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Uncovering and Resolving Social Conflicts Contributing to Chronic Pain: Emotional Awareness and Expression Therapy

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Abstract
Chronic pain is pain experienced on most days for three months or more. It is one of the most frequent patient reported problems. It can be a primary or a secondary symptom. A number of psychological factors predict the development and impact of chronic pain. Adverse social experiences as well as stressful conflictual interpersonal interactions can precipitate and exacerbate chronic pain. Emotional awareness and expression therapy (EAET) is an approach to addressing interpersonal and emotional conflict with patients with chronic pain. The core principles of EAET and the life stress interview protocol are described and illustrated.

Keywords Chronic pain · Psychosocial stressors · Adverse childhood experiences · Social conflict · Treatment of pain · Emotional awareness · Emotional expression

Clinical Vignette

Patrick[1] is a single, 45-year-old male who presents with widespread chronic pain that has become intolerable. His GP cannot find any physical reason for the current exacerbation of his pain and consequent disability—and made the referral for an assessment. His pain started in his 20s when he experienced a number of sports injuries (football, motorbike racing). His also reports poor health habits (he contracted Hepatitis C from intravenous drug use, was homeless for a period, and reportedly drank excessively). Patrick reports that his spinal pain didn't initially bother him enough to seek treatment because it did not interfere with his ability to function for most of his life. He was a self-taught musician, consistently employed, and a full-time caretaker for his mother at the end of her life. Recently, however, Patrick's pain spread to "every inch" of his body. It has become unmanageable—preventing him from looking after himself and leaving him socially isolated, depressed, and anxious. Patrick reports that he was routinely neglected and emotionally abused by his mother after his father was "kicked out." Patrick did not see his father again until he was in his 20s. Patrick has not had a close, intimate partnership with a woman in his adult life. He lives with and cares for his brother who has a disability. You think to yourself how unkind life has been to him and how unkind he has been to himself. Yet, he regularly goes an extra step to take care of others. How can you best help him with his current situation, pain, and difficult interpersonal interactions?

[1] "Patrick" is not a specific patient but represents a patient with a history we commonly see.

Clinical Challenge

The Nature of Chronic Pain

Chronic pain is defined as pain experienced on most days for three months or more (Deyo et al., 2014). Chronic pain may occur as a result of injury (e.g., orthopedic trauma or repetitive musculoskeletal strain), surgery (e.g., chronic post-surgical pain), disease (e.g., diabetic neuropathy), or the treatment of disease (e.g., chemotherapy-induced neuropathy). Chronic pain may also be a secondary symptom of another chronic health condition. Patients with cancer, endometriosis, or diabetes may develop chronic pain as their disease progresses.

Chronic pain may also manifest as a *primary* disease state originating in the brain and spinal cord (a process called "central sensitization") (Nicholas et al., 2019). Primary pain conditions include irritable bowel syndrome, chronic pelvic pain, temporomandibular disorder, chronic orofacial pain (headaches and migraines), fibromyalgia, and non-specific low back pain. There is some evidence indicating that primary pain conditions are associated with higher levels of

disability, greater emotional distress, and increased disruption to social relationships than chronic pain that is secondary to injury or disease (Kouyanou et al., 1998; McWilliams, 2017; Schroeter et al., 2015; Vranceanu et al., 2008; Walker et al., 1997). Nevertheless, a wide range of chronic pain conditions—both primary and secondary in origin—benefit from psychological treatments that help people manage cognitive, behavioral, social and/or emotional contributors to pain and disability.

Prevalence and Impact of Chronic Pain

Chronic pain is very common—affecting approximately one in five adults in developed countries (Dahlhamer et al., 2018). Slightly over 50% of older adults living in the community report experiencing bothersome pain in the preceding month (Patel et al., 2013). Chronic pain accounts for 35% of pediatric health care visits and 10–16% of emergency department admissions (Bernard and Wright, 2004; Todd et al., 2010).

The impact of chronic pain on individuals' daily functioning and quality of life varies widely. Many people living with chronic pain are able to manage their symptoms with little to no medical intervention and can function without limitations. However, it is estimated that 8–14% of the US population experience what is termed "high impact chronic pain." High impact chronic pain is characterised by more severe pain that interferes significantly with work, self-care activities, social integration, and social role functioning (Dahlhamer et al., 2018; Pitcher et al., 2019). In turn, higher levels of disability are associated with worse quality of life, worse mental and physical health, a higher number of co-morbid health conditions, and a higher incidence of pain-related cognitive impairment.

