Pain Dynamics: A compass for navigating through the experiential process

We are excited to present an integrative model conceptualizing *emotional pain and its transformation*. The model is an outcome of many hours of working with clients as AEDP therapists and helping supervisees find their way in the forest of endless therapeutic options. We believe the model can be used as a major navigation system (or a compass) in any experience-near therapy session. The model we are presenting divides the psychodynamics of psychological pain into three major domains, three different worlds, each with its own language and story of origin and its unique healing path: core emotional pain, relational pain and self-pain.

Core emotional pain

Originates from traumatic experiences of overwhelmingly intense emotion in situations that were too much to contain, too early in the developmental process, and/or where one was too alone. These traumatic experiences lead to dissociation and unprocessed emotion getting painfully "stuck in the body". In therapy, transformation may occur through undoing aloneness, regulation, and processing emotions to completion.

Relational pain

Originates from experiencing ruptures in the attachment relationship when caregivers were unresponsive or critical. This causes internal conflict about expressing emotional needs and maintaining connection. In therapy, transformation may be accomplished through validation and expression of emotional needs and emotions, and through corrective receptive experiences of connection.

Self-pain

Originates from repeated experiences of attacks on aspects of the self by important others or experiences of humiliation and exclusion by peers or society in general. These lead to feelings of shame, inferiority and worthlessness, and a resulting tendency of hiding one's identity. In therapy, transformation may be accomplished through compassion and finding new meaning and value for one's previous attacked parts of the self.

Though patients experience all three types of pain in their life, usually one particular pain is dominant in a specific session. Identifying the dominant pain in the session directs the therapist towards one of the three transformational pathways. It thus provides focus for the work, but also leaves plenty of room for intuitive moment-to-moment tracking of emerging experience. The conceptual model furthermore can assist to systematically select interventions and techniques from a variety of experiential models.

Recognizing and Transforming Core Emotional Pain

As we have noted, core emotional pain originates from intense emotions that are stuck in the body as they have not been processed to completion. This pain is created in situations where the intensity of the emotion is larger than the resources available for the person for dealing with it.

The patient may experience the pain by feeling overwhelmed by emotion (intense activation) or by disconnection from emotion (dissociation).

Patients will typically present their core emotional pain in problems like:

a. A clear traumatic event that the patient can't "put aside": "Whenever I drive my, car I start imagining how every car coming towards me is going to crash at me, just like what happened in the accident in which my husband died "
b. Pain that they are afraid to touch since it will never end or make them feel too miserable. "Just thinking about this little girl, I was, alone in the hospital, makes me feel so bad there is no way I am going to agree to go there, it will make me feel too miserable"
c. Emotional numbness around an event that they understand must have had emotional impact on them. "I feel so bad that I just have no emotion around the death of my sister, does this make sense? am I a robot or what?"

Transforming core emotional pain entails activating the intense emotion while providing the patient with enough resources so that the emotion can be regulated and processed to completion[1]. The task of the therapist here is to keep the experienced emotion of pain within the ”window of tolerance” by, on the one hand, activating dissociated pain, and on the other, providing enough regulation for excessive activation.

Activating the emotion is classically done by going back in detailed imagination (portrayal) to the original painful situation or to a close-enough version with the same structure and triggering painful elements, only this time using resourcing interventions so that the patient is not overwhelmed or immobilized by the situation.

Common resources for regulation can be: Explicit warm and protective presence of the therapist, bringing in protecting soothing imaginative figures (adult self, grandfather), slowing down, focusing on the body with mindfulness, and creating physical and temporal distance (new perspective).

In addition, the therapist can select techniques and procedures from various models that are tailored for transforming core emotional pain. For example: Titrating, and Pendulation (SE), Un-blending, Unburdening (IFS), Capacity Building, Recap (ISTDP), Retelling Trauma, Empathic Affirmation, Self-Soothing (EFT), Dyadic Affect Regulation, Rescue Portrayals, Undoing Aloneness (AEDP), Bilateral Stimulation (EMDR).

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[1] Fosha,2000

Recognizing and Transforming Relational Pain

As we have stated previously, relational pain originates from the constriction of the natural flow of expression and from the lack of the fulfilment of emotional needs. This pain is created by frequent ruptures with one's caregivers (abandonment, neglect, rejection) that occur because of expressing one's emotional needs, causing the child to experience pain over unmet needs and feeling disconnected from one's caregivers.

Depending on the specific experiences with the caregiver, the patient can develop several relational strategies to deal with this. For example, he may express his needs intensely and control others to make sure they meet his needs, or he may become fearful of rejection and abandonment and constrict his self-expression to express only what is being responded to positively. Another strategy might involve suppressing one's yearning for connection altogether, so that not to feel the pain of the missing connection.

Patients will typically present their relational pain in current-day problems like:

a. Ongoing issues (conflicts/ frustration) most commonly with life partners but also parents, children, friends, colleagues/bosses.
b. Difficulties with emotional closeness and /or sexual intimacy in romantic relationships
c. A tendency to be independent and self-sufficient in relationships.
d. A tendency to be pleasing and accommodating out of fear of being rejected in relationships.
e. Feeling inhibited in expressing a specific kind of emotion such as anger, sadness, fear, joy and more.

Transforming relational pain involves activating the pain and finding new experiences of expression and reconnection in relation to the caregiver. The pain can be activated by the therapist validating the pain over relational rupture and unmet needs, recalling a concrete situation or imagining a typical interaction. Imaginary expression of withheld emotion towards the caregiver can lead to (a combination of) several transformational outcomes:

a. Full expression and integration of needs and feelings – for example: pain over abuse, rejection, loneliness; conflicting feelings of anger, guilt, and love towards the parent.
b. Corrective receptive experiences – for example: the imaginary parent is responsive, feels compassion and remorse, or meets the patient's needs.
c. Letting go of the need[2]: Giving up unrealistic hope, i.e., mourning the parent one never had, and acceptance

Common techniques for accessing relational pain and its expression: portraying specific situations or typical interactions where the patient confronts and shares with the parent the emotions he

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[2] Greenberg, 1993

feels; validation of emotional needs and pain; countering the patient's defense of the parent[3]: moral, cultural, and relational reservations about upsetting, hurting or accusing the parent; encouraging expression of "unacceptable" feelings and impulses such as anger, rage, guilt: finding and expressing needs, wishes, and positive feelings of love and connection.

In addition, the therapist can select techniques and procedures from various models that are tailored for transforming relational pain for example: Empty Chair work for Unfinished Business (EFT), Rage Portrayals (ISTDP), Limited Reparenting (ST), Reparenting (IFS), Redo and Reunion Portrayals, Receptive Affective Experiences; Corrective Relational Experiences (AEDP).

Recognizing and transforming self-pain

As we have explained before, self-pain originates from feelings of shame and from hiding or compensating for characteristics of oneself that are perceived as inferior or defective. This pain is created by frequent experiences of attacks on aspects of the self by significant others, or by peers and by experiences of exclusion from social groups. These experiences lead to shame, unworthiness, and isolation from one's social groups and eventually to an internalization of a negative self-image of being flawed and inferior.

In order to avoid feelings of shame and renewed humiliation or marginalization, the individual sometimes adopts one or more coping strategies. These help to hide or compensate for the unworthy characteristics such as: self-attack, splitting of inferior self-aspects, adopting a (grandiose) false self, being critical and devaluating others, etc.

Patients typically present their self-pain in the form of problems like:

a. Feelings of shame, inferiority, self-blame, self-harm, withdrawal from social situations and roles.
b. Feelings others as critical, feeling judged all the time, and constantly justifying oneself.
c. Grandiose self-esteem, anger at others for not recognizing one's value, inability to remain in relationships, chronic infidelity
d. Being overly concerned with acceptance, obsessively comparing oneself with others, being highly dependent on approval
e. A general feeling of loneliness in the context of not being part of social groups or feeling constantly insecure in social groups.
f. Confusion about identity, non-authenticity, imposter syndrome

Transforming self-pain in therapy is centered around identifying negative core self-concepts and activating the pain resulting from such unworthy aspects of self, and eventually finding compassion, new value or new meaning in the eyes of the adult self. The pain may be activated by reviewing recent and past experiences of shame, humiliation, and exclusion or by exploring

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[3] Pilliero, 2019

feelings of shame the patient feels in the current interaction with the therapist. An imaginary interaction of the adult self with these “unworthy” self-parts can lead to (a combination of) several transformational outcomes that will help to reintegrate the hidden or disowned aspects into the whole of the self:

a. Finding compassion for the pain that is caused by experiences of shaming and rejection by important others and by the subsequent attacking and hiding of inferior aspects of the self by the self.
b. Finding new value for aspects of self that were previously viewed as unworthy. (E.g. being “selfish” is now seen as healthy capacity for self-assertion, being a “weak cry baby” is now viewed as a sensitive and empathic part.)
c. Finding new meaning in that certain traits are not bad by themselves, but are discriminated or devalued in the context of a particular society (e.g. a person of color in a racist society, or an introvert in an outgoing western society)
d. Finding acceptance for being born with certain traits or in certain conditions which are socially-deemed “unfavorable” (e.g. dysfunctional family, physical or mental imperfections, being neuro-atypical) for instance by viewing it as a shared human condition or a conditions that contributed to one’s learning and identity.

It is important to note that these transformations do not only involve a deep emotional experience, but also a restructuring of cognitive meaning as the self-pain derives from a negative self-concept.

Common techniques for accessing and transforming self-pain: precise identification of negative self-concept; portraying imaginary dialogues between the adult self and the attacked shameful part; deshaming of the shameful aspects from an adult perspective. Finding self-compassion (e.g. patient is stuck in relentless self-attack or in a hopeless collapse in feeling worthless) may be promoted by a radical compassionate stance of the therapist or bringing in imaginary compassionate others (e.g. Dalai Lama, Grandmother). New value or meaning may be found by bringing in larger existential perspectives of being embedded in culture, society and the human condition (e.g. symbolic and historic portrayals imaging the humiliating message and environment and going back generations to rebel against it).

In addition, the therapist can select techniques and procedures from various models that are tailored for transforming some of the elements of self-pain for example: Two-chair dialogue for Self-Critical Split (EFT), Critical Parts Work (IFS), Intra-Relational Portrayals, Fierce Love (AEDP), Reframing and Reattribution (ST), Cognitive Reappraisal (CBT).