Emotional Awareness and Expression Therapy (EAET) for Fibromyalgia and Other Centralized Pain Disorders: Principles and Procedures

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In this document, we have pasted a number of our writings and thoughts about EAET and related therapeutic approaches. Pages 1 through 7 were written primarily by Mark and are overviews or brief summaries. You will find redundancies here, as he wrote variations on the theme. Pages 8 to 14 are from Howard and provide a more detailed and clinically-friendly description of the process of EAET. Finally, pages 15-17 are references to, and brief descriptions of, peer-reviewed articles supporting EAET.

In May 2019, the US Department of Health and Human Services Pain Management Best Practices Inter-agency Task Force Report listed EAET as a behavioral treatment option for chronic pain:
https://www.hhs.gov/sites/default/files/pmtf-final-report-2019-05-23.pdf

In June 2019, NPR did a story about a patient with fibromyalgia who was successfully treated with EAET. The accompanying 6-minute audio story is valuable:
https://www.npr.org/sections/health-shots/2019/06/10/727682322/can-you-reshape-your-brains-response-to-pain

Howard's patient workbook, *Unlearn Your Pain*, has been of great value to many patients, which can be found at his website (along with lots of other things): www.unlearnyourpain.com.

We are offering a training course in EAET for professionals. You can get on the waitlist for it at www.unlearnyourpain.com.

We also suggest that you look up the website of the Psychophysiological Disorders Association, which has a wealth of valuable information for providers and patients:
https://ppdassociation.org/

Goal of EAET:

Supportively (empathically) encourage (push) patients to shift from emotionally avoidant and fearful to engaging in emotional experiences, people will experience greater freedom, power, confidence, and pride. As a result, they will experience decreased and resolved stress, and their physical health will improve, and symptoms, including pain, will remit.

Core Principles and Techniques of EAET:

1) Patients need to learn that their brain—rather than their peripheral tissues—is the organ that generates or amplifies their pain and other somatic symptoms. Peripheral processes (e.g., muscle tension, autonomic dysregulation, inflammation) may contribute to pain, but even these

processes are largely controlled by the brain. Moreover, the neural pathways regulating pain and these peripheral processes are intimately tied to patients' cognitions and emotions. Discussions with patients about these principles are augmented by demonstrations that activate patients' emotions so that patients can more easily recognize their emotion-brain-pain links. Such discussions should be done with compassion so that patients understand that their pain is real, they are not weak or mentally ill, and are not to be blamed for having pain.

2) The brain has been strongly shaped by experiences throughout one's life, including painful injuries or procedures; abuse, neglect, or victimization; and interpersonal or intrapsychic conflicts. Stressful experiences can generate or amplify pain, especially when avoidance of uncomfortable experiences (trauma memories, emotional conflicts, interpersonal interactions, and even pain itself) leaves patients feeling helpless and fearful, preventing both psychological growth and the reduction of pain and other symptoms. It is important, therefore, to help patients recognize, disclose, and process their traumas and conflicts.

3) Therapy helps patients face these avoided emotion-laden situations, become aware of and experience their feelings, and adaptively express them. The two most commonly avoided emotions or drives are the need for agency, power, protection, or independence—which are activated by patients' anger and pride—and the need for relatedness, communion, attachment, or dependence—which are activated by connecting feelings such as sadness, love, and healthy guilt.

4) In therapy, patients are encouraged to recall a conflict person and situation and express their underlying emotions to the imagined / remembered other person, using words, voice tone, facial muscles, and body. Such expression amplifies emotional experience, clarifies motives, and reduces fear of expression. Patients need to express the "right emotion at the right target" rather than secondary emotions at substitute targets. Patients benefit by "rescripting" their story, accessing or creating new, adaptive emotions (e.g., anger, sadness, love) that were not originally expressed.

5) To further reduce both stress and pain, patients are encouraged to identify their needs and feelings that might be expressed in actual relationships. Healthy communication often involves a combination of assertion balanced by connecting feelings, but also may involve setting new boundaries or even distancing oneself from others. Planning for and role playing such interpersonal encounters occurs in session, followed by actual attempts in real life.

Key Practice Points:

1) Confronting or engaging an emotional experience that elicits anxiety and other inhibiting symptoms (embarrassment, tension, guilt, shame, numbness, and pain) usually means that this experience is an important target of change; that is, important emotions and relational issues need to be experienced rather than blocked / avoided.

2) It helps a lot to be an "avoidance detective." Try to be on the lookout for cognitions, behaviors, and relationships that help the person to avoid or minimize the experience and expression of their emotions, wishes, and needs—that is, detecting their defenses.