Psychological and Social Contributors to Chronic Pain

A number of psychological factors predict the development and impact of chronic pain. Emotional distress (anxiety and depression), fear of pain (pain catastrophizing), perceived inability to cope with pain (pain self-efficacy), and fear that movement will induce pain (kinesophobia) predict the chronification of pain after injury (Edwards et al., 2016). Injury itself does not necessarily predict the development of persistent pain, but the psychological condition of the injured worker/person has been shown to impact the trajectory of pain. These psychological contributors are often the focus of interventions aimed at preventing and managing chronic pain associated with injury, surgery, or disease.

In addition to these psychological risk factors, adverse social experiences increase individuals' risk of developing high-impact chronic pain. Adverse social experiences include living in poverty, homelessness, and residing in neighborhoods with high levels of violent crime. Most commonly, however, adverse social experiences are interpersonal in nature and include relationship conflict (particularly with primary caregivers), being a victim of neglect, bullying, discrimination, or abuse, experiences of inequality or oppression, and growing up in a chaotic or unpredictable home environment (Cronholm et al., 2015; Nelson et al., 2018). To the extent that these social conflicts cause individuals ongoing emotional distress, they can escalate the chances of developing chronic pain, and can exacerbate the severity and impact of chronic pain on people's lives.

The Relationship Between Social Conflict and Pain

The experience of current or unresolved social conflicts can precipitate and exacerbate chronic pain in a number of ways. The repeated experience of social conflict undermines individuals' sense of self-worth and willingness to ask for and receive care and support from others (Simpson, 2007). Consequently, people who report low self-worth and low trust in others exhibit higher pain sensitivity, lower levels of pain tolerance, are less likely to receive social support following injury, and are more likely to develop persistent pain and disability (Åslund et al., 2010; Guite et al., 2007; Krahé et al., 2013).

Moreover, current or unresolved social conflicts can cause feelings of loneliness, depression, anxiety, and anger. These emotions, in turn, are associated with increased pain sensitivity and higher levels of catastrophising, which both predispose individuals to develop chronic disabling pain, and work to maintain and exacerbate chronic pain on a day to day basis (Wolf & Davis, 2014; Sturgeon & Zautra, 2016).

Further, the experience of "social pain" may contribute to the experience of physical pain by exacerbating inflammatory responses in the body. Social stressors increase circulation of proinflammatory cytokines like Interleukin-6 and long-term hyper(re)activity of corticotrophin releasing factor (CRF), both of which are associated with the development of chronic pain (Francis et al., 1999; Heard-Garris et al., 2020). Research suggests that current or unresolved social conflicts may also exacerbate chronic pain by priming the brain to perceive bodily sensations as threatening (and painful) (Karos et al., 2018).

Addressing Social Conflicts in the Treatment of Pain

The role of current or unresolved social conflicts in chronic pain and disability is important to explore and address in pain management. Psychological treatments for pain do not, however, typically deal with the social conflicts that contribute to individuals' pain experience and coping strategies. The most common (and most often studied) psychological interventions for chronic pain are cognitive-behavioral therapy (CBT) and

acceptance-based therapies. CBT teaches patients to manage their symptoms of pain and current experience of pain-related distress via skills training rather than identifying and addressing historical or unresolved sources of distress. Acceptance-based therapies also focus primarily on responses to stress in the present moment and encourage patients to engage in valued life activities to develop well-being while accepting (rather than resolving) their previous experiences and current pain. These approaches, while effective in helping depression and anxiety, do not directly target the life adversity or social conflicts that appear to be a wellspring for chronic pain.

By teaching patients to use short-term emotion regulation strategies, such as suppression, distraction, and intellectualization, CBT can be effective in providing patients with a means of coping with pain in the present moment. However, these therapeutic strategies may inadvertently contribute to the longer term maintenance of chronic pain by helping patients to disengage from or avoid processing and resolving traumatic memories, coping with real life adversity, and resolving interpersonal conflicts. Consistent with this, research has found that CBT approaches to chronic pain management are *least* effective for patients reporting high levels of interpersonal distress (Broderick et al., 2016). Hence, psychological interventions that directly address interpersonal conflict and social life stress hold promise for providing some longer term relief from persistent pain. Emotional awareness and expression therapy (EAET) is one such intervention. EAET directly addresses core social conflicts and sources of interpersonal distress that lead to chronic stress and consequently exacerbate and maintain persistent pain.

