The Origin and Transformation of Emotional Pain: the 3 Triangles of Pain¹

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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: 1. core emotional pain from experiencing unbearably intense emotion; 2. relational pain from experiencing disconnection and unresponsiveness by attachment figures, and 3. self-pain from experiencing unworthiness and exclusion from the social group.

Each of these types of pain has been described numerous times by different theorists and therapists in the past, but recognition of these 3 “paradigms” and the systematic distinction between them was still lacking. The authors show how each type of emotional pain has not only distinct developmental etiology and evolutionary function, but especially the clinical relevance of this distinction as each type requires a fundamentally different transformational process to be healed. Though patients 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. The authors argue in each of the 3 transformational process memory reconsolidation takes place on different levels of representation of information. Thus distinguishing the type of emotional pain provides information about what ingredients are needed for an contrasting experience to effectively reconsolidate the problematic emotional memories. 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.

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Introduction

In this article we will argue that psychological pain can be divided into three distinct categories that are different in origin, evolutionary function, complexity of learning, and, therefore, require distinctly different psychotherapeutic interventions to undo their emotional learning.

We tried to create a new integrative framework in which we brought together theories on emotion (Greenberg, 1993; Panksepp, 2009; Timulak, 2015), attachment (Bowlby, 1973; Ainsworth, 1991; Mikulincer et al., 2003), psychodynamics (Freud, 1900; Malan, 1979; Fosha, 2000), emotional development (Tronick, 2007; Trevarthen, 2005), trauma (van der Kolk, 2015; Fisher, 1999), learning, and memory (Watson, 1913; Skinner, 1938; Duda, 2004).

Unfortunately, very few of these theories have solid scientific proof. Therefore, the validity of the theories in our field is determined by the accuracy with which they can describe and predict phenomena, which is a rather subjective notion. These theories use metaphors and sophisticated terminology that may give an illusion of depth of understanding which, in reality, is not justified. To test our understanding of these things, we will break these concepts down to their simplest units. Furthermore, we will try to stay as close as possible to the phenomena we want to describe and explain, using a step-by-step approach with many examples. In this method, we follow the idea of Richard Feynman who argued that if you can't explain something complex in simple terms, you don't really understand it (Gleick, 1992).

In this article, we will propose two major conceptual innovations of existing views on emotional pain. The first is distinguishing 3 types of emotional pain that are not only different in origin but also require distinctly different interventions to undo their emotional learning. Our second conceptual innovation is to distinguish the original experience of emotional pain from the process of remembering emotional pain. This distinction, which is often not made explicit, is essential because psychotherapy should be equipped to change memory of emotional pain and to undo the defenses against such remembering.

Each of the 3 types of pain we are going to introduce in this article has been described in the past numerous times by different theorists and therapists, 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 patient'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

defenses² 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.

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.

² 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 Pain³

From our clinical experience we have found that there are three kinds of emotional pain that have fundamentally different characteristics and origins.

Core 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, too alone) 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. As there is no resolution the process immobilizes halfway and gets 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 emotional 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 disconnection. 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.

³ It may warranted to distinguish a separate 4th category of spiritual pain around existential issues such as meaning and death, but this idea is still in development.

Evolutionary function of emotional pain

From an evolutionary perspective, these emotional categories of pain are plausible, as they are rooted in 3 distinct affective systems, each safeguarding a particular domain that is crucial to our survival.

The first domain is the relation of the individual with its natural environment. Categorical emotions (e.g., fear, anger, joy) ensure the 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 activation because our physical wellbeing is under threat, this results in the fear of disintegration or annihilation. 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 get their basic physical and emotional needs met. Later in life, a similar need for attachment will arise towards significant others, 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 separation. 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 survival 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).

In reality, these 3 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 core emotional pain. Events often cause more than one kind of pain. For instance, cases of extreme relational pain (e.g., abuse) can also cause core 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, pleasurable or painful.

Three paradigms of psychotherapy

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).

Core emotional pain is at the heart of the *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 and metabolizing, and liberating the body of such traumatic memories. This trauma paradigm has greatly influenced therapies such as EMDR (Shapiro, 2001), Somatic Experiencing (Levine, 1997), Internal Family Systems (Schwartz, 1995), AEDP (Fosha, 2000), Sensorimotor Psychotherapy (Ogden & Fisher, 2016), and others.

Relational pain is at the heart of the *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 unacceptable or cause anxiety in the caregiver, they need to be repressed in order 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. This paradigm of conflict has greatly influenced therapies such as (Relational) Psychodynamic Therapies (Safran, 2012), Intensive Short Term Dynamic Psychotherapy (Davanloo, 1990), Emotion Focused Therapy (Greenberg, 1993), AEDP (Fosha, 2000), and Schema Therapy (Young et al., 2003).

Self-pain is at the heart of the *Paradigm of Identity* (e.g., Adler, 1927; Rogers, 1959; Kohut, 1971; 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 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. This paradigm of identity was influential for therapies such as Existential therapies (Frankl, 1945), Narrative Therapies (Niemeyer & Mahoney, 1995; Bruner, 2004), EFT couples therapy (Goldman & Greenberg, 2013), and Schema Therapy (Young et al., 2003), AEDP (Fosha, 2013).

Remembering emotional pain

An important aspect of emotional pain is that under certain conditions, it is stored in memory. It is not totally clear when the organism “decides” to remember emotional pain, but it is certainly more likely to happen when emotions are more intense and/or occur repeatedly. When natural responses are ineffective, new learning becomes relevant and is naturally catalyzed (Tulving, 1983) by the inherent higher levels of pain.