3) There are many avoided emotional experiences that hold much potential for helping patients become aware of, experience, and express their emotions, and to accept, learn from, and be motivated by their emotions. These are often subtle, so the therapist should be evaluating every action, statement, idea, and story of patients with the following thought: "What are they avoiding in their speech / thoughts / actions / relationships?"

4) The most important emotional experiences that patients avoid involve:

    a) Assertion or anger expression
    b) Intimacy, closeness, or vulnerability expression
    c) And possibly sharing secrets (which is related to vulnerability)

5) Have patients <u>engage in emotionally avoided experiences</u> that will be corrective or adaptive for them—help them unlearn past maladaptive emotional learning. They can, at first, talk about it, but help them move toward "re-experiencing" it. You can do this by:

    a. Have them elaborate their story with details, especially if the story remains vague.
    b. Have them close their eyes and tell the story in the present tense, rather than past tense. Doing this usually enlivens their emotional experience.
    c. Have them "talk to the other person" as if they were present, such as in an empty chair.
    d. Have them activate their voice, language, and bodily motions so that the emotional expression becomes more intense. Be on the look-out for "holding back" with their voice, words, or body, and try to unlock that.
    e. Model for them or show them how they might express more genuinely, fully, and powerfully.
    f. Having them write an unsent letter to the key person, at home, and then bring that back to session….and have them read it aloud.

6) Other helpful comments to deepen emotional experiences include:

    a. "What feelings or desires are you NOT experiencing, expressing, doing"?
    b. "What do you really, honestly, want to express, deep inside?"
    c. "Make a statement—don't ask. Tell that other person your feelings directly."
    d. "What do your feelings (e.g., anger, sadness, love) want or need to do to that person?"

7) Such emotional activation usually brings up one or both of the core, dysfunctional beliefs, which need to be challenged:

    a) I fear that it will turn out badly ("probability overestimation")
    b) If it does turn out badly, I won't be able to handle it ("catastrophizing")

    I think that the best way to challenge such beliefs is experientially; help patients have new experiences and then reflect on what they have learned, rather than try to "talk them out" of these beliefs in the first place.

Another Summary of Key Corrective Emotional Experiences:

1) The central corrective technique is to experience, express, and release emotions related to traumatic, victimizing, conflicted, or painful relationships. This is done in the safety of a private place or in the therapy session, but is done out loud, with voice, face, and expressions, often with some intensity, to help patients overcome their fears of expression.

2) This often progresses through the emotions of anger or rage, then often leads to guilt, sadness or longing, and sometimes love—especially with family members. However, sometimes the patient can start with connecting feelings / compassion toward the other, which will help them subsequently experience and express anger. (Note that some sources of victimization with whom the patient does not have long-standing or familial relationship often do NOT elicit the latter feelings of love or longing or sadness. For example, a date rape usually should not elicit connecting feelings.)

3) Such work usually results in relief, but therapists can help this by offering encouragement to "let go" of the person or situation. For example, "I won't allow you to hurt me anymore." The larger goal is to have patients overcome their inhibitions / emotional avoidances and free them from constrained behavior. It will be very "eye-opening" as they find that they can actually do things that they have avoided, and that terrible things do not happen. This usually activates many healthy emotions as well.

Experiential Enactments: Key situations to use these questions:

1) When patients ask "why?" of the other person ("Why did you do this to me?" or "how could you do that?"):
   Therapist: "Tell that person your feelings…don't ask "why?"

2) When patients start telling the details of a story:
   Therapist: "What are your feelings?" "What should you express directly?"

3) When patients state how much the other person has harmed, damaged, upset them ("You messed up my life!" or "I'm in pain because of you!" or "I'd rather be dead because of you!"):
   Therapist: "Tell that person what they did wrong, not how broken you are. Be stronger than that!"

4) When patients don't know what they are feeling:
   Therapist: They may need help in identifying feelings. You can state: "If I was in that situation, I might feel angry, sad, afraid, etc."

5) When patient asks questions about the program, therapist, or techniques:
   "Tell me directly, honestly, what you are feeling and what you want!"
   "Take a chance….be direct with me. Tell me."

6) What patients "balk" at confronting avoided experiences:

   Ask, "What do you fear will happen if you stop avoiding it? If you give it a try?

   This usually elicits one or both of the core incorrect / unhelpful fears: a) it will turn out bad; and/or b) I won't be able to handle it.

   Therapist can then say, "I believe that the bad thing will not happen." "I believe that you will be able to handle it." And "I believe that you will come out stronger and healthier by doing it, rather than avoiding it."

   And then the therapist should continue to gently encourage, with confidence, that the patient can do it.

