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Triangles of Emotional Pain: A Conceptual Model for AEDP[1]

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Abstract: The authors present a theoretical integrative model of *Triangles of Emotional Pain* for the categorization and transformation of emotional pain in experiential psychotherapies. We propose two major conceptual innovations to existing views on emotional pain. The first is distinguishing three 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 distinguishing the originating experience of emotional pain from the problematic emotional learning that can result from these experiences. Integrating data from research literature and clinical work, the model distinguishes between three types of emotional pain differentiated by three different functional systems through which pain is registered and processed: core emotional pain, relational pain, and self-pain. The authors show how each type of emotional pain has a distinct developmental etiology and evolutionary function, and how 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 a 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 Triangles of Emotional Pain* can thus be not only an important conceptual model for working within AEDP but also a useful tool for systematically selecting and integrating interventions and techniques from a variety of experiential models.

[1] This extended version of our article, *Pain Dynamics: An Integrative Roadmap for Navigating Through the Experiential Process*, was originally published in *Person-Centered & Experiential Psychotherapies* (2022, Vol. 22, Issue 3, pp. 322–347). We thank the publisher for granting permission to reproduce portions of this article for publication in *Transformance: The AEDP Journal*. Substantial parts are identical to the previously published article, other parts were rewritten using AEDP's triangle of experience.

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Introduction

From its inception, AEDP has emphasized a bottom-up approach and moment-to-moment tracking as hallmarks of its clinical work (Fosha 2000, 2021; Prenn

& Fosha, 2016, Hanakawa, 2021). At the same time, AEDP is likely one of the most integrative platforms, drawing from a wide range of theoretical paradigms - including psychodynamic theory, attachment theory and neuroscience - to understand psycho-emotional functioning and explain transformative change. AEDP has been careful to maintain the balance between top-down conceptual and a bottom-up experiential approach, ensuring that conceptualization does not interfere with the relational presence and the experiential focus of moment-to-moment of tracking.

While the key road maps for AEDP interventions - the 4-State model and the triangle of experience - guide the AEDP therapist in moment-to-moment tracking through State changes, it is undeniable that theoretical concepts adapted from infant research, affective neuroscience, and psychodynamic theory, are present in our clinical decision-making, even when not explicitly referenced.

In this article, we add to AEDP's repertoire of experiential focus by proposing a new conceptual framework identifying 3 types of emotional pain – core emotional pain, self-pain and relational pain -, which can further help AEDP therapists with clinical decision-making by delineating three transformational paths. It is a conceptualization that avoids "case conceptualization," relying instead on identifying what type of pain is active and present in a specific moment or session, helping to clarify transformational processes in the realm of core emotion, relational work, and issues related to the self. We believe it informs and guides the therapist toward the new experiences that will be most transformative, while preserving the precious moment-to-moment emergent experience.

We initially developed this model of the "Three Triangles of Pain" to choose between different setups for portrayals (e.g., self-event, self-self, self-other, etc.), but later we found it to be extremely useful for supervision in general. The feedback from supervisees was that it provided guidance for their clinical work, which they felt had been missing.

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

We have tried to create a new integrative framework that brings 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 (A. Freud, 1936; Trevarthen, 2005;

Tronick, 2007;), trauma (van der Kolk, 2015; Fisher, 1999), learning, and memory (Watson, 1913; Skinner, 1938; Duday, 2004).

Unfortunately, very few of these theories have solid scientific proof. As a result, the validity of the theories in our field is determined by the accuracy with which they describe and predict phenomena, which is a somewhat subjective notion. 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 Richard Feynman's reasoning, who argued that if one can't explain something complex in simple terms, they don't really understand it (Gleick, 1992).

This is a very long article, as we will discuss the implications for many aspects of clinical work in AEDP. The reader might also want to consult a short 5-page version in Addendum A., which might be used both as an introduction before in-depth reading about the model, as well as a cheat sheet when starting to work with the model

Part I

Two Conceptual Innovations

We are proposing two major conceptual innovations to existing views on emotional pain.

1. We propose that emotional pain can be divided into three distinct categories – core emotional pain, self-pain and relational pain. These categories of pain differ in origin, evolutionary function, and complexity of learning, and, therefore, require distinctly different psychotherapeutic interventions.

Each of the three types of pain we introduce in this article has been described numerous times by different theorists and therapists and is also amply present in AEDP in fully integrated form. In that sense, we are not introducing anything new but rather suggesting an integrative framework that makes the implicit explicit!

Distinguishing among these types of pain is necessary, as therapeutic change requires three distinct therapeutic processes for each type of pain. Identifying the patient's active pain in the session can help with mapping the entire transformational path, such as: what kind of painful experience needs to be activated, what techniques and resources are most appropriate, what defenses and challenges to expect, and how to structure the work to promote finding new experiences at the right level.

2. Our second conceptual innovation applies of memory reconsolidation theory of change to our conceptualization of types of emotional pain, distinguishing the originating experience of emotional pain from the problematic emotional learning that can result from such experiences (Ecker, 2012; Welling, 2012). This allows us to define more precisely the core emotion, inhibitory affects and defenses in the triangle of experience. This distinction, which is often not made explicit, is essential because

psychotherapy should be equipped to change the memory of emotional pain and to undo the defenses against such remembering.

1. Three Types of Emotional Pain[2]

Our conceptualization of emotional pain is distinct in several ways from existing models of emotional pain, which classify pain according to types of causal events or types of resulting emotions. For example, Timulak's (2015) model classifies pain according to three classes of maladaptive emotions: fear/terror, loneliness/sadness, and shame. Other models classify pain according to events such as loss, entrapment, or 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. 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, and shame or various events like loss, loneliness, or abandonment can play a role in all three types of pain systems.

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[3] 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 (Van der Kolk, 2015; Fisher,1999**;** Medley, B. 2021).

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 leads to a negative response from the caregiver (e.g., neglect, rejection), this will lead to the fear of abandonment or disconnection (Ainsworth, 1991; Bowlby, 1973; Frederick, 2021). 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 leads to a 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

[2] It may be 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.
[3] Some readers found "basic emotional pain" or "situational pain" a better designation.

status in the social group/family. This results in additional pain from hiding one's true nature and living in a false "improved" self (Kaufman, 1996; Piliero, 2021; Winnicott, 1965).

The Evolutionary Function of Emotional Pain

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

The first domain is the relationship of the individual with its natural environment. Categorical emotions (e.g., fear, anger, joy) ensure the needs and well-being 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 well-being is under threat, it results in a 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 arises toward 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 three systems are not as separate as the above sections may suggest. The attachment system is a supplemental system that supports the survival needs of the categorical emotion system. A good attachment relationship can provide regulation when dealing with core emotional pain. Furthermore, 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 corresponding to three types of emotional pain

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

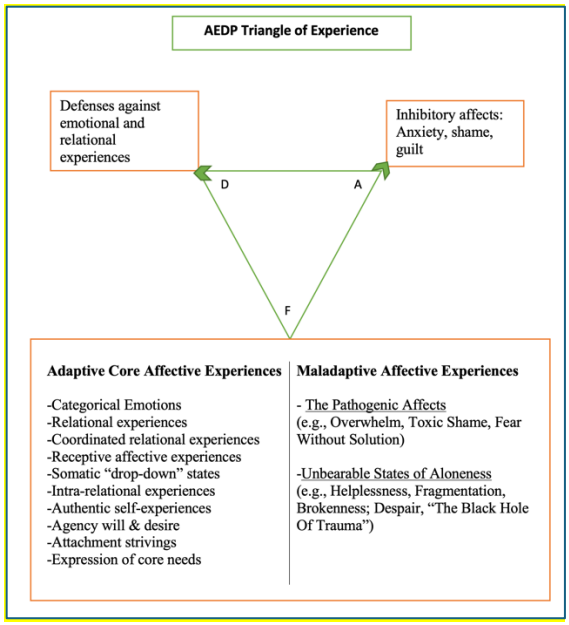
to view them as three different paradigms because of their use of distinct theoretical metaphors, therapeutic focus, and methods (compare Kuhn, 1962).

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 an overwhelming fashion, "hijacking" mental functions. Therapies center around retrieving, reprocessing, 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, 2021), 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 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 Intensive Short Term Dynamic Psychotherapy (Davanloo, 1990), Emotion Focused Therapy (Greenberg, 1993), AEDP (Fosha, 2000, 2021), and Schema Therapy (Young et al., 2003), Relational Psychodynamic Therapies (Safran, 2012).

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 the self, and the 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 (Neimeyer & Mahoney, 1995; Bruner, 2004), EFT Couples Therapy (Goldman & Greenberg, 2013), Schema Therapy (Young et al., 2003), and AEDP (Fosha, 2013).

These three paradigms exist in a totally integrated form in AEDP as is most evident in the triangle of experience (Fosha, 2000; Pando-Mars, 2021) that considers the full palette of human experience.



As will become clear in the discussion about the triangles of pain, our proposal for conceptualization implies dividing AEDPs triangle of experience, into 3 separate triangles: identifying specific core affective experiences, inhibitory affects and defenses, and, most importantly, transformational paths for each pain. But before we engage in this discussion we first will examine the nature of the emotional learning that can result from experiencing emotional pain.

2. Conceptualizing Learned Emotional Pain

A second important aspect of our model is that we distinguish between experiencing emotional pain, which is not necessarily problematic, from the problematic emotional learning that can result from (repeated) experiences of emotional pain.

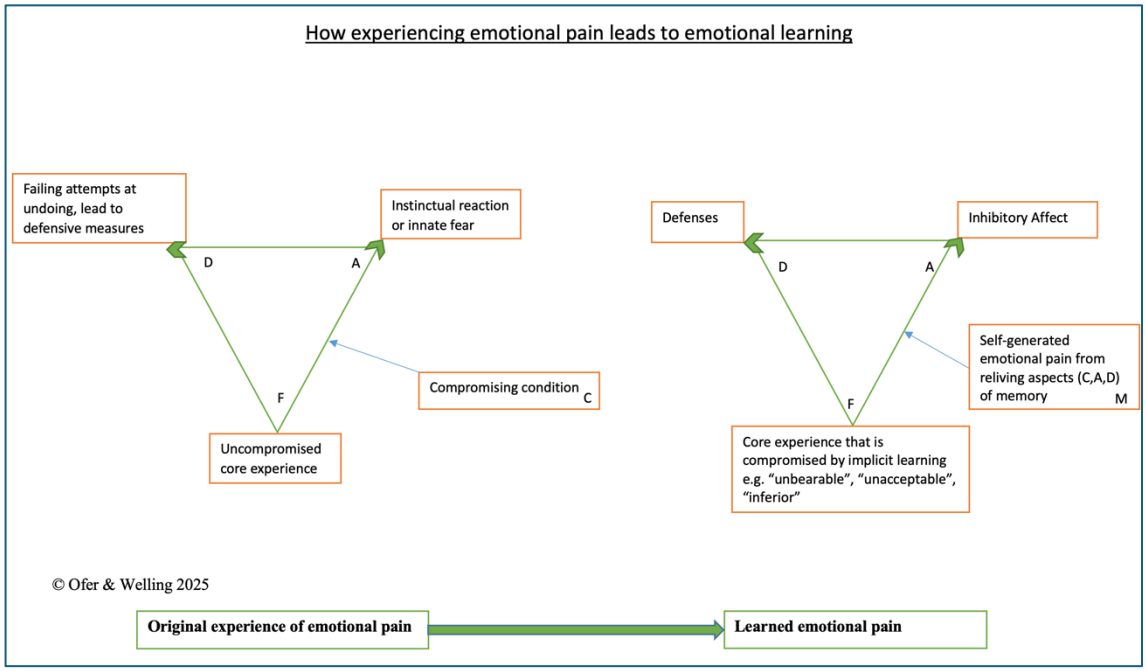
The experience of emotional pain, under certain conditions, is stored in emotional or 'implicit' memory (Ecker 2012). It is not entirely understood under what conditions an event will be remembered as emotional learning, but it is certainly more likely to happen when emotions are more intense and/or occur repeatedly. When natural responses to pain are ineffective, emotional learning is naturally catalyzed (Tulving, 1983) by the inherent higher levels of pain.