As we grow older and circumstances change, these emotional learnings that once protected us from emotional pain become the source of unnecessary suffering. We keep suffering from events that are long gone and are a part of our history but no longer relevant today. Re-living such pain can cause emotional suffering well into adulthood even when there haven’t been negative outcomes for many years. Because the memory of the concrete events that originally caused these learnings are usually not accessed, such strong emotional reactions⁴ like anger, fear, or hopelessness, are often puzzling to the patient and are felt to be exaggerated or out of proportion. In other cases, the patient is so accustomed to them that he sees them as an inherently inevitable part of life.

Schematically we can represent this learning as follows:

⁴ Greenberg (1993) referred to this as problematic reactions.

In the left triangle we can see the situation where the natural sequence of the action tendency following the emotional pain from an unfavorable event are compromised: no resolution is found as adaptive attempts are failing. When the intensity of the emotional pain and fear rises, an emotional memory will be formed, represented in the triangle on the right.

At the bottom of the triangle of remembered pain we find the learning that resulted from the experience of emotional pain. The perception of internal or external elements (e.g., sound, facial expression, wish) associated to the original painful event now trigger the memory of the emotional pain causing the individual to relive aspects of the original painful experience (e.g., the innate fear, the pain from non-resolution or repression). In the right top corner are the inhibitory affects (e.g., anxiety or shame) that motivate the individual to distance oneself from this rising pain through defensive responses (left top corner) such as distancing oneself physically or diminishing inner awareness of the pain.

The most important difference between felt pain and remembered pain is that with remembered pain, there is a system that feels anxiety about feeling this pain (inhibitory affect) and a system that defends against the pain (defenses). Thus, the reaction of remembered pain is much more complex as it not only involves remembering all the aspect of the old pain, but also a system that works against experiencing emotional pain (again) and creates additional, more complex suffering.

Emotional pain in and of itself is not a problem and an important mechanism to motivate the individual to take corrective action and protect oneself from unfavorable circumstances.

It is the repeated remembering of emotional pain, the inhibitory affects and the defenses against reliving emotional pain, that cause problematic suffering and brings people to psychotherapy. If emotional pain wasn't remembered, there might be no need for psychotherapy at all. The maladaptive self-generated emotional pain which results from emotional learning is at the heart of what we try to change in psychotherapy. As Panksepp states: "Reconsolidation of affective-cognitive memories needs to be the prime concern of psychotherapy" (Panksepp, 2009, p. 26).

Transforming emotional pain

Because in psychotherapy we want to change *remembered* emotional pain, we need to use techniques that are appropriate for changing memories. Our conceptual model based on learning, remembering and transforming emotional pain fits very well with *memory reconsolidation*, which has been proposed as a crucial underlying mechanism of change in psychotherapy (Welling, 2012; Lane et al., 2015). In memory reconsolidation, 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, 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. This 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 might be expected from the fact that each type of emotional pain originates from very different experiences, we found that each of the 3 types of the emotional pain also requires different kinds of corrective experiences to effectively reconsolidate such memory. In cases of *core emotional pain*, the painful experience of unbearably intense emotion is transformed by a new experience of regulated emotion which involves undoing aloneness and increasing resources, thereby allowing emotions and action tendencies to be processed to completion. In cases of *relational pain*, the painful experience of unmet needs and disconnection is transformed by a new relational experience through relational safety and validation of needs, allowing for reconnection, regained expression, and reception of emotional needs. In cases of *self-pain*, the painful experience of exclusion and defectiveness is transformed by a new experience of self through undoing shame, compassion, and re-assessment allowing for integration of parts that were disowned as unworthy.

The fact that each kind of pain transforms differently and therefore require a different therapeutic approach, is probably the most important clinical implication of this model, as it provides a map for the clinical interventions and a guide for treatment selection from the different paradigms for each type of pain.

With this basic understanding about pain, memory, and transformation in place, we will now discuss each of these 3 pains and their transformation in greater detail.

1. Core Emotional Pain⁵

1.1 Pain from unbearably intense emotion: fear of disintegration

The system of categorical emotions (Fosha, 2000) generates mental states that are crucial for the survival of the individual in response to the environment. Emotions provide very fast and clear perceptions of the meaning of events around us, signaling what is best for our development and survival. For example, feeling fear is signaling important information that something is dangerous, sadness that something is being lost, anger that something is blocking our goal or intruding our space, and joy that something favorable is happening.

At the same time, categorical emotions create an action tendency of how to react adaptively to (changes in) the environment. They motivate us toward adaptive action such as fight, flight, withdrawal, or approach. There are around 6 basic emotions (Ekman, 1984) with universal body and facial expression. Only 2 of them are experienced as pleasant: joy and surprise. These “positive” emotions motivate us to approach or to be curious and energize us to explore and relate. The other four: fear, anger, sadness, and disgust, are experienced as unpleasant⁶. These “negative” emotions motivate the individual for withdrawal and distancing. Fear tells us to run away, anger helps us to fight and defend what is ours or what we want, sadness makes us mourn and search for comfort, and disgust motivates us to expel what is bad or toxic for us.

The activation of negative emotions is experienced as emotional pain. Just as in physical pain, 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 loss⁷ or feeling fear when one is trapped and can’t run. In that case, there will be no relief in the emotion, and the intensity will quickly rise. 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

⁵ Some readers found “basic emotional pain” or “situational pain” a better designation.

