

EMDR treatment of Chronic Pain



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EMDRAA webinar.
Sat 19 Aug , 2017

Outline

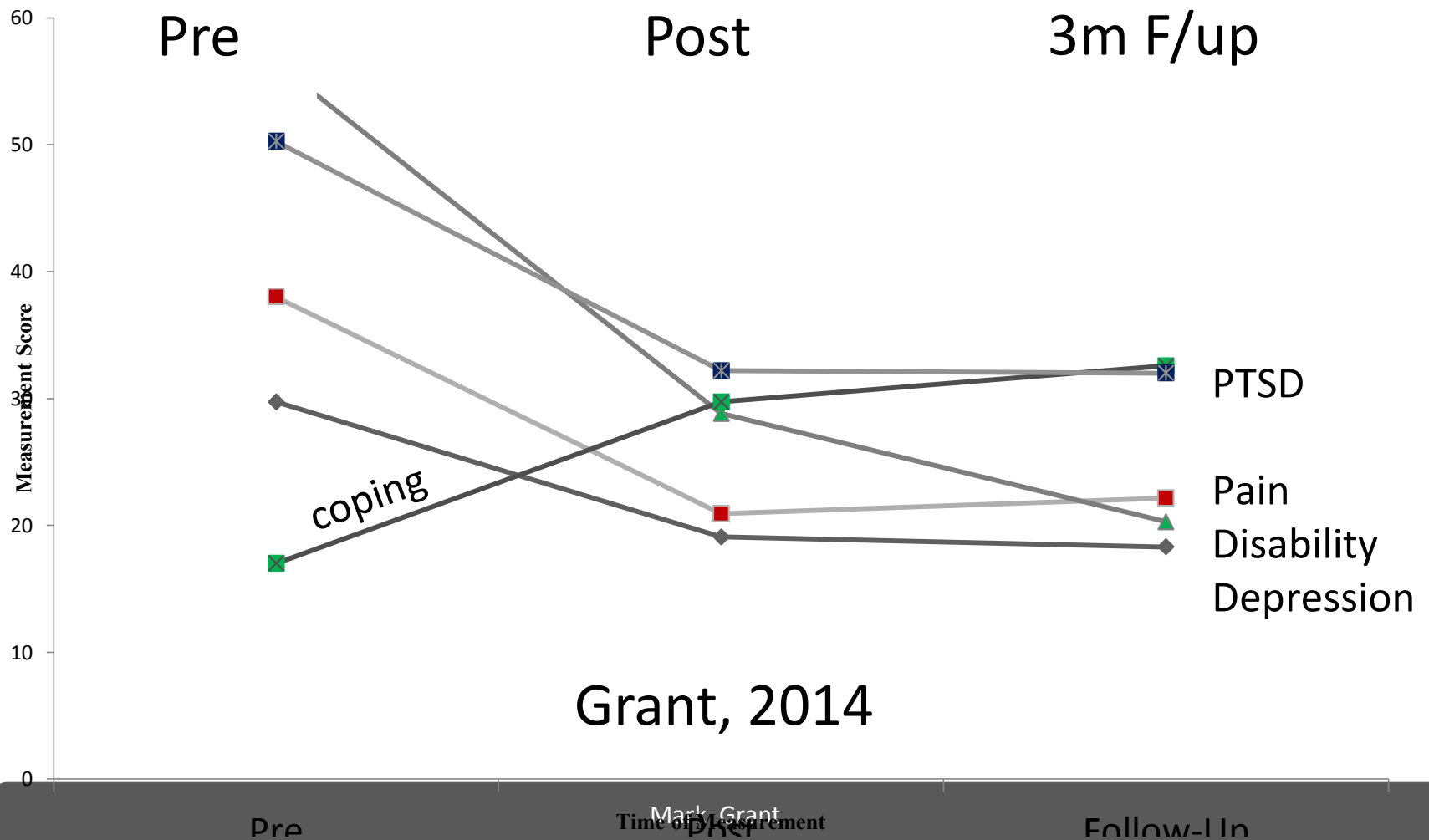
- Research update
- 7 stages of pain management with EMDR
- EMDR Pain protocol
- Case example #1: Whiplash/ASD
- Case example # 2 Back pain (CLBP)
- Dealing with blockages
- Dealing with the effects of ongoing pain
- Other sensory & cognitive strategies

