Allowing and Accepting Painful Emotional Experiences

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ABSTRACT. In this article, the authors describe a process-diagnostic approach to working with emotion. This involves using different interventions at different times, depending on what emotional process the client is currently engaged in. One such process, the allowing and accepting of pain, is discussed. The phenomenological experience of pain as a state of brokenness and the steps involved in resolving that type of emotional pain are discussed. The steps include overcoming avoidance, reowning, mobilizing an unmet need, having an awareness of maladaptive beliefs, and finally feeling relief and self-affirmation. The authors also demonstrate that emotional change leads to change in meaning.

IN THIS ARTICLE, WE INTEGRATE traditional experiential theory (Perls, Hefferline, & Goodman, 1959; Rogers, 1959) with current emotion theory and research and explicitly argue for the central role of emotion in functioning and psychotherapeutic change (Greenberg & Paivio, 1997; Greenberg, Rice, & Elliott, 1993). The consensus among emotion theorists (e.g., Fridja, 1986; Lazarus, 1991) is that a discrete number of innate emotions are biologically adaptive and enhance functioning. Each of those emotions is associated with a distinct action tendency or physiological readiness to act in a way that promotes survival. The implication for therapy is that full awareness of those emotions enhances adaptive functioning because such awareness accesses the client's associated adaptive information.

Emotional experience is encoded in memory and is part of a complex associative network of feelings, beliefs, learned responses, episodic memory, and motivation. These components are embedded in an emotion structure or scheme (Greenberg & Paivio, 1997). Emotional experience thus involves the processing of physiological, sensorimotor, episodic, and conceptual information and is a rich source of multimodal information. By attending to and acti-

vating core emotional experience in therapy, one accesses the core of associated information about self. Through maladaptive learning, however, components of this information complex can be maladaptive and need to be not only accessed but also modified. In either case, emotion schemes need to be activated in therapy in order to access the associated information and to make maladaptive components available for change.

The efficacy of experiential approaches for different disorders is empirically supported by Greenberg, Watson, and Lietaer (1998). Experiential interventions, with their emphasis on activating emotion, seem particularly well suited for treating trauma-related disturbances (Paivio & Patterson, 1998; Paivio, Tran, & Jellis, 1998).

Disrupted emotional processes are at the core of psychological disturbances stemming from trauma. Traumatic stressors range from a single circumscribed event, such as a natural disaster, to prolonged and repeated exposure to interpersonal violence in early attachment relationships. Trauma entails overwhelmingly painful feelings (e. g., helplessness and terror) associated with the event itself and painful feelings associated with the after-effects of the event. These include impotent rage at betrayal or violation; sadness at loss, including loss of cherished beliefs; alienation; and shame at denigration. Symptoms of posttraumatic stress disorder (PTSD) as stated in *Diagnostic and Statistic Manual of Mental Disorders* (4th ed.; *DSM-IV;* American Psychiatric Association, 1994) include problems with emotion dysregulation and avoidance and numbing of affective experience. There also is a high incidence of comorbidity with other anxiety disorders and depression (Foa, Riggs, & Gershuny, 1995). It makes sense that addressing this complex of affective disturbances can require a complex integration of emotionally focused intervention strategies. Such a comprehensive treatment approach requires a differentiated perspective on the different emotional experiences, states, and processes involved in an appropriate intervention. The following review of the role of emotion in functioning can contribute to such a differentiated understanding.

Process Diagnosis

A four-part process-diagnostic scheme for assessing emotional expression in therapy has been delineated (Greenberg & Paivio, 1997; Greenberg & Safran, 1989). In that scheme, primary emotion is distinguished from secondary and instrumental responses. The term *primary emotion* refers to a person's fundamental, initial response to a stimulus that is not reducible to other cognitive–affective components. Secondary emotional responses, by contrast, are reactions to the more primary feelings or are secondary to thoughts. Secondary emotional responses are the end products of simple sequences, such as expressing anger when feeling afraid, or result from more complex processes,

such as feeling anxious when anticipating the shame of negative evaluation. In the case of responses to trauma, thinking about how one should have behaved differently in the circumstances or that one is somehow responsible for the event can contribute to secondary feelings of guilt, shame, and depression. Instrumental emotions, on the other hand, are experienced and expressed in order to achieve some end, for example, expressing anger to dominate or dismay to impress others with one's moral virtue. The anger characteristic of borderline disturbances, which frequently are associated with exposure to trauma, is intended (usually unconsciously) to prevent dreaded abandonment and, therefore, is considered instrumental.