⁶ The pleasantness or unpleasantness of an emotion is often referred to as the valence of the emotion (Russel, 1980)

⁷ The fact that grieving loss and separation of an attachment figure is a process of core 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 (Bowlby, 1973, 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.

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 losing 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”.

Emotions are felt and experienced as waves of feelings and sensations, starting low, intensifying, and then calming down again when the process comes to completion. This natural sequence is a basic psycho-physical quality of emotion. Instinctively the presence of others will enhance the sense of safety and will bring the anxiety down to tolerable levels. The parent holding the child physically and soothing him by talking calmly will usually quickly bring down the level of distress. For example, when a child feels intense sadness over the loss of a favorite toy, emotion is released by crying (self-regulation) and she will calm down as she gets consoled (other-regulation). The repeated soothing from the parent is required to learn the capacity for self-soothing and a sense of safety in the world. The soothing or holding by others or self is what enables someone to experience the wave of emotion until it naturally calms down.

Children are very dependent on their immediate perception and do not have the cognitive capacities for understanding the changes in the environment that adults have at their disposal. Only with maturation, will the child gain the basic capacities to understand that a mother is near although he can't see her (object constancy), a notion of time and an ability to see ahead imagining good outcome, or understanding why certain things are happening and thus changing the meaning of the threat or of their hurting. More sophisticated resources can be the understanding of the inner world of others and their reasons for action (mentalization) or finding a creative solution to deal with the situation. As the child grows, he becomes less vulnerable, but even adults can experience overwhelming emotional pain from extreme events like car accidents, violence, or situations of war.

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 disintegration⁸ (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

⁸ Compare annihilation anxiety (Freud, 1926).

of being stuck halfway in a process without resolution⁹. Eventually, the person will detach himself (dissociate) from the awareness of this unbearable emotional and physical experience.

In summary, core 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 core emotional pain will be stored into memory. The way certain events can lead to core emotional pain and how such pain is remembered is schematically represented in the following diagram.

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 affect¹⁰ (e.g., terror, intense emotion). In extreme cases, they may result in a full flashback, where not only the emotional dimension is re-experienced but

⁹ Napier (2019) refers to this as unmetabolized emotion gets stuck in the body.

¹⁰ Janina Fisher (1999) refers to this as *feeling flashbacks* or *intrusive affects* that represent *feeling memories*.

also the physical sensations (e.g., pain), perceptions (noises and images), and mental state (e.g., confusion, dissociation).

In many cases full reactivation may not occur as anxiety motivates the person to distance oneself from triggering elements to avoid re-experiencing the emotional pain. As a result, we often actually only experience anxiety over triggering stimuli and not the underlying painful affect. Again, this is an automatic process and in most cases, an individual is not aware of exactly which cues in the situation triggered the negative affect or anxiety.

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.

Mary when she was 6 visited her dying mother in hospital feeling the terrible pain of her loss. The learning from this pain makes her avoid remembering this terrible event, avoiding associated places and experiences that make her anxious (hospitals, going to a doctor)

A person may also start avoiding internal triggers like bodily sensations and emotions that are associated with the painful event. It is also possible that the person detaches internally from any feelings at all, habitually living numbed and disconnected from their inner experience.

In summary, the suffering caused by the memory of core 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.

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?"

1.2 Transforming core emotional pain

Therapy addressing core 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 3 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 models¹¹ that are tailored for transforming core 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). If well targeted, core emotional pain caused by one particular traumatic event at times is resolved in a single session, unlike the other 2 types of pain.

¹¹ 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)

The following case example will illustrate the process regulation by undoing aloneness in a concrete case of core emotional pain:

A patient 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 12, 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 was sleeping, but she would routinely wake up from her father's severe screaming and swearing at her mother. In an imaginary exercise (portrayal¹²) the patient went back to a specific incident when she was 8 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 core 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 patient was 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 patient 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 patient 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 patient 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

¹² Portrayal is a typical AEDP imaginary technique in which the patient 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.

father's devastating rage. After the soft weeping the patient 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 patient 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"*. As a result, she was less triggered and ceased becoming paralyzed during arguments with her husband.

In this example undoing the aloneness with the therapist and adult self, brought enough regulation to allow the patient to go through and experience to completion the feeling of terror. Processing the pain released her from the memory of the pain and from the early learning that this pain was too big for her to process.

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 core 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

Young children are dependent for their survival on their caretaker's help, encouragement, and satisfaction of their emotional needs. Therefore, infants constantly monitor the attachment relationship with their caregiver and are very sensitive to signs that this relationship might be in danger. Ruptures in the relationship with the caregiver will cause relational pain and motivate the child to repair these ruptures in order to reconnect to the attachment figure.

The system of attachment strivings provides us with meaning and action tendencies with respect to the relationship with our primary caregivers. Children will instinctively react with panic and despair over (the threat of) emotional separation or loss of an attachment figure, motivating them to seek proximity. Feelings of love, happiness, and calm signal that proximity was established.

Children have many kinds of emotional needs, of which Timulak & Pascual-Leone (2014) have identified 3 categories: appreciation, connection, and protection. These form a good working set for the problems we commonly encounter in psychotherapy. Examples of appreciation are the need to be respected, accepted, seen, or validated. Examples of connection are the need to be connected, reached out to, loved, cared for, and included. Examples of protection are the need for protection, safety, control, and mastery.

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, they will welcome and stimulate these tendencies and help the child find ways to satisfy his needs.

