.
Our model is most similar to existing models that are based on needs. For instance, the *safety*, *belongingness & love* and *esteem* needs of Maslow's motivational pyramid (1954) bear close resemblance to the 3 evolutionary functions that we believe underly each pain system. We consider that *attachment* and *identity* needs in EFT (Greenberg & Goldman, 2008; 2019) are to a large extent equivalent to what we describe as relational pain and self pain. New and crucial in our conceptualization, though, is that we argue that these three different systems of pain respond to distinct types of interventions. Thus the identification of the pain system has foremost a clinical relevance as it provides a clear indication of change mechanisms (transformational path) that will be effective and what defenses against experience are likely to be found.
We will start by describing the three categories of pain, their origin, dynamics, and transformation and then show the implication of these ideas for memory reconsolidation and for enhancing therapeutic outcome.

[1] In this article we will use the terminology of psychodynamic defenses (Freud, 1936/66) to refer to the regulatory processes and coping mechanisms as we find they provide the most elaborate and precise descriptive framework.

Three Types of Emotional Pain

From our clinical experience we have found that there are three kinds of emotional pain that have fundamentally different developmental origins and require very distinct change processes in order to be transformed through psychotherapy.

Basic emotional pain is the feeling of being overwhelmed or stuck as a result of unbearably intense emotion that occurs when the demands of the situation outweigh the resources of the individual (too much, too early) and the inherent adaptive action tendencies (e.g., fight, flight) are ineffective. When emotions (e.g., fear, anger, sadness) are too intense, the individual experiences fear of (emotional and/or physical) disintegration and the emotions cannot be processed to completion. Without any resolution, the process immobilizes halfway and becomes painfully stuck in the body.

Relational pain is the feeling of disconnection and inhibition that originates from experiencing ruptures in the attachment relationship with our caregivers. When the expression of emotions, drives, and needs (e.g., presence, care, love) repeatedly lead to a negative response from the caregiver (e.g., neglect, rejection) this will lead to the fear of abandonment or losing love. This results in additional pain from repressed expression and unfulfilled needs.

Self-pain is the feeling of worthlessness and not belonging which originates from repeated experiences of attacks on aspects of the self by important others or experiences of humiliation and exclusion by peers or society. When the expression of certain aspects of one's individuality (e.g., traits, character) repeatedly lead to negative reaction (e.g., criticism, humiliation, discrimination) from members of the family, peer group, or society in general, this will lead to a fear of unworthiness and losing one's role, place, or status in the social group/family. This results in additional pain of hiding one's true nature and living in a false "improved" self.

Adding validity to this categorization of emotional pain is the fact that they can be easily identified in many existing models of psychotherapy. In fact, it may be warranted to view them as three different paradigms because of their use of distinct theoretical metaphors, therapeutical focus and methods (compare Kuhn, 1962).

Basic[2] emotional pain is at the heart of a *Paradigm of Trauma* (e.g., Herman, 1997; Levine, 1997; van der Kolk, 2015). The notion of trauma centers around intense emotional events that are seen as too big to process by the organism and become stored in the body as traumatic memories. Certain circumstances can function as triggers that cause these memories to be relived in overwhelming fashion, "hijacking" mental functions. Therapies center around retrieving, reprocessing, metabolizing, and liberating the body of such traumatic memories.

Relational pain is at the heart of a *Paradigm of Conflict* (e.g., Freud, 1926; Bowlby, 1969; Safran, 2012). The central notions of this paradigm are the needs for protection, care, and love from the attachment figures that can lead to ruptures in the connection with the caregiver. When these needs, wishes, and impulses are

[2] This category we previously called "core emotional pain", but we chose to refer to it in this article as "basic emotional pain" to avoid confusion with existing uses of "core pain" in the PCE literature (e.g. Timulak, 2015; Greenberg & Goldman, 2019).

unacceptable or cause anxiety in the caregiver, they need to be repressed to safeguard the attachment relationship, causing an internal conflict. Psychological suffering is caused by repeating these modes of interaction and unexpressed emotion. Therapy centers around corrective experiences to change these internal dynamics and relational patterns.

Self pain is at the heart of a *Paradigm of Identity* (e.g., Adler, 1927; Rogers, 1959; Kohut, 1971; Greenberg & Goldman, 2008; Beck, 2011). The notion of identity centers around the tension and compromise between the expression of one's inborn nature and characteristics of the self and what is valued in the social context in which one lives. Psychological suffering is caused by the negative self-concept, hiding aspects of self, and a self-deception that is needed to maintain a valued role, power and meaning in the social environment. Therapy centers around changing the self-concept and finding a new adaptive narrative and meaning which is more in accordance with one's true nature and a valued role in the world.

These three distinct kinds of emotional pain also make sense from an evolutionary perspective, as each safeguards the individual's wellbeing in a particular domain that is crucial for survival:

The first domain is the relation of the individual with its natural environment. Categorical emotions (e.g., fear, anger, joy) ensure the (physical) needs and wellbeing of the individual in relation to the natural environment through their inherent action tendency which motivates adaptive action. When there is intense emotional arousal because our physical wellbeing is under threat, this results in the fear of disintegration. This innate response corresponds to Panksepp's *fear* system (Panksepp, 2009).

The second domain is the attachment relationship with caregivers, which is especially important in early childhood, as children depend on caregivers to meet their basic physical and emotional needs. Later in life, a similar need for attachment will arise towards other significant figures, such as one's life partner. When there is disconnection or when our attachment relationship is under threat, it results in the fear of abandonment or disconnection. This innate response corresponds to Panksepp's *panic-grief* system (Panksepp, 2009).

The third domain is the relationship between the individual and their larger social group (e.g., peers, society). This becomes increasingly important as one grows older, as surviving without the resources of the larger group is almost impossible. When we don't have a place in the group or our place is threatened, this results in the fear of unworthiness and losing one's role, place, or status in the social group. This innate response corresponds to the *shame* system (Sznycer et al., 2016).

These three systems are not as separate as the above sections may suggest. The attachment system is a supplemental system that supports the survival needs of the categorical emotion system. A good attachment relationship can provide regulation when dealing with basic emotional pain. Events often cause more than one kind of pain. For instance, cases of extreme relational pain (e.g., abuse) can also cause basic emotional pain and self-pain. In real life events, these three systems never function independently but interact constantly so that in any given moment they are all participating in creating the emotional experience, whether pleasurable or painful.

Memories of experiences of emotional pain become the sources of prolonged and self-generated suffering and are the focus of what we want to change in psychotherapy. As Panksepp states: “Reconsolidation of affective-cognitive memories needs to be the prime concern of psychotherapy” (Panksepp, 2009, p. 26). This changing of the memory of emotional pain can be achieved through the process of *memory reconsolidation (MR),* which has been shown to be a crucial underlying mechanism of change in many psychotherapies (Welling, 2012; Lane et al., 2015). In MR, the triggering of painful memories can be unlearned by a sequence of (1) re-activation of painful emotional memories, followed by (2) finding a new contrasting experience which is then (3) experienced repeatedly alongside the old experience (Ecker et al., 2012). This new neutral or positive emotional experience will change the emotional loading of the memory and thus undo the emotional learning when the memory is restored (reconsolidated) in an updated form. It will uncouple the association of certain events, emotions, needs, or traits with painful affects and may even associate them with new positive affective states. In psychotherapy, after the memory of emotional pain is re-activated, the new contrasting experience can be a real one such as a real life experience with an important other (Ecker et al, 2012) or in the session with the therapist (Fosha, 2000; Levenson et al., 2020), an imaginary one such as chair-work (Greenberg et al., 1993), or portrayals (Fosha, 2000). As we saw that the three types of emotional pain originate from very different experiences, our conceptual model predicts that different kinds of corrective experiences are needed to effectively reconsolidate the memory of each type of emotional pain.

In order to help therapists recognize what pain is activated in each session, we will now discuss the origin, dynamics, and possible transformation of each of these three kinds of pain in greater detail.

1. Basic Emotional Pain

1.1 Pain from unbearably intense emotion: fear of disintegration

The arousal of negative emotions is experienced as emotional pain. Just as in physical pain, basic emotional pain warns us there is a survival threat, making us ready for adaptive action. However, it may take a long time before change happens and sometimes the adaptive action does not result in any change at all. In such situations emotional intensity may rise to intolerable levels and become dysregulated.

The most typical example is the emotional reaction to an irreversible loss[3] or feeling fear when one is trapped and can't run. The younger we are, the less able we are to tolerate emotion by ourselves and even relatively low levels of emotion activate distress and fear. This is because the demands of the situations exceed the resources of the child. This is what is called "too much, too soon" (House, 2011). From the relational AEDP perspective we want to add to this "too alone". Events such as being alone in a hospital for an operation, physical pain, watching one's parents fight, a parent loosing emotional control, physical violence, and sexual abuse are events that can easily become "too much". A major means for regulating these states of intense emotion and getting back into tolerable levels of distress, in both children and adults, is through the presence of significant others. As Fosha (2000) put it, "relational support is needed to bear intense affect".