Emotional Awareness and Expression Therapy (EAET)

Lumley and Schubiner (2019) have developed a treatment approach aimed at addressing interpersonal and emotional conflict among patients with chronic pain, much of which is precipitated by social, namely relational (or interpersonal), conflict. The following sections describe the core principles of EAET, a life stress interview protocol, and a detailed description of the clinical process of exploring and resolving conflict in interpersonal interactions.

Core Principles of EAET

The EAET protocol has undergone several iterations that have been empirically tested. These range in format and target population, including individual format and group format, with varying number of sessions. The core principles of EAET include the following:

1. Psychoeducation: the importance of recognizing the role of the central nervous system in pain conditions.
2. Identifying the links between stress and conflict (emotional and social) in the onset or exacerbation of pain conditions.
3. Facing avoided emotion-laden situations by bringing awareness to core emotions underlying interpersonal conflict/needs, experiencing those emotions/needs, and expressing them.
4. Expressing all emotions/needs underlying a conflictual key relationship in the person's life—linking "the right emotion at the right target."
5. Identifying the key interpersonal needs that can be expressed in actual relationships.

Life Stress Interview Protocol

Ziadni et al. (2018) developed the single session version of EAET—an extended 90-minute "life stress EAET interview." It was tested in two settings: primary care among patients with medically unexplained symptoms (MUS) and in a tertiary urology center among women with various chronic pelvic pain. Improvement was noted with both patient groups, with lower pain intensity and severity, and with improvement in other but differing symptoms in each group. Thus, EAET can be used with patients with specific pain problems or non-specific pain problems. The basic steps in the Life Stress Interview Protocol are derived from the core principles of EAET and include the following:

1. Brief Psychoeducation/Presentation of Study Rationale

To begin, the therapist presents the patients with ground rules for the session(s), followed by an introduction of the rationale behind the therapeutic approach. The therapist starts by explaining that "*my role is helping you understand the potential role of stress on your health; I want to see what role, if any, stress plays in your health.*"

This is typically followed by meta-communication and encouragement for the patient due to the sensitive and vulnerable nature of the questions and session content: "*We are going to go through a variety of questions about your life, including questions about your health, relationships, and stressful life experiences. I know that some of these topics might be difficult to talk about with me, and you might not be comfortable doing so. It is normal to feel reluctant, especially because you barely know me, and you don't know how I might respond to you. But I encourage you to be honest and open with me and give it a try."* This is typically followed by an introduction of the role of the central nervous system in pain conditions, and if time allows, an introduction of the gate control theory. This is important for patients who are focused on their physical symptoms, and helps motivate them to consider the role of psychosocial factors in their pain condition.

2. Creating a Timeline: Stress History, Medical History, and Links Between the Two

The next step is to get an overview of the patient's health history, including the onset and development of symptoms and/or medical conditions from birth until now, with approximate ages. The patient is handed a sheet of paper and asked to draw a timeline with an overview of their health history. The therapist can use the following prompts and checklists to help the patient with recall: "*Tell me about what kinds of health problems you've had in your life, starting in childhood until now."* The therapist can either present the patient with a checklist of conditions or read off a list including but not limited to abdominal pains, IBS, headaches, unexplained rashes, insomnia, fibromyalgia, chronic pain, pelvic pain, PMS, TMJ, or fatigue.

The goal in this process is to help the patient to disclose, begin emotionally processing, and eventually start to develop an awareness that their physical symptoms are linked to their stress/emotions. The therapist introduces the task as follows: "*I want you to go through your life, from birth to now, telling me any stressful events or difficult experiences that you have had."* The patient is provided the space to share and is encouraged to write down the events on their timeline.

In order to ensure that the patient has tapped into key emotional and interpersonal conflict, the therapist can share a list of stressful experiences and conflicts with the patient to help with recall and awareness of conflictual experiences. "*I want you to know that many people have gone through these experiences. I will ask you about some specific events and situations that we know are not uncommon experiences for people and we want to know better what your experience with these situations is."* The therapist can present the patient with a checklist or read a list that includes, but is not limited to, childhood maltreatment, violence between family members, divorce, emotional abuse or neglect (i.e., being shamed, embarrassed, ignored, or repeatedly told that you were no good), abortion or miscarriage, caregiving for a family member or someone with a handicap, harassment in the form of sexual remarks, jokes, or demands for sexual favors, death of a loved one, and so forth. Many of these core conflicts are of interpersonal nature or are likely to lead to interpersonal tension and conflict.

3. Identifying Core Emotional and Social Conflicts in Patients' Lives

During this portion of the session, the therapist aims to identify the patient's core conflicts or private struggles beyond the major stressful life events. The therapist may go one step further and inquire about any secrets, conflicts, or private struggles: "*I would like you to share something you never shared before or haven't shared with me, maybe something private like a secret. You don't know me well, or how I might respond, but I encourage you to be honest and open with me. I can understand if you feel reluctant to share that with me, but I really encourage you to give it a try, even if it is difficult or embarrassing or upsetting."*

Again, the therapist may use a checklist to facilitate awareness and disclosure. The checklist typically includes private conflicts and psychological consequences of these conflicts. Examples of private conflicts include struggles over sexual behaviors, identity of relationships, not fitting in or feeling ostracized, feeling inferior to siblings or other relatives, and resentment or anger towards family members, religious leaders, or neighbors. Psychological consequences of these conflicts include feeling pressure to be perfect, disappointing people, getting too close to people, avoiding people or memories, feeling loss and abandonment, never feeling loved or cared for, not trusting others, avoiding being too close or being too close with others, never feeling good enough, having to "earn" love from parents, or feeling criticized much of the time.

At this point in the session, the therapist also checks in with the patient regarding their physical symptoms: "*How would you rate your physical symptoms right now, on a scale from 0-10; 0(no pain), 10(worst pain)."* The goal of the check-in is to help raise the patient's awareness about their physical symptoms, and how these symptoms may get worse with recalling and recounting stressful life events. This will begin to demonstrate the connection between stress (emotional and relational) and physical health in session.

4. Creating Awareness of Emotional/Relational Conflict and Experiencing or Expressing Needs

The therapist may review material covered to this point in the session (or in the previous session, if more than one session is needed). This might also include re-stating the rationale and connection between stress and health. The therapist applauds the patient for recognizing conflict and sharing vulnerable information: "*Thank you for sharing those experiences with me. That was very brave of you."* The therapist explains that these private conflicts and struggles normally show up in what patients say and do with other people in their lives. The therapist then introduces the concept of an "Emotions Flow Chart" and discusses the model linking emotional suppression (which results in suppressing interpersonal needs) and emotional expression to health.

The basic principle of the model is that there are two core interpersonal domains/needs: agency (independence, assertiveness, power) and communion (love, connecting, trust). Everyone has these two core interpersonal needs. The first domain/need speaks to individuals' need to be independent, strong, even powerful, to take care of and protect ourselves, and to push others away if they are hurting or victimizing us. The second domain/need is that to be loved, accepted and

cared for, and to be able to trust and connect to others. The therapist explains that these two needs show up in our important and key relationships (e.g., parents, siblings, primary caregivers, loved ones). Ideally people should be free to express both needs, but what usually happens is that it is hard to do so, at least in some key relationships.

A general demonstration may be applied (or not) prior to proceeding to the specific demonstration. The general demonstration entails having the patient show what it is like for them to express both of the aforementioned domains/needs, "*show me what it would look like to use voice, tone, and body to engage in assertiveness and being powerful, and the other side of caring, connection, and love.* When it comes to communion, this can be accomplished by asking the patient to demonstrate how they express sadness, or love, or longing for someone.

If the patient experiences difficulty, some questions can be used to facilitate the demonstration. For example *"what words or sayings can you share that help bring you closer to another person, to connect with them?" "what tone do you have in your voice" and "what posture do you show with your body and face?"*

Similarly, for the second aspect agency, the patient can be asked *"what are some of the words that you use when you mean that you are strong, powerful or independent?" "how can your voice show power and strength?" and "what posture can you use to show power or strength?"* The therapist may check in with the patient about how they are feeling, and the difficulty of this exercise for them. The therapist may also conduct a check-in on the patient's pain levels. The overarching goal of this exercise is to prime the patient for accessing the tools for expressing their core emotional and interpersonal needs in a safe and non-threatening context.

The therapist then moves to a specific demonstration, which focuses on accessing core emotional/interpersonal needs as it pertains to key conflictual relationships. In session, the patient is encouraged to recall a conflict person/situation and express their underlying emotion/needs to this person (imagined or remembered). This expression amplifies their emotional experience, gives voice to avoided needs and emotions, and reduces avoidance and fear of expression. This intense emotional expression is clinically powerful and helps the patient face demons from their past, "rescript" their story, and communicate their needs in core relationships. This corrective experience, albeit intense, is healing to the patient and addresses the trauma and conflict underlying their pain condition.