Ruptures and repairs in the relationship with the caregiver are frequent and even necessary to help the child develop into more autonomous and capable. Finding one's way and self soothing help the child to gradually find its own way to cope independently with the challenges of the world. When ruptures are frequent and not followed by repair this will cause insecurity in the child that will lead to patterns of clinginess and fear of distancing from the parent or in other cases giving up seeking support from the caregiver altogether.¹³ When, for example, the child's needs are 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

¹³ This pattern of over activation or under activation are the strategies underlying insecure and avoidant attachment styles (Mikulincer et al., 2003).

originates from the attachment relationship. Relational pain around unfulfilled needs is highly specific and idiosyncratic for each person, as it depends on what specific need was frustrated and at what age. For instance, the pain around loneliness at an early age may have the quality of feeling physically alone, which, at a later age, may be understood as “*nobody played with me*”, and at a still later age, as “*nobody was interested in me*” or “*nobody understood me*”.

Parents have varying difficulties in dealing with the affective expression of needs of their children. 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)¹⁴. The capacity of the parent in receiving, holding, and encouraging the child’s expression of his needs can be quite different depending on the age of the child. Parents can be excellent at earlier ages knowing how to cuddle, pamper, and protect, but unable to deal with the needs for autonomy and angry adolescence. Other parents feel awkward and unequipped with the more physical needs of the younger child but can be more responsive in later phases where intellectual guidance is required.

It is important to note that the parent’s response is also relevant for the expression of various positive emotions. When a child expresses positive emotions like love, enthusiasm, and curiosity, he needs to get an emotionally synchronized response. If ignored or attacked, he will be hurt in a similar way feeling shame and fear of losing the connection (Tronick, 2007).

Over time, children learn that certain behaviors or expression of certain emotional needs may lead to disconnection and frightening negative reactions from the caregiver¹⁵. 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

¹⁴ It is not the mere occurrence of negative interactions with the caregiver which causes emotional pain, but the repeated and systematic negative interactions in the absence of positive emotional interaction. Research shows (Fosha, 2000) that instances of regulated positive emotion in the interaction between parent and child are protective of relational trauma. Similarly, Tronick (2007) found that it is not so important that ruptures occur but that it is crucial that ruptures are repaired or not.

¹⁵ 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.

expression. He will suppress the expression¹⁶ of the need and hide his “unacceptable” emotions and needs 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 wishes¹⁷.

The way these failures in the attachment relationship can lead to relational pain and how memories of relational pain are triggered are schematically represented in the following diagram¹⁸.

¹⁶ Mikulincer et al. (2003) refers to these strategies as overactivation versus underactivation, which form the basis of ambivalent and avoidant attachment styles

¹⁷ 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.

¹⁸ The right triangle of remembered relational pain is very similar to the “triangle of conflict” by Malan (1979).

If 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 emotional learning is 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.

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.

A boy expressed anger and disappointment on his birthday as he didn't get the present he wanted so badly. His father made fun of his crying and accused him of being ungrateful. The boy felt shame, anger, and left alone. He learned about the unacceptability of wishing something or showing disappointment, and as an adult, he may not like birthdays or getting presents, and develop a worry about not being grateful enough.

These memories of the relational pain can now be triggered by the associated elements (i.e., birthdays, presents, being laughed at, having wishes, feeling disappointed), which will cause the memory of the relational painful state (i.e., unmet need, shame, rejection & fear of disconnection). When approaching such triggering situations/stimuli, he will experience anxiety which will motivate him to develop defensive strategies to distance himself internally or externally from such triggering elements.

Depending on the effectiveness of the defenses there is quite a variety of triggered responses. The first possibility is that one remembers the painful event. The second is that one doesn't remember, but experientially falls back into the old feelings state (one feels now how one felt then without awareness of the origin). The third possibility is that one does not feel (or only very shortly) the painful emotional state, and instead will be experiencing strong anxiety or shame over feeling certain emotions or wishes. Notice that this suffering is now entirely internally generated—no bad outcome actually happens (e.g., there might be nobody around that is critical). But the suffering is caused now by the anxiety and self-criticism over the wish and emotion that wants to be expressed or announces expression. Tragically, one may become afraid or phobic of one's inner lively experiences (McCullough, 1997).

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 anxiety and 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 experience¹⁹.

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.

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.

¹⁹ 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.

2.2 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

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 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.*" If the expression is not validated, it will initiate mourning and accepting of what was lost and cannot be undone, like time spent in suffering, disconnected, and in need.

Reestablishing connection after the expression of needs and emotions may not always be possible or feel realistic for the patient. 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 models²⁰ that are tailored for transforming relational pain for example: empty chair work for unfinished business, two-chair

²⁰ ISTDP: Intensive Short-Term Dynamic Psychotherapy (Davanloo, 1990). ST: Schema Therapy (Young et al., 2003)

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 in relational pain through validation of needs, expression, and reconnection:

A patient 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 patient, he then explored his feelings when visiting his father and "not being able to have any 'real conversation' with him". The patient 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 patient 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 patient 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 patient to imagine the reaction his father has to all that he heard. The patient 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 patient 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 patient, if he felt safe enough, to put to words what the father would say. The patient 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" (*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."(*mourning*) The patient 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 patient 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.

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 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-pain²¹.

“Self” refers to broad aspects of ourselves, such as traits or identity, which define our merit or value as a person, and it is organized around self-concepts. (Harter, 1999). We monitor our role in the group and when valued and appreciated by others, we feel pride and confidence. It gives us the security that characteristics of our self like beauty, strength, intelligence, and humor are valued and appreciated by the members of the group we belong to. It allows us to bring our natural and inborn tendencies, interests, opinions, and (sexual) identity to expression. If we feel that some aspect of ourselves is somehow viewed by others as bad or unacceptable, or counter dominant values in society, we instinctively start to feel shame and the fear of unworthiness and exclusion. The emotional pain of the endangered role or the risk of being marginalized from the social group motivates us to reinforce our role and demonstrate our value. Shame is a key emotion that motivates us to hide defective or improve flawed aspects of our self to protect ourselves from losing connection or being excluded from the group.