Settings for Trying Corrective Emotional Experiences

It is important to realize that many or most new emotional experiences can be done in one of several settings or situations:

1) Private: This is the safest, least risky setting. There is no danger to engaging in emotional experiences in this context. Patients can do such new experiences when alone, such as by:
   a) Imaging or visualizing, perhaps with the help of stimuli in their environment (e.g., pictures or other mementos)
   b) Viewing or reading about some avoided thing
   c) Writing / journaling about avoided experiences
   d) Talking out loud; practicing new behaviors or words out loud
   e) Visiting some avoided location by oneself

2) Individual therapy: The therapist can facilitate the emotional work of the patient by encouraging and gently pushing, while also supporting and validating the patient. The therapist can set up "empty chair" exercises for the patient to express feelings to imagined / remembered people who are sources of stress or conflict. It is not uncommon for patients to "push back" on the therapist in such settings, or even become angry with the therapist for pushing them. Therapists might invite patients to express those feelings directly to the therapist, and therapists should non-defensively accept them.

3) Group therapy: In group settings, with both a therapist and other group members, emotional expression can be scarier but also more "real," because it includes other people. Such a setting is ideal for avoided experiences that involve others. But it also is safer, because all members and therapist have agreed to support each other in new behaviors, and therapist can moderate as needed.

4) Public, or in real life with important others. This is the riskiest situation, because there could be adverse consequences to expression. Here, the patient needs to take some risks, but their expression to the other person is tempered by listening, perhaps expressing both care / love as

well as setting boundaries. Assertion training is handy here, but assertion given in the context of the desire to maintain some good relationships (so the connecting feelings are also shared.)

NOTE: It is valuable to address all of these settings. The private setting allows for full expression of anger and other feelings. This full expression can include violent fantasy that unlocks subconscious blocks that create symptoms. The group setting normalizes and destigmatizes their experiences and emotions. The public setting allows for assertive action and connection but would not include full (or fantasy) expressions of anger.

Tips for therapists with training in other types of therapy

These therapy principles are quite common, cutting across many different forms of therapy.

1) If you have training in any **cognitive-behavioral "exposure" therapies** for anxiety disorders, you can use those techniques, particularly helping the patient with exposure to trauma-related stimuli (memories, places, emotions, people).

2) If you are **psychodynamic** in orientation, you are insightful about the conflicts and defense the patient uses. Instead of focusing on insight or following your patient's lead / waiting for them "go there" try to create emotional experiences in session by more directly pressing on or activating core conflicts. Borrow some of the work from the intensive short-term dynamic models.

3) If you are trained in **Acceptance and Commitment Therapy (ACT)**, help the patient to "value" experiencing emotions that have been avoided, and engage in scary but important behaviors in actual relationships. Mindfulness exercises might also be used to help the person approach emotionally difficulty memories or images and then accept feelings rather than block them.

Successful Therapists will have these 4 "C" Characteristics

Commitment: Believes in the theoretical model that emotional avoidance or suppression is unhealthy, that it causes (or at least triggers or exacerbates) the pain and other physical symptoms of the patient, and that such symptoms can be reversed by corrective emotional experiences.

Curiosity: Keeps wondering and exploring what patients are avoiding experiencing and expressing in every situation (their minds, their past, their outside relationships, their activities, and even in the room with the therapist).

Creativity: Thinks broadly of activities or experiences that patients could engage in that will help them confront rather than avoid their feelings and experiences.

Courage: Has the courage to push patients to have new emotional experiences rather than continued avoidance, even though it is scary and difficult for patients and therapists. At the same time, therapists must be able to support patients in doing this work.

Another Way to Think about EAET for Various Practitioners

1) Chronic pain is often triggered, exacerbated, or maintained by background emotional processes.

2) Difficult external and internal experiences, throughout one's life, create emotional conflict, trauma, and tension.

3) If people do not resolve such emotional struggles, they often experience a range of symptoms, including not only anxiety, depression, shame, and numbness, but also various somatic symptoms, including pain.

4) Such symptoms stem largely from various central nervous system / brain circuits. Fortunately, we believe that the brain is changeable, especially powerfully by corrective emotional experiences.

5) Our field knows a lot about how to treat fear-based problems, conflict, and trauma. Emotional disclosure, exposure, processing, and subsequent cognitive changes appear to be key.

6) There are many specific techniques to accomplish these goals, but fundamentally, it is important to "approach" rather than "avoid" emotionally-difficult experiences (memories, emotions, people, places, sensations).

7) I target two avoided adaptive or primary emotion-related needs connected to trauma or conflict, which all humans have: "agency" (autonomy, power, independence) and "communion" (attachment, connection, vulnerability, dependence). Helping people identify (become aware) and express (speak, show) these core emotions seem to be quite valuable as a way to overcome trauma and conflict, free people, enhance their adaptive capacities, and reduce various symptoms, including pain.

But whatever specific techniques one might use, I encourage people to remember the principle: **"emotional exposure" or "emotional processing" of avoided experiences**....and this will usually suffice.

From Howard Schubiner: Step-by-step description of the process of EAET for therapists

1) Explanation of the model

Our pasts cannot be changed, of course. However, we only know what our past is by our memories of the past. And, it turns out, memories are constantly changing and can be changed. You can discuss the science of memory, how false memories are easily implanted, how memories are typically changed and forgotten over time. You can note that we have the ability to literally create new or corrective memories about traumatic events. These new memories will lay on top of the old memories in our brain's memory centers, allowing the older memories to fade or have less emotional control over us.

The most powerful memories, of course, are emotional memories. Emotions are remembered in a way that lingers in our minds and in neural pathways that affect how we react to the events in our lives. This process occurs on a subconscious level and so that we are typically unaware that these old emotional reactions affect us in small or large ways in our lives.

Stressful life events, especially in our early years, usually lead to a great deal of fear and feelings of being powerless and victimized. These feelings activate the danger/alarm signal in the brain on a continual basis thus activating a kind of a hypervigilant state over time. This hypersensitized danger/alarm mechanism is much more easily triggered by stressful events that occur later in life, especially to life events that are similar in emotional tone to those that occurred earlier in life. Obviously, someone with a controlling parent might have a stronger emotional reaction to a controlling boss or spouse. These events are then likely to trigger the danger/alarm mechanism to creates pain, anxiety, depression, fatigue and other symptoms. This is the basis of psychosomatic or neural circuit induced symptoms.

In addition to fear, hurtful events tend to cause resentment, which is a normal response to being hurt. However, if we are unable to express or act on those feelings of resentment (especially since we might have been powerless at the time), these feelings held in are powerful activators of the danger/alarm mechanism, which leads to the development of pain, anxiety, depression, insomnia and fatigue. There are a variety of terms for and degrees of this resentment. Patients often refer to it as annoyance and frustration, but at its core, it's really anger and rage. This is particularly true for hurtful events that occur early in life or occurred on a regular basis. Even when the actual memories of these hurtful events are dim or the patient feels that they have already forgiven their abuser, it is often the case that these feelings of anger are there, living in the subconscious brain and danger/alarm mechanism.

Often there are guilty feelings as well, and when guilt lingers over time, it also makes physical pain worse. There are two main categories of guilt: 1) guilt about harboring anger towards someone (especially someone who the patient loves or is supposed to love, such as a parent, sibling or child) and 2) guilt for something the patient thinks they did wrong, for example, blaming themselves for somehow deserving the hurtful events. It is important to

identify these sources of guilt and address them to prevent these feelings from further activating the danger/alarm pathways leading to neural circuit induced symptoms.

Finally, there is often a great deal of sadness and grief that accompanies hurts and those are often held in, leading to increased pain and suffering. This grief is often minimized by patients, especially when they were mistreated as a child and learned that they didn't really deserved to be cared for, appreciated and loved.

Therefore, stressful life events can lead to pain and other symptoms via fear, and "held in" emotions, such as anger, guilt and sadness.

There is a way of out this fortunately. A new and emerging type of therapy helps people to reverse the held in emotions and express them in a safe and healthy way. This creates new emotions in the brain that are connected to the stressful events, which leads to feeling better and reducing the impact of those events on you. This is known as memory reconsolidation and it consists of laying down new "emotional memories" that are corrective to what happened in the past. Since our memories are constantly changing, we can take advantage of that fact by creating new memories to supersede the old ones and allow the patient to feel relieved of some of the burden they had carried.

This is done by going back to the time of the original hurt, not to relive it (which only makes things worse), but to actually change it, i.e., to change the emotions connected to it. Rather than reliving the fear and powerlessness, and abandonment, this process guides you to change it and learn to activate feelings of power, control (with anger and standing up for yourself) and feelings of caring and compassion for yourself to replace the abandonment.

For example, someone can return to a time when they were abused in some way, and allow feelings of anger to occur, and imagine (in a fantasy) standing up for yourself, speaking what you wish you had been able to say (without any pushback since this is your "new" story and you control it completely), and imagining acting to allow the anger to be expressed in some kinds of actions (which might include yelling, hitting, or getting revenge on the person in the fantasy). This often feels very good. Then you can finish the revised story in ways that allow you to move past the event.

After that, the process moves to other emotions, such as guilt (if present), sadness (if present), and compassion for yourself (and maybe for others as well). These feelings are activated, identified and addressed in turn in order to complete the process of memory reconsolidation. This is a method for reversing the neural pathways of pain that are connected to emotions.

Process

Go to the situation

Start with getting a verbal consent from the patient to begin. Explain the rationale for the process as described above. Remind them that it is up to them if they engage in this process

or not; and if they decide to go ahead, that they are in charge of the process. They can completely control the corrective experience that they create. They can stop at any time. Let them know that this is therapeutic and most people feel quite relieved when they are able to go back in time and "change" the events that were so hurtful.

Recognize that there is often a significant amount of ambivalence that may arise at this point. As they begin to remember and go back to these hurtful events, some aspects of their psyche will want to participate in this process fully, while other aspects will shy away from that. When this ambivalence arises, help them to see that it is normal to hold both sides of these psychological aspects (or parts of them) at the same time. At these times, you can use concepts of Internal Family Systems therapy to "speak" directly to these different parts and ask them to allow the others to be activated, knowing that this will be a safe process and that each of the parts will be honored and "listened to." These different parts often arise when you get to the part of the memory reconsolidation process when anger towards an abuser is activated. A part of the patient will want and need to allow that anger to be expressed, but another part may be afraid of that. See footnote regarding expression of anger.

When they are ready, ask them to go back (in their mind) to the time of the event(s), not to relive it, but to change it. Encourage them to feel whatever emotions arise as they go back in time. Or you can ask them to go to the feelings of the situation that is occurring in the present situation in their life that is hurtful.

There are usually a few responses to beginning this process. They may go the feelings of fear and helplessness, which had occurred at the time. They may access resentment and anger or may go directly to sadness and grief.

If they go to the fear, powerlessness and victimization, gently cut them off and tell them that that was the only way that they could feel then, but that this process is meant to reverse those feelings. They are not going back to relive the experiences the way they were, but rather to change them. They are going back as an observer from the distance that time has created. They are older now and wiser and more able to reflect on what happened. They are able to see what was happening and what needs to be done to correct it. They are going back to assist and help the person who they were at a younger age. They can choose not to go to fear, but to access other emotions, such as anger or sadness.

Access sadness if that arises first

Ask them what arises now. If it's sadness, encourage them to feel that sadness and grief. Allow that to sit with them for a few moments. Validate that it is very sad for the person who was hurt in that way. Help them see that the tears they are shedding are for them, because they care about their younger self and want to help her/him.

Ask them to imagine their grown-up self (current self) going back in time to their younger self. See if they can imagine a scene where their current self goes back across time and space to their former self. See if they can picture walking into a room, sitting down beside

them, putting their arm around the former self, rubbing their back, etc. Ask them if they can offer compassion and caring to that person who was hurt in those ways. Ask them to speak directly to their younger self with words of compassion and caring. Facilitate those phrases for them, which often include the following: "You didn't deserve to be treated that way," "This is not your fault," "You are good person," "You are beautiful," "You will be OK, you will get through this" "I will be here for you," "I will love you and protect you." Ask if the younger self can hear these messages.

Identify and access anger

Often feelings of anger and resentment are present at the beginning of this exercise. If that is the case, help the patient access those feelings.

If sadness occurred first, once you have processed those feelings as described above, then ask if there are other feelings present, such as feelings of resentment or anger. Help them to see that they didn't deserve to be treated that way, that the situation was not their fault, and that they can now express resentment for that. See footnote on anger for help if these feelings continue to be blocked.

Once feelings of anger begin to be activated, ask them to allow those feelings to grow, not to block them or censor them. Ask if they can sit up straight, or stand up, or clench their fists. Ask them if they can feel what it feels like in their body if they allow the anger to be felt. Tell them that their anger is justified, that their anger needs to be expressed, to come out, to be heard and felt. The more that they can actually identify and experience feelings of anger, the better. Remind them that anger is healthy and an important powerful emotion to protect us.

Once this anger is activated and felt, ask them what the anger would say or do to protect them. Tell them that this is their new story and that the other person has absolutely no power over them anymore. They are in control of the story and what happens. This is reverse the hurts and help them to feel powerful and strong.

Encourage them to express what the anger would say. Remind them that this is not what they would actually say in real life, or what they would have or could have said, but what the anger within them wants or needs to say. Help them to move past questions (such as "Why did you do this to me?") to powerful statements (such as "You had no right to do this; I'm angry or furious; and I will not put up with this anymore"). Encourage them to be as forceful as they can, praising them for letting this anger out instead of holding it in.

Give them positive feedback and validation for each statement or action. Tell them, "Good," "That's right," "That's necessary," etc. Be active in guiding them and encouraging them.

Proceed eventually to actions. What would the anger do? Again, not what they would or could do, but what the anger needs to do to protect them; to make them safe. Ask what is the whim or the urge that they feel, that pops into their mind.

Give them options, such as yelling, pushing, taping a mouth shut, tying them up, hitting, kicking, using weapons, etc. Again, offer validation for each act, noting that this is what is needed.

After those options are played out, ask if there is anything else, such as exposing the person in public, jailing them, punishing them in any way imaginable. They might want to bring other people in to see what was done or what this person is really like. I have found that what is necessary to correct the situation is to stop the abuse, get their younger self to safety, and to make it so that the abuser feels something of what they felt at the time, whether that is embarrassment, pain, or loss of power and control.

Keep going, asking what else the anger needs to do to finish the situation. Ask when they are ready to walk away, if they are through, and if they can leave this behind them now. If they are not yet ready to walk away, ask what else the anger might need to do to complete the corrective experience.

When all of the anger is expressed, ask how they feel in general. Ask how their body feels. Ask if they can now allow the anger to go. Ask them to take some deep breaths and let the anger go, send it away from them to where it belongs. Tell them that they don't need to hang onto anger, but that they can revisit it anytime they choose, but that they will be better off as they let it go. Have them take deep breaths as necessary to let the anger be released a little bit more with each exhalation.

Ask them if their anger is justified and make sure that they see that it is. When they feel that they are done, ask them to "wipe their hands" and walk away with their heads held high, and even with a smile of satisfaction on their face, if possible.

Search for guilt

Then ask if there is any guilt that they feel at this point.

If the patient states that they have no guilt, you can affirm that they need not have any. Validate that their anger is justified and that they have no need for guilt. Congratulate them on the work they have done.

As mentioned above, there are two kinds of guilt that are often activated by this process: guilt for the anger itself (as if they had expressed this anger in real life) and guilt for something that they did that they think was wrong.

If there is guilt for the anger, that should be welcomed. This shows they are not a "psychopath" and that they are a caring person who would not have acted that way. Guilt over anger is generally seen in people who are angry at a relative or someone for whom they have caring feelings. When this occurs, ask them if they really care for the person underneath the anger. Ask them to speak to the person "from their heart" and ask what they think the person would say to them "from their heart" if they could see how much they

hurt the patient. Here you are activating caring feelings on both sides of the relationship (if possible) in order to find some repair of the relationship.

If there is guilt over some action or inaction that occurred, it is important to address this. People may feel that they did something wrong, when in fact, they really were not at fault. Examples include guilt over being raped or staying in a marriage too long. It is important to identify this type of "undeserved" guilt and help them to realize that they really did nothing wrong, that they were trying their best, or that they acted with good intentions. Help them to state that they really "did nothing wrong" or were "just doing the best they could."

If they feel guilty about doing some kind of harm to another, this may be a case of "deserved" guilt. In this situation, you can help them to forgive themselves and make amends if necessary. Ask them if they would forgive someone who had acted that way, if they were truly sorry. Help them to state that they "forgive themself" if they can.

Return to sadness, grief and compassion

If these emotions weren't accessed at the beginning, facilitate their expression now, as described above (in the "Access sadness if that arises first" section), using the technique of asking their current self to visit their former self in imagination.

In addition, ask them what they would tell themselves right now if they were to speak to themselves with kindness and compassion. What advice would they give themselves about this situation?

Help them to send compassionate messages to themselves, such as "You can handle this," "You'll be OK; you'll get through this," "You are a good person," and "You did your best, and this will be good enough."

Wrap up

At the end of the exercise, check in with them. Ask how they are feeling now. Ask how their body is feeling right now. They usually express feelings of lightness, release, and well-being. Ask them to breathe deeply and let go of the whole situation. Ask if it's OK if you move on and let this be for now. Often, a symptom will have disappeared or lessened dramatically.

If there is a lot of tension, ask if there are certain emotions that are still on their mind. Ask if there is something that still needs to be done in terms of reversing the situation, such as another person who needs to be dealt with or another action that needs to be taken. If so, you can return to the process, or you can simply remind them that this process may need to be completed a few more times before it can be let go of. Let them know that we teaching them how to process emotions and that they can do this work on their own during the next

week. Give them handouts or descriptions of this process in writing (see *Unlearn Your Pain* or *Unlearn Your Anxiety and Depression*). Then proceed to engage in the actions in the above paragraph.

NOTE: Techniques for dealing with ambivalence regarding the expression of anger.

1. Deal with guilt as it arises, the psyche feeling that they are actually doing these acts, when in fact, they are only imagining doing them.
2. Deal with the concern that the anger is coming out towards the person in their current life, when in fact, it is coming out towards them at a time many years earlier.
3. Deal with the concern that they are not allowed to be angry, that good people don't get angry or perform acts out of anger, and that anger means that they are acting like their abuser.

Footnote about anger expression: Expression done in a safe place, such as with a therapist, can be intense, but it is important to emphasize with the patient that such anger should not be expressed intensely with others in their lives. Rather, it should be assertive, often balanced by caring feelings.

Publications Supporting EAET

Here are numerous publications on clinical trials testing EAET. # 1 listed below is an overview and review. The others are original empirical articles of EAET used in different populations, format of intervention (group, individual, in person, remote, internet), duration of intervention (1 session to 8 sessions), and control / comparison conditions (no comparison, control group with no treatment, comparison to relaxation training or to CBT).

1) This article reviews the background and development, principles, and trials of EAET, and then critically evaluates the state of the research.

Lumley, M.A., & Schubiner, H. (2019). Emotional awareness and expression therapy for chronic pain: Rationale, principles and techniques, evidence, and critical analysis. *Current Rheumatology Reports*, 21, 30. https://link.springer.com/article/10.1007/s11926-019-0829-6

2) Initial, uncontrolled trial of early version of EAET, showing substantial long-term reductions in pain from Howard Schubiner's practice, with 2/3 of patients showing clinically significant improvement (at least 30% pain reduction) and fully 1/3 showing substantial improvement (at least 70% improvement), which is almost unheard of in pain management programs:

Burger, A.J., Lumley, M.A., Carty, J.N., Latsch, D.V., Thakur, E.R., Hyde-Nolan, M.E., Hijazi, A.M., & Schubiner, H. (2016). The effects of a novel psychological attribution and emotional awareness and expression therapy for chronic musculoskeletal pain: A preliminary, uncontrolled trial. *Journal of Psychosomatic Research, 81*, 1-8. https://doi.org/10.1016/j.jpsychores.2015.12.003

3) Major, large-scale, multi-site NIH funded trial: group-based EAET proved superior on almost all outcomes to a well conducted basic comparator: FM education, and even superior on several pain-related measures to bonafide (expertly-conducted) CBT:

Lumley, M.A., Schubiner, H., Lockhart, N.A., Kidwell, K.M., Harte, S., Clauw, D.J., & Williams, D.A. (2017). Emotional awareness and expression therapy, cognitive-behavioral therapy, and education for fibromyalgia: A cluster-randomized controlled trial. *PAIN, 158*, 2354-2363. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5680092/

4) This clinical trial by Brandon Yarns found that group-based EAET was superior to group-based CBT in reducing pain severity (large effect) and pain interference (medium effect) in a sample of older veterans (mean age 73.5 years; mostly male, over half non-White) at the West Los Angeles VA.

Yarns, B.C., Lumley, M.A., Cassidy, J.T., Steers, W.N., Osato, S., Schubiner, H., & Sultzer, D.L. (2020). Emotional awareness and expression therapy achieves greater pain reduction than cognitive behavioral therapy in older adults with chronic musculoskeletal pain: A preliminary randomized comparison trial. *Pain Medicine*, *21*, 2811-2822. https://doi.org/10.1093/pm/pnaa145

5) Controlled test of EAET in IBS: 3 sessions of individual EAET improved IBS symptoms better than waitlist control, whereas 3 sessions of relaxation training (RT) did not. Both EAET and RT improved IBS-related quality of life. EAET was not as successful as RT in reducing anxiety/depression at least in this 10-week follow-up.

Thakur, E.R., Holmes, H.J., Lockhart, N.A., Carty, J.N., Ziadni, M.S., Doherty, H.K., Lackner, J.M., Schubiner, H., & Lumley, M.A. (2017). Emotional awareness and expression training improves irritable bowel syndrome: A randomized controlled trial. *Neurogastroenterology and Motility, 29*:e13143. https://doi.org/10.1111/nmo.13143

6) Single, intensive session of EAET (interview) conducted in a family medicine clinic, proving superior to no interview 6 weeks later on reducing various somatic symptoms.

Ziadni, M.S., Carty, J.N., Doherty, H.K., Porcerelli, J.H., Rapport, L.J., Schubiner, H., & Lumley, M.A. (2018). A life-stress, emotional awareness and expression interview for primary care patients with medically unexplained symptoms: A randomized controlled trial. *Health Psychology, 37*, 282-290. http://dx.doi.org/10.1037/hea0000566

7) A similar study of a single, intensive session of EAET for women with chronic pelvic (urogenital) pain, superior on a couple of measures (pelvic symptoms), compared to no interview:

Carty, J.N., Ziadni, M.S., Holmes, H.J., Tomakowsky, J., Peters, K., Schubiner, H., & Lumley, M.A. (2019). The effects of a life-stress, emotional awareness and expression interview for women with chronic urogenital pain: A randomized controlled trial. *Pain Medicine, 20*, 1321-1329. https://doi.org/10.1093/pm/pny182