When events do exceed the child's capacity for dealing and in spite of the parents' best efforts to help and regulate, the individual goes outside his *window of tolerance* (Siegel, 2012) and will experience fear of disintegration[4] (terror). This is a signal from the body that the amount of emotional activation has become dangerous for the system. Emotions can no longer be held in awareness, expression is interrupted, movements stop, and are held in muscle tension. Now the emotion cannot be processed to completion (Fosha, 2005), and this leads to a very painful state of being stuck halfway in a process without resolution[5]. Eventually, the person will detach himself (dissociate) from the awareness of this unbearable emotional and physical experience.

In summary, basic pain is made up of the experience of unbearably intense emotion, fear of disintegration, feeling stuck in unresolved action/emotion, and dissociating from one's experience.

Especially high levels and repeated events of basic emotional pain will be stored into memory. When this happens, the circumstantial and situational elements that were present at the time of the painful event are connected in an idiosyncratic way to the painful memory. These elements may be, for instance, smells, objects, noises, an angry face, physical closeness, headache, tight spaces, playground. The perception of such associated elements that were present during the original event can now trigger this emotional memory and will cause the falling back into a state of painful affect [6] (e.g., terror, intense emotion). In extreme cases, they

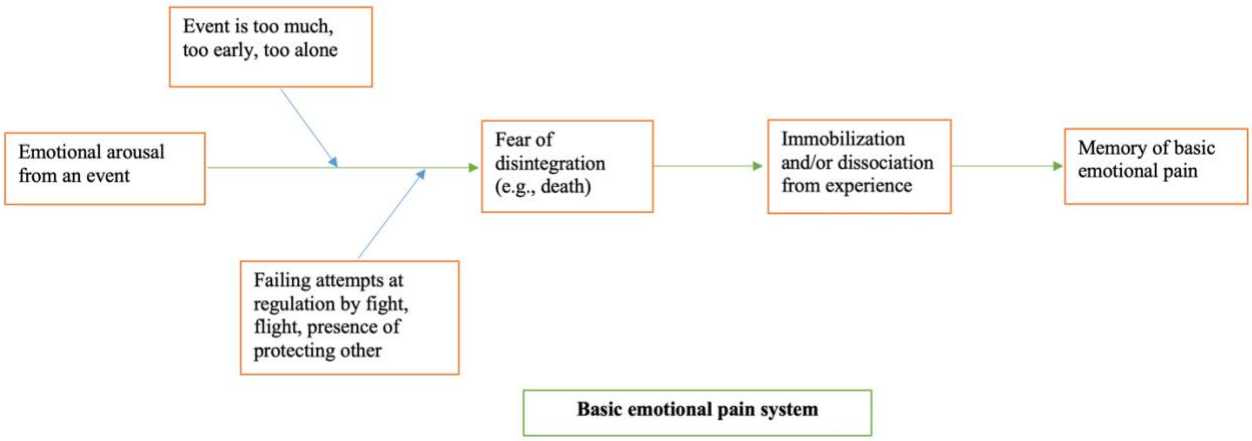
[3] The fact that grieving loss and separation of an attachment figure is a process of basic emotional pain rather than a relational pain may be confusing at first, especially as separation and loss are the titles of the seminal books on attachment by Bowlby (1980). The loss (e.g., death) of the attachment figure is not a failure or conflict that results from within the attachment relationship (only feeling anger at the parent for dying might come up as relational pain in the context of such an event). (Emotional) abandonment or rejection happen within the attachment relationship and therefore lead to relational pain.

[4] Compare annihilation anxiety (Freud, 1926).

[5] Napier (2019) refers to this as unmetabolized emotion that get stuck in the body.

[6] Janina Fisher (1999) refers to this as *feeling flashbacks* or *intrusive affects* that represent *feeling memories*.

may result in a full flashback, where not only the emotional dimension is re-experienced but also the physical sensations (e.g., pain), perceptions (noises and images), and mental state (e.g., confusion, dissociation).



Anxiety is an inhibitory affect which signals that we are approaching the dangerous (painful) memories and sets off defensive action such as *avoiding* certain interactions or situations that may contain such triggering elements. This avoidance may start to increasingly spread to more areas of a person's life. For example, a memory of dread from visiting a dying parent in hospital can cause anxiety over elements such as illness or death and which in turn may lead to *avoiding* places and experiences that could cause a reactivation of the anxiety (e.g., hospitals, funerals, going to a doctor) and eventually lead to extremely limiting symptoms.
A person may also start avoiding internal triggers like bodily sensations and emotions that are associated with the painful event (e.g. sadness). The individual may end up detaching internally from any feeling, living habitually numbed and disconnected from their inner experience.

In summary, the suffering caused by the memory of basic emotional pain consists of:
reliving the old pain, feeling anxiety, and defenses like limiting one's life by avoiding certain situations and being habitually disconnected from inner experiences.

1.2 Transforming basic emotional pain

Therapy addressing basic emotional pain will focus on work around the bodily experience of painful overwhelming emotional experiences in the past and present, undoing defenses such as dissociation, numbing, and avoidance in order to get to a new adaptive experience on a bodily-emotional level to be reconsolidated into the emotional memory.

The transformation of pain in this paradigm is achieved by regulating the dysregulated emotional experience, allowing emotions to be processed to completion (Fosha, 2000) and changed into a new adaptive emotion (Greenberg, 2010). Since the overwhelming experience arises when it is experienced as "too much, too early, and too alone", regulation can be brought about in three major ways:

1. Countering "too alone" by bringing in more presence, by for example the therapist's explicit presence and/or the safe and calming presence of other imaginary calming figures.

2. Countering "too early" by creating temporal distancing (*this happened long ago when you were so young and vulnerable*).
3. Countering "too much" by, for example, physical distancing (*imagine you witness the memory from a distance or from the outside*), partial experience (*allow yourself to feel just a little bit*), or attending to behaviors previously not noticed which can be significant in overcoming the situation *(I notice now that all this time my legs were ready to run away*).

This new regulation undoes fear of disintegration allowing for the new experience of tolerating intense emotions to be processed to completion. Processing the emotion to completion involves the (imaginary) completion of the stuck action tendency such as fight, flight, or grieving. This results in new learning such as, "I can handle such intense events/ emotions". The therapist can select techniques and procedures from various models[7] that are tailored for transforming basic emotional pain. For example: titrating; pendulating (SE), un-blending; unburdening (IFS), retelling trauma, empathic affirmation for vulnerability, self-soothing (EFT), rescue portrayals, undoing aloneness (AEDP), bilateral stimulation (EMDR).

The following example illustrates such work of undoing the "too alone" in a concrete case of basic emotional pain:

A client was deeply affected every time she and her husband were fighting even mildly in the presence of their children. She would totally freeze after these relatively small incidents and go to bed for hours feeling alone helpless and almost dead of tiredness. She even found it hard to take care of her child after these incidents, finding herself full of guilt and self-loathing.
When exploring this subject, she recalled her father being extremely aggressive (in words and gestures) towards her mother, from as early as she could remember until around the age of twelve, when a crisis transformed her father's behavior. Usually, the incidents would end in her father slamming the door and leaving the house and the mother sitting with a coffee on the kitchen table totally quiet. Most of these instances, as she recalled, happened late in the evenings when she was supposedly sleeping, but she would routinely wake up from her father's severe screaming and swearing at her mother. In an imaginary exercise (portrayal[8]) the client went back to a specific incident when she was eight years old, lying in bed motionless, listening with terror to everything that was happening on the other side of the wall. We could see her body all still and paralyzed in horror, all the attention focused on her ears, listening to every sound, trying to figure out if her mother is safe, but with no resources whatsoever to do anything. All these were signs for the therapist that basic emotional pain was active in the session and soothing and processing the fear to completion was likely the best transformational path. The therapist suggested they both approach the girl she was back then in her bed and try to sit next to her and see if there was any way they could comfort her. The client was

[7] SE: Somatic Experiencing (Levine, 1997), IFS: Internal Family Systems (Anderson et al., 2017), EFT: Emotion focused Therapy (Greenberg et al., 1993), AEDP: Accelerated Experiential Dynamic Psychotherapy (Fosha, 2000), EMDR: Eye Movement Desensitization of Reprocessing (Shapiro, 2001)
[8] Portrayal is a typical AEDP therapeutic task in which the client interacts with significant others or parts of oneself, imagining reparative, avoided or wished for experiences. (Fosha, 2000). It is in many ways equivalent to the different chair-work enactments of EFT. The authors who have training in both AEDP and EFT use these techniques interchangeably.

frightened of the idea and asked that the therapist come with her to the room and stand at the door to make sure she is safe, while she approached the girl and sat by her bedside.

In the beginning, the client felt paralyzed, and the therapist acknowledged her immense courage in willing to go in the room and sit with the girl. The therapist guided the client with slowed breathing so she could gain some more strength sitting beside the girl's bed and promised to be there with her all the time. It took a while before the client got more regulated, and the girl could now slowly take comfort and feel safer in the presence of her adult self and the therapist. Very slowly she started crying very silently and could whisper to the adult self and the therapist about her terrible fear of her mother getting hurt and the horror of her father's devastating rage. After the soft weeping the client could hug the young girl and say, with aid from the therapist, "This is so frightening, you are in such horror but now you are safe and I am with you" and the young girl burst into frantic tears and crying. She cried until she calmed down. As waves of crying softened, the client said, "I feel that all this horror was stuck in my body and soul for so many years. I didn't even know it; well, I guess in a way I knew but I was sure that if I ever felt this again, I would collapse. I feel that now I am kind of protected, I don't know, maybe kind of strong and resilient".

In this example undoing the aloneness with the therapist and adult self, brought enough regulation to allow the client to go through and experience to completion the feeling of terror. As a result, she was less triggered and ceased becoming paralyzed during arguments with her husband.

But in this case, there were also indications for relational pain (fighting with the husband) and self-pain (feeling guilty and feeling self-loathing). But the extreme freeze response was hinting to the basic emotional pain as the most active pain. If the therapist would have tried to work on the relationship with the husband first, this would have been blocked by the dissociation of the traumatic reaction carried inside and activated so forcefully. Starting to work on the self-pain first would have missed the heart of the matter of releasing and feeling the pain around the original incidents. The self-pain in this case is a reaction to the freeze response from the trauma and thus could not be transformed without working on the trauma.

2. Relational Pain

2.1 Pain in the attachment relationship: fear of abandonment and disconnection

The child expresses his emotional needs in various ways to the caregivers. He will cry when he feels sad, in pain, or wants closeness; he will be angry when demonstrating and trying to get what he wants. He may show pride in his achievements or express excitement and expansiveness when he feels joy and pleasure in what he is doing. When the parent is responsive and competent, he/she will welcome and stimulate these tendencies and help the child find ways to satisfy his needs.

When for example, the child's needs are consistently not met with the adequate response from the attachment figure it will leave the child feeling alone, unloved, misunderstood, and unprotected. We call this *relational pain*, as it originates from the attachment relationship. Fosha (2000) made a very useful division of these failures of handling emotionally laden interactions into *errors of omission* (e.g., abandonment, neglect) and *errors of commission* (e.g., rejection, abuse).

Over time, children learn that certain behaviors or expression of certain emotional needs may lead to disconnection and frightening negative reactions from the caregiver[9]. Children will try out various strategies to deal with these circumstances. When the parent is non-responsive to the child's expression of his needs, the child will attempt to intensify his appeals for getting them met. When the parent is consistently unreceptive, abandoning or dismissing, the expression of individual needs threatens the attachment relationship, and the emotional needs of the child are in conflict with the need for a secure attachment relationship. Since a child will do everything to protect the relationship with the caregiver, he will privilege connection over expression. He will suppress the expression[10] of the need and hide his "unacceptable" emotions from the caregiver.

Thus, relational pain is not only made up of the unmet needs but also a variety of feelings that stem from this inner struggle around the conflict between the individual's need and the need for maintaining the good connection with the parent. In summary relational pain consists of the pain over the rupture in the attachment relationship, the pain from unmet needs, the fear of disconnection and abandonment, and the pain of suppressed expression of needs and emotion when hiding one's "forbidden or dangerous" feelings and wishes[11].

When parents repeatedly react negatively or are non-responsive to the expression of certain emotional needs, information about the interactions and habitual responses from the caregivers will be stored in our emotional memory. The child now expects that certain emotions will not be met and can even lead to rupture with significant others. The emotional need is now connected to an habitual painful outcome state that is activated every time specific needs or emotions are experienced or expressed.

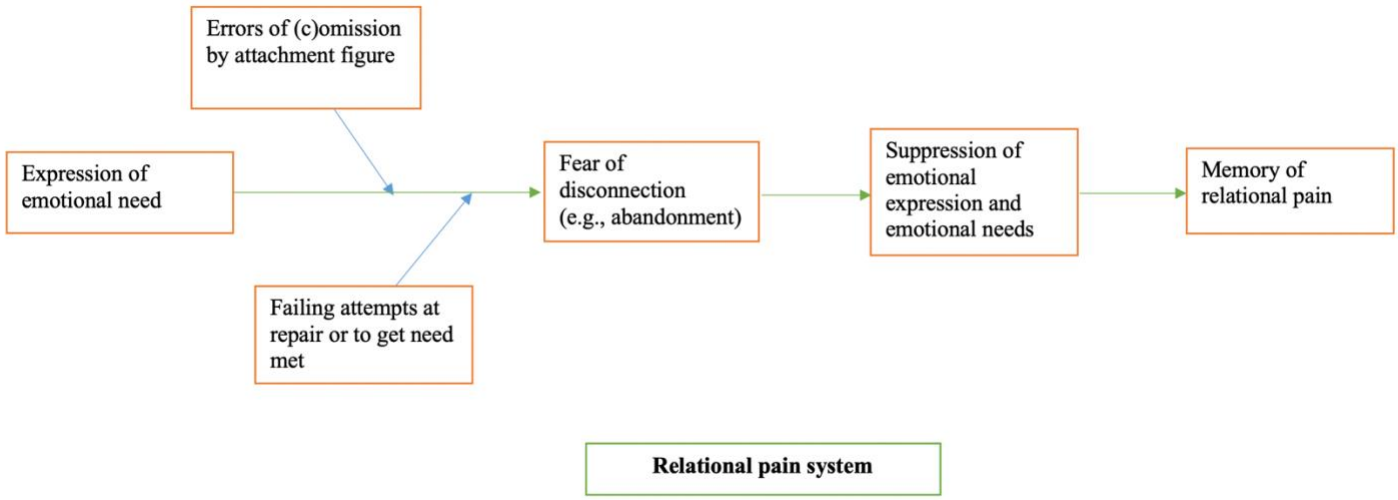
---

[9] Sometimes this learning is not from first-hand experience with the parent, but from observing the outcomes of interactions between siblings and parents, or from the interaction of parents with each other.

[10] Mikulincer et al. (2003) refers to these strategies as overactivation versus underactivation, which form the basis of ambivalent and avoidant attachment styles

[11] Davanloo (1990) noted that not only the expression of certain needs can be dangerous and will be repressed, but that also the disappointment and anger over the pain of the unmet needs, rejection, abandonment or abuse by the parent is repressed.

In this learning not only the (internal) emotional elements of the emotional expression (e.g., anger) are connected to the relational pain (e.g., rejection and shame), but also all kinds of other elements that are present during the repeated painful interaction, such as facial expressions, words, places, noises, or objects. The perception of such associated elements (both internal and external) that were present during the original event can now trigger this emotional memory and will cause the painful affect to be re-experienced.



Therefore, re-experiencing the pain and/or feeling shame and anxiety will not only motivate to suppress expression of this specific emotion (e.g., anger, sadness) but also to use defenses (e.g., reaction formation, denial, rationalization) to counter awareness of certain needs and emotions. Defenses may get so strong that the individual is neither aware of painful affect nor of anxiety or shame and feel generally out of touch with emotion. This will lead to additional pain of feeling confused about and detached from one's inner experience[12].

Thus, the memory of relational pain causes suffering in several ways: by reliving the old pain of disconnection, by feeling the inhibitory emotions of anxiety and shame, by limiting one's emotional expression, and by being confused about or disconnected from needs and inner experience.

22 Transforming relational pain

Therapy addressing relational pain will focus on feelings towards significant others from past or present, including the therapist, and undoing defenses of repression, rationalization, and self-criticism, attempting to get to new adaptive experience on a relational level to be reconsolidated into the emotional memory.

The transformation here aims at re-owning unmet needs and emotional expression, which will promote reestablishing connection. From our experience as therapists and supervisors we found that there are three common transformations in the relational pain:

1. Re-owning needs and expressing the unexpressed.
2. Experiences of connection (with an attachment figure).
3. Mourning what is lost and cannot be undone.

[12] Davanloo (1990) considers the repression of prolonged anxiety over feelings and impulses that may threaten the attachment relationship as the main cause of psychosomatic symptoms like migraines, bowel problems, etc.

Reowning unmet needs and bringing these needs and withheld emotions back to expression is therapeutically achieved by *validation* and *relational safety*. *Validation* can be brought about by, for example: therapist affirmation, resignification of need, and emotional expression as universal, natural, or developmentally necessary. *Relational safety* can be brought about by, for example: a warm, accepting, and responsive presence from the therapist[13] or an imagined other. Safety can undo the fear of disconnection and abandonment, allowing for the new experience of freely expressing emotion to the parent this time without losing the connection.

When the *expression* of emotion and the unspoken truth is validated, it can lead to corrective experiences of restored connection, as well as new receptive experiences of being loved, appreciated, protected, and being met in one's needs. This results in new learning like, "Needs are valid and emotional expression may not lead to indifference or rejection but to gratification."

Reestablishing connection after the expression of needs and emotions may not always be possible or feel realistic for the client. In this case the mourning takes on a central role in the form of a process of *separation* (Elliott & Greenberg, 2007). Examples of separation can be giving up unwarranted hope, grieving the parent one will never have, acceptance, and emotional distancing from the parent.

The therapist can select techniques and procedures from various models[14] that are tailored for transforming relational pain for example: empty chair work for unfinished business, two-chair dialogue for anxiety split (EFT), rage portrayals (ISTDP), limited reparenting (ST), reparenting (IFS), redo and reunion portrayals (AEDP).

The following vignette is a clinical example of transformational work through validation of needs, expression, and reconnection:

A client experienced severe pain and frustration whenever his wife would be emotionally distant from him. "It's impossible for me to tolerate just doing the things we need around the house and the children when I feel she is distant from me." He reported that his sensitivity to these incidents is growing all the time and he finds himself being anxious when he knows they are going to spend time together. After the therapist *validated* the importance of the need for connection for the client, he then explored his feelings when visiting his father and "not being able to have any 'real conversation' with him". The client recalled that it was not always like this and could actually remember that it became like so when his father was injured during work and underwent endless physical treatments. The therapists helped the client connect to the feeling of not being able to really access the father and not understanding what had happened as a child (i.e., connecting to the pain). The therapist encouraged the client to talk to the father in imagination (i.e., expression in a portrayal) telling him of how lonely he felt in his presence, not knowing what to do to get his father's emotional attention. He *expressed* this while crying deeply and recalling the hidden pain for the lost connection. The therapists then asked the client to imagine the reaction his father has to all that he heard. The client broke into tears and said it is impossible since the father feels so much remorse and pain at hearing it and said the father would never be able to survive this remorse and pain. The client then realized something he never really understood: the father couldn't connect to his son's pain since he had severe PTSD from war that was triggered by the injury he had during work. The therapist asked the client, if he felt safe enough, to put to words what the father

[13] Such therapeutic presence reflects the three core conditions for therapeutic change (empathy, unconditional positive regard and congruence) as proposed by Rogers (1957). As such they are facilitating in working with all three kinds of pain, but are at the heart of the change process in relational pain.

[14] ISTDP: Intensive Short-Term Dynamic Psychotherapy (Davanloo, 1990). ST: Schema Therapy (Young et al., 2003)

would say. The client deeply wept when trying to talk on behalf of the father and said he can't say it out loud but inside he heard his father say, " The most painful thing in my life is that I couldn't give you my youngest son, the closeness you deserved. I saw it and I saw your pain, but I couldn't" (i.e., reconnection*)*. "That's why I always save up money and give it to you. I do this so that you know I love you. My biggest pain is that I left you deserted like that."(i.e., mourning) The client said that he will never be able to have this conversation with his real father, but that now he felt much calmer, less alone, and more held, though he had a lot of pain. Being with his father was much easier from then on and he began reading more about PTSD. With further work, the client was able to speak to his wife about what happens for him when she distances herself and he could gradually tolerate this tendency of hers in a much more regulated manner.

In this session the therapist chose the relational pain as a priority. Had the therapist chosen to focus on the basic emotional pain by encouraging the client to approach himself as a child and help him hold the pain , it would probably calm the client for the session but would not transform the heart of the issue which lies in the full understanding and experiencing of the pain of losing the connection with the father and reconnecting to the father's love and pain which the "child" could not grasp at the time

3. Self-Pain

3.1 Pain in the self: fear of unworthiness and exclusion

People have an innate concern about their self-worth with respect to the people that surround them (Gilbert, 2007). Self-worth is the notion of ourselves as being valuable and lovable and the feeling that, by merit, we belong to our family or group. Just as we need the attachment relationship with our caregiver(s) to survive, we also need to be accepted and have a valued role in the larger group of our family, peers, and society. This is likely evolutionarily determined as it is critical for our survival to be protected by the group and to have access to the group's resources. When we feel that some aspect of ourselves is viewed by others as bad or unacceptable, we feel shame, unworthiness, and the fear of being excluded. We call this type of emotional pain self-pain[15].

"Self" refers to broad aspects of ourselves such as traits, identity, and value and it is organized around self-concepts. Self-concepts are generalizations produced from our experiences with ourselves, the physical world, and people around us. The value we attach to self-concepts is attributed in accordance with the values of the society we live in. Self-concepts with a high value create a good emotional feeling around them while negative self-concepts create self-pain. This pain drives us to either change our characteristics if possible or at least hide them so they will not create this terrible feeling.

It is important to note that in the case of self-pain, we are not merely dealing with unacceptable behavior, emotions, or needs but with wider self-concepts regarding self-worth. For example, it's not about "don't show your anger because you will be shamed" but rather "you are a selfish angry person and this is a bad trait you'd better hide". These processes are highly complex mental procedures involving abilities like mentalizing and abstract thinking. Only around the age of nine has the brain sufficiently matured to start generating rather stable self-concepts from the interactions between self, others, and the environment.

Self-pain has three important sources: experiences with peers, significant others, and society; the relationship with the attachment figures and big T trauma.

The first major source of self-pain occurs in the interactions with peers, important others (parents, siblings, teachers, spouses, employers), and society's values. Experiences of attack and criticism on aspect of the self and exclusion, disrespect, humiliation, and bullying shape the view of one's importance, dignity, and self-esteem. Many times, a negative self-concept is created without direct or explicit experiences of shaming or rejection by others. Socially unvalued traits like physical appearance, irregular mental capacities, cultural habits, economical state, and sexual and gender identity can lead to shame and feelings of inferiority. These later experiences of self-pain are not completely separate from earlier ones, as those experiences which occur in relation with the caregiver will create a vulnerability to experiencing later self-pain with peers and social interactions.

Not only explicit criticism from parents on aspects of the self, but also prolonged *relational* pain inflicted by caregiver(s) can develop into *self*-pain. For instance, continued neglect, rejection or abuse may create a self-

[15] We prefer self-pain over the term *social-pain* (MacDonald & Jensen-Campbell, 2011) as the notion of self has more clinical relevance and self-pain can be caused in other contexts than the social one (See next paragraphs).

concept in the child of being bad, weak, or selfish. As Fosha (2013, p18) states: "inattention, indifference, disinterest, and non-involvement of the caregiver map onto the self as shaming unworthiness".
Finally, big T-trauma can be the source of self-pain. In this case *basic emotional* pain develops into *self*-pain as it is often accompanied by blaming oneself for being unable to defend oneself, becoming paralyzed, or not having stopped ongoing abuse, leading to perceive oneself as selfish, passive, weak, or as "damaged goods"[16]. When we feel ashamed of our characteristics, we start hiding them or trying to improve them. We are afraid that the members of the group/family we belong to will discover these bad aspects of our inner life. We actively make sure these aspects will not be seen by others and even not by ourselves, by actively attacking "bad" aspects which cannot be totally repressed.

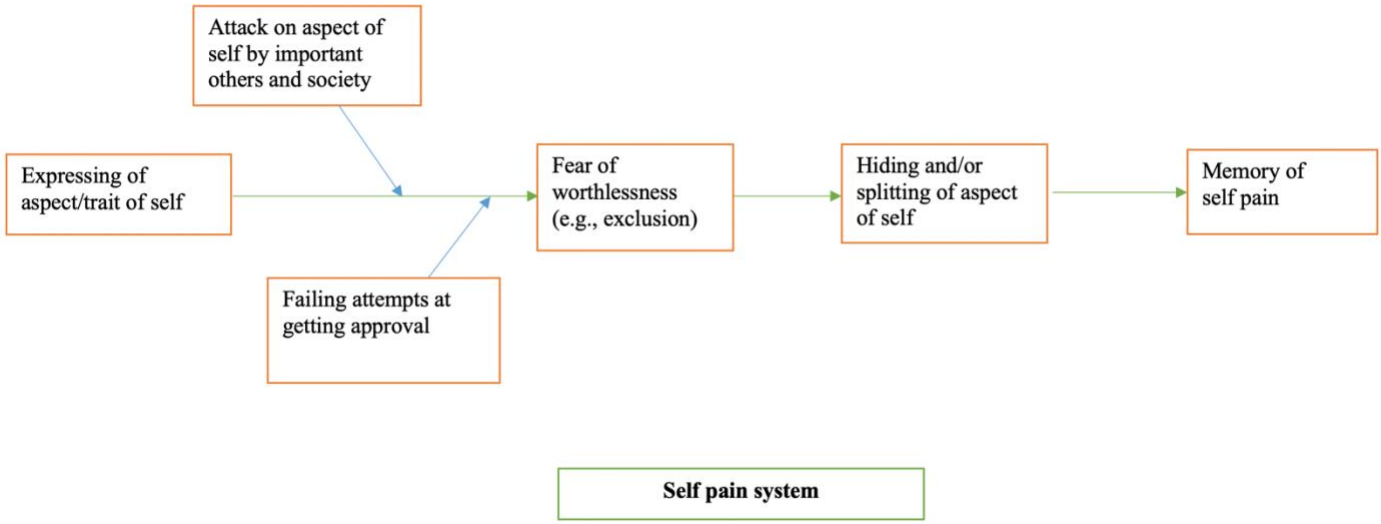
In summary, self-pain is made up of: the pain of exclusion and attack on aspects of the self; the fear of being unworthy and being excluded; the shame of feeling flawed and defective; and finally, the pain of having to hide or even disown parts of our *true self* (Fosha, 2005)[17].
Experiences of intense and repeated self-pain will be stored in our emotional memory and the aspect of self that was attacked will now be connected to a painful memory state. As self-pain involves rather broad concepts of unacceptable characteristics such as weakness, stupidity, neediness, or weirdness, self-pain is much easier to trigger than basic emotional or relational pain which are essentially triggered by events or emotions.