The therapist starts by explaining the rationale behind the upcoming experiential exercise, and how stress often results when the two domains conflict with each other or are suppressed. Stress is often being trapped when you have these important things to be expressed, but you feel stuck—that it is wrong or dangerous to express them. To dismantle fear or anxiety, the therapist assures the patient, "*you are doing these things in this private meeting, this doesn't mean that we are encouraging you to do them in your relationships. The goal here is to have you 'try on' new ways of expressing yourself."*

The therapist then encourages the patient to identify a key conflictual relationship, inquires about the patient's needs in this relationship, and asks the patient to demonstrate their ability to express both needs in the context of this relationship. The therapist encourages the patient to dig deeper and access the raw primary emotions that underlie their needs by asking probing questions such as *"show me what it looks like to be angry with person X, or loving and vulnerable with person X."*

The therapist takes the patient through a test run of expressing these important primary emotions that underlie their interpersonal needs. The exercise is repeated with a second key conflicted relationship in the patient's life and takes them through expressing their emotions to this individual. The therapist identifies the domain that seems more challenging for the patient and helps them access these emotions, normalizes them, and pushes the patient to express the full range of the emotional experience.

At the end of this intense experiential exercise, the therapist checks in with the patient by asking if the exercise was challenging, and may ask the patient to rate their physical symptoms or their pain on a scale from 0-10 (with 0 meaning no pain, and 10 meaning worse pain). If the patient engages fully in the experiential and expression exercise, it is expected that they will experience relief and a reduction in physical symptoms. If the patient reports some pain at this stage, the therapist can inquire if there are remaining emotions that need expressing and can encourage the patient to access and express the full range of these emotions.

5. Practicing Assertive Communication in the Context of a Conflictual Relationship

During the last portion of the single session (and the last session of a brief series of sessions), the therapist reviews the material covered and guides the patient to utilize the acquired skills in real life situations by practicing assertive communication.

The therapist begins by inquiring about the patient's experience and may ask *"what have you discovered about yourself? Your symptoms? The connections?"* The therapist may also elicit feedback regarding the experiential exercise by asking *"how did you feel about the experiential exercise? What were your reactions? Likes/dislikes?"* This gives the patient an opportunity to reflect on the experience and their own reactions and self-discoveries.

Next, the therapist may offer feedback regarding the patient's process, typically as a hypothesis "*this is an area of strength, this is an area of strength. Seems like expression of anger is anxiety provoking for you, that's pretty common, it may be beneficial for you to work on it and get more*

comfortable about expressing anger in conflictual relationships where you have been hurt or victimized."

Later in the session, the therapist guides the patient to express a balanced message in conflictual relationships by giving voice to both domains/needs. The therapist may provide some basic tips regarding assertive communication in that it differs from aggressive or passive communication and represents a healthy and balanced messaging. The patient will practice assertive communication in session that includes a balanced expression of both agency and communion needs. This exercise may occur in the context of a current relationship, or with a deceased person, as the goal is to empower patients to express their interpersonal needs regardless of the responsiveness of the other person.

At the end of this exercise, the therapist wraps up the session and reiterates the importance of engaging in assertive communication, "*for many people, the stress of keeping things suppressed actually contributes to their physical symptoms, and that relief from symptoms happens when they are able to express their genuine feelings. This can be done in writing, privately when you are alone, and even directly to a person, though when you do that, you usually need to communicate more gently, both of your needs (love and power).*"

Applying EAET in Diverse Healthcare Settings With Diverse Problems

EAET has been tested in a number of formats (ranging from one to eight sessions), treatment settings (e.g., primary care, outpatient clinics; individual vs. group sessions), and with patients presenting with a variety of pain conditions (e.g., fibromyalgia, primary centralized pain, pelvic pain, irritable bowel syndrome, head pain, non-specific musculoskeletal pain). These trials indicate that EAET can be an effective treatment in diverse healthcare settings with a variety of patient groups.

Low attrition rates observed by the researchers (Lumley & Schubiner, 2019) suggest that most patients have been open to this emotion-focused approach to addressing sources of life stress and treating chronic pain. But, it should be noted that all published trials of EAET to date have been with exclusively well-educated and self-selected female samples (motivated and open to the idea of practicing emotional awareness and expression). Research is needed with more socioeconomically diverse groups and with males.