Self-pain has three important sources: experiences with peers and significant others, and society (1); the relationship with the attachment figures (2) and big T trauma (3).

1. 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 aspects of the self, disrespect or abuse by important others such as parents,

²¹ 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).

siblings, teachers, spouses, employers shape the view of one's importance, dignity, and self-esteem. Example can be criticism for being too weak, too selfish, too feminine or masculine, ugly, dumb, too demanding, too loud, too sensitive.

Often, inherently normal aspects of development can become labeled negatively: being proud over achievement becomes arrogance, sensitivity becomes weakness, being lively becomes being difficult. Such attacks lead to developing a concept of ourselves as flawed, defective, useless, or unworthy. Physical abuse and incest will almost certainly lead to self-pain for blaming oneself of what has happened and will internalize as feeling disgust towards one's body, disgust towards one's sexuality, and disgust towards oneself overall.

Experiences of exclusion, humiliation and bullying by peers are a central cause of self pain and shame, and will damage the sense of one's self worth, dignity and sense of belonging to the group. 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.

This is because the child and adolescent learn that these traits are unvalued by the dominant groups in the social group he is part of. This inferiority often stems from cultural negative messages (sometimes blunt but more often "transparent" and as if "matter of fact") about different aspects of his or her identity. This is the process in which racism, discrimination, and other forms of social marginalization create severe self-pain in a "natural", silent and unnoticed way.

2. 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 and rejection may create a self-concept in the child of being bad, weak, or selfish.

Until adolescence, children are evolutionarily programmed not to question their parents' authority. They will naturally assume them to be older and wiser, justified by the parents' life experience as well as cognitive and emotional development. This means that in the case of neglect or abandonment, the child will always feel shame and find fault with himself for what has happened. He will always question himself what he has done wrong. Ignored and neglected needs and urges will gradually be felt as inherently "bad" and having them makes oneself bad. For instance, extreme neglect can lead to the idea, "*I don't deserve love*", or "*what I want is bad*" and rejection and abuse to the conclusion, "*I deserved this*". As Fosha states (Fosha 2013: 18), "*inattention, indifference, disinterest, and non-involvement of the caregiver map onto the self as shaming unworthiness*".

3. Finally, a third source of self-pain can be big T trauma. In this case *core 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 perceiving oneself as selfish, passive, weak or as “damaged goods”²². In such cases, shame and self-pain do not always bear the clear markers of explicit badness or defectiveness, like being ugly, dumb, or lazy, but may be found in implicit self-concepts, like being helpless (“*I am worthless*”; “*I am without strength or power*”), things happen to me without meaning (“*I am not important or insignificant*”), this only happened to me (“*I am less than other to whom this didn’t happen*”).

It is important to note that in the case of self-pain, we are not merely dealing with unacceptable behavior, emotion or needs but with wider self-concepts around 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 are cognitive constructs that are emotionally charged and are built from learning about the self through self-reflection and feedback from others about oneself. These processes are highly complex mental procedures involving abilities like mentalizing and abstract thinking. Only when the brain matured sufficiently (somewhere around the age of 9) a person can start generating self-concepts from the interactions between self, others, and the environment. As we described above core emotional pain and relational pain that happened much earlier in life, can later develop into self-pain when the brain is sufficiently developed to form self-concepts. Later experiences of self-pain are also not completely separate from early ones, in the sense that experiences in relation with the caregiver will create a vulnerability to experience self-pain in later experiences with peers and social interactions. The earliest roots of self-worth come from the attachment relationship that can transmit delight, appreciation, and confidence (Stern, 2005).

When we feel ashamed of characteristics, we start hiding them or try 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. This causes the pain of repressed expression of our natural self, disowning of the “bad” parts of ourselves, and possibly faking other more acceptable traits to camouflage the bad ones.

²² Pavio & Pascoal-Leone (2010) have an excellent chapter on shame and self-blame resulting from such trauma and abuse.

In summary, self-pain is made up of the following: 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)²³

Experiences of intense and repeated self-pain will be stored in our emotional memory. The way in which self-pain is caused and then triggered, remembered, and dealt with is schematically represented in the following diagram.

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.

Feelings of shame, worthlessness, and fear of exclusion are activated every time this specific trait is manifested or perceived in oneself. Associated elements (e.g., making mistakes,

²³ 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* (Rogers, 1961), *Self (Energy)* in IFS (Anderson et al., 2017), *birthright self* in IRT (Benjamin, 2018) or the *Intact Self* in AEDP (Piliero, 2018).

evaluation, eating too much, ridicule) that were present during attacks on the self may also trigger these memories of self-pain.

Different from core emotional pain and relational pain, remembering self-pain is more conceptual and involves the identification of “unacceptable” or “bad” characteristics of oneself. It involves more complex elements of the self, like traits, typical behaviors, and general styles of expressing one’s self, such as talking loudly, being fat, being bad in math. These can be perceived as flawed aspects of the self, such as weakness, ugliness, stupidity, neediness, weirdness, selfishness, etc. Therefore, self-pain is much easier to trigger than core emotional or relational pain which are essentially triggered by events or emotions. Anything that recalls or is associated with such themes, even if never before experienced, may start to activate the self-pain and may lead to a generalization of shame to other semantically related traits. For example, when criticized for “being selfish”, one may restrict oneself from expressing any kind of wish, need or ambition.

The recollection of intense shame surrounding specific unworthy aspects of ourselves motivates us to hide these characteristics and attack ourselves for having them. Self-pain is now self-generated through self-blame and self-attack. This process continues throughout life and many aspects comprehended as “bad” in childhood, are still attacked even though in current circumstances they are not “bad” at all. The information about their badness is never updated since they are constantly attacked and hidden from self and others. For example:

A patient 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 patient 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 it 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 into others or viewing oneself as superior.

Because self-pain is so easily triggered, self-pain can easily get worse over time from repeated and prolonged experiences of remembered shame and feeling defective. The shame over bad aspects and traits of 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 and flawed becomes so burnt²⁴ into the nervous system (Hebb, 1949), that it starts to feel like the core truth about oneself and 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, withdrawing in 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 the formation of 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, patients 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.

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. Feeling 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

²⁴ Schore (2019), remarks: “During early critical periods, frequent dysregulated and unrepaired relational experiences are “affectively burnt in” to the infant's early developing right brain”

3.2 Transforming Self-pain²⁵

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 patient 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.

Patients 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 patient 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

²⁵ We want to acknowledge that many of these ideas about the conceptualization and treatment of shame, were developed in collaboration with Einat Shaket Gross

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 have evolved from various experiences in the patient's life: experiences 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 patient is naturally critical about his flawed self-aspects, in most cases it is necessary to find some compassion first before the patient can go into the painful feelings of shame and unworthiness more deeply. There are many ways the therapist can help the patient finding a more compassionate stance. For example, by using an explicit empathic stance toward the patient's self-part, by suggesting the patient imagine a compassionate other being looking at the self-part, or by asking the patient 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 patient 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 patient and therapist may find *new value* or *new meaning* from this examination.

Finding new value

When examining the unworthy aspects of self, there are several ways in which the patient 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").

Finding new meaning

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", "it made me a better person") 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 core 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 models²⁶ 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), cognitive reappraisal (CBT). Self pain involves the most complex learning of the 3 types of pain and takes most time to change in therapy as it is widespread through emotions, relational attitudes, and identity. Undoing defenses, working through these four tasks for several (related) self-concepts can take many months if not years.

²⁶ CBT: Cognitive Behavioral Therapy (Beck, 2011).

The following case example will illustrate the process of compassion and re-assessment in a concrete case of self-pain:

A patient 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 patient 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 patient and therapist found out that the patient 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. One of the evenings, 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 patient 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 patient 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 patient 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 patient look back at the way the younger part was taking all this in, and she asked the patient if she now thinks that these pronunciation problems are really signs of stupidity. The patient

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 patient 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 patient answered all the questions until it felt to her that the young girl was really taking in this new appraisal (i.e., reassessment). The patient 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 patient 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 3 triangles of pain

Our complete integrative model of emotional pain conceptualizes three types of emotional pain, warded off by three different types of defenses^{27,28}, requiring three fundamentally different therapeutic processes in order to be transformed in psychotherapy. Using this new model of emotional pain enables the therapist to create a map of the different elements of the original learning experience, the dynamics of the remembered emotional pain and the possible transformational path. Below we will now summarize the dynamics of experiencing, remembering and transforming emotional pain.

Core emotional pain

Experiencing

-Core emotional pain is caused by unfavorable events in the environment and signals that the physical well-being of the individual is under threat. This happens for instance when there is a danger, obstacle, or loss. The aroused categorical emotions (fear, anger, sadness) will motivate adaptive action tendencies. When events are too big to deal with for the individual, often in association with the absence of a soothing and protective figure, the inherent adaptive action tendencies (flight, fight, grief) are ineffective. Then emotions become unbearably intense and cause fear of disintegration (emotional and/or physical). This disabling emotional intensity immobilizes the organism and mental dissociation from the overwhelming experience. This causes the painful experience of unprocessed emotions and unresolved action tendencies which are stuck in the body and the experience of disconnection from one's emotional and physical awareness.

Remembering

-All aspects of this core emotional pain (intense negative emotion, fear of disintegration, stuck in unresolved action/emotion and dissociation from experience) are stored in emotional

²⁷ These categories *detaching, countering, and displacing* defenses, are inspired by ISTDP's categories of isolation of affect, repression and projection (Davanloo, 1990). In our attempt to use simpler language, we chose the more insightful terms of detaching, countering, and displacing defenses. These categories are similar but completely equivalent: for instance, we distinguish mild self-criticism as a defense in triangle 2 to counter unacceptable feelings, from a more severe self-attack in triangle 3 resulting from a self-concept of defectiveness. Defenses can further be divided into external and internal defenses. Internal defenses have an effect in the outside world e.g. avoidance, suppressing expression. Internal defense diminish inner awareness e.g. repression or splitting.

²⁸ McCullough (1997) described 3 categories of defensive functions: *avoiding affect, avoiding closeness and false/impaired self*, that are congruent with the defensive function of our 3 categories.

memory. Associated internal and external experiences that are associated with the painful experience can now trigger re-experiencing emotional pain. The painful emotional memory, which reflects the learned expectation of unbearable emotion and ineffective action, will lead to defensive action in order to distance oneself from a painful affect and triggering situations. Patients with core emotional pain will primarily use *detaching* defenses such as dissociation, distracting, and avoidance of the experience.