A client had a hard time doing schoolwork due to a learning disability which severely compromised her reading skills. During all her school years she had to fight the critical remarks from her schoolmates and teachers, in early years for reading errors and spelling mistakes and later for spending so much time on schoolwork and being a slow thinker. With not enough explanation and emotional attention, the client felt slow and stupid. Today she is very anxious whenever she needs to present something to her fellow workers and is afraid of making a mistake or misspelling a word. Before presentations, she memorizes everything by heart for hours and makes her husband listen to the presentation many times.

As it is difficult to "repress" or hide an entire trait of self, defenses often take the form of splitting the trait off from awareness and disowning such aspects of ourselves and "adopting" a false, more "worthy" self. In this case our real nature becomes hidden from ourselves, which can cause intense confusion and pain regarding identity. Other defensive strategies for not feeling this toxic shame may include projecting negative characteristics of oneself onto others or viewing oneself as superior.

[16] Pavio & Pascoal-Leone (2010) have an excellent chapter on shame and self-blame resulting from such trauma and abuse.

[17] This concept of our true nature, identity, or the one we were born or meant to be can be found in many therapeutic approaches such as the *self which one truly is* in PCEP (Rogers, 1961), *Self (Energy)* in IFS (Anderson et al., 2017), or *birthright self* in IRT (Benjamin,2018).



Because self-pain is so easily triggered, it tends to worsen over time from repeated and prolonged experiences of remembered shame and feeling defective. The shame over bad aspects and traits of the self can become *generalized* into a feeling of being totally and inherently flawed, which turns into *toxic shame* (Russel, 2015). This repeated state of feeling inferior over time will start to feel like the core truth about oneself and this becomes very difficult to undo. Fosha (2013) refers to this as the development of a *core pathogenic self*. It is characterized by feeling totally worthless and hopeless about any possibility of changing something which is flawed in its essence. The person feels that there is no way out and is only left with attacking oneself and withdrawing into isolation, while feeling unworthy of love or interest from others. Shame occurs both in relational pain and in self-pain, though quite differently. In relational pain, shame arises as an inhibitory affect that motivates us to hide the expression of “dangerous” feelings (e.g., crying, anger) that may put the relationship with the caregiver in jeopardy. As the child matures, the shame influences self-concepts, and a conviction of one's "badness" takes root (e.g., needy, selfish, weak). When one starts believing and seeing oneself as inherently bad, they cross the border to self-pain and shame becomes toxic. Sharbanee et al. (2019, pp 236) make a similar point about what in this model would distinguish relational pain from self pain: “The central distinguishing feature between insecure and self-critical self-organizations is whether they orient around attachment or identity needs”.

In summary, the suffering caused by the memory of self-pain consists of: re-experiencing the pain of unworthiness and not belonging; pain from self-attack; toxic shame; and living alienated from one’s true nature in a constructed false self.

3.2 Transforming Self-pain[18]

Therapy addressing self-pain will focus on the negative perception of the self in the present and past, undoing defenses such as splitting, projections, idealization, and self-attack. It should attempt to bring about a new adaptive experience of the self on a conceptual level to be reconsolidated into the emotional memory.

Transformation of self-pain is achieved through *compassion* and *re-assessment* in the following four tasks:

a. Understanding the core negative self-concept and finding the origin
b. Finding compassion and connecting to the pain
c. Re-assessing aspects of self
d. Integrating aspects of self

a. Finding and understanding the origin of the negative self-concepts

It is important to connect the self-attack or flawed feeling of the client to a more central negative self-concept from which this feeling stems, so that we will be working on an essential negative self-concept and not on a derivative of it which is too general or too specific.

Clients tend to refer to either very specific flaws like, "I am always late" or "I am lazy in doing schoolwork", or to very general statements like, "I am an unlovable person" or "I am an awkward person". In both cases we need to help the client find the underlying negative trait, characteristic, or aspect that is in the core of these statements. We do this by asking questions like, "So what kind of bad thing about you lies under this tendency to be late?" or " This carelessness that you are describing, what essential trait or nature in you does it actually reveal?" or "You're saying this very important thing that you feel unlovable. What is the trait that you feel you have that makes people not able to love you?"

The other aspect we want to clarify is the source of these negative self-concepts. As we explained above (4.1), these concepts could of have evolved from various experiences in the client's life: experience within the family, experiences with wider social groups, and experiences of trauma. The therapist guides this exploration with a very empathic un-shaming attitude to facilitate a curious space. Examples of questions of this nature may be: "have you always felt this way about yourself?"; "From when do you remember feeling this uneasiness about this trait?"; "Does this feeling of inferiority take you back to any specific time of your life?"

b. Finding compassion and connecting to the pain

Connecting to the pain is an essential step for activating the painful memory to be changed in MR. As the client is naturally critical about his flawed self-aspects, in most cases it is necessary to find some compassion

[18] We want to acknowledge that many of these ideas about the conceptualization and treatment of shame, were developed in collaboration with Einat Shaket Gross

first before the client can go into the painful feelings of shame and unworthiness more deeply. There are many ways the therapist can help the client finding a more compassionate stance. For example by using an explicit empathic stance toward the client's self-part, by suggesting the client imagine a compassionate other being looking at the self-part, or by asking the client how he would feel if it was his child/nephew's part instead of his own.

Once compassion is acquired, it is very important to stay with the pain and explicitly validate and let it "open up fully" or "arrive at the pain" (Greenberg 2010).
We have seen many times that when the pain is not fully accessed and activated, the process stays mainly cognitive, and the essential transformation does not take place. This accessing of the pain can be facilitated by compassionately talking with the suffering self-part, asking questions, recognizing the pain etc. with sentences like: "Of course you were paralyzed, how can a young boy do something when his teacher is attacking him like that?!" or "Of course you felt that you were stupid, if your own parent was so disappointed at your academic achievements, time after time!"

c. Re-assessment

After activating the pain, we want to help the client find a new contrasting experience about the self by reassessing the flawed aspect or traits. *Re-assessment* is the process of examining the traits of self that are viewed as flawed or with shame. Depending on the nature of the aspect of self, the client and therapist may find *new value* or *new meaning* from this examination.

<u>Finding new value</u>
When examining the unworthy aspects of self, there are several ways in which the client and the therapist may find new value which undoes the inferior quality of the trait. Examples are:
-Recognizing underlying good intention or quality of aspects (e.g., weak becomes kind-hearted, distant becomes not wanting to burden).
-Using adult understanding and finding the acceptability of a trait (e.g., "There is nothing wrong with feeling proud"; "When I was young, I thought feeling envy and being competitive meant I was bad, but now I know these are natural feelings for an eight year old.")
-Discovering that one actually does not possess the trait ("I was told that I was selfish, but I am actually very caring"; "When I was young I was sure that the fact that I am black means I am no good but now I know this is a social bias which is totally wrong").
-Understanding that the attacks did not result from one's own fault or failure (e.g., "I couldn't do anything else, I was just a little girl", "feeling this is normal for a child", "my mother was too insecure to see my beauty", "I wasn't born scared").

<u>Finding new meaning</u>
In some cases, the negative self-concept originates from "actual" attributes that are valued negatively in the society one lives in (e.g., major mental illness, being very short, having a small penis, physical or mental disability), and therefore it is often not possible for re-assessment to result in changing value for the better. In those cases, new meaning may be found from the new experience of *existential acceptance.* Examples of

existential acceptance can be: giving up unwarranted hope; understanding the trait as a shared human condition (e.g., physical imperfection); acceptance of one's misfortune of being born with unvalued traits in the current cultural, biological, historical context; finding meaning (e.g., "I learned from this") or identity (e.g., "this is my life", "it made me who I am") in leading a life with extraordinary conditions.

We can see from these examples of re-assessment that cognitive elements and self-narrative play a more important role in finding a disconfirming experience for self-pain, because self-pain is more conceptual in nature than basic emotional pain and relational pain. A new relational experience (e.g., feeling the therapist's affection and appreciation) may be an important new self-affirming experience, but likely won't undo a broader self-perception of being "uninteresting" or "needy". On the other hand we must not forget that an isolated conceptual or cognitive reappraisal (e.g. "I know I am not stupid" or "homosexuality is normal") will not transform self pain as it always needs to go hand in hand with deep emotional experience and processing.

d. Integration

Newly found value or meaning will help to integrate the unworthy part into the self. Self-concepts which have lost their negative value in the reassessment will naturally reintegrate as the previous rejected aspect of self will now be welcomed as valuable parts. Self-concepts that have found new meaning but still hold a negative value as they burden the self in his life circumstances are now ready to be accepted and reintegrated. This will involve a process of mourning what is lost or what one will never have because of having such traits.
The reintegration of these previously disowned characteristics of the self will create an experience of oneself as whole and authentic. It brings a new experience of self-acceptance, feeling worthy, and being part of the social group. For example, feeling proud and giving full expression of identity (e.g., sexual, gender, race) and interests (e.g., poetry), owning psychological traits (e.g., being introverted, dyslexia), and not hiding physical aspects (e.g., being bold, old). This results in a new learning: "my true identity is acceptable or even valuable resource for the group"; "I am a gentle person but had to learn to be aggressive to protect myself."

The therapist can select techniques and procedures from various models that are tailored for transforming self-pain for example: two-chair dialogue for self-critical split (EFT), working with critical parts (IFS), reframing, reattribution (ST), intra-relational portrayals, fierce love (AEDP).

The following case example will illustrate the process of compassion and re-assessment in a concrete case of self-pain:
A client came in with an array of somatic symptoms, the worst of them being irritable bowel syndrome. She was referred by a doctor who suggested that the symptoms might be psychosomatic and originated with severe stress she was experiencing. In the first session, the client revealed she was under impossible pressure to have outstanding grades in her studies and was experiencing high anxiety and obsessive studying.
When this was explored through empathic questioning, the client and therapist found out that the client was sure she was not intelligent enough, even stupid, (identifying negative core concept) and that she was constantly trying to hide this by excelling in her studies. She shared with the therapist how she felt severe shame around her being the only unintelligent member of the family and reported always feeling afraid that it will be revealed.

When exploring where this conviction came from (by asking questions like: "Were you born stupid? How and when did you learn this about yourself? Do you remember ever feeling differently about yourself?*")* she recalled many situations where she felt stupid, most of them at school and around friends. She also remembered her older brothers often making fun of her. One particular painful incident took place when she was six. Her parents were on vacation and she was left with her older brothers. On one of the evening one of her brothers decided to teach her some lines from the constitution. She remembered that until the age of 12 when her teeth were straitened, she had a slight speech impediment and therefore had a hard time pronouncing long words and specific sound combinations. Her two brothers made a whole scene laughing at her mispronunciations. This went on for a while until the babysitter noticed her distress and intervened. When going back with her to this scene, she could feel the profound humiliation, shame, and helplessness. During further exploration the client recalled that the fear of making mistakes when speaking long words would preoccupy her during all her school years and she remembered how hard it was to deal with it (i.e., identifying the origin of the negative self-concept). From this work the client was able to start feeling some compassion for the little girl that suffered so much only because of a speech impairment and how this was connected to feeling stupid (i.e., self-compassion toward the young part).

In a crucial session, the client contacted (in portrayal) the young self, an encounter that brought about much deeper feelings and pain. The young self talked of feeling stupid and of the fear that everybody would laugh at her if they discovered how stupid she was (i.e., accessing and feeling the pain). As a deep emotional connection was established, the therapist helped the client look back at the way the younger part was taking all this in, and she asked the client if she now thinks that these pronunciation problems are really signs of stupidity. The client explained that now she knows they are not even connected to stupidity but to her speech impairment. The therapist asked her if she can contact the young girl and acknowledge her pain and bring in new adult understanding: that she is not stupid but was suffering from a speech impairment that was used to make fun of her. The client did this, and the girl was listening and asking, "You really mean that? So why are they laughing at me? Why is my brother saying I am stupid?" and various other questions. The client answered all the questions until it felt to her that the young girl was really taking in this new appraisal (i.e., reassessment). The client then grieved the loneliness and shame she felt about herself for so many years in so many incidents in her early years in school. At the end, she said, "I never thought about it this way, so strange I had all the dots but never connected them". She reported a strong feeling of wholeness and lightness as if a huge burden was taken away (i.e., integration).

In the next session she reported looking differently at herself, viewing herself as more competent and intelligent. After this transition more work was done, and her stress gradually resided together with her somatic symptoms.

We can see here that transforming self-pain was very fruitful and was a better choice than, for example, helping the client express anger at her brothers for humiliating her or at her parents for not protecting her. Doing this kind of relational pain work could not have undone the deeper pain that the self was eliciting on itself. It is also important to notice that just finding compassion would also not give the needed results, as the pain was more complex and held important complex cognitive elements.

Summary of the *pain-dynamics* model

Our complete integrative model of pain-dynamics conceptualizes three types of emotional pain, warded off by three different types of defenses[19], requiring three fundamentally different transformational paths to achieve reconsolidation of the problematic memory.

Basic emotional pain

-Basic emotional pain is caused by unfavorable events in the environment that are too big to deal with for the individual, often in association with the absence of a soothing and protective other. As the inherent adaptive action tendencies (flight, fight) are ineffective, emotions become overwhelmingly intense, and the organism immobilizes. Emotions and action tendencies can't be processed to completion and become painfully stuck in the body.

- Reexperiencing basic emotional pain will be primarily defended against by using *detaching* defenses such as dissociation, distraction, and avoidance.

-Transformation requires undoing such defenses and finding newly regulated experiences, especially on a physical emotional level (e.g., feeling fear without terror).These new experiences can be promoted undoing aloneness[20], processing emotions to completion, mobilizing actions that were stuck in the body, facilitated by a soothing presence (of the therapist), using more adult resources, and piecemeal processing (ref techniques). Undoing defenses and emotional transformation will bring emotional relief, calm, and completion as well as a feeling of being deeply connected to one's body and experience, which will all reconsolidate into the revised emotional memory.

Relational pain

-Relational pain is caused by ruptures in the connection with an attachment figure. When the expression of needs is repeatedly not responded to (ignore, neglect) or responded to negatively (rejection, shaming) the child will repress the expression of his needs to safeguard the relationship with the caregiver. This will cause a painful state of unfulfilled needs and inhibited expression.

- In addition to *detaching* defenses, client will defend against reexperiencing relational pain primarily by using *countering* defenses, such as repression, denial, rationalization, self-criticism, and reaction formation, to fight off unacceptable feelings and experiences.

-Transformation of relational pain requires undoing these defenses and finding a new experience that is corrective on the relational level (e.g., expressing anger without rejection in direct interaction). These new experiences can be found in experiences of reconnection, restored emotional expression towards significant

[19] These categories *detaching, countering, and displacing* defenses, are inspired but not completely equivalent to ISTDP's categories of isolation of affect, repression and projection (Davanloo, 1990). For instance, we distinguish mild self-criticism as a defense to counter unacceptable feelings from a more severe self-attack resulting from a self-concept of defectiveness.

[20] Undoing aloneness (Fosha, 2000) is crucial for transformation in all three types of emotional pain, though the aloneness has a different quality in each type: aloneness from feeling vulnerable and being unprotected in basic emotional pain (e.g., alone in the forest (example from Les Greenberg, 2019)); aloneness from feeling disconnected and being uncared for in relational pain (e.g., alone in bed with dirty diaper(example from Les Greenberg, 2019)); aloneness from feeling defective and being excluded in self-pain (e.g., alone in the playground/party).

others, and receptive experiences of needs being fulfilled, which are facilitated by validation of needs and relational safety. Undoing defenses and emotional transformation will bring well-being through freely expressing, fulfillment of receiving what one needs, and security of relational safety, all of which will reconsolidate into the revised emotional memory.

Self-pain

-Self-pain is caused by attacks on aspects of the self by important others which are internalized as a self-concept.

When there is severe neglect or abuse by caregivers or shaming and exclusion by members of a larger (peer) group, the individual will hide and/or not express his true nature or will compensate by showing an altered and "improved" socially appreciated version of self in order to safeguard place in the group. This causes painful perception of self (traits) as defective and unworthy (toxic shame) as well as pain from hiding one's true self and displaced expression (false self).

- In addition to *detaching* and *countering* defenses, clients will defend against reexperiencing self-pain primarily by using *displacing* defenses such as idealization/devaluation (self-attack) or splitting and projection, to change the perception of the unworthy characteristics.

-Transformation of self-pain requires undoing these defenses and finding a new experience that is disconfirming on a semantic/conceptual level (e.g., I am not weak, because everybody is afraid when he is young). These new experiences can be found in experiences of belonging, receiving appreciation, reowning attacked parts as worthy, and free expression of true self, all facilitated by deshaming, compassion, and re-assessment of self-characteristics. Undoing defenses and emotional transformation will bring a sense of wholeness, authenticity, pride, and security of belonging, all of which will reconsolidate into the revised emotional memory.

Using the emotional pain model enables the therapist to create a map of the different elements of the original learning experience and the dynamics of the remembered emotional pain. Single events may cause more than one type of pain. For instance, in the case of abuse by a sibling we can find basic emotional pain in overwhelming emotions present in moments of the abuse, we can find relational pain around the failing parent that didn't listen or protect, and there might be self- pain from feeling worthless and blaming oneself for being abused. Throughout their lives, clients will experience all three kinds of emotional pain in varying degrees and in various combinations.

Conceptualizing emotional pain

An important merit of pain dynamics is that it helps the therapist to find and maintain focus for the work during the session. Though the therapy process will have to address all three types of pain, certain symptoms and problems are indicative that a certain type of pain is likely to be dominant in the session, and can help the therapist to determine which one requires initial focus to bring about the most needed change.
As with every conceptual framework, it is important to not lose contact with the unfolding process which is paramount to experiential work. Tracking and following the moment-to-moment markers of emotional activation, non-verbal cues, poignancy, the client's idiosyncrasies, fantasies, and healing tendencies can lead to changes and transformation unforeseen by our conceptualization. We intend that this framework will help therapists to gently guide their choices of intervention during the process. Using it in this way, the top- down process of conceptualization facilitates the bottom up process of moment-to-moment tracking. In that sense it may be best to see conceptualization as a process where we determine during the session what pain is in the foreground or active in the moment and what transformational process is needed now to heal this particular pain. This view on conceptualization holds the middle ground between *case conceptualization* "…determine the core painful emotion scheme self-organizations that are central to the presenting issues" (Timulak, 2015, p.74) and moment to moment *process formulation*: "From session to session, therapists listen for what has become figural for the person " (Goldman & Greenberg, 2015, p.115).
There isn't one marker that identifies the active pain in a particular session, but rather various indicators in the session like originating event, dominant emotion, the client's wording and concern, typical symptoms and defenses, and the client's known history, that all point in the same direction. Though at times it can be ambiguous, in our practice and supervisions we found that it is usually quite evident what pain is dominant in the session if we take into account these various indicators[21]. May be this is best illustrated by two examples.

A first example is a client who lost her mother at a young age. If the client usually tries not to remember the death of her mother, is anxious and experiencing intense emotional distress when talking about the moment she heard that her mother had died, we are likely dealing with basic emotional pain. If the client speaks in terms of often missing the mother, feeling alone and sad, of feeling guilt about being angry, we are likely in the realm of relational pain. If the patient focusses on feeling an orphan, feeling different and less than other children or being bullied for not having a mother probably self-pain is active.

A second example may be a client who experienced sexual betrayal by his wife. If the client describes he has gone numb and confused, and doesn't know what he feels about what happened, working on basic emotional pain might be a good first choice. If there is a lot of sadness and fear of the couple breaking up, fear to discuss the issue with his wife, together with a known history of abandonment, we can assume that the event in the first place has activated (memories of) relational pain. If it brings up feelings of rage over humiliation, shame about talking about it to the therapist, issues about his masculinity or deep self doubt if he is enough for his wife, we can understand that self pain is in the foreground.

[21] This reminds of Wittgenstein's (1953) argument that concepts may be easy to understand or use, but elusive to define in terms of their formal attributes.

Not being totally clear about the active pain may be problematic for research, but has important clinical value of clarifying a therapeutic choice point in a session(for instance choosing between more self-soothing and regulating interventions or a more expressive and interactive direction).

Also, in the case of lack of progress, reflecting on the pain dynamics may help the therapist to change the focus of the work[22]. It may for instance happen that the client apparently does meaningful work with a lot of emotional activation and clearly new healing experiences, but it turns out in subsequent sessions that it doesn't make a lot of difference for the problems the client is experiencing. Here is an example:

In a case where a young woman was constantly worried about her career and comparing herself with others, the therapist followed a lead of painful memories of the client who was made fun of and excluded in primary school for having facial dysmorphia. The therapist did an intra-relational portrayal of accessing the pain of loneliness and rejection in a number of situations during her early school years where she felt angry and lonely and tended to isolate herself to avoid experiences of rejection. There was a lot of emotional release, some anger was expressed, the adult self felt compassion for her suffering as a child and this undid her aloneness. The next session the client blamed herself for not having made the improvements that might be expected from the therapy work, which helped the therapist understand that they had worked with the pain of loneliness and rejection (relational pain) but that the client had not sufficiently accessed the self-pain of unworthiness. When the therapist focused directly and explicitly on her feelings of shame and defectiveness, the work immediately felt deeper and more impactful. She first felt the deep pain of feeling ugly and being seen as weird by others. She could feel compassion for her misfortune and could contrast the rejection with her recent experience feeling appreciated and her merit in having found real friendship during her university years.

Pain dynamics may also be helpful to establish priorities as it might be necessary to first work on one type of emotional pain before it is possible to work on others. We often found that it is easiest to work self-issues first, then relational issues, and finally basic emotional issues. For example, the treatment of the self-pathology will need priority over accessing relational pain when the client feels undeserving of reception and expression of her needs[23]. Relational pain may need priority over processing basic emotional pain, as relational safety, especially in the therapeutic relationship, is needed for the necessary regulation to access and process intense emotional pain to completion. Similarly, working on basic emotional pain like loss or fear, will be less effective if there is an anxious relational layer about having unacceptable needs. The order can also be reverse: there can be such strong dysregulation from basic emotional pain, that this must be addressed first in order to make work on relational or self-pain possible. For example:

In a 35-year-old client fear of the father dying had constantly been present in her life since her father was diagnosed with cancer when she was 5. As presently the illness was getting worse, she was obsessively thinking about the possibility of the father's death. Any work on relational pain with the father was overshadowed by the terror of losing him which was triggered by such work. After work on basic emotional pain in a portrayal

[22] In the autobiography "the choice" (Eger, 2018) there is a beautiful account of how a first therapy that focused on relational issues, was ineffective to help her with her (basic emotional) pain from overwhelming concentration camp experiences and (self) pain around worthlessness and feeling undeserving.

[23] Sharbanee et al. (2019, pp. 247) while discussing task analysis in EFT have made a similar point: "In addition, there is an intriguing idea in the insecurity model of a possible sequence in which people need implicitly or explicitly to solve negative self-treatment before they can feel entitled to having had their unmet need met in primary relationships.

where the client imagined grieving and dealing with the father's death, fear subsided, and it became possible to do relational work with the father about her anger and her unfulfilled needs for closeness because the father had been so absorbed in his illness. This was followed by mourning the life she had missed and feeling compassion for the girl who had lived all her life with this dread.

Implications for memory reconsolidation

Conceptualizing emotional pain in three categories gives important insights into some of the open questions regarding memory reconsolidation: in what way does the activating experience have to be similar to the original learning (Lane et all 2015), and in what way does the new disconfirming experience need to be different from the original learning (Ecker, 2020).

As the three types of emotional pain we described originate from fundamentally distinct learning experiences, both activating and disconfirming experiences need to match the experiential "modality" of the original learning experience in order to effectively activate and reconsolidate emotional memory. For basic emotional pain which originates from overwhelming emotional experiences, the client will need a regulated experience that is contrasting, especially on a physical-emotional level (e.g., remembering an event without terror, grieving over loss). In cases of relational pain which originate from unmet needs and ruptures in the attachment relationship, the client will require experiences that are corrective on the relational level (e.g., expressing joy or anger towards someone without rejection, receptive experiences of having one's need met and reconnection). In cases of self-pain which originates from the perception of self as defective and inferior, transformation can be achieved by a new experience that is disconfirming on a semantic-conceptual level (e.g. having a compassionate view of oneself, recognizing qualities and pride about characteristics).

In the case of basic emotional pain, the primacy is with the emotion, as the new emotional valence can be directly reconsolidated into the memory without conscious awareness or understanding of the client. Change often comes as a surprise to the client (e.g., "I don't understand why I feel different now"). Semantic understanding doesn't seem to play an important role except in a posterior understanding (e.g., "intense emotions are not dangerous", "I can overcome loss")[24].

Reconsolidation in relational pain can be both emotional in nature (e.g., expressing anger, receptive experiences of love and connection) and conceptual ("my needs are valid", "stopping my anger was needed to protect me"), but always seems to be most effective when experienced directly in a relational context.

When we think about dissolving the self-pain, a new transforming experience is not possible without conscious semantic content in the form of new meaning or facts about self, others, or events (e.g., "I am not inferior, many people felt this", or "I am not unlovable, my mother is incapable of love"). We may thus conclude that each emotional pain seems to have its own language that speaks to it.

[24] This is a process that can be promoted by, for example, by metaprocessing (Fosha, 2000, Iwakabe & Conceição, 2016).

References

Adler, A. (1927). *Understanding human nature*. Greenberg

Anderson, F.G., Sweezy, M., Schwartz, R.C. (2017). *Internal Family Systems Skills Training Manual of Trauma-Informed Treatment for Anxiety, Depression, PTSD & Substance Abuse.* Pesi.

Beck, J. (2011). *Cognitive behavioral therapy: basics and beyond* (2nd Edition). Guilford Press.

Benjamin L. S. (2018). *Interpersonal Reconstructive Therapy (IRT) for anger, anxiety and depression: It's about broken hearts, not broken brains.* American Psychological Association

Bolger E. (1999) Grounded theory analysis of emotional pain. *Psychotherapy Research* 99, 342–362.

Bowlby, J. (1969). *Attachment and loss: Vol. 1. Attachment*. Basic Books.

Bowlby, J. (1980). *Attachment and Loss: Vol. 3. Loss: Sadness and depression*. Basic Books.

Davanloo, H. (1990*). Unlocking the Unconscious*. *Selected Papers of Habib Davanloo*. Wiley.

Ecker, B*., Hulley, L., & Ticic, R (*2012*) Unlocking the Emotional Brain*. Routledge.

Ecker, B. (2020). Erasing Problematic Emotional Learnings: Psychotherapeutic Use of Memory Reconsolidation Research. In R.D. Nadel & L. Nadel, (Eds.), *Neuroscience of Enduring Change Implications for Psychotherapy*. Oxford Press.

Eger, E.E. (2018). *The Choice: Embrace the Possible*. Scribner

Elliott, R. & Greenberg, L. (2007). The essence of process-experiential: emotion-focused therapy. *American Journal of Psychotherapy*, 61 (3). pp. 241-254.

Fisher, J. (1999). *The work of stabilization in trauma treatment*. Paper presented at The Trauma Center Lecture Series

Fosha, D. (2000). *The Transforming Power of Affect: A Model of Accelerated Change.* New York: Basic Books.

Fosha, D. (2005). Emotion, true self, true other, core state: Toward a Clinical Theory of Affective Change Process. *Psychoanalytic Review*, 92(4), 513–551

Fosha, D. (2013) A Heaven in a Wild Flower: Self, Dissociation, and Treatment in the Context of the Neurobiological Core Self. *Psychoanalytic Inquiry*, 33:5.

Freud, A. (1936/66) , *The Ego and the Mechanisms of Defence*. Karnac.

Freud, S. (1926). *Inhibitions, symptoms and anxiety*. SE : 20: 77-175.

Gilbert, P (2007). The evolution of shame as a marker for relationship security. In J.L., Tracy, R.W., Robins & J.P Tangney, (Eds). *The Self-Conscious Emotions: Theory and Research*. Guilford.

Goldman, R. N., & Greenberg, L. S. (2015). *Case formulation in emotion-focused therapy: Co-creating clinical maps for change*. American Psychological Association.

Greenberg, L. (2010) Emotion-focused therapy: a clinical synthesis. *Focus*, 8, 32-42.

Greenberg, L (June 2019). EFT level 2 training. Tel Aviv

Greenberg, L., Rice, L., & Elliott, R. (1993). *Facilitating Emotional Change: The Moment-by-Moment Process*. Guilford Press.

Greenberg, L. S., & Goldman, R. N. (2008). *Emotion-focused couples therapy: The dynamics of emotion, love, and power*. American Psychological Association.

Greenberg, L. S., & Goldman, R. N. (2019). (Eds.), *Clinical Handbook of Emotion-Focused Therapy.* American Psychological Association.

Herman J.L. (1997). *Trauma and recovery: The Aftermath of Violence--From Domestic Abuse to Political Terror*. Basic Books

House, R. (2011) (Ed.) *Too Much, Too Soon? Early Learning and the Erosion of Childhood*. Stroud.
Iwakabe, S., & Conceição, N. (2016). Metatherapeutic processing as a change-based therapeutic immediacy task: Building an initial process model using a task-analytic research strategy. *Journal of Psychotherapy Integration, 26*(3), 230–247.
Kohut, H. (1971). *The analysis of the self*. International Universities Press.
Kuhn, T.S. (1962). *The Structure of Scientific Revolutions*. University of Chicago Press
Lane, R. D., Ryan, L., Nadel, L., & Greenberg, L., 2015. Memory reconsolidation, emotional arousal and the process of change in psychotherapy: New insights from brain science. *Behavioral and Brain Sciences,* 38:1-80
Lane, R. D. & Nadel, L. (2020). (Eds.), *Neuroscience of Enduring Change: Implications for Psychotherapy*. Oxford University Press
Levenson, H., Angus, L., and Erica Pool (2020) Viewing Psychodynamic/ Interpersonal Theory and Practice Through the Lens of Memory Reconsolidation. In R.D. Lane & L. Nadel, (Eds), *Neuroscience of Enduring Change: Implications for Psychotherapy* Oxford Press
Levine P. & Frederick, A.; (1997) *Waking the tiger: Healing trauma.* Berkeley, North Atlantic Books.
MacDonald, G., & Jensen-Campbell, L. A. (Eds.), (2011). *Social pain: Neuropsychological and health implications of loss and exclusion*. American Psychological Association.
Maslow, A.H. (1954). *Motivation and Personality*. Harpers.
Mikulincer, M., Shaver, P. R., & Pereg, D. (2003). Attachment theory and affect regulation: The dynamics, development, and cognitive consequences of attachment-related strategies. *Motivation and Emotion*, 27, 77–102.
Napier, N.J. (2019). *Unblocking What's Stuck: Working with Parts and Coupling Dynamics Using Body-Based Approaches*. Retrieved from https://vimeo.com/ondemand/unblockingwhatsstuck
Panksepp, J. (2009). Brain emotional systems and qualities of mental life: From animal models of affect to implications for psychotherapeutics. In D. Fosha, D. J. Siegel, & M. F. Solomon (Eds.), *The healing power of emotion: Affective neuroscience, development & clinical practice* (p. 1–26). W. W. Norton & Company.
Paivio, S. C., & Pascual-Leone, A. (2010). Emotion-focused therapy for complex trauma: An integrative approach. American Psychological Association.
Rogers, C. R. (1957). The Necessary and Sufficient Conditions of Therapeutic Personality Change. *Journal of Consulting Psychology*, 21, 95-103
Rogers, C. R. (1959). A Theory of Therapy, Personality, and Interpersonal Relationships: As Developed in the Client-Centered Framework. In S. Koch (Ed.), *Psychology: A Study of a Science. Formulations of the Person and the Social Context* (Vol. 3, pp. 184-256). McGraw Hill.
Rogers, C.R. (1961). *On becoming a person*. Houghton Mifflin
Russell, E. (2015). *Restoring resilience: Discovering your clients' capacity for healing*. W. W. Norton & Company.
Safran, J. (2012). *Psychoanalysis and psychoanalytic therapies*. American Psychological Association.

Shapiro, F. (2001). *EMDR: Eye Movement Desensitization of Reprocessing: Basic Principles, Protocols and Procedures (2nd ed.).* Guilford Press.
Sharbanee, J.M., Goldman, R.N., Greenberg, L.S. (2019) Task analyses of emotional change. In Greenberg, L.S. & Goldman, R.N. (Eds.), *Clinical Handbook of Emotion-Focused Therapy.* American Psychological Association.

Siegel, D. J. (2012). *Pocket guide to interpersonal neurobiology: An integrative handbook of the mind*. W. W. Norton & Company

Sznycer, D., Tooby, J., Cosmides, L., Porat, R., Shalvi, S., & Halperin, E. (2016). Shame closely tracks the threat of devaluation by others, even across cultures. *Proceedings of the National Academy of Sciences*, 113(10), 2625–2630.

Timulak, L. (2015). *Transforming Emotional Pain in Psychotherapy*. Routledge.Van der Kolk, B. (2014*) The Body Keeps the Score: mind, brain and body in the transformation of trauma*. Allen Lane.

Welling, H., 2012. Transformative emotional sequence: Towards a common principle of change. *Journal of Psychotherapy Integration*, 22(2), 109 -136.

Wittgenstein, L. (1953). *Philosophical Investigations*. Basil Blackwell.

Young, J.E., Klosko, J.S., & Weishaar, M. (2003). *Schema Therapy: A Practitioner's Guide*. Guilford.