The learned emotional response triggered by similar circumstances involves reliving aspects of the emotional pain, inhibitory affects, and defenses, and is adaptive as it prevents further emotional pain.

As we grow older, however, and circumstances change, emotional learning that once protected us from emotional pain can become the source of unnecessary suffering, e.g. redundant defenses and painful inhibitory and maladaptive affects. We continue to suffer 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. When the explicit memory of the concrete events associated with emotional learning is inaccessible, strong emotional reactions[4] 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 they see them as an inherently inevitable part of life.

Schematically, we can represent emotional learning as follows:



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 is compromised: no resolution is found as adaptive attempts fail. 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 implicit learning that resulted from the experience of emotional pain. The perception of implicit internal or external elements (e.g., sound, facial expression, wish) associated with the original painful event now triggers 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 themselves from this rising pain through defensive responses (left top corner) such as distancing themselves physically or diminishing inner awareness of the pain.

[4] Greenberg (1993) referred to these as "problematic" reactions.

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 to remembered pain is much more complex, as it not only involves remembering all the aspects of the old pain but also a system that works against experiencing emotional pain again, creating additional, more complex suffering.

Emotional pain in and of itself is not a problem; it is 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 bring people to psychotherapy. If emotional pain weren't remembered, there might be no need for psychotherapy at all. The maladaptive self-generated emotional pain that 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 learning 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 theory, 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), or an imaginary one, such as chair work (Greenberg et al., 1993), or portrayals (Fosha, 2000; Medley, 2021).

As might be expected from the fact that each type of emotional pain originates from very different experiences, we found that each of the three types of 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. For example, 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 reassessment, allowing for integration of parts that were disowned as unworthy.

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

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

Part II. Applications

1. Core emotional pain

1.1 Pain from Unbearably Intense Emotion: Fear of Disintegration

The system of categorical emotions 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 signals important information that something is dangerous, sadness that something is being lost, anger that something is blocking our goal or intruding on our space, and joy that something favorable is happening.

At the same time, each categorical emotion has an associated action tendency that enables us to respond adaptively to changes in the environment. They motivate us toward adaptive actions such as fight, flight, withdrawal, or approach. There are around six basic emotions (Ekman, 1984) with universal body and facial expressions. Only two of them are experienced as pleasant: joy and surprise. These "positive" emotions motivate us to approach or be curious and energize us to explore and relate. The other four—fear, anger, sadness, and disgust—are experienced as unpleasant[5]. These "negative" emotions motivate the individual toward withdrawal and distancing. Fear tells us to run away, anger helps us 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 that there is a survival threat, making us ready

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

for adaptive action. However, adaptive action may not be possible or effective. In such situations, emotional intensity may rise to intolerable levels and become dysregulated. A typical example is the helpless protest to an irretrievable loss[6] or the experience of terror when one is trapped and cannot run in response to fear. In such cases, there will be no relief in expression of emotion and its adaptive action. The intensity of emotion will quickly rise and become dysregulated. The younger we are, the less able we are to tolerate emotion by ourselves, and even relatively low levels of emotion may activate distress and fear. This is because the demands of the situation exceed the resources of the child. This is what is called "too much, too soon" (House, 2011). From the relational AEDP perspective, we want to add to this "too alone" (Fosha, 2000, 2013; Lamagna, 2021). Events such as being alone in a hospital, physical pain, watching one's parents fight, experiencing 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 put it, "Without relational support intense affects can become toxic instead of promoting optimal functioning and well-being" (2000, p. 5).

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 psychophysical 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 them 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 is 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 oneself 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 even though he can't see her (object constancy), develop a notion of time, an ability to see ahead and imagine a good outcome, or understand why certain things are happening, thus changing the meaning of the threat or of their pain. More sophisticated resources include understanding the inner world of

[6] 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.

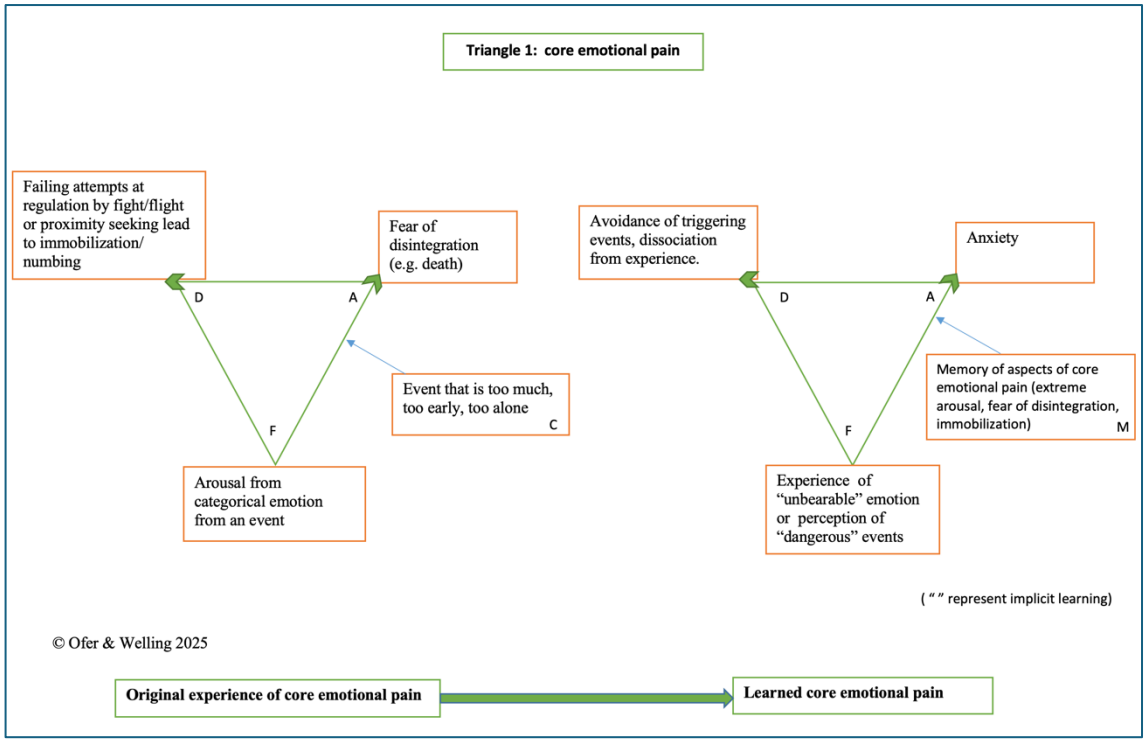
others and their reasons for action (mentalization) or finding a creative solution to deal with the situation. As the child grows, he becomes less vulnerable, but even adults can experience overwhelming emotional pain from extreme events like car accidents, violence, or situations of war.

When events exceed the child's capacity for coping, despite the parents' best efforts to help and regulate, he is outside his "window of tolerance" (Siegel, 2012) and will experience a fear of disintegration[7] (terror). This is a signal from the body that the amount of emotional activation has become dangerous for the system. Emotions can no longer be held in awareness, expression is interrupted, movements stop and are held in muscle tension. Now the emotion cannot be processed to completion (Fosha, 2005), and this leads to a very painful state of being stuck halfway in a process without resolution[8].

In summary, core emotional 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 of core emotional pain and repeated events will be stored in implicit memory.

1.2 Learned core emotional pain

The way events can lead to core emotional pain and how such pain is remembered is schematically represented in the following diagram.



[7] Compare annihilation anxiety (Freud, 1926).
[8] Napier (2019) refers to this as unmetabolized emotion gets stuck in the body.

When emotional learning occurs, the circumstantial and situational elements present at the time of the painful event are connected in an idiosyncratic way to the painful memory. These elements may include, for instance, smells, objects, noises, an angry face, physical closeness, headaches, tight spaces, or playgrounds. A present-day encounter of such associated elements that were present during the original event can now trigger an emotional memory, causing the person to fall back into a state of painful affect [9] (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 also the physical sensations (e.g., pain), perceptions (e.g., 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 only experience anxiety over triggering stimuli and not the underlying painful affect. Again, this is an automatic process, and in most cases, the individual is not aware of exactly which cues in the situation triggered the negative affect or anxiety.

Anxiety is an inhibitory affect that signals we are approaching dangerous (painful) memories and triggers *detaching* defenses[10]. Such a defense may involve distancing oneself from external stimuli for example by avoiding certain interactions or situations that may contain triggering elements. This avoidance may begin to spread to more areas of a person's life. For example, a memory of dread from visiting a dying parent in the hospital can cause anxiety over elements such as illness or death, which in turn may lead to avoiding places and experiences that could cause a reactivation of the anxiety (e.g., hospitals, funerals, going to the doctor), eventually leading to extremely limiting symptoms.

Mary, when she was six, visited her dying mother in the hospital, feeling the terrible pain of her loss. The learning from this pain makes her avoid remembering this terrible

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

[10] The 3 categories of defenses we named *detaching (*in Core emotional pain*), countering (*in Relational pain*),* and *displacing* (in self-pain), 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 two to counter unacceptable feelings, from a more severe self-attack in triangle three resulting from a self-concept of defectiveness. Defenses can be further divided into external and internal defenses. Internal defenses have an effect in the outside world e.g. avoidance, suppressing expression. Internal defenses diminish inner awareness e.g. repression or splitting. McCullough (1997) described three categories of defensive functions: *avoiding affect, avoiding closeness and false/impaired self*, that are congruent with the defensive function of our three categories.

event and associated places and experiences that make her anxious (e.g., hospitals, going to the doctor).

A person may also begin avoiding internal experiences, such as bodily sensations and emotional states, by detaching oneself (dissociation) from the awareness of unbearable emotional and physical experiences. It is also possible that the person ends up habitually detaching internally from all feelings, living in a state of numbness and disconnection from their inner experience.

Patients can therefore experience their core emotional pain in very different ways:

-A clear traumatic event that the patient can't "put aside":

"Whenever I drive my car, I start imagining how every car coming toward me is going to crash into me, just like what happened in the accident in which my husband died. "
(reliving old pain in intrusive memories)

-Pain that they are afraid to touch since, fearing it will never end or will 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'm going to agree to go there, it will make me feel too miserable."
(experiencing anxiety in response to triggering stimuli)

- Emotional numbness around an event that they understand must have had an 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?"
(suffering from defenses)

In summary, the suffering caused by the memory of core emotional pain consists of reliving the old pain, feeling anxiety, and experiencing the consequences of defenses, such as the limiting of one's activities by avoiding certain situations and being habitually disconnected from inner experiences.