A final differentiation is important, especially with regard to trauma. Primary emotion can be further subdivided into biologically adaptive and learned maladaptive reactions. Panic attacks and different types of phobias are examples of primary learned responses that are maladaptive. Automatic alarm responses characteristic of PTSD are examples of this type of primary maladaptive responses based on traumatic learning. Conditioned fear responses are activated by stimuli resembling the traumatic situation. They are maladaptive because the danger is not real and are considered primary because they are the person's initial response. They are not secondary to, or generated by, other feelings or thoughts. This has important treatment implications that are discussed later.

Not all emotions, however, are fundamentally adaptive. Thus, in addition to learned maladaptive responses, such as conditioned fear, secondary and instrumental emotions are the cause of much of the bad press that these emotions have rightfully received. Certain emotional responses are not adaptive, nor are they desirable, and they do need to be controlled.

Therapy for the effects of trauma can involve all of the above types of emotion and affective processing difficulties. Thus treatment for the effects of trauma integrates accessing suppressed adaptive emotions, such as sadness and anger, managing secondary rage, changing maladaptive shame and depression, and counterconditioning the automatic alarm reactions. The fundamental treatment principle for all emotional disturbances is that even maladaptive emotion needs to be activated in order to be changed.

However, accessing is complicated because avoidance of feelings and thoughts associated with trauma is frequently the prevalent way of coping with painful experiences. Avoidance interferes with reexperiencing and change. The basic therapeutic challenge, therefore, is to help people overcome avoidance and allow painful experience. In therapy for trauma, this needs to be done in such a way as not to overwhelm or retraumatize the client. Facilitating the process of allowing requires understanding the negative consequences of chronic avoidance of primary emotion and emotional pain.

Avoidance of Emotion

According to Pennebaker (1989), the chronic inhibition of thoughts, feelings, and behavior requires effort; it is a drain on resources; and it places cumulative stress on the organism. Pennebaker presented evidence from various contexts that the chronic inhibition of trauma-related feelings and thoughts results in increased risk of health-related problems. Furthermore, trauma material that is avoided cannot be processed and integrated into current self-systems but continues to exert a negative influence on perceptions and behavior.

If feelings are not to be avoided, are they always to be trusted? This is a complex issue to which the answer is a definite *possibly*. It depends on what feelings are to be trusted and in what way. Trusted blindly to determine action? No. Trusted as primary sources of information about reactions and experience? Absolutely. After all, feeling is a central part of the process of being.

Two subtypes of emotional experience—pain and bad feelings—require special attention. The distinction between the two is important because it promotes differential intervention. Broadly put, emotional pain is adaptive but frequently is avoided, and it is the chronic avoidance of pain that can be maladaptive. A common example of this is the inability to grieve over a major loss. Intervention, therefore, involves overcoming avoidance and accessing the painful experience. On the other hand, bad feelings, such as depression, are themselves maladaptive, and intervention entails accessing and changing the underlying cognitive and affective processes that generate the bad feeling state. Therapy for the effects of trauma involves treating both maladaptive bad feelings and maladaptive avoidance of emotional pain. Most of the literature in the area focuses on changing bad feelings and offers little information on emotional pain. In the following discussion, the focus is on the nature and unique characteristics of emotional pain and implications for treatment, especially in relation to trauma.

Painful Emotional Experience

Emotional pain is a complex, bodily felt experience of damage or trauma to the self. The pain can be experienced in the heart, head, stomach, or other parts of the body. People refer to feeling shattered, broken (thus a broken heart), ripped, or torn apart; having gaping wounds; and feeling empty and hopeless (Bolger, 1996). Subjective reports of pain suggest that the primary emotions of anger, sadness, and shame can be connected with pain, anguish, and overwhelming hurt. When experiencing emotional pain, people feel out of control, overwhelmed, and weak and fear being unable to stop crying. Emo-

tional pain can be extremely frightening, partly because of the sensation of losing control. Pain is aversive, and it is avoided, along with the emotions associated with the painful experience. When pain becomes unbearable, people freeze up and numb themselves. They detach, shut off, disconnect, and dissociate. These responses are frequently observed in trauma-related disturbances. However, allowing pain that previously has been avoided, although initially frightening, often leads to relief and feelings of being alive, connected, and letting go. Experiencing painful emotion has healing properties and leads to change. The treatment challenge, therefore, is to facilitate the client's allowing of adaptive emotional pain.

The adaptive function of emotional pain differs from that of the primary emotions. Primary emotions have an anticipatory function or escape value. They are designed to promote action that prevents undesirable occurrences. Pain, however, possesses survival value by teaching one to avoid things in the future that have been discovered to hurt or be harmful. Pain is protective only after the painful event has occurred. Primary emotions, such as fear and anger, clearly alert us to impending dangers and threats and prepare us to meet them. Pain tells us that something bad has happened and teaches us to avoid it happening again. Rather than use emotional pain as a signal of harm that requires attention and repair, we learn to avoid it, particularly if there is no support for enduring the pain and no experience of benefiting from it. Intense psychological pain is accompanied by a fear of shattering or annihilating the self, and people therefore attempt to escape annihilation by cutting off the associated feelings. Again, the painful feelings that are cut off are primary adaptive emotions, such as anger at the violation and betrayal and sadness at the loss.

Thus, emotional pain provides valuable survival-oriented information. Initially, it is ego-protective but, if chronic, avoidance of painful emotions is not adaptive because it cuts one off from one's primary orientation and response system. Again, in the case of trauma, avoidance is thought to perpetuate the more distressing symptoms of PTSD, such as flashbacks, nightmares, and hyperarousal, and prevents the trauma from being fully processed. The trauma remains an "unfinished business," pressing from completion and integration and intruding on current awareness. For example, children who grow up in abusive environments learn to cope with the pain of the abuse by pushing it away through dissociation. They did not have learning experiences whereby they could internalize the soothing of an attachment figure and, therefore, did not develop self-soothing or emotion regulation skills. Those parts of self that contain the traumatic feelings, memories, and thoughts are blocked from awareness. Through prolonged exposure to interpersonal violence in early development, children learn that it is dangerous to be vulnerable and open about their feelings. They learn not to trust others and avoid seeking comfort from others or relying on others. With limited external supports and internal

regulatory resources, they suppress their own painful feelings of sadness at loss and anger at violation and betrayal and become increasingly unaware of them or alexithymic. Again, they are cut off from their primary orienting and response system.

Under those circumstances, avoidance is the only coping strategy available to protect from being overwhelmed. Thus the rage, pain, and anguish of being abused are disassociated to protect the person from conscious awareness of the painful situation. However, the disavowed experience continues to influence perceptions and behavior at a preconscious level (Bowlby, 1988). The person may feel afraid without knowing why or feel nothing at all. These split-off experiences need to be reexperienced and reowned in therapy and worked through from an adult perspective. The trauma that is frozen in memory can be changed by being reexperienced and forming new and adaptive associations. Treatment needs to facilitate the reprocessing of emotional information, and that can only be accomplished by allowing the painful feelings. The act of confronting trauma memories has been found to reduce the physiological and cognitive work of inhibiting trauma-related thoughts and feelings (Pennebaker, 1986).

Research on exposure treatment for PTSD from rape supports the central role of allowing pain in the process of changing trauma-related disturbance (Jaycox, Foa, & Morral, 1998). Higher client ratings on the Subjective Units of Distress Scale, which measures the degree of psychological distress (pain), during exposure sessions were associated with reduced symptomatology at outcome. Similar findings emerged in emotion-focused therapy for the long-term effects of traumatic child abuse. Paivio, Tran, and Jellis (1998) contended that higher levels of psychological and emotional engagement in imaginal confrontation of abusive and neglectful others, early in therapy, were associated with better outcome. Their research supports the view that allowing the painful experience of trauma is associated with change. However, findings from those studies also suggest that people vary in their willingness and capacity to allow such painful experiences. Therefore, as clinicians, we need to understand the process of overcoming fear and avoidance of a painful experience in order to help clients approach and allow it.