EMDR pain research review

- First case report (burn pain) McCann 1992
- 2017: 4 x RCT's (170 subjects)
- 13 x observational studies (116 subjects)
- PLP, headache, chronic musculoskeletal pain, Fibromyalgia, post-operative pain
- Complete pain relief in 15-40% of subjects (5/12 studies) Tesarz, 2014
- 'Pain relief vs pain management'
- Pain with a strong emotional component (trauma)

Tesarz, Leisner et al, 2014

EMDR outcomes



EMDR rx pain & NHMRC criteria

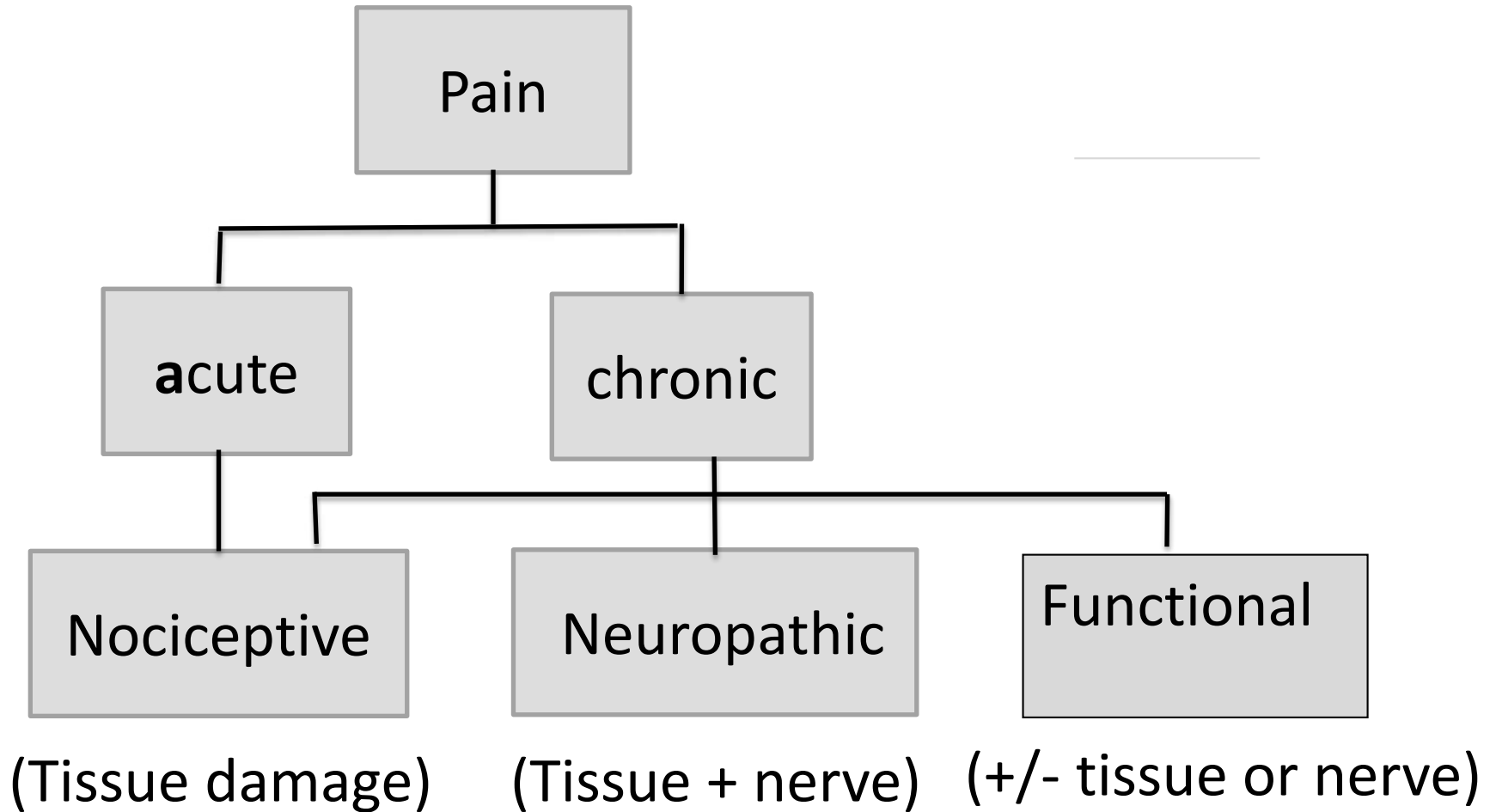
- Level 1
Systematic review of all RCT's
- Level 2
At least one properly designed RCT
(Gerhardt et al, 2016)
- Level 3
Well designed pseudo-randomized RCT's
- Level 4
Case-series (pre-test and post-test)