1.3 Transforming core emotional pain

Therapy addressing core emotional pain focuses on working with the bodily experience of painful, overwhelming emotional experiences from the past and present, undoing defenses such as dissociation, numbing, and avoidance in order to reach a new adaptive experience on a bodily-emotional level that can be reconsolidated into 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 new adaptive emotions (Greenberg, 2010). Since the overwhelming

experience arises when it is experienced as "too much, too early, and too alone," regulation can be brought about in three major ways:

1. Countering "*too alone*" by bringing in more presence, 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 (e.g., "this happened long ago when you were so young and vulnerable").

3. Countering "*too much*" by introducing physical distancing (e.g., "imagine you witness the memory from a distance or from the outside"), partial experience (e.g., "allow yourself to feel just a little bit"), or attending to unnoticed behaviors that can be significant in overcoming the situation (e.g., "I notice now that all this time my legs were ready to run away").

This new regulation undoes the 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 freeze. This results in new learning, such as, "I can handle such intense events/emotions." The therapist can select techniques and procedures from various models[11] that are tailored to transforming core emotional pain. For example: titrating; pendulating (SE), unblending; unburdening (IFS), retelling trauma, empathic affirmation for vulnerability, self-soothing (EFT), rescue portrayals, undoing aloneness (AEDP), and bilateral stimulation (EMDR). If well-targeted, core emotional pain caused by one particular traumatic event can sometimes be resolved in a single session, unlike the other two types of pain.

The following case example illustrates the process of 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 or even when they had arguments in front of their children. She would totally freeze after these relatively small incidents and retreat to bed for hours, feeling alone, helpless, and almost dead from exhaustion. She even found it hard to take care of her child after these incidents, feeling full of guilt and self-loathing.

When exploring this subject, she recalled her father being extremely aggressive (in words and gestures) toward 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 with her father slamming the door and leaving the house, while her mother sat quietly at the kitchen table with a cup of coffee. Most of these incidents, as

[11] EFT: Emotion focused Therapy (Greenberg et al., 1993), SE: Somatic Experiencing (Levine, 1997), AEDP: Accelerated Experiential Dynamic Psychotherapy (Fosha, 2000), IFS: Internal Family Systems (Anderson et al., 2017), EMDR: Eye Movement Desensitization of Reprocessing (Shapiro, 2001)

she recalled, happened late in the evenings when she was supposed to be sleeping, but she would routinely wake up to her father's severe screaming and swearing at her mother.

In a portrayal, the patient revisited a specific incident when she was 8 years old, lying in bed motionless, listening in terror to everything happening on the other side of the wall. Her body became still and paralyzed with horror, her attention focused entirely on her ears, listening for any sign that her mother was safe, but with no resources to act. All these signs indicated to the therapist that core emotional pain was active in the session and that soothing and processing the fear to completion was likely the best transformational path.

The therapist suggested that they both approach the little girl she was back then in her bed and try to sit next to her to see if there was any way they could comfort her. The patient was frightened by the idea and asked that the therapist come with her to the room and stand at the door to make sure she was safe while she approached the girl and sat by her bedside.

Initially, the patient felt paralyzed, and the therapist acknowledged her immense courage in being willing to go into the room and sit with the girl. The therapist guided the patient with slow breathing, allowing her to gain more strength while sitting beside the girl's bed and promising to be there with her the entire time. It took a while before the patient became 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 began crying softly and was able to whisper to her adult self and the therapist about her terrible fear of her mother being hurt and the horror of her father's devastating rage. After the soft weeping, the patient was able to hug the young girl and say, with the therapist's support, say, "This is so frightening. You are in such horror, but now you are safe, and I am with you." The young girl burst into frantic tears and cried until she calmed down. As the 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 like now I am kind of protected, I don't know, maybe kind of strong and resilient." As a result, she became less triggered and stopped becoming paralyzed during arguments with her husband.

In this example, undoing the aloneness with the therapist and the adult-self brought enough regulation to allow the patient to go through the feeling of terror and process the experience to completion. 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 of relational pain (fighting with the husband) and self-pain (feeling guilty and self-loathing). However, the extreme freeze response indicated that core emotional pain was the most active pain. If the therapist had attempted to work on the relationship with the husband first, the effort would likely have been blocked by the dissociation of the traumatic reaction carried inside and

activated so forcefully. Similarly, addressing self-pain first would have missed the core issue of releasing and feeling the pain around the original incidents. In this case, the self-pain was a reaction to the freeze response from the trauma and, therefore, 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 on their caretakers for survival, emotional support, and the satisfaction of their emotional needs. As a result, infants constantly monitor the attachment relationship with their caregiver and are highly sensitive to signs that this relationship might be in danger. Ruptures in the relationship with the caregiver cause relational pain and motivate the child to repair these ruptures in order to reconnect with the attachment figure.

The system of attachment strivings provides us with meaning and action tendencies concerning the relationship with our primary caregivers. Children 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 has been established.

Children have many kinds of emotional needs, which Timulak & Pascual-Leone (2014) have identified in three categories: *appreciation*, *connection*, and *protection*. These categories form a useful framework for understanding the problems commonly encountered in psychotherapy. Examples of *appreciation* include the need to be respected, accepted, seen, or validated. Examples of *connection* include the need to feel connected, loved, cared for, or included. Examples of *protection* include the need for safety, security, control, and mastery.

The child expresses emotional needs in various ways to the caregiver. They will cry when feeling sad, in pain, or in need of closeness; they will be angry when trying to assert their desires; they may show pride in their achievements or express excitement and expansiveness when experiencing joy and pleasure in what they are doing. When the parent is responsive and competent, they will welcome and encourage these tendencies, helping the child find ways to satisfy their needs.

Ruptures and repairs in the relationship with the caregiver are frequent and even necessary for helping the child develop into a more autonomous and capable individual. These ruptures allow the child to gradually find their own way and self-soothe, developing the capacity to cope independently with the challenges of the world. However, when ruptures are frequent and not followed by repair, this causes insecurity

in the child, leading to patterns of clinginess and fear of distancing from the parent, or, in some cases, giving up on seeking support from the caregiver altogether.[12]

For example, when the child's needs are not met with an adequate response from the attachment figure, the child is left feeling alone, unloved, misunderstood, and unprotected. We call this *relational pain*, as it originates from the attachment relationship. Relational pain around unfulfilled needs is highly specific and idiosyncratic for each person, depending on which specific need was frustrated and at what age. For instance, the pain of loneliness at an early age may be experienced as the 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 their children's needs. Fosha (2000) made a very useful division of these failures in handling emotionally laden interactions into *errors of omission* (e.g., abandonment, neglect) and *errors of commission* (e.g., rejection, abuse).[13] The capacity of a parent to receive, hold, and encourage the child's expression of needs can vary strongly depending on the child's age. Some parents may excel at earlier stages, knowing how to cuddle, pamper, and protect, but struggle with the needs for autonomy and the anger of adolescence. Others may feel awkward and unequipped to handle the more physical needs of a younger child but become more responsive in later phases when intellectual guidance is required.

It is important to note that the parent's response is also crucial for the expression of various positive emotions. When a child expresses positive emotions like love, enthusiasm, and curiosity, they need to receive an emotionally synchronized response. If ignored or attacked, the child will feel hurt in a similar way, experiencing shame and fear of losing the connection (Tronick, 2007).

Over time, children learn that certain behaviors or expressions of certain emotional needs may lead to disconnection or frightening negative reactions from the caregiver.[14] Children will try various strategies to cope with these circumstances. When the parent is

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

[13] 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.

[14] 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.

non-responsive to the child's expression of needs, the child will attempt to have those needs met by may intensifying their appeals. When the parent is consistently unreceptive, abandoning, or dismissive, the expression of individual needs threatens the attachment relationship, putting the child's emotional needs in conflict with the need for a secure attachment relationship. Since a child will do anything to protect the relationship with the caregiver, they will privilege connection over expression. The child will suppress the expression[15] of their needs and hide their "unacceptable" emotions from the caregiver.

Thus, relational pain is not only made up of unmet needs but also includes a variety of feelings that stem from the inner struggle around the conflict between the individual's needs and the need for maintaining a good connection with the parent. In summary, relational pain consists of the pain from the rupture[16] in the attachment relationship, the pain from unmet needs, the fear of disconnection and abandonment, and the pain of suppressed expression of needs and emotions when hiding one's "forbidden or dangerous" feelings and wishes[17].

2.2 Learned Relational Pain

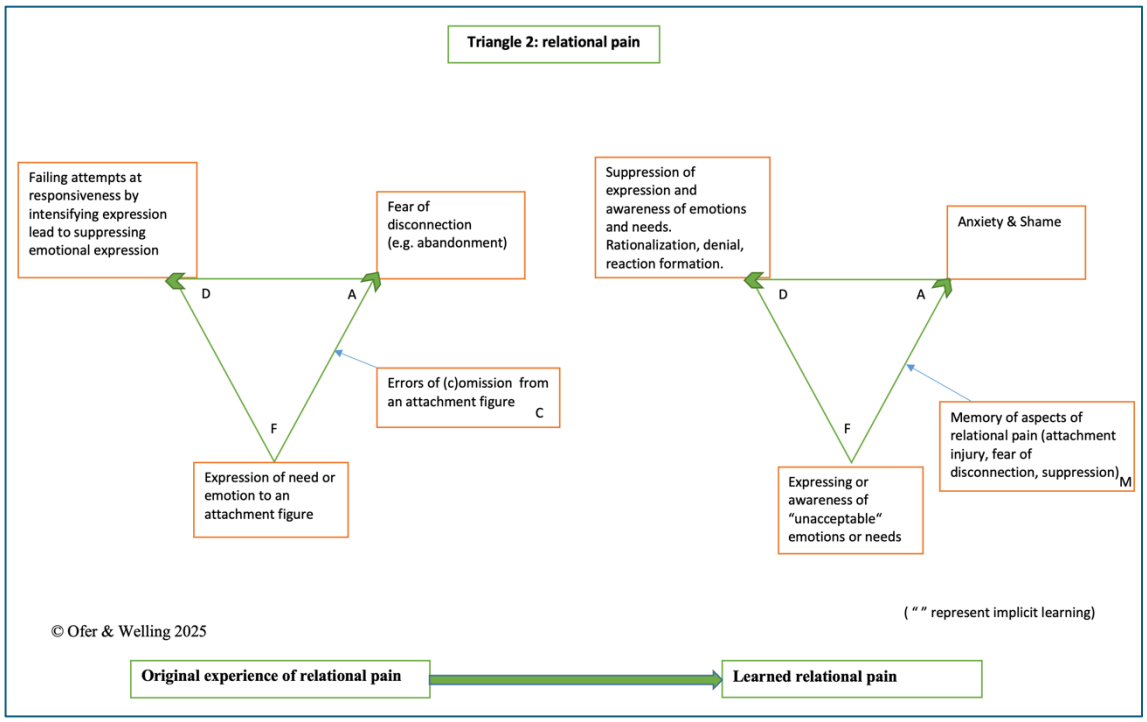
The way these failures in the attachment relationship can lead to relational pain and how memories of relational pain are triggered are schematically represented in the following diagram[18].

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

[16] Ruptures by themselves are not the cause of relational pain. Ruptures and repairs are a normal and necessary aspect of human relationships and are an important for growing and learning to be resilient and adaptive in relating to others. Relational pain is caused from a certain unpredictability of responses, or recurrent ruptures and failures that are not followed by repair.

[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).



When parents repeatedly react negatively or are non-responsive to the expression of certain emotional needs, information about these interactions and habitual responses from the caregivers is stored in emotional memory. The emotional learning that takes place teaches the child that certain emotions will not be met and may even lead to a rupture with significant others. The emotional need is now linked to a habitual painful outcome state that is activated whenever specific needs or emotions are experienced or expressed.

In this learning, not only are the internal emotional elements of emotional expression (e.g., anger) connected to the relational pain (e.g., rejection, shame), but also all kinds of other elements that were 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 the emotional memory, causing the painful affect to be re-experienced.

For example:

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 his mother accused him of being ungrateful. The boy felt shame, anger, and left alone. He learned about the unacceptability showing anger and feeling disappointment. As an adult, he may not like celebrating birthdays or getting presents and develop a worry about not being grateful enough.

These memories of relational pain can now be triggered by the associated elements (e.g., birthdays, presents, being laughed at, having wishes, feeling disappointed), causing the memory of the relational painful state (i.e., unmet need, shame, rejection,

fear of disconnection) to resurface. When approaching such triggering situations or stimuli, the individual may experience anxiety, which motivates the development of defensive strategies to distance themselves, either internally or externally, from such triggering elements.

Depending on the effectiveness of these defenses, there can be a variety of triggered responses. The first possibility is that one remembers the painful event. The second possibility is that one doesn't remember the event but experientially falls back into the old feeling state, experiencing the same emotions they felt at the time, without being aware of the origin. The third possibility is that one does not feel (or only very shortly) the painful emotional state, and instead experiences strong anxiety or shame arises over feeling certain emotions or desires. Notice that this suffering is now entirely internally generated—no bad outcome is actually happening (e.g., there may be no one around who is critical). The suffering is caused now by the anxiety and self-criticism over the wish or emotion that wants to be expressed or is on the verge of expression. Tragically, one may have become afraid or phobic of one's emotions (McCullough, 1997).

Therefore, re-experiencing the pain and/or feeling shame and anxiety will not only motivate the suppression of specific emotions (e.g., anger, sadness) but also lead to the use of *countering* defenses (e.g., reaction formation, denial, rationalization) to reduce anxiety and awareness of certain needs and emotions. Defenses may become so strong that the individual is no longer aware of either the painful affect or the accompanying anxiety or shame, leaving them feeling generally out of touch with their emotions. This will lead to the additional pain of feeling confused about one's motives, being self-critical or conflicted about one's wishes and/or being out of touch with one's emotional experience[19].

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

Patients will typically present their relational pain through current-day problems such as:

a. Ongoing issues (conflicts/frustration), most commonly with life partners but also with parents, children, friends, colleagues, or bosses.
b. Difficulties with emotional closeness and/or sexual intimacy in romantic relationships.
c. A tendency to be overly independent and self-sufficient in relationships.
d. A tendency to be pleasing and accommodating out of fear of being rejected in relationships.

[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.

e. Feeling inhibited in expressing specific emotions, such as anger, sadness, fear, or joy.

2.3 Transforming Relational Pain

Therapy addressing relational pain will focus on feelings toward significant others from the past or present, including the therapist, and undoing defenses such as repression, rationalization, and self-criticism, while attempting to facilitate new adaptive experiences on a relational level that can be reconsolidated into emotional memory.

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

Re-owning unmet needs and bringing these needs and withheld emotions back into expression is therapeutically achieved through validation and relational safety. Validation can be fostered through therapist affirmation, reframing of need, and emotional expression as universal, natural, or developmentally necessary. Relational safety can be established through the warm, accepting, and responsive presence of the therapist or an imagined other. Safety undoes the fear of disconnection and abandonment, allowing for the new experience of freely expressing emotion toward 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 having one's needs met. This results in new learning, such as, "My 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 the acceptance of what was lost and cannot be undone, such as time spent 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, mourning takes on a central role in the form of a process of separation (Elliott & Greenberg, 2007). Examples of separation can include giving up unwarranted hope, grieving the parent one never had, acceptance, and emotional distancing from the parent.

The therapist can select techniques and procedures from various models[20] that are tailored for transforming relational pain. Examples include empty chair work for unfinished business, two-chair dialogue for anxiety splits (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 was emotionally distant from him. "It's impossible for me to tolerate just doing the things we need around the house and with the children when I feel she is distant from me," he said. He reported that his sensitivity to these incidents was growing all the time, and he found himself becoming anxious whenever he knew they were going to spend time together. After the therapist validated the importance of his need for connection, they explored his feelings when visiting his father and "not being able to have any 'real conversation' with him." The patient recalled that it wasn't always like this and remembered it began when his father was injured at work and underwent endless physical treatments. The therapist helped the patient connect to the feeling of not being able to truly access his father and not understanding what had happened as a child (i.e., connecting to the pain). The therapist encouraged the patient to talk to his father in imagination (i.e., expression in a portrayal), telling him how lonely he had 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 from the lost connection. The therapist then asked the patient to imagine how his father would react to what he heard. The patient broke into tears, saying it was impossible because his father would feel so much remorse and pain; he believed his father would never be able to survive such feelings.

The patient then realized something he had never fully understood: his father couldn't connect to his son's pain because he had severe PTSD from the war, which was triggered by the work injury. The therapist asked the patient if he felt safe enough to put into words what the father would say. The patient wept deeply and, while attempting to speak on his father's behalf, said he couldn't say it out loud but internally 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 saved up money and gave 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 acknowledged that he would never be able to have this conversation with his real father, but now he felt much calmer, less alone, and more held, even though there was still pain. Being with his father became much easier from that point on, and he began reading more about PTSD. With further work, the patient

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

was able to talk to his wife about what happened to him when she distanced herself, and he gradually became able to tolerate her distancing in a much more regulated way.

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 people around them (Gilbert, 2007). Self-worth refers to the notion of ourselves as being valuable and lovable and the sense that we belong to our family or group by merit. Just as we need an attachment relationship with our caregiver for survival, we also need to feel accepted and have a valued role in the larger group of our family, peers, and society. This is likely evolutionarily determined, as it was 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 experience shame, unworthiness, and the fear of being excluded. We refer to this type of emotional pain as *self-pain.*[21]

"Self" refers to broad aspects of who we are, such as traits or identity, which define our merit or value as a person and are organized around self-concepts (Harter, 1999). We monitor our role in the group, and when we feel valued and appreciated by others, we experience pride and confidence. This provides security that characteristics of ourselves, such as beauty, strength, intelligence, and humor, are valued and appreciated by the members of the group to which we belong. It allows us to express our natural tendencies, interests, opinions, and (sexual) identity. If we sense that some aspect of ourselves is viewed by others as bad, unacceptable, or counter dominant values in society, we instinctively feel shame, unworthiness, and fear of exclusion. The emotional pain associated with the threat to our 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 perceived defects or to improve flawed aspects of ourselves in order to protect against losing connection or being excluded from the group.

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

1. The first major source of self-pain occurs in interactions with peers, significant others (parents, siblings, teachers, spouses, employers), and societal values. Experiences of attack and criticism on aspects of the self—such as being disrespected, criticized, or abused by important others—shape one's view of personal importance, dignity, and self-esteem. Examples include criticism for being too weak, too selfish, too feminine or masculine, ugly, dumb, too demanding, too loud, or too sensitive.

Often, inherently normal aspects of development can become labeled negatively: being

[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).

proud of achievement becomes arrogance, sensitivity becomes weakness, and being lively becomes being difficult. Such attacks lead to the development of a concept of ourselves as flawed, defective, useless, or unworthy. Physical abuse and incest almost always lead to self-pain, as the individual blames themselves for what happened, internalizing feelings of disgust toward their body, sexuality, and themselves overall.

Experiences of exclusion, humiliation, and bullying by peers are central causes of self-pain and shame, damaging one's sense of 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. Traits such as physical appearance, mental capacities, cultural habits, economic status, and sexual and gender identity are often the targets of social stigma and can lead to feelings of shame and feelings of inferiority when targeted.

This happens because children and adolescents learn that traits deviating from socially constructed norms are judged harshly by dominant social groups. Their sense of inferiority often arises from cultural messages that devalue aspects of their identity—sometimes explicitly, but more often subtly, as if they are simply "facts." In this way, racism, discrimination, and other forms of social marginalization inflict deep psychological pain in a seemingly natural, silent, and unnoticed manner.

2. Not only can explicit criticism from parents about aspects of the self, but also can prolonged relational pain inflicted by caregivers develop into self-pain. For instance, continued neglect and rejection can lead a child to develop a self-concept of being bad, weak, or selfish.

Until adolescence, children are evolutionarily programmed not to question their parents' authority. They naturally assume their parents are older and wiser, justified by the parents' life experience as well as cognitive and emotional development. This means that in cases of neglect or abandonment, the child will always feel shame and find fault with themselves for what has happened. They will always question what they have done wrong. Ignored and neglected needs and urges will gradually be felt as inherently "bad," and having them makes the child feel bad. For instance, extreme neglect can lead to the idea, "I don't deserve love," or "what I want is bad," while rejection and abuse may lead to the conclusion, "I deserved this." As Fosha states, "inattention, indifference, disinterest, and non-involvement of the caregiver map onto the self as shaming unworthiness" (Fosha, 2013, p.508).

3. 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 self-blame for being unable to defend oneself, becoming paralyzed, or failing to stop ongoing abuse. This leads to seeing oneself as selfish, passive, weak, or as "damaged goods."[22] In such cases, shame

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

and self-pain do not always bear the clear markers of explicit badness or defectiveness, such as being ugly, dumb, or lazy, but instead manifest as implicit self-concepts, such as being helpless ("I am worthless," "I am without strength or power"), feeling that things happen to them without meaning ("I am unimportant or insignificant"), or believing that "this only happened to me" ("I am less than others 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, emotions, or needs but with broader self-concepts related to self-worth. For example, it's not simply "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, built from learning about the self through self-reflection and feedback from others. These processes are highly complex mental procedures involving abilities like mentalizing and abstract thinking. Only when the brain matures sufficiently can a person start generating self-concepts from interactions between the self, others, and the environment.

As described earlier, core emotional pain and relational pain experienced earlier in life can later develop into self-pain once the brain is mature enough to form self-concepts. Later experiences of self-pain are also not entirely separate from earlier ones in the sense that experiences with caregivers create a vulnerability to experiencing self-pain in later interactions with peers and in social contexts. The earliest roots of self-worth come from the attachment relationship, which can transmit delight, appreciation, and confidence (Stern, 2005).

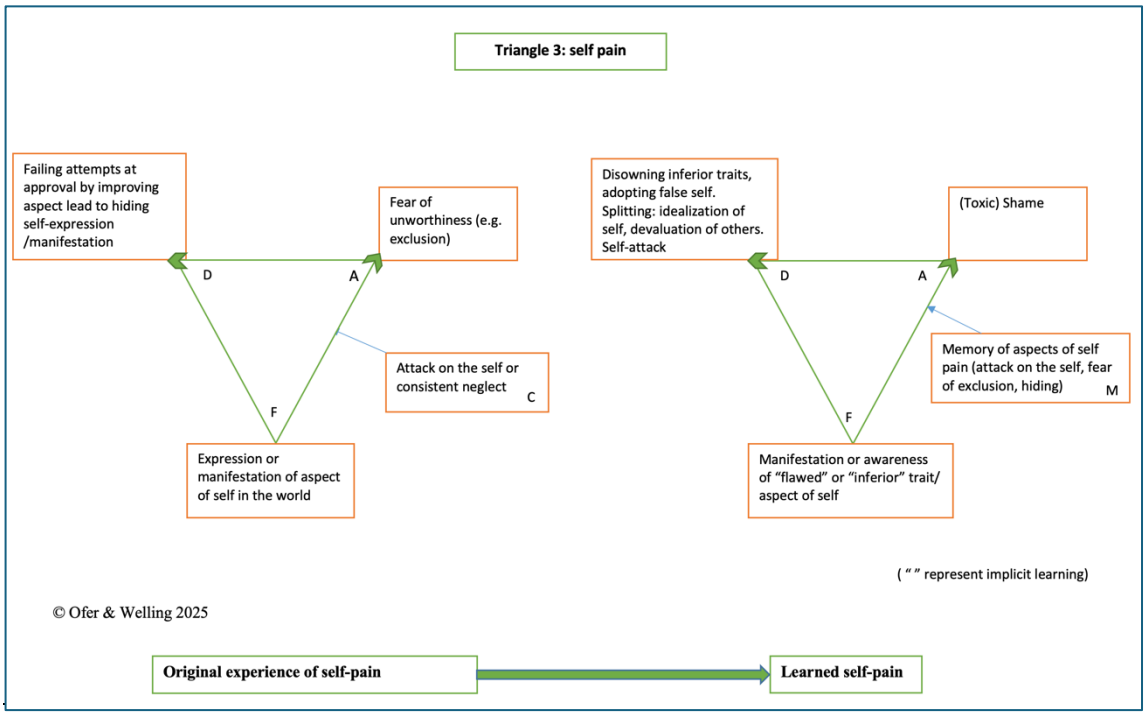
When we feel ashamed of characteristics, we begin hiding them or trying to improve them. We fear that the members of our group or family will discover these "bad" aspects of our inner life. We actively ensure that these aspects will not be seen by others, or even by ourselves, by actively attacking these "bad" traits that cannot be fully repressed. This causes the pain of repressing the expression of our natural self, disowning the "bad" parts of ourselves, and potentially faking more acceptable traits to camouflage the bad ones.

In summary, self-pain consists of the pain of exclusion and attack on aspects of the self; the fear of being unworthy and 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]

[23] This concept of our true nature, identity, or the one we were born with 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).

3.2 Learned Self-Pain

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



Experiences of intense and repeated self-pain are stored in our emotional memory, and the aspect of the self that was attacked is now 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, evaluation, eating too much, ridicule) that were present during attacks on the self may also trigger these memories of self-pain.

Unlike core emotional pain and relational pain, remembering self-pain is more conceptual and involves identifying "unacceptable" or "bad" characteristics of oneself. It involves more complex elements of the self, such as traits, typical behaviors, and general styles of expressing oneself, such as manners of expression, physical presentation, or intellectual style. These traits may be perceived as flawed aspects of the self, such as weakness, ugliness, stupidity, neediness, weirdness, or selfishness. Therefore, self-pain is more easily triggered than core emotional or relational pain, which are primarily triggered by events or emotions. Anything that recalls or is associated with such themes, even if never experienced before, can start to activate self-pain and lead to the 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 viewed 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 both the self and others.

For example:

A patient had a hard time doing schoolwork due to a learning disability that severely compromised her reading skills. Throughout her school years, she had to fight against the critical remarks from her schoolmates and teachers—early on for reading errors and spelling mistakes, and later for spending too much time on schoolwork and being a slow thinker. Without enough explanation or emotional attention, the patient felt slow and stupid. Today, she is very anxious whenever she needs to present something to her colleagues and is terrified 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 the self, the typical defenses against for self-pain are *displacing* defenses. For example splitting off unworthy traits from awareness and disowning such aspects of oneself, while "adopting" a false, more "worthy" self. In such cases, our real nature becomes hidden from ourselves, which can cause intense confusion and pain regarding identity. Other displacing strategies for not feeling this toxic shame may include projecting negative characteristics of oneself onto others or viewing oneself as superior.

Because self-pain is so easily triggered, it can worsen over time from repeated and prolonged experiences of remembered shame and feelings of defectiveness. The shame over perceived bad aspects and traits of the self can become generalized into a feeling of being inherently and totally flawed, which turns into *toxic shame* (Russell, 2015). This repeated state of feeling inferior and flawed becomes so "affectively burnt-in"[24] to the nervous system (Hebb, 1949) that it starts to feel like a 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 perceived as flawed in its essence. The

[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"

person feels there is no way out and is left only with withdrawing in self-attack, isolation, and the sense of being unworthy of love or interest from others.

Shame occurs both in relational pain and in self-pain, though in quite different ways. In relational pain, shame arises as an inhibitory affect that motivates us to hide the expression of 'dangerous' feelings (e.g., distress, anger) that might put the relationship with the caregiver in jeopardy. As the child matures, this 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 into self-pain, and shame becomes toxic. Sharbanee et al. (2019, p. 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 such as:

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

3.3 Transforming Self-Pain[25]

Therapy addressing self-pain focuses on the negative perception of the self in both the present and past, undoing defenses such as splitting, projection, idealization, and self-attack. The goal is to bring about a new adaptive experience of the self on a conceptual level, which can then be reconsolidated into emotional memory.

The transformation of self-pain is achieved through compassion and re-assessment, following these four tasks:

[25] We want to acknowledge that many of these ideas about the conceptualization and treatment of shame and the transformation of self-pain, were developed in collaboration with Einat Shaked Gross an AEDP therapist in Israel collaborating and teaching with Netta Ofer.

a. Identifying and understanding the origin of the negative self-concepts
b. Finding compassion and connecting to the pain
c. Re-assessing aspects of the self: finding new value and new meaning
d. Integrating aspects of the self

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

It is important to connect the self-attack or the patient feeling flawed to a more central negative self-concept from which these feelings stem, ensuring that we work on an essential negative self-concept rather than on a derivative that may be too general or too specific.

Patients often refer to either very specific flaws like, "I am always late" or "I am lazy in doing schoolwork," or to more general statements like, "I am an unlovable person" or "I am awkward." In both cases, we need to help the patient identify the underlying negative trait, characteristic, or aspect at the core of these statements. This can be done by asking questions like, "So what kind of bad thing about you lies beneath this tendency to be late?" or "This carelessness you're describing, what essential trait or nature in you does it actually reveal?" or "You're saying you feel unlovable. What trait do you feel you have that makes people unable to love you?"

The next step is to clarify the source of these negative self-concepts. As explained earlier (3.1), these concepts may have evolved from various experiences in the patient's life—experiences within the family, in wider social groups, or from trauma. The therapist guides this exploration with a highly empathic, un-shaming attitude to create a safe and curious space. Some helpful questions might be: "Have you always felt this way about yourself?" or "When do you remember first feeling this uneasiness about this trait?" or "Does this feeling of inferiority take you back to any specific time in 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 during memory reconsolidation (MR). Since the patient is naturally critical of their flawed self-aspects, finding compassion is usually necessary before they can go into the painful feelings of shame and unworthiness more deeply.

There are several ways the therapist can help the patient develop a more compassionate stance. For example, by using an explicitly empathic stance toward the patient's self-part, by suggesting the patient imagine a compassionate figure looking at the self-part, or by asking how the patient would feel if it were their own child or nephew feeling the same way.

Once compassion is established, it's important to stay with the pain and explicitly validate it, allowing it to "open up fully" or "arrive at the pain" (Greenberg, 2010).

We observed that many times, when the pain is not fully accessed and activated, the

process remains cognitive, and essential transformation does not occur. Accessing the pain can be facilitated by compassionately talking to the suffering self-part, asking questions, and recognizing the pain with statements like, "Of course you were paralyzed; how could a young boy do anything when his teacher was attacking him like that?" or "Of course you felt that you were stupid if your own parent was so disappointed with your academic achievements time after time!"

c. Re-assessing of aspects of the self

After activating the pain, the next step is to help the patient find a new contrasting experience about the self by re-assessing the flawed aspect or trait. Re-assessment involves examining the traits of the self that are viewed as flawed or shameful. Depending on the nature of the aspect, the patient and therapist may uncover new value or meaning through this process.

Finding new value: When examining the unworthy aspects of the self, there are several ways in which the patient and therapist may find new value, which undoes the inferior quality of the trait. Examples include:

- Recognizing an underlying good intention or quality of aspects (e.g., weak becomes kind-hearted, distant becomes not wanting to burden others).
- Using adult understanding to find 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 does not actually possess the trait (e.g. "I was told I was selfish, but I am actually very caring"; "When I was young, I thought that being Black meant I was no good, but now I know this is a social bias that is completely wrong").
- Understanding that the attacks were not a result of personal 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 devalued by the society in which one lives. Therefore, it may not be possible for re-assessment to change the trait's value. In such cases, new meaning may be found from the new experience of existential acceptance. Examples of existential acceptance include giving up unwarranted hope, understanding the trait as a shared human condition (e.g., physical imperfection), accepting one's misfortune of being born with devalued traits in the current cultural, biological, or historical context, and 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.

These examples of re-assessment show that cognitive elements and self-narrative play a more significant role in finding disconfirming experiences for self-pain because self-pain is more conceptual in nature than core emotional or relational pain. While a new relational experience (e.g., feeling the therapist's affection and appreciation) may provide a new self-affirming experience, it likely won't undo a broader self-perception of being "uninteresting" or "needy." At the same time, we must remember that a purely conceptual or cognitive reappraisal (e.g., "I know I am not stupid" or "Homosexuality is normal") will not transform self-pain—it always needs to go hand-in-hand with deep emotional experience and processing.

d. Integrating aspects of the self

Newly found value or meaning will help integrate the unworthy part into the self. Self-concepts that have lost their negative value through re-assessment will naturally reintegrate, as the previously rejected aspects of the self will now be welcomed as valuable parts. Many times bad aspects do not change to totally good and the new value exists side by side with the inconveniences, e.g. "being so sensitive has caused me a lot of trouble but has also provided me with rich and worthwhile experiences." Self-concepts that have found new existential meaning but still retain negative value are now ready to be accepted and reintegrated. This process often involves mourning what was lost or what will never be because of having these traits.

The reintegration of these previously disowned characteristics of the self will create an experience of wholeness and authenticity. It brings a new sense of self-acceptance, worthiness, and belonging within the social group. For example, one may feel proud and give full expression to their identity (e.g., sexual, gender, racial) and interests (e.g., poetry), own psychological traits (e.g., introversion, exuberance), and no longer hide physical aspects (e.g., size, age). This results in new learning: "My true identity is acceptable, or even a valuable resource for the group," or "I am a gentle person but had to learn to be aggressive to protect myself."

The therapist can select techniques and procedures from various models that are tailored to transforming self-pain. Examples include two-chair dialogue for self-critical splits (EFT), working with critical parts (IFS), reframing, reattribution (ST), intra-relational portrayals, fierce love (AEDP), and cognitive reappraisal (CBT). Self-pain involves the most complex learning of the three types of pain and takes the most time to change in therapy, as it is widespread through emotions, relational attitudes, and identity. Undoing defenses and working through these four tasks for several (related) self-concepts can take many months, if not years.

Case Example: Compassion and Re-assessment in Self-Pain

A patient came in with an array of somatic symptoms, the worst of which was irritable bowel syndrome. She had been referred by a doctor who suggested that the symptoms might be psychosomatic, originating from the severe stress she was experiencing. In the

first session, the patient revealed that she was under enormous pressure to achieve outstanding grades in her studies and was experiencing high anxiety and obsessive studying.

When this was explored through empathic questioning, the patient and therapist discovered that the patient was convinced she was not intelligent enough, even stupid (identifying the negative core concept), and she was constantly trying to hide this belief by excelling in her studies. She shared with the therapist that she felt severe shame about being the only unintelligent member of the family and was always afraid this would 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 or around friends. She also remembered her older brothers often making fun of her. One particularly painful incident occurred when she was six. Her parents were on vacation, and she was left with her older brothers. One evening, one of her brothers decided to teach her some lines from the Constitution. She remembered that, until the age of 12 when her teeth were straightened, she had a slight speech impediment and therefore struggled with 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 revisiting this scene, she felt profound humiliation, shame, and helplessness. During further exploration, the patient recalled that the fear of making mistakes when speaking long words preoccupied her throughout her school years, and she remembered how difficult it was to cope with (i.e., identifying the origin of the negative self-concept). From this work, the patient began to feel some compassion for the little girl who had suffered so much simply 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) her younger self, an encounter that brought much deeper feelings and pain. The young self spoke of feeling stupid and feared that everyone 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 reflect on how the younger part was processing this and asked if she now believed that these pronunciation problems were really signs of stupidity. The patient explained that she now understood that they were not even connected to stupidity, but rather to her speech impairment. The therapist asked if she could contact the young girl, acknowledge her pain, and bring in new adult understanding: that she was not stupid, but suffering from a speech impairment that was used to make fun of her. The patient did this, and the girl listened and asked, "You really mean that? So why were they laughing at me? Why did my brother say I was stupid?" and various other questions. The patient answered each question until she felt 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 during her early school years. By the end, she said, "I never thought about it this way, so strange—I had all the dots but never connected them." She reported feeling a strong sense of wholeness and lightness, as though a huge burden had been lifted (i.e., integration).

In the next session, she reported seeing herself differently, viewing herself as more competent and intelligent. After this transition, more work was done, and her stress gradually decreased, along 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 the self was inflicting on itself. It is also important to note that simply finding compassion would also not have produced the necessary results, as the pain was more complex and involved significant cognitive elements.

Part III summary and Implications:

1. Summary of Triangles of Emotional Pain

Our complete integrative model of emotional pain conceptualizes three types of emotional pain, each warded off by different types of defenses and requiring 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 potential transformational path. Below, we summarize the dynamics of experiencing, remembering, and transforming emotional pain.

A. 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 danger, an obstacle, or a loss. The aroused categorical emotions (fear, anger, sadness) motivate adaptive action tendencies. When events are too big to deal with for the individual, often in association with the absence of a soothing or protective figure, the inherent adaptive action tendencies (fight, flight, grief) become ineffective. The emotions become unbearably intense, causing fear of disintegration (emotional and/or physical). This disabling emotional intensity immobilizes the organism, leading to mental dissociation from the overwhelming experience. As a result, the painful experience of unprocessed emotions and unresolved action tendencies becomes stuck in the body, causing a disconnection from one’s emotional and physical awareness.

Remembering

All aspects of this core emotional pain (intense negative emotions, fear of disintegration, being stuck in unresolved action/emotion, and dissociation from experience) are stored in emotional memory. Associated internal and external experiences tied to the painful event can now trigger re-experiencing emotional pain. The painful emotional memory, reflecting the learned expectation of unbearable emotion and ineffective action, leads to defensive actions to distance oneself from painful affects and triggering situations. Patients with core emotional pain primarily use detaching defenses, such as dissociation, distraction, and avoidance of the experience.

Transforming

Transformation requires undoing 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 aloneness[26], processing emotions to completion, and mobilizing actions that were stuck in the body, all facilitated by a soothing presence (e.g., the therapist), using more adult resources, and piecemeal processing. Undoing defenses and achieving emotional transformation will bring relief, calm, and completion, as well as a deep connection to one's body and experience, which will all be reconsolidated into revised emotional memory.

B. Relational Pain

Experiencing

Relational pain is caused by ruptures in the connection with a caregiver and signals that the relationship with an attachment figure is under threat. This occurs when the 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 fail, and the caregiver repeatedly ignores or negatively responds to the needs, the individual experiences fear of losing the connection. In this conflict between emotional needs and the need to maintain the connection with the caregiver, the individual will prioritize safeguarding the relationship by repressing the expression of his emotional needs, which results in additional pain from unmet needs and repressed expression.

Remembering

[26] 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).

All elements of this relational pain (ruptures, fear of disconnection, unmet needs, and repressed expression) are stored in emotional memory. Internal and external experiences associated with the painful experience can now trigger emotional pain. The reactivated emotional pain, reflecting the learned expectation of rupture and unmet needs, causes shame and anxiety and leads to defensive actions designed to distance oneself from painful affects and triggering situations. In addition to detaching defenses, the patient defends 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

- The 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 being rejected in a direct interaction). These new experiences may involve restored emotional expression toward significant others, reconnection, and receptive experiences of having needs met, which are facilitated by validation of needs and relational safety. Undoing defenses and achieving emotional transformation will result in well-being through freely expressing oneself, fulfilling of emotional needs, and security of relational safety, all of which will reconsolidate into revised emotional memory.

C. Self-Pain

Experiencing

Self-pain is caused by attacks on aspects of the self by important others and signals that one's place or role in the group/family is under threat. This occurs when there are early experiences of severe neglect or abuse by caregivers, or later experiences of rejection or exclusion by members of a larger peer group. The individual will attempt adaptive action by improving or hiding aspects of the self. When these attempts to hide or improve oneself, or demonstrate one's worth fail, and attacks, shaming, or exclusion of certain aspects of individuality continue, the recurrent shaming leads to fear of unworthiness and losing one's role, place, or status in the social group or family. To safeguard inclusion in the group, the individual hides or suppresses their true nature or compensates by showing an altered and "improved" socially appreciated version of the self. This leads to a painful self-perception as defective and unworthy (toxic shame) as well as the pain of hiding one's true self and expressing a displaced or false self.

Remembering

All aspects of self-pain (attacks, fear of exclusion, feeling defective, disowning/hiding parts of the self) are stored in emotional memory. Associated internal and external experiences linked to the painful event can now reactivate the memory of emotional pain. This painful emotional memory, reflecting the learned expectation of exclusion and shameful unworthiness, triggers defensive actions designed to distance oneself from painful affects and triggering situations. In addition to detaching and countering

defenses, patients defend against reexperiencing self-pain primarily by using displacing defenses, such as idealization/devaluation (self-attack), splitting, and projection, to alter the perception of their unworthy characteristics.

Transforming Self-Pain

Transformation of self-pain requires undoing defenses and finding a new experience that disconfirms the negative self-concept on a semantic/conceptual level (e.g., "I am not weak because everyone is afraid when they are young"). These new experiences can be found in feelings of belonging, receiving appreciation, re-owning attacked parts of the self as worthy, and expressing the true core self freely, all facilitated by de-shaming, compassion, and reassessment of self-characteristics. Undoing defenses and achieving emotional transformation will bring a sense of wholeness, authenticity, pride, and security in belonging, all of which will be reconsolidated into 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 the overwhelming emotions present during the abuse, relational pain related to the failing parent who didn't listen or protect, and self-pain from feeling worthless and blaming oneself for being abused.

2. Implications

A. Conceptualizing Emotional Pain

One key merit of the "triangles of emotional pain" is that it helps the therapist to find and maintain focus their work during the session. Throughout their lives, patients will experience all three kinds of emotional pain to varying degrees and in different combinations. Therefore, therapy must address all three types of pain. The triangles of pain help the therapist reflect on which type of pain requires initial focus to bring about the most needed change, as certain symptoms and problems indicate which type of pain is likely dominant in the session. Determining the active pain in the session informs the therapist about the necessary transformational path, what inhibitory affects and defenses can be expected, and which techniques to select from the corresponding psychotherapeutic paradigm.

However, as with any conceptual framework, it is important not to lose contact with the unfolding process, which is paramount in experiential work. Tracking and following moment-to-moment markers of emotional activation—such as non-verbal cues, poignancy, patient idiosyncrasies, fantasies, and healing tendencies—can lead to changes and transformations unforeseen by our conceptualization. We intend this framework to help therapists gently guide their intervention choices 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[27]. (e.g., regulation by compassionate presence, expression toward a significant other, or re-evaluation of aspects of the self).

There is no single marker that identifies the active pain in a session; instead, multiple indicators—such as the originating event, dominant emotion, the patient's wording and concerns, typical symptoms and defenses, and the patient's known history—point in the same direction. While it can sometimes be ambiguous, in our practice and supervision we have found that it is usually quite clear which pain is dominant in the session if these indicators are considered together.[28]

Not being entirely certain about the active pain may pose challenges for research but holds important clinical value by signaling a therapeutic choice point in a session. For example, the therapist may need to choose between focusing on self-soothing and regulating interventions or taking a more expressive and interactive approach. The following two examples illustrate how the therapist might determine the active pain in a session:

Example 1:

A patient who lost her mother at a young age might present with various emotional responses. If she typically tries not to remember her mother's death and becomes anxious and emotionally distressed when talking about the moment she learned of her mother's passing, core emotional pain is likely active. If the patient frequently speaks of missing her mother, feeling alone and sad, or feeling guilty about being angry, relational pain may be at the forefront. However, if the patient focuses on feeling like an orphan, feeling different and less than other children, or being bullied for not having a mother, self-pain is likely dominant.

Example 2:

A patient who experienced sexual betrayal by his wife might present with different emotional responses. If he describes feeling numb and confused, and doesn't know what to feel, working on core emotional pain may be a good first choice. If there is significant sadness, fear of the couple breaking up, fear of discussing the issue with his wife, along with a known history of abandonment, it suggests that relational pain is active. However, if the patient expresses rage over humiliation, shame about discussing the matter with the therapist, issues about his masculinity, or deep self-doubt about whether he is enough for his wife, then self-pain is likely in the foreground.

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[27] This perspective on conceptualization strikes a middle ground between case conceptualization - "…determine the core painful emotion schemes and 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).

[28] 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.