Allowing and Accepting Painful Experience

In allowing and accepting emotional pain, the dreaded feeling needs to be approached, rather than avoided. This is similar to the process of approaching bad feelings, except that the change process involves less exploration and unpacking of the underlying cognitive–affective processes. Approaching emotional pain sets in motion a process that leads to further emotional processing. It is feeling the painful feelings, such as those associated with grief, and the

creation of new meaning from that experience that results in completion, relief, and change. Facing pain requires overcoming fear of the self being shattered, at least enough to risk approaching the pain. Taking that risk regarding trauma-related feelings can be safely accomplished only if the experience can be contained. That requires a therapeutic context of regulation and support to protect the client from feeling overwhelmed and accurate labeling of the experience to create a safe distance from it. Emotional processing of painful experience is a type of exposure treatment—an exposure to the pain in order to change elements of the pain-producing structure. In experiential therapy for trauma, the emphasis is on creation of new meaning rather than simple habituation by learning that the pain can be tolerated.

From a phenomenological perspective, in coming to deal with core-dreaded painful aspects of self or with bad feelings, people do learn that they can survive what they previously believed was unendurable. By living through the experience they face their own existential death and are reborn. The critical differences from a typical behavioral approach to exposure are as follows: (a) Facing painful or bad feelings is exposure to previously avoided internal experience rather than to an avoided external stimulus; (b) there is a change in meaning rather than a change in conditioning; and (c) novelty is introduced by accessing new internal affective information and from new interpersonal learning with the therapist, rather than by engaging in new behavior.

The therapeutic relationship and engagement in experiential interventions, such as imaginal confrontation and enactments, are vehicles for accessing this new information. The interventions have behavioral components that provide more complex and multimodal experiences than do imaginal exposure or cognitive restructuring alone. The experiential interventions seem particularly well-suited for addressing the complex disturbances stemming from repeated and prolonged abuse in early attachment relationships.

In sum, solutions to the problems of emotional pain do not lie in understanding the sources of the pain (e.g., the losses suffered), which often are only too evident. Rather, change comes by allowing and accepting the previously avoided painful feelings and by experiencing and expressing the feelings to live them through to completion. The transformation that occurs in allowing painful feelings has been one of the most undocumented processes of psychological healing. The process of resolving pain is a complex one, involving a variety of processes and can result in both relief and enduring change. Although allowing and accepting painful feelings relies on some organismic muscular release and neurochemical recuperative process (experienced as the ability to "go on" after having suffered the pain), it is not just the release of feeling and relief that leads to change. That experience also involves change at a cognitive level.

A model of pain resolution has been developed and is based on intensive

analyses of the therapeutic resolution of painful experience (Bolger, 1996; Greenberg & Safran, 1987; Greenberg & Paivio, 1997). The model, with its components, is shown in Figure 1. According to the model, the therapeutic resolution of painful experience is a stage process. Acknowledging the painful feelings is an early step in the process in which the previously avoided painful feelings first must be approached, allowed, and accepted as part of oneself. The decision to approach, for the first time, that which has been previously avoided involves both intentional and attentional processes. This is a change in internal relations that results in reowning a previously avoided experience with an increased sense of agency in the feeling. Agency (i.e., I chose to allow this, and I am the one who is feeling this) offers a form of containment or control over the feeling. That helps create a safe distance from it and allows the attendant need or affective goal (e.g., to seek comfort) to be mobilized. The accessed need is a healthy internal resource that can help combat or challenge maladaptive processes and cognitions that were preventing or causing the pain. The process of facing pain, accessing needs, and combating dysfunctional beliefs results in a sense of relief and the adoption of a more self-nurturing and self-affirming stance. Thus, the tolerance of the pain plus an internal reorganization result in change.

Having accepted the previously avoided feeling and survived the experience, people no longer rigidly attend to threat cues signaling the emergence of the dreaded feeling; nor do they focus solely on attempting to escape. Rather, now they are more flexible and open to new information. The conditions and opportunity for novelty, for seeing new possibilities and creating new meaning, now exist. By attending to, rather than avoiding, their internal experience, people begin to access previously inaccessible resources and to look for novel ways of coping. It is the shift to accessing organismic needs, and the survival and growth motivation of the essential self, that provides the basis for new coping. Knowing what one wants and needs is a first step in empowering the individual to act on his or her own behalf to get those needs met. The nurturing and support needed to face painful feelings can be obtained internally, in the form of self-soothing and self-affirmation, and interactionally, in the form of asking for support from others or defining personal boundaries.