Transforming

-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 found in newly regulated emotional experiences, undoing aloneness²⁹, 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. 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

Experiencing

-Relational pain is caused by ruptures in the connection with a caregiver and signals that the relation with an attachment figure is under threat. This happens when expression of needs (e.g., presence, care, love) is not responded to (neglect) or responded to negatively (rejection, shaming). The individual will attempt adaptive action by either increasing or decreasing the expression of the need. When these adaptive actions are not successful, and needs continue to be ignored by the caregiver or rejection, shaming occurs repeatedly. The recurrent ruptures cause fear of losing the connection. In the resulting conflict between one's emotional needs and the need to safeguard the connection with the caregivers, the individual will prioritize the latter by repressing the expression of his emotional needs. This will in turn cause additional pain from unfulfilled needs and repressing expression.

²⁹ Undoing aloneness (Fosha, 2000) is crucial for transformation in all 3 types of emotional pain, though the aloneness has a different quality in each type: aloneness from feeling vulnerable and being unprotected in core emotional pain (e.g., alone in the forest (example from Les Greenberg)); aloneness from feeling disconnected and being uncared for in relational pain (e.g., alone in bed with dirty diaper (example from Les Greenberg)); aloneness from feeling defective and being excluded in self-pain (e.g., alone in the playground/party).

Remembering

-All elements of this relational pain (ruptures, fear of disconnection, unmet needs, repressed expression) are stored in emotional memory. Internal and external experiences that are associated to the painful experience can now reactivate emotional pain. The reactivated emotional pain, which reflects the learned expectation of rupture and needs unmet, causes shame and anxiety and will lead to defensive action intended to distance oneself from painful affect and triggering situations. In addition to *detaching* defenses, patient 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.

Transforming

-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 restored emotional expression towards significant others, reconnection 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

Experiencing

-Self-pain is caused by attacks on aspects of the self by important others and it signals that one's place or role in the group/family is under threat. This happens when there are early experiences of severe neglect or abuse by caregivers and/or later experiences when the expression of rejection or exclusion by members of a larger (peer) group occurs. The individual will attempt adaptive action by improving or hiding aspects of the self. If attempts to hide, improve oneself, or demonstrate one's worth fail, and the attacks, shaming, and exclusion of certain aspects of one's individuality continue, then the recurrent shaming causes fear of unworthiness and losing one's role, place, or status in the social group/family. To safeguard inclusion in the 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. 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).

Remembering

-All aspects of this self-pain (attacks, fear of exclusion, feeling defective, disowning/hiding parts of self) are stored in emotional memory. Associated internal and external experiences that are associated with the painful experience can now reactivate the memory of emotional pain. The painful emotional memory, which reflects the learned expectation of exclusion and shameful unworthiness, will lead to defensive action involving distancing oneself from painful affect and triggering situations. In addition to *detaching* and *countering* defenses, patients 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.

Transforming

-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 core 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. Single events may cause more than one type of pain. For instance, in the case of abuse by a sibling we can find core 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.

Conceptualizing emotional pain

An important merit of the triangles of emotional pain is that it helps the therapist to find and maintain focus for the work during the session. Throughout their lives, patients will experience all three kinds of emotional pain in varying degrees and in various combinations, thus the therapy process will have to address all three types of pain. The triangles of pain can help the therapist reflect on which one requires initial focus in order to bring about the most needed change, as certain symptoms and problems are indicative that a certain type of pain is likely to be dominant in the session. Determining the active pain in the session informs the therapist about the transformational path, what inhibitory affects and defenses can be expected and select techniques from the corresponding psychotherapeutic paradigm.

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 patient'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. (e.g., regulation by compassionate presence, expression towards a significant other, reevaluation of aspects of the self). This view on conceptualization holds the middle ground between *case conceptualization* "...determine the core painful emotion schemes' self-organizations that are central to the presenting issues" (Timulak, 2015, p.74) and *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 patient's wording and concern, typical symptoms and defenses, and the patient'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 indicators³⁰.

Not being totally clear about the active pain may be problematic for research, but has

³⁰ 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.

important clinical value by signaling a therapeutic choice point in a session (for instance choosing between more self-soothing and regulating interventions or a more expressive and interactive direction). The following two examples can illustrate how the therapist might determine what pain is active in the session:

A first example is a patient who lost her mother at a young age. If the patient 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 core emotional pain. If the patient 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 is a patient who experienced sexual betrayal by his wife. If the patient describes he has gone numb and confused, and doesn't know what he feels about what happened, working on core 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.

The 3 triangles 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 Triangle 3 issues first, then Triangle 2 issues, and finally Triangle 1 issues. This is due to the fact that the treatment of the pathology of self will need priority over accessing relational pain when reception and expression are experienced as undeserved in the presence of an unworthy self. For example, the treatment of the (triangle 3) self-pathology will need priority over accessing (triangle 2) relational pain when the patient feels undeserving of reception and expression of her needs³¹ In other cases, relational pain may need priority over processing core emotional pain, as relational safety is needed for the necessary regulation to access and process intense emotional pain to completion. Working on core 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

³¹ 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.

Triangle 1 core 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 patient 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 Triangle 2 work with the father was overshadowed by the terror of losing him which was triggered by such work. After Triangle 1 work in a portrayal where the patient 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.