B. Setting Priorities in Therapy

The triangles of pain can also help establish priorities, as it may be necessary to address one type of emotional pain before working on others. In general, we have found it easiest to work on *Triangle 3* issues (self-pain) first, followed by *Triangle 2* issues (relational pain), and finally *Triangle 1* issues (core emotional pain). For example, treating *Triangle 3* self-pathology will often need to come before addressing *Triangle 2* relational pain, as the patient may feel undeserving of expressing their needs[29] or receiving care. Relational pain often needs to take priority over core emotional pain, as relational safety is often required for the necessary regulation to access and process intense emotional pain to completion. For example, working on core emotional pain related to loss or fear may be less effective if there is an anxious relational layer about having unacceptable needs. In other cases the reverse order can also be true: severe dysregulation from *Triangle 1* core emotional pain may need to be addressed first to make work on relational or self-pain possible.

Case example:

In the case of a 35-year-old patient, fear of her father dying had been a constant presence in her life ever since her father was diagnosed with cancer when she was 5 years old. As his illness worsened, she became obsessively focused on the possibility of his death. Any Triangle 2 *work addressing her relationship with her father was overshadowed by the terror of losing him, which was triggered by this work. After* Triangle 1 *work in a portrayal where the patient imagined grieving and dealing with her father's death, her fear subsided. This allowed her to do relational work with her father, addressing her anger and her unfulfilled need for closeness due to his preoccupation with his illness. This process was followed by mourning the life she had missed and feeling compassion for the girl who had lived her entire life with this dread.*

In cases with lack of progress, reflecting on the triangles of emotional pain may help the therapist shift the focus of the work[30]. For example, it may seem that the patient is doing meaningful work, with lots of emotional activation and new healing experiences. However, subsequent sessions may reveal that this work has not significantly impacted the patient's core issues. Here is an example where a shift in focus proved helpful:

Case example

In the case of a young woman constantly worried about her career and comparing herself to others, the therapist followed the lead of painful memories of exclusion and

[29] 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.

[30] 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.

*being made fun of in primary school for having facial dysmorphia. The therapist used an intra-relational portrayal to access the patient's pain of loneliness and rejection, addressing a number of situations from her early school years where she felt angry, rejection. There was significant emotional release, some anger was expressed, and the adult-self felt compassion for the suffering child, which helped undo her sense of aloneness. However, in the next session, the patient blamed herself for not making the progress expected from the therapy work. This helped the therapist realize that they had worked on loneliness and rejection (*Triangle 2 *relational pain) but that the patient had not yet accessed the deeper Triangle 3 self-pain of unworthiness. When the therapist directly addressed her feelings of shame and defectiveness (Triangle 3 self-pain), the work immediately deepened and became more impactful. She connected with the deep pain of feeling ugly and being seen as weird by others, found compassion for her misfortune, and contrasted her rejection with her recent experience of feeling appreciated and developing real friendships during her university years.*

In this case, while the initial work was important, it wasn't focused on the type of emotional pain responsible for the specific symptoms the patient was experiencing. Such realizations often come from reflecting on all relevant aspects of the process—history, emotional responses to interventions, body language, etc. We have found that identifying the affective system of pain driving the patient's suffering, and determining the needed transformation, can be crucial in unlocking stuck healing potential.

C. Implications for Memory Reconsolidation

Conceptualizing emotional pain into three categories provides valuable insights into some of the open questions regarding memory reconsolidation (MR): To what extent does the activating experience need to resemble the original learning? (Lane et al., 2015). In what way does the new disconfirming experience need to be different from the original learning? (Ecker, 2020).

Since the three types of emotional pain originate from fundamentally distinct learning experiences, we argue that both the activating and disconfirming experiences must experientially match the "modality" of the original learning experience 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 type of pain differs because with each pain, a new layer of complexity is added. *Core emotional pain* is largely shaped by simple classical conditioning, where an event or aspect of an event becomes associated with an emotional state. For example, loud noises may become associated with fear, or physical closeness with pain. *Relational pain* adds a more complex layer of operant conditioning, as the individual learns from repeated interactions how their behavior affects a significant other's behavior (e.g., expressing sadness leads to rejection, or the need for protection is ignored). In Self-pain, even more abstract mental operations come into

play, forming a self-concept that includes both the representation of one's physical and mental characteristics and their social value.

Each type of pain gains complexity by adding a new essential ingredient, which becomes the focus of the contrasting experience needed for reconsolidation. The focus for transforming *Core emotional pain* is entirely emotional/physical in nature. In the reconsolidation of *Relational pain*, the focus is on the relational experience of connection and care, supported by emotional/physical dimensions. *Self-pain* reconsolidation focuses on the semantic layer of the self-concept, in addition to relational and emotional/physical components.

This means that depending on the type of pain being transformed, MR takes place at different levels of representation of information, requiring 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 that originates from overwhelming emotional experiences, the patient will need a regulated experience that contrasts with the original pain, especially on a *physical-emotional level* (e.g., re-experiencing a terrifying event in a regulated manner or processing grief to completion). The ideal setup to activate and find the mismatching experience for MR through imaginary work (e.g., portrayal) is to revisit the self in the event that caused the unbearable emotional pain.

To reconsolidate relational pain, which originates from unmet needs and ruptures in the attachment relationship, the patient requires corrective experiences on the *relational level* (e.g., expressing joy or anger towards someone without being rejected, having one's needs met, or experiencing reconnection). Therefore, the first choice for setting up MR through imaginary work will be a direct interaction of *self with the important other* who caused the relational pain.

In cases of self-pain, which originates from the perception of the self as defective or inferior, transformation is achieved through a new experience of the self that disconfirms the negative self-concept on *a semantic-conceptual level* (e.g., developing a compassionate view of oneself, recognizing new value, or feeling pride in one's characteristics). The key interaction for achieving MR of self-pain through imaginary work is an interaction of *self with self.*

Distinguishing between different kinds of pain may help resolve the ongoing debate about memory reconsolidation, particularly the question of whether emotion or semantic

content holds primacy (see Ecker, 2020). In the case of core emotional pain, the primacy lies with the emotion, as new emotional valence can be directly reconsolidated into memory without the patient's conscious awareness or understanding. Change often comes as a surprise (e.g., "I don't understand why I feel different now"). Semantic understanding plays a limited role, except in posterior understanding (e.g., "intense emotions are not dangerous," "I can overcome loss")[31]. In contrast, when addressing self-pain, a new transforming experience is not possible without conscious semantic content in the form of new meaning or facts about oneself, others, or events (e.g., "I am not inferior; many people feel this way," or "I am not unlovable; my mother is incapable of love"). In this case, the primacy lies in the semantic realm, though emotion is still essential to the process.

D. Implications for the Role of the Therapist

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

First and foremost, the safe and affirming relationship with the therapist is fundamental in any therapeutic work and in addressing all three types of pain. As we have noted, each type of pain is characterized by a particular form of *aloneness* (see footnote 27), and undoing this aloneness takes different forms in each case:

- In *Triangle 1* work on trauma, the therapist acts as a resource where the presence of the therapist brings regulation to the intense emotions making it possible to process those emotions to completion.

- In *Triangle 2* work on relational trauma, the therapeutic relationship itself can be a catalyst for healing, with the therapist often taking on the role of an attachment figure. The therapist may be at the heart of the corrective experience, explicitly processing the connection, love, and care in relation to the patient, and facilitating the patient's receptivity to these aspects of the experience.

- In *Triangle 3* work on self-pain, the therapist's compassion and affirmation are crucial for creating a shame-free environment in which the patient can open up to the painful feelings of shame. This can involve "fierce love" (Piliero, 2020), where the therapist actively undoes toxic shame and advocates for the patient's worth and dignity. However, the therapist must be mindful that, while important, this cannot substitute for the crucial renewed evaluation of the self by the self in transforming this type of pain.

Finally, the triangles also provide guidance on the therapist's stance in countering the specific fears that drive each triangle of pain:

- To counter the *fear of disintegration* in Triangle 1, the therapist should be encouraging, secure, and holding.

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

- To counter the *fear of disconnection* in Triangle 2, the therapist should be highly loving, validating, and caring, ensuring the patient's feelings and needs are seen and reflected.
- To counter the *fear of worthlessness* in Triangle 3, the therapist should be especially affirming, explicitly non-judgmental, and compassionate.

In Conclusion:

Conceptualizing the three types of emotional pain as subdivisions of the triangle of experience can be an important tool for therapists to recognize the phenomenology of emotional pain and obtain a more precise mapping of core emotional experience, inhibitory affects, defenses and core fears involved in emotional pain. Everyone experiences all three types of pain and conceptualization is on the level of active pain in the session, which is very compatible with AEDP's tracking of moment-to-moment experience. This understanding informs the therapist about what kind of new corrective experience is needed and helps the therapist to design an adequate transformational path and tailor his role as a therapist. Conceptualization of emotional pain is an excellent tool for supervision to analyse the patient's experience and help understand why affectively deep and meaningful work may not be resulting in the needed change for the patient.

Addendum A. 5-page synopsis

The 3 Triangles of Pain: A compass for navigating through the experiential process

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

Core emotional pain

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

Relational pain

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

Self-pain

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

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

Recognizing and Transforming Core Emotional Pain

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

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

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

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

Transforming core emotional pain entails activating the intense emotion while providing the patient with enough resources so that the emotion can be regulated and processed to completion[32]. The task of the therapist here is to keep the experienced emotion of pain within the "window of tolerance" by, on the one hand, activating dissociated pain, and on the other, providing enough regulation for excessive activation.

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

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

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

Recognizing and Transforming Relational Pain

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

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

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

a. Ongoing issues (conflicts/ frustration) most commonly with life partners but also parents, children, friends, colleagues/bosses.
b. Difficulties with emotional closeness and /or sexual intimacy in romantic relationships
c. A tendency to be independent and self-sufficient in relationships.
d. A tendency to be pleasing and accommodating out of fear of being rejected in relationships.

[32] Fosha,2000

e. Feeling inhibited in expressing a specific kind of emotion such as anger, sadness, fear, joy and more.

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

a. Full expression and integration of needs and feelings – for example: pain over abuse, rejection, loneliness; conflicting feelings of anger, guilt, and love towards the parent.
b. Corrective receptive experiences – for example: the imaginary parent is responsive, feels compassion and remorse, or meets the patient's needs.
c. Letting go of the need[33]: Giving up unrealistic hope, i.e., mourning the parent one never had, and acceptance

Common techniques for accessing relational pain and its expression: portraying specific situations or typical interactions where the patient confronts and shares with the parent the emotions he feels; validation of emotional needs and pain; countering the patient's defense of the parent[34]: moral, cultural, and relational reservations about upsetting, hurting or accusing the parent; encouraging expression of "unacceptable" feelings and impulses such as anger, rage, guilt: finding and expressing needs, wishes, and positive feelings of love and connection.

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

Recognizing and transforming self-pain

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

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

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

a. Feelings of shame, inferiority, self-blame, self-harm, withdrawal from social situations and roles.
b. Feelings others as critical, feeling judged all the time, and constantly justifying oneself.
c. Grandiose self-esteem, anger at others for not recognizing one's value, inability to remain in relationships, chronic infidelity
d. Being overly concerned with acceptance, obsessively comparing oneself with others, being highly dependent on approval

[33] Greenberg, 1993
[34] Pilliero, 2019

e. A general feeling of loneliness in the context of not being part of social groups or feeling constantly insecure in social groups.
f. Confusion about identity, non-authenticity, imposter syndrome

Transforming self-pain in therapy is centered around identifying negative core self-concepts and activating the pain resulting from such unworthy aspects of self, and eventually finding compassion, new value or new meaning in the eyes of the adult self. The pain may be activated by reviewing recent and past experiences of shame, humiliation, and exclusion or by exploring feelings of shame the patient feels in the current interaction with the therapist. An imaginary interaction of the adult self with these "unworthy" self-parts can lead to (a combination of) several transformational outcomes that will help to reintegrate the hidden or disowned aspects into the whole of the self:

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

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

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

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

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Addendum B. 4 Diagrams

Diagram 1: How experiencing emotional pain leads to emotional learning (page 8.).

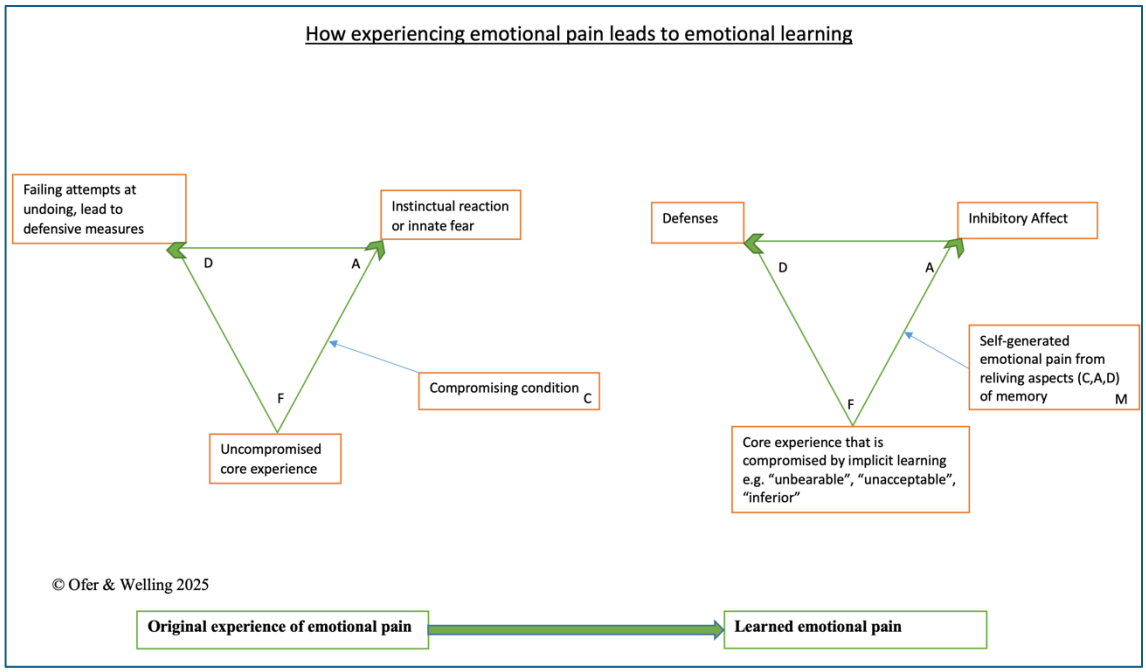


Diagram 2. Triangle 1: core emotional pain (page 12).

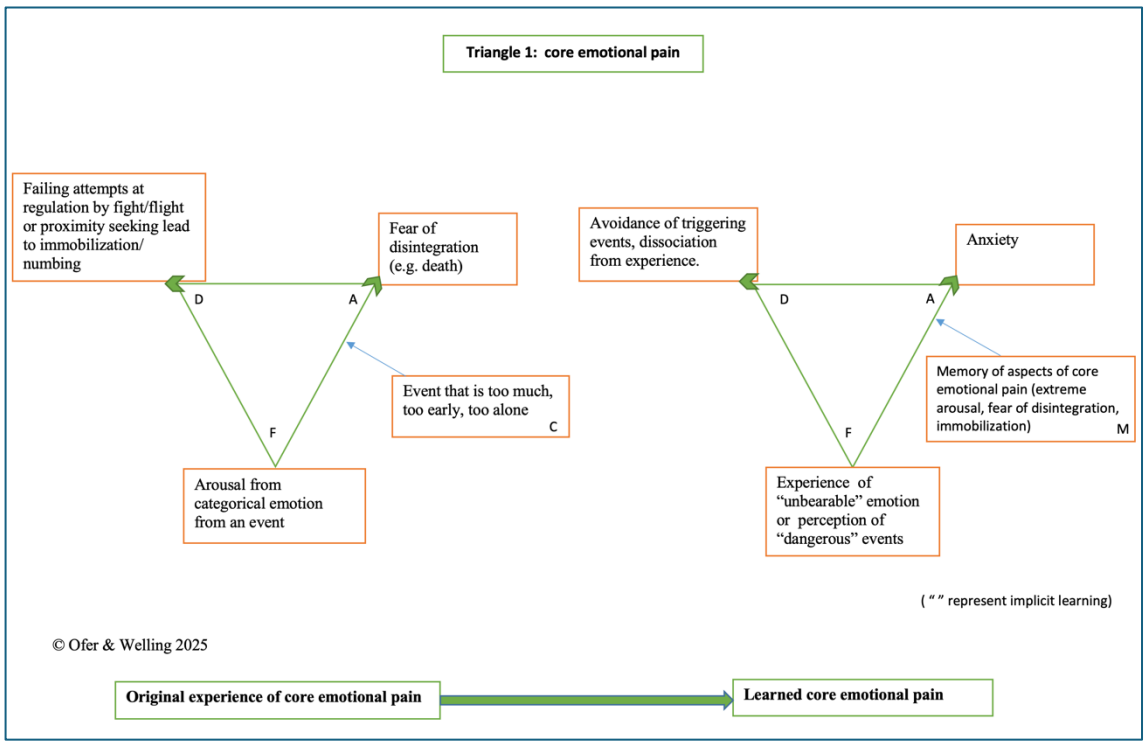


Diagram 3. Triangle 2: relational pain (page 21).

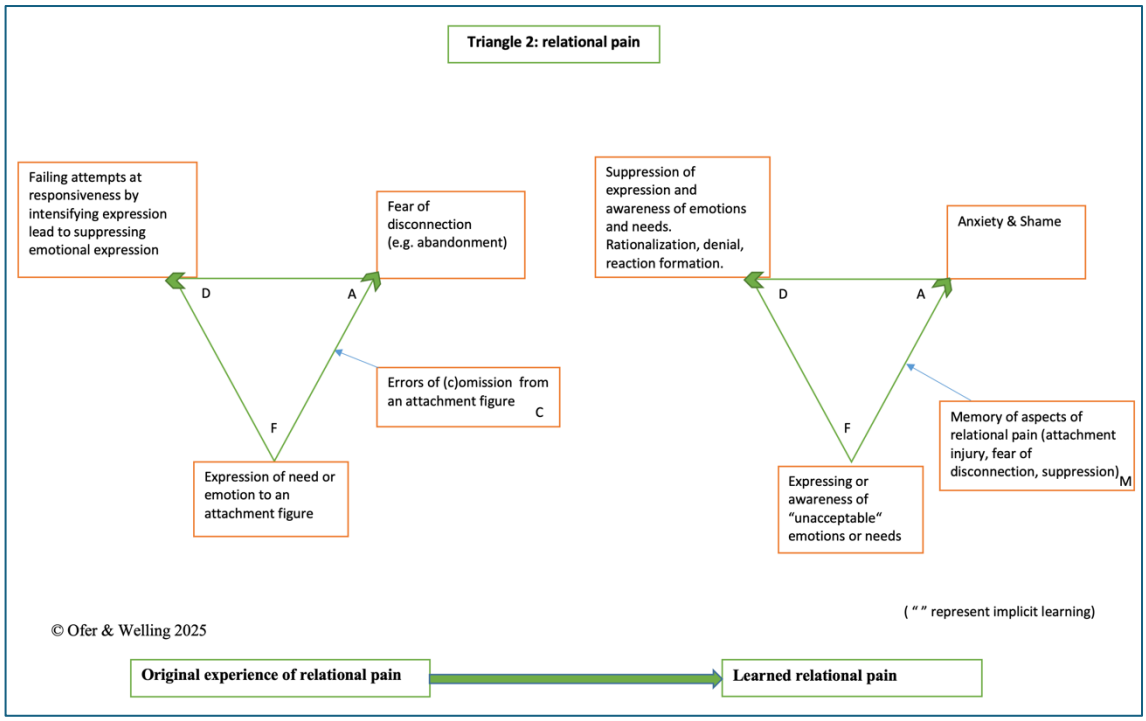
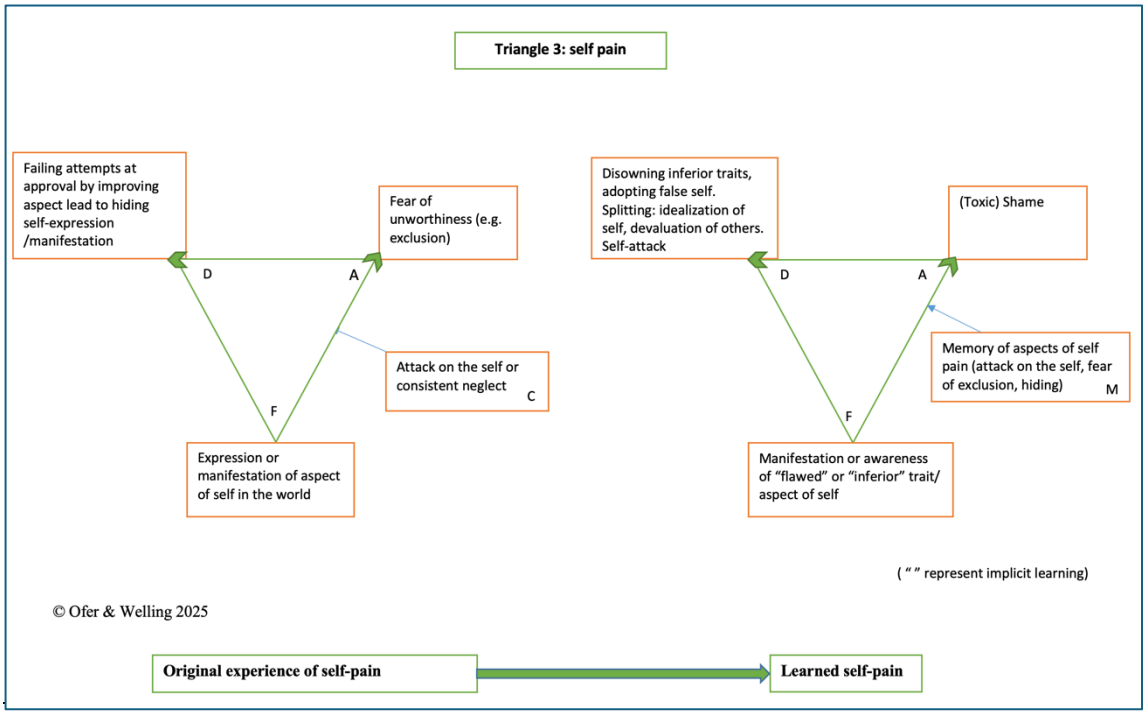


Diagram 4. Triangle 3: self pain (page 28).



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