While the format of EAET delivered in research trials was designed to be distinct from comparison treatment arms (cognitive-behavioral and acceptance-based treatments), Lumley and Schubiner (2019) suggest that EAET may be equally, if not more, effective if integrated with other evidence-based pain management strategies such as pacing, desensitization, relaxation, and mindfulness. Since EAET is delivered in a manner similar to other psychological therapies (individually or in groups, in primary care or outpatient clinic settings), it is conceivable that EAET techniques can be easily integrated with other psychological approaches to the treatment of chronic pain conditions

EAET has been studied in several formats, including an online version. The treatment has established efficacy among patients with chronic pain, with a recent application in the VA setting among veteran men with chronic pain (Jazi et al., 2019). This treatment lends itself to inpatient rehabilitation programs for pain. However, it has not yet been systematically studied in other non-pain outpatient settings.

We have attempted to implement this treatment at a methadone clinic by training substance abuse counselors to provide EAET with highly complex, heroin-addicted patients. However, there were significant challenges in training the drug abuse counselors. They experienced difficulty in understanding and implementing the treatment with patients who presented multiple problems and complex lives.

Primary pain conditions have been the target of most documented trials of EAET, so its effectiveness for chronic pain conditions that are secondary to disease, illness, or injury requires further testing. For example, it is not known whether EAET would be acceptable or helpful to cancer survivors living with persistent pain associated with the treatment of cancer. EAET has not been tried with patients with neuropathic pain conditions. However, research suggests that the psychological characteristics of this pain population are not different from those of people living with primary pain conditions (Hush et al., under review).

We do not believe that EAET would be appropriate for the psychological treatment of pediatric chronic pain. Certainly, it will be important to address and provide psychological support for children coping with social threats (e.g., sexual abuse, bullying, parental anxiety). However, EAET may activate more negative emotions than younger patients are able to tolerate. Emotional regulation skills training might be more beneficial.

EAET is probably not a good "fit" for every therapist. Many clinicians find intense emotional expression by patients to be distressing. Cognitive behavioral therapies offer clinicians a certain degree of control over patient interactions. CBT offers clinicians strategies for helping patients regulate their emotional expression and re-appraise situations in order to change patients' emotions. EAET uses a different approach.

Emotion-focused therapies, like EAET, encourage patients to feel, acknowledge, accept, and express their emotions. There is no expectation that patients should change the way they feel—only how they communicate the way they feel. Hence, EAET requires therapists to "sit with" intense patient emotions rather than play an active role in the regulation of patient emotions. This can be challenging. It may conflict with

therapists' motivation to sooth and heal. Supervision is recommended. EAET is emotionally demanding on therapists, and without clinical supervision and guidance, may be associated with an increased risk of emotional exhaustion or burnout.

Thinking About Patrick From an EAET Perspective

Let us return to our opening vignette and think about Patrick and his life's journal from the perspective of EAET. We note several early childhood adversities and continuing social threats and physical challenges during adulthood. Unresolved feelings and unexpressed emotions related to all of these experiences seem likely.

- Being emotionally abused and neglected by his mother after his father was "kicked out." In addition, he likely witnessed domestic violence or disputes between his parents during childhood. Also, abuse by a parent is particularly threatening because a parent is supposed to provide protection, safety, and love, all of which may impact his view on parenting and romantic relationships.
- Having an estranged relationship with his father, whom he did not see until he was in his 20s, in addition to being emotionally abused by his mother resembles neglect/abandonment by both parents—two people who failed the patient in their roles as parents.
- Lack of intimacy throughout his adult life. This is likely a result of feeling unloved or unworthy (from messages during childhood) and/or witnessing domestic violence between parents, all of which could interfere with his ability and desire to initiate or maintain a romantic relationship.
- Patrick puts others before himself, and cares for others before caring for himself. The tendency to put others' needs before one's own needs can stem from feeling unworthy of receiving care and love.

Wrapping Up

The EAET approach can benefit patients in a number of ways:

- EAET can help patients identify relationship conflict throughout their life and the links between these stressors and physical health/symptoms.
- EAET can help patients face avoided emotions by bringing awareness to core emotions underlying their conflict with others over the course of their life.
- EAET can help patients experience these emotions/needs in their body and express them in the safety of the therapeutic relationship. This means expressing/giving voice to the range of emotional and interpersonal needs underlying core conflictual relationships.
- EAET can help patients identify their key interpersonal needs that can be expressed in actual relationships.
- EAET can provide patients with a corrective emotional experience, which may empower them, enhance their sense of self-worth, and encourage pursuit of meaningful new relationships where they are better able to recognize and express their interpersonal needs.

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