This process of allowing and accepting pain, therefore, requires that the pain be evoked in the session and lived through, not just talked about. That new experience restructures the pain-producing emotion schemes.

Two sources of new experience are critical in dealing with pain in the here and now: (a) the safe, valued presence of the therapist whose comfort, validation, and soothing presence is internalized (Greenberg, Rice, & Elliott, 1993), and (b) the disembedding of oneself from the pain so that one can view it and how it was created from a distance and then reflect on it. With the help of these two aids—interpersonal support and an internal shift in perspective—

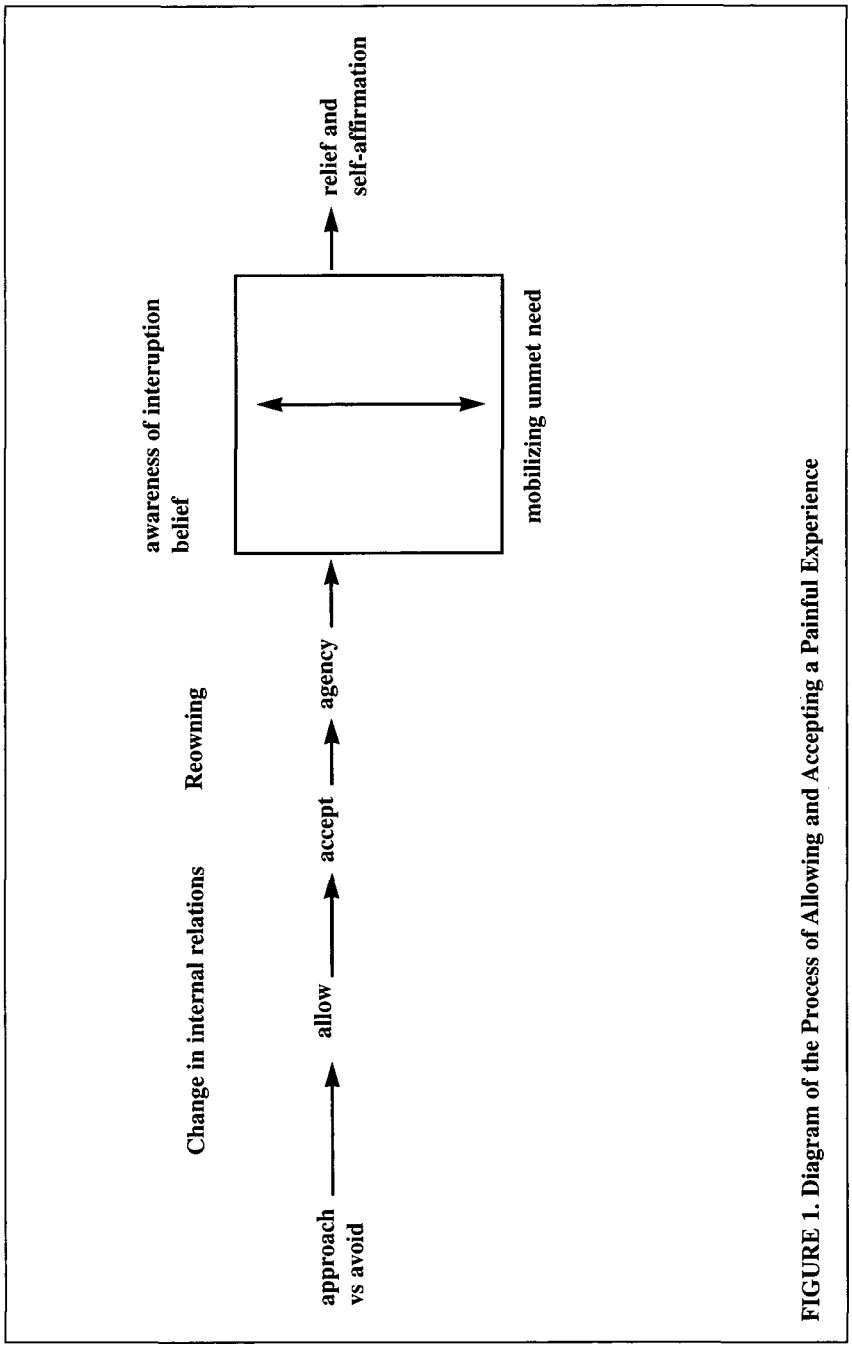

FIGURE 1. Diagram of the Process of Allowing and Accepting a Painful Experience

one is able to access and develop a more self-nurturing and affirming set of functions.