In the case of lack of progress, reflecting on the pain dynamics may help the therapist to change the focus of the work³². It may for instance happen that the patient 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 patient is experiencing. Here is an example where such a shift was helpful:

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 patient 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 patient 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 (Triangle 2 relational pain) but that the patient had not yet accessed the self-pain of unworthiness. When the therapist focused directly and explicitly on her feelings of shame and defectiveness (Triangle 3 self-pain), 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

³² 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 (core emotional) pain from overwhelming concentration camp experiences and (self) pain around worthlessness and feeling undeserving.

recent experience feeling appreciated and of having found real friendship during her university years.

In this case, although the work the patient and therapist did initially was important, they weren't working on the right type of emotional pain responsible for this particular problem and symptom. Such understanding comes from reflecting on all relevant aspects of the process, namely history, emotional responses to intervention, body language, etc. We have found that in these cases, identifying the affective system of pain that is creating the patient's suffering, and deducting from it the needed transformation, can be extremely helpful in releasing the stuck healing potential.

Implications for memory reconsolidation

Conceptualizing emotional pain in three categories gives important insights into some of the open questions regarding memory reconsolidation (MR): in what way does the activating experience have to be similar to the original learning ? (Lane et al, 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 originate from fundamentally distinct learning experiences, we argue that both activating and disconfirming experiences need to experientially match the experiential “modality” of the original learning experience in order to effectively activate and reconsolidate emotional memory. We might say that each emotional pain seems to have its own language that speaks to it.

The learning in each pain is different because with each pain a new layer of complexity is added. Core emotional pain is largely made up by simple classical conditioning, where an (aspect of an) event becomes associated to an emotional state. E.g. loud noise to fear, or physical closeness to pain. Relational pain adds a more complex layer of operant conditioning to this as the person learns about repeated interaction of how his own behaviour is influencing the behavior of a significant other. (E.g. expressing sadness leads to rejection, the need for protection is ignored). In self pain even more abstract mental operations have come into play to form a self concept which includes both the representation of one’s physical and mental characteristics and their social value.

Each type of pain gains in complexity by adding a new essential ingredient that becomes the focus of the contrasting experience for reconsolidation. The focus for transforming core emotional pain is entirely made up of emotional/physical experience. The focus for reconsolidation of relational pain the relational experience of connection and care supported by emotional/physical dimensions. Reconsolidation of self pain focusses on a semantic layer of the self concept in addition to relational and physical /emotional components.

This means that depending on the type of pain that is being transformed MR takes place at different levels of representation of information, and thus requires distinct activation and mismatching experiences:

	Mismatching Experience
Core emotional pain	Contrasting physical-emotional experience
Relational pain	Corrective relational experience
Self-pain	Disconfirming experience of self-concept

For transforming core emotional pain which originates from overwhelming emotional experiences, the patient will need a regulated experience that is contrasting, especially on a physical-emotional level (e.g., reexperiencing a terrifying event in regulated fashion; processing grief to completion). The ideal setup to find the right activation and mismatching experience for MR through imaginary work (e.g. portrayal) is the self in the event that causes the unbearable emotional pain.

In order to reconsolidate relational pain which originates from unmet needs and ruptures in the attachment relationship, the patient 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 needs met; experiences of reconnection). Therefore the first choice for setting up MR through imaginary work will be a direct interaction with the important other that was the cause of the relational pain.

In cases of self-pain which originates from the perception of self as defective and inferior, transformation can be achieved by a new experience of self that is disconfirming on a semantic-conceptual level (e.g. having a compassionate view of oneself; recognizing new value and feeling pride about one's characteristics). Therefore the key interaction for achieving MR of self pain through imaginary work will be an interaction of self with self.

Distinguishing different kinds of pain may thus help to resolve the recent debate concerning memory reconsolidation with respect to the primacy of emotion vs the primacy of semantic content (see Ecker, 2020).

In the case of core 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 patient. Change often comes as a surprise to the patient (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”)³³. 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”). The primacy for this type of pain lies in the semantic realm, but emotion is also essential.

³³ This is a process that can be promoted by, for example, by metaprocessing (Fosha, 2000, Iwakabe & Conceição, 2016).

Implications for the role of the therapist

These different transformational processes of each type of pain also clarify the role of the therapist for each change process.

In the first place the safe and affirming relationship with the therapist is fundamental in any kind of therapeutic work and in working with all 3 types of pain. As we pointed out that each type of pain is characterized by a particular kind of aloneness (see footnote 27) it follows that undoing the aloneness also takes different forms in each type of pain

In Triangle 1 work on trauma the therapist is instrumental as a resource: the presence of the therapist brings regulation of the intense emotions that makes it possible to process emotions till the completion.

In Triangle 2 the therapeutic relationship can be a catalyst for processing relational trauma, but as the therapist often takes the role of an attachment figure, the therapist can also be at the heart of the corrective experience, by explicitly processing the connection, love, care in relation to the therapist and all the receptive aspects of that experience.

In Triangle 3 self-pain the compassion and affirmation of the therapist are crucial to create a shame-free environment to be able to open up to the painful feelings of shame. This can take the form of fierce love (Piliero, 2020) where the therapist actively undoes the toxic shame and advocates for the patient's worth and dignity. However, the therapist should be aware that though important it cannot be a substitute for the crucial renewed evaluation of the self by the self for this type of pain.

Finally, the triangles also inform us about the stance of the therapist that is needed to counter the specific kind of fear that drives each triangle. To counter the fear of disintegration in triangle 1 the therapist should be encouraging, secure and holding. With the triangle 2 fear of disconnection the therapist should be highly loving, validating and caring of needs and seeing and reflecting the patient's feelings. In triangle 3 where there is a fear of worthlessness the therapist should be especially affirming, explicitly non-judgmental and compassionate.

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