CBT pain research review

Central assumptions	“Unsubstantiated”	
Mechanisms of change	“No clear theory”	
Efficacious elements	“Unclear”	
Pain control	“Weak – nothing”	
Effects on Disability	“Moderate – nothing”	
Effects on Mood	“Moderate – small”	
Overall effects	“small”	

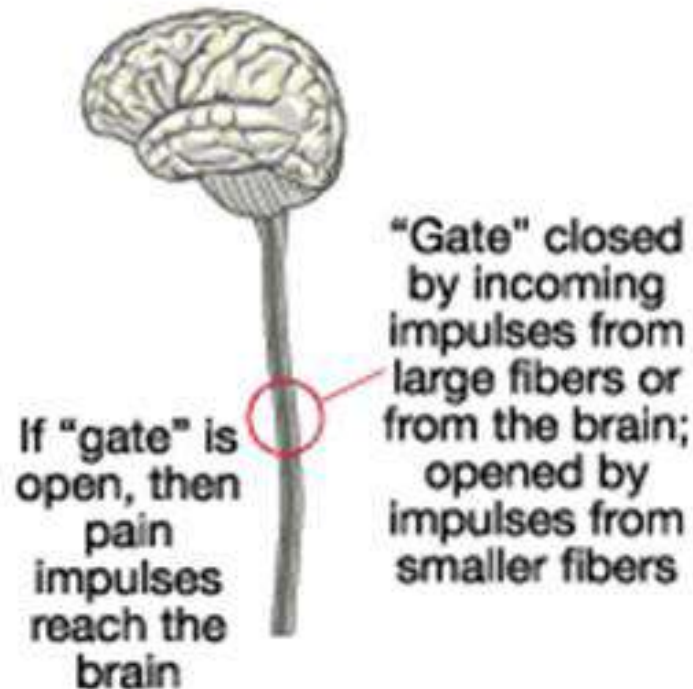
- Williams Eccleston & Morely 2013

Nosology of pain



Gate Control Theory (1965)

THE GATE-CONTROL THEORY OF PAIN



Neuromatrix Theory (1996).

“Pain is produced by the output of a widely distributed neural network in the brain rather than directly by sensory input evoked by injury, inflammation, or other pathology.”