In working with pain, therapists need to promote the previously mentioned steps of resolving pain, using the emotionally focused intervention principles of attending to internal experience, intensifying affective arousal, and symbolizing (articulating, enacting) the meaning of experience. That can be accomplished only in an environmental context of safety and support so that the person is able to take such risks. Ultimately, allowing emotional pain is a deliberate decision (intentionality) to risk doing something different, and therapy must create a context that facilitates and reinforces that decision.

Client Experiences

A further source of data for refining and validating the performance model is clients' recall of their subjective experience of allowing pain. The following data were collected by means of interpersonal process recall (IPR) interviews in which the client reviews, with a researcher, videotaped episodes of the therapy sessions in which they engaged in particular processes. The client, then, is asked to recall his or her internal experience at important moments in the episode. Clients' descriptions of their experience of allowing painful feelings is largely consistent with the observational model, presented in Figure 1. Categories of client experience that support the model are avoidance, allowing, owning, interruptive belief, relief, and self-affirmation. Additional categories that emerged from grounded theory analysis of the client's reports enrich the model with information about the client's subjective internal experience of this change event. The additional categories are control and reason–emotion polarity, struggle to allow, and awareness and questioning of interruption.

Examples of recall data in each of these categories are presented for three clients who engaged in an episode of allowing painful emotion. The clients were in therapy (Paivio & Greenberg, 1995) to resolve painful and traumatic interpersonal issues from the past, namely unfinished business with a significant other.

Avoidance

Client 1: I remember quite often staring at that cloth (on the wall) and my mind would just blank, total blank. Couldn't draw out a thought, couldn't draw out an emotion.

Client 2: I was afraid. It was sort of like going back 25 years and feeling the pain again, only it was stronger (now) because at that time I didn't allow it to happen. I pretended that everything was fine.

Client 3: I'm avoiding, I usually avoid trying to feel it again.

Control and Reason–Emotion Polarity

Client 1: I can see there (in the video) that my head and my emotions are not in sync with each other or something. And my logic sometimes takes over and says "what can you do about it, deal with the pain and get over with it."

Client 2: The restraint has been so powerful it's almost immobilized me, I guess, when I think about it, in dealing with some of this, I feel immobilized.

Client 1: It's like I'm too rational in my approach to things, I can't, the emotions won't come out.

Client 2: This part of myself is saying don't feel, diminish. It's this internalized mother saying, "Your hurt is not important."

Client 3: But I didn't know if my head was ready to let me say it. Like, I was intellectualizing, I guess, my emotions were there, yet my head was saying something different than what was here.

Struggle to Allow

Client 1: So I really had to struggle with bringing the emotions to the surface because it's just been ground down for all these years.

Client 2: Should I talk about it, should I break down? The fear of that, I guess, was very strong, of allowing myself to, because I knew I was going to, and I wasn't sure whether I wanted that to happen.

Client 3: But I feel that I still didn't get it out. It was like I've never allowed myself to do that. And I find it very difficult sitting in the chair talking to myself (in a gestalt two-chair dialogue). Sometimes I can lose myself in it, when I get really emotional, I lose myself in it. But for the most part, I find that difficult.

Client 3: Some resistance, and also of having to build up and convince myself that it was legitimate, okay and valid to feel. One part of me sort of wants to diminish it. So when I was crying, I didn't feel, it just seemed like a natural progression from what we had been doing.

Awareness and Questioning of Interruptive Processes

Client 3: It's like just becoming aware of what I have done all these years. Um, accepting that that's what I did and saying "Okay, that's brought you pain so don't do it anymore."

More Client Reaction

The following two statements are current client reactions to seeing their in-session behavior on videotape during the IPR session, rather than reports on in-session experience. They suggest the usefulness of the IPR method, not

only as a data-gathering technique but also as an awareness-enhancing intervention that could promote client intentions to relinquish interruptive processes in the future.

Client 1: What I'm doing to myself there (in the video), it drains me when I look at that. I say, "Why are you doing that to yourself?"

Client 2: And I'm looking at it now and saying "is that what you do to yourself?" That's really what I was thinking. Is that really how you handle hurt all the time?

Allowing

Client 1: And I was feeling so much in pain that, at some point, I allowed myself to feel it and it kinda took over, you know, the emotion then took over, and I did lose myself in it. But it's not often I can do that.

Client 3: As soon as I was feeling it, it just came flooding back with such force I thought "Gee, there's no reason to resist this." When I cried, it just flooded into me.

Owning

Client 1: I said, "It was me! That was me!" That's what struck me that, don't forget that was me, because my way of coping, all the way along, has been to say this, almost that that wasn't me.

Dysfunctional Belief

Client 1: I'm afraid I'm going to, that I wouldn't stop, that I'd lose it. I'd lose it. If I let myself go there, I would lose it.

Client 2: My belief that I couldn't show my vulnerable side you know. Once I did do that I realized that the world doesn't change, that it's very permissible for me to do that. And how the other person takes it is not my concern. It's how I feel about it myself that's of importance.

Relief

Client 1: I was so completely and totally drained, but I felt like a burden had lifted, like I was carrying something here (points to chest) and it lightened, that feeling.

Client 2: Yes, because I can remember when it was over that it was a sense of sort of relief about having said how I felt about that situation, about him.

Client 3: Felt immense relief and release. I don't have to keep this emotion down and away, just let it be, not suppress it.

Self-Affirmation

Client 2: I don't know, memories were opened up, and I felt that it was okay to cry and that these feelings of mine were legitimate.

Summary Statements

Client 1: What shifted was I allowed myself to really feel the pain of what I went through when my husband just simply walked away. I never really dealt with that pain before, I don't think I've ever dealt with it like that. I don't think I felt it so strongly as I did. It was almost like a revelation that, was I in that much pain that I would feel that deeply and feel that hurt. And I felt a sense of relief. That was a good feeling. That was probably the biggest change.

Client 3: I just feel like I've been walking around all this time with stuff buried, and it's so great to release it, acknowledge it, and come to terms with it. This has been invaluable, I have felt so optimistic.

Conclusion

One key aspect that operates in working with emotion in therapy is the allowing of the previously inhibited painful experience. That phenomenon is particularly salient to therapeutic work with trauma survivors because that work relies on reexperiencing of trauma material as a mechanism of change. The experience of allowing emotional pain appears to facilitate change through three necessary processes: a change in internal relations, a reowning of experience, and an increased sense of agency. The change in internal relations involves a move from avoidance and negative evaluation of the painful experience to an accepting stance. Painful, bad, and hopeless feelings are products of internal relations. The person's new acts of intentionally approaching, attending to, and accepting or positively evaluating one's pain lead to its transformation.

Reowning is the process of identifying with feelings and associated thoughts, memories, needs, and action tendencies that have been disowned or disavowed. Disowned experience, although not integrated into the dominant self-organization, continues to influence behavior. People tend to deal with the unacceptable by depersonalizing their feelings and not experiencing them as their own, thus weakening their self-organization. Therapy can be understood, not so much as a process of bringing previously unconscious material into consciousness, but more as a process of reclaiming disowned experience and creating new meaning from it. Gestalt therapists (Perls et al., 1951), for example, use deliberate awareness interventions to promote experiences of "It is me who is thinking, feeling, needing, wanting, or doing this." People can

distinguish between the conceptual processing of information at an intellectual level, and the experiential linking of that information to the self (Greenberg, et al., 1993). It is the latter that is important in therapeutic change.

Finally, an increased sense of agency results from the two processes. With reowning comes an increased sense of self in relation to a domain of experience. Hope develops as one senses that "It is I who is feeling this, it is I who is an agent in this feeling" and then "it is I who can do something about this." Although a sense of agency may not yet provide a concrete plan of action, there is a feeling of mastery, self-control, and confidence that action is possible and that change can occur.

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