8) Colleagues in Sweden created an internet-administered version of EAET, and in this uncontrolled study of people with centralized syndrome disorders, found substantial reductions in somatic symptoms:

Maroti, D., Ek, J., Widlund, R-M., Schubiner, H., Lumley, M.A., Lilliengren, P., Bileviciute-Ljungar, I., Ljótsson, B., & Johansson, R. (2021). Internet-administered emotional and awareness and expression therapy for somatic symptom disorder with centralized symptoms: A preliminary efficacy trial. *Frontiers in Psychiatry, 12*(104), doi:10.3389/fpsyt.2021.620359

9) The Swedish group followed-up their uncontrolled trial with a controlled trial of this intervention (against waitlist controls), which found that I-EAET reduced somatic symptoms at both post-treatment and follow-up.

Maroti, D., **Lumley, M.A.**, Schubiner, H., Lilliengren, P., Bileviciute-Ljungar, I., Ljótsson, B., & Johansson, R. (2022). Internet-based emotional awareness and expression therapy for somatic symptom disorder: A randomized, controlled trial. *Journal of Psychosomatic Research,* Article 111068. https://doi.org/10.1016/j.jpsychores.2022.111068

10) A 2-hour version of EAET was created for a group of patients—a class of about 20 people with pain—to be administered remoted (via Zoom). In this uncontrolled trial, this single class led to meaningful reductions in pain intensity and interference in people with a range of chronic pain conditions.

Ziadni, M.S., Sturgeon, J.A., & Lumley, M.A. (2022). "Pain, stress, and emotions": Uncontrolled trial of a single-session, telehealth, Emotional Awareness and Expression Therapy class for patients with chronic pain. *Frontiers in Pain Research*.

Other Published Articles Supporting EAET and Related Approaches for Chronic Pain

1) Ashar, Y.K., Gordon, A., Schubiner, H., Uipi, C., Knight, K., Anderson, Z, Carlisle, J., Polisky, L., Geuter, S., Flood, T., Kragel, P., Dimidjian, S., Lumley, M.A., & Wager, T.D. (2021). Effects of Pain Reprocessing Therapy vs. placebo and usual care for patients with chronic back pain: A randomized clinical trial. *JAMA Psychiatry, 79,* 13-23. doi:10.1001/jamapsychiatry.2021.2669

2) Lumley, M.A., & Schubiner, H. (2019). Psychological therapy for centralized pain: An integrative assessment and treatment model. *Psychosomatic Medicine*, *81*, 114-124.

3) Donnino, M. W., Thompson, G. S., Mehta, S., Paschali, M., Howard, P., Antonsen, S. B., . . . Grossestreuer, A. V. (2021). Psychophysiologic symptom relief therapy for chronic back pain: a pilot randomized controlled trial. *PAIN Reports, 6*(3), e959.

4) Slavin-Spenny, O., Lumley, M.A., Thakur, E.R., Nevedal, D.C., & Hijazi, A.M. (2013). Effects of anger awareness and expression training and relaxation training on chronic headaches: a randomized trial. *Annals of Behavioral Medicine, 46*, 181-192.

5) Lumley, M.A., Sklar, E.R., & Carty, J.N. (2012). Emotional disclosure interventions for chronic pain: From the laboratory to the clinic. *Translational Behavioral Medicine: Practice, Policy, Research, 2*, 73-81.

6) Lumley, M.A., Cohen, J.L., Borszcz, G.S., Cano, A., Radcliffe, A., Porter, L., Schubiner, H., & Keefe, F.J. (2011). Pain and emotion: A biopsychosocial review of recent research. *Journal of Clinical Psychology, 67*, 942-968.

7) Hsu, M., Schubiner, H., Lumley, M.A., Stracks, J., Clauw, D.J., & Williams, D. (2010). Sustained pain reduction through affective self-awareness in fibromyalgia: A randomized controlled trial. *Journal of General Internal Medicine, 25*, 1064-1070.

8) Lumley, M.A., Cohen, J.L., Stout, R.A., Neely, L.C., Sander, L.M., & Burger, A.J. (2008). An emotional exposure-based treatment of traumatic stress for people with chronic pain: Preliminary results for fibromyalgia syndrome. *Psychotherapy: Theory, Research, Practice, Training, 45,* 165-172.

9) Abbass, A., Town, J., *Holmes, H.J.*, Luyten, P., Cooper, A., Russell, L., **Lumley, M.A.**, Schubiner, H., Allinson, J., Bernier, D., De Meulemeester, C., Kroenke, K., & Kisely, S. (2020). Short-term psychodynamic psychotherapy for functional somatic disorders: A meta-analysis of randomized controlled trials. *Psychotherapy and Psychosomatics, 89*, 363-370.