Melzack, 2001

AIP model

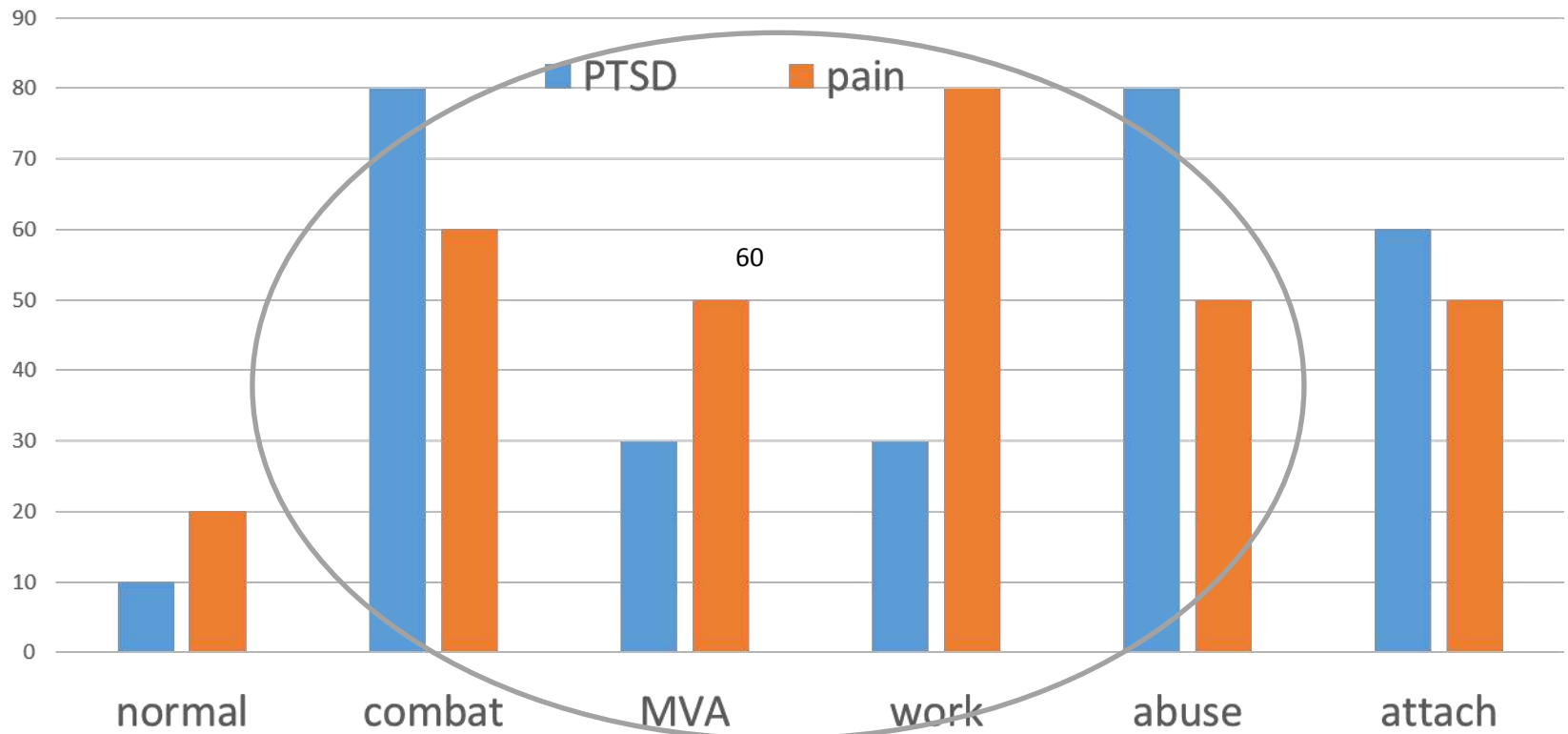
“Except for organic damage or lack of information, inadequately processed or inappropriately stored memories are the basis of all clinical pathology”

Francine Shapiro, 2009

Chronic pain causal/predisposing factors

- Physical injury/illness
- Stress, trauma (past or present)
- Emotional neglect
- Stress-related physical, biochemical and
Neurological changes
- Personality factors
- Genetic factors

PTSD and pain



Dissociation

Dissociative symptoms in chronic pain

- Normal population (3%)
- Chronic pain sufferers (11%)
- Chronic pain + PTSD (17%)
 - DES absorption,
 - depersonalization,
 - amnesia

- Duckworth *et al* (2000)

EMDR pain protocol

“EMDR in the treatment of chronic pain requires a greater variety of targets and more flexibility in the protocol application compared with the treatment of PTSD.

Targets for desensitization and reprocessing should neither be restricted to the pain nor to traumatic life events, but should be adapted to the individual as required.”

- Tesarz et al, 2014.

Key pain protocol differences

- Safety; disability, life circumstances, treatment issues
- Targets;
 - trauma,
 - present pain (TICE/S)
 - effects of pain
- Negative cognition themes
- Use of continuous (auditory) BIs
- Increased focus tracking and facilitating responses bls
- “Incomplete processing,” SUDs < 0
- Creation of pain resources/antidote imagery

7 tasks/stages of pain management

1. Tame the pain
2. Emotional regulation
3. Trauma processing
4. Self care
5. Uncover meaning of pain
6. Deal with other stressors
7. Reintegration

Phase oriented targeting

Stage	Target
1. Tame the pain	Pain (“theres something wrong”)
2. Emotional regulation	Effects of pain (“I’m useless”)
3. Trauma processing	Trauma
4. Self care	Effects of pain/trauma
5. Meaning	Effects of pain/trauma
6. Dealing with other stressors	Effects of pain (“I’m useless”)
7. Reintegration	“I am strong again”

EMDR pain protocol (stages 1-3)

1 History;

Trauma; pain memory or previous/indirect
Injury, illness, medical treatment issues,
Effects of pain (eg; on functioning, identity)
Other life stressors

2. Preparation;

Safety, (eg; treatment issues, pain control, life functioning)

3 Assessment; (EMDR Targets)

1) trauma

2) pain

3) effects of pain (incl emotional regulation)

History

- Health history
- Trauma History
- Personality
- How/when did pain start?
- Diagnosis (What injury or illness?)
- How is pain related to other stresses/trauma?
- Involvement of 3rd parties

Preparation

Safety

- Tolerable pain levels
- Access to medical/other treatment
- Support & protection
- Stable life circumstances
- Absence of conflict/adversarial 3rd party
- Safe/calm place (trauma)

Assessment

TICES and trauma/pain

Trauma;

- T
- I
- C
- E
- S

Pain;

- T
- I
- C
- E/S

Assessment

TICES and present pain

Trauma

- T
- I
- C
- E
- S



Present Pain

- T
- S
- I
- C

Negative cognitions (trauma).

Lack of safety/vulnerability:

- *I'm helpless*
- *I'm going to die*

Lack of control/power:

- *I'm trapped*
- *I'm helpless'*
- *'I can't control it (the trauma)'*

Negative cognitions (pain).

Responsibility/being defective*:

- *'I'm weak'*

- ‘ – *'There's something wrong with me'*

Lack of control/power*:

- *'I'm trapped'*

- *'I'm helpless'*

- *'I can't control it (the pain)'*

NC (effects of pain/meaning).

Responsibility/feeling defective:

- *'I'm worthless/useless'*
- *'I'm unlovable'*
- *'I deserve to suffer'*
- *'I'm a burden'*
- *'I'm a failure'*

EMDR pain protocol (stages 4-8)

4. Desensitization;

Variations bls (Continuous, auditory, self-use)

Sensory focus

Tracking and facilitating changes

“Incomplete processing”

5. ‘Installation’ (PC themes);

Safety/vulnerability, control/power (Trauma),

Control/power, responsibility/defective (Pain)

Coping resources

6-8. Body Scan/Closure/Reintegration;

Integrating pain-related changes to identity

Core EMDR treatment skills for pain

- **Know;** About pain
- **Understand;** Case Conceptualization
- **Engage;** bringing client into contact with their pain/trauma to enable processing
- **Maintain;** Maintaining flow of processing
- **Sustain;** antidote resources for ongoing pain dealing with other trauma/problems
- **Support;** Use of adjunctive strategies

Know

“Stressors have destructive effects on muscle, skeletal and hippocampal neural tissue, which may become the immediate basis of pain, *or provide a basis for the devastating effects of later minor injuries in which the severity of pain is disproportionately far greater than would be expected from the injury.*”

- Melzack, 1999

Understand

Case conceptualization comet

Developmental trauma

Injury/illness

Pain

Effects of Pain

Chronic stress (past)

Recent Trauma

Major life stressors (present)

Other psychopathology

Personality factors

Engage

Managing transference

“Experiencing the pain and causing the pain begin to merge and [the analysts] escalating failure to do something about the patient’s pain gradually leads him to become in fact, the person that the patient already experiences him to be.”

- Bromberg, 2006

Trauma-related pain

- WAD (Whiplash)
- PLP (Phantom Limb Pain)
- Fibromyalgia
- IBS (Irritable Bowel Syndrome)
- Vaginismus
- CLBP (Chronic low back pain)
- Burn Pain

Trauma-related pain

“..a traumatic event whose completion is truncated by lack of spontaneous resolution of a freeze/immobility response ... is associated with a complex set of somatic pathologic events...

...kindling is intrinsic to the self-perpetuation of this pathologic process, driven by internal cues derived from unresolved procedural memory of threat, and enhanced by endorphinergic mechanisms inherent to both the initial response to threat, and subsequent freeze/dissociation.”

- Scaer, 2001

Whiplash case example

- 'Railroad spine'
- Pain (head, neck and back),
+ neurological + psychological symptoms.
- 50% survivable MVA's; 50% recover 12 months
- Severity; grade 0 - 4
- 28% PTSD, 31% MDD, 20% GAD
- PTSD symptoms/attachment > severity
- Psycho/neurological disorder (Scaer 2001)
- Best results early intervention (< 3 months)

Whiplash/ASD case example

- Recent MVA trauma + Grade 1 WAD
- Plus; 3 x friends killed in similar accident last year
- Plus; current stress (marital separation).
- Personality; stable well-regulated
- Target selection (Trauma vs pain); Trauma.
- NC: “I’m going to die”
- Emotion; terror
- Post bls; decreased respiration, calmer, > pain
- PC: “I’m not going to die for a while” SUD’s 0.

Case conceptualization.

Developmental trauma

Injury/illness

Pain

Effects of Pain

Recent Trauma

Chronic stress (past)

Major life stressors (present)

Other psychopathology

Personality factors

'Medical' pain

- Nociceptive &/or neuropathic
- CLBP (Chronic Low Back Pain)
- CRPS (Chronic Regional Pain Syndrome)
- Arthritis
- Burn pain
- Post-operative pain
- Cancer pain
- Tinnitus

Chronic Low Back Pain (CLBP)

- Inflammatory pain
- One of most common pain complaints
- 1 year prevalence rate 12-14%
- PTSD: 25% of CLBP sufferers
50% of combat veterans
- Higher likelihood of physical or sexual abuse

CLBP case example

48 year old male with CLBP (herniated disc)

- Personality: achievement oriented, high N control
- Current life stressors: workers compensation, RTW duties (non-transferrable skills)
- Financial pressures (5 children)
- 3 rd party involvement
- Effects of pain: decreased physical capacities
- Depressed (+ family history)
- High blood pressure

CLBP case example

1. Target: Back pain
2. NC: 'I'm defeated'
3. Emotion: sad/angry
4. Sensations: burning, stabbing

Outcomes;

- Reduced pain, depression, anger & sadness
- PC: "I've won"
- Improved physical functioning, more +ve outlook
- Ceased anti-depressants, Normal BP

Case conceptualization

Developmental trauma

Injury/illness

Pain

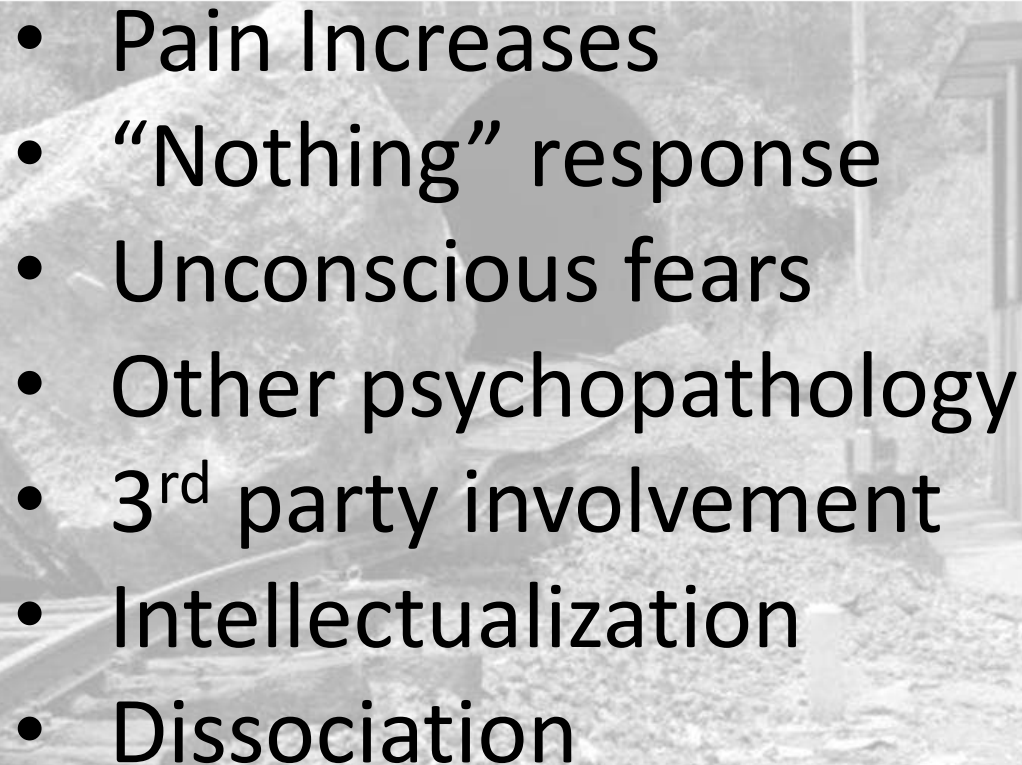
Effects of Pain

Other life stressors

Other psychopathology

Personality factors

Dealing with 'Blockages'.

- 
- Pain Increases
 - “Nothing” response
 - Unconscious fears
 - Other psychopathology
 - 3rd party involvement
 - Intellectualization
 - Dissociation

If pain increases following bls

1. **Stop:**
2. Check client ok to continue
3. Continue with Bls
4. Change Bls modality
5. After 2-3 x sets of pain increasing cease bls and discuss with client (eg; pain too severe, bad target/set-up, effect of other stressors, client not suited for EMDR..)
6. Try other interventions and leave bls for another time

“Nothing” or “no change”

Cognitive Interweaves

- **New Information:**

Do you notice a feeling of distance.. lightness?

How does the pain feel NOW compared with how it felt BEFORE”

- **Whose responsibility is it?;**

Did you ask to be in pain?

Do you like feeling like a burden?

- **“I’m confused”;**

If you’re really so worthless how come....

Accessing unconscious fears

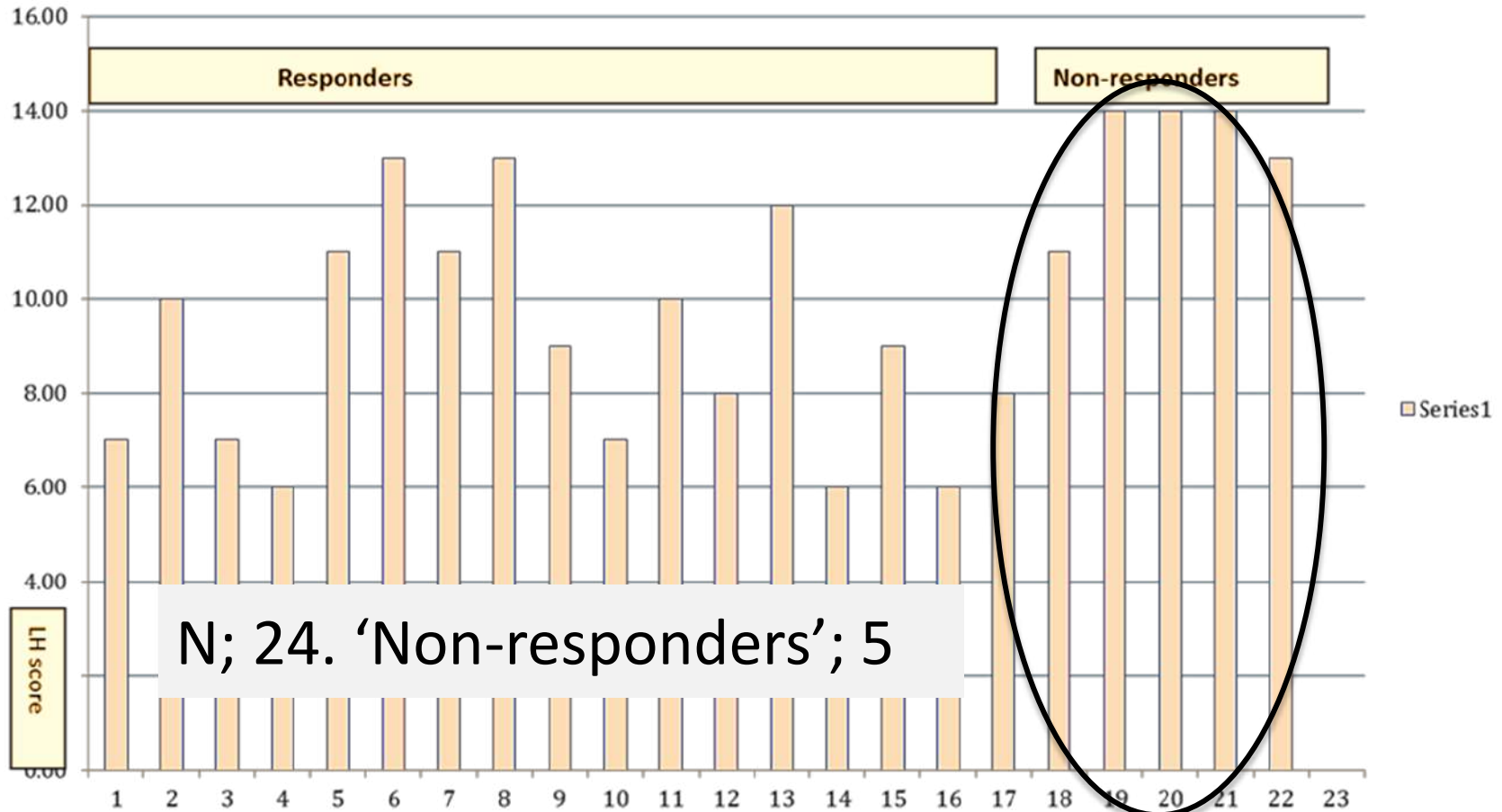
- *“Is there any part of you that might need this pain?”*
- *“is there anything that might be stopping the pain from getting better?”*
- *“If there was an emotional contributor to this pain, what might it be?”*
- *“Is there something else your body needs in order to feel better?”*

Mind-body (TMS) Therapy

- Review diagnosis
- Psychoeducation (re; pain and healing)
- Uncover and address trauma, blocking beliefs, punitive parts
- Check no further 'need' for the pain
- Acknowledge and thank the pain
- Say goodbye to the pain (repeatedly)
- Future template if no change after 2 weeks

John Sarno

Hemispheric dominance



3rd party involvement.



Dealing with effects of on-going pain

- Coping skills
- Adjustment counselling
- Identity issues
- Grieving losses
- Reintegration

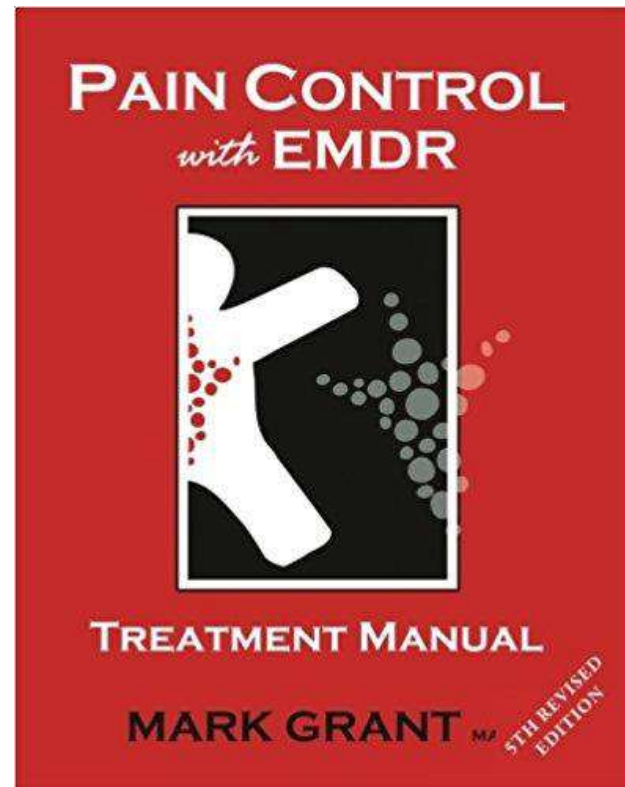
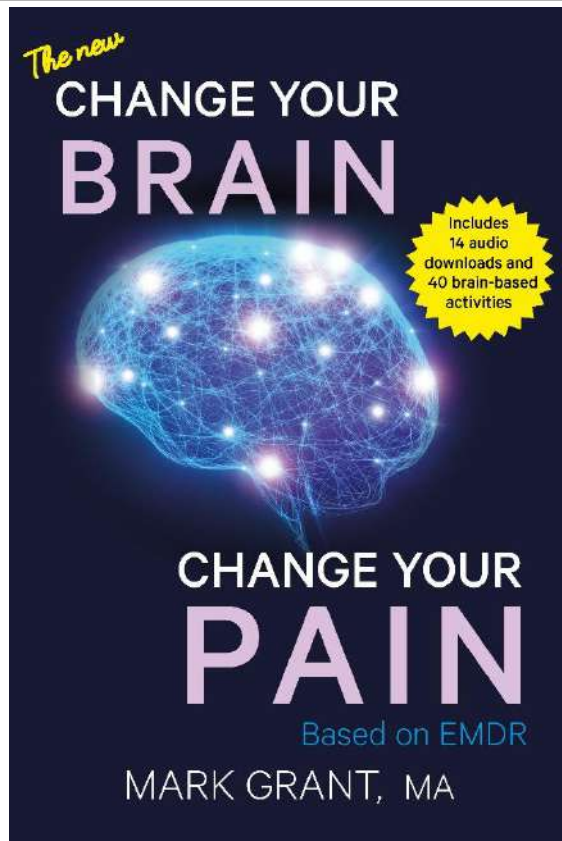
Adjunctive interventions (Sensory)

- Contralateral stimulation
- Head hold
- Circular breathing
- Breathing + imaginal antidote
- Pendulation
- Enjoyable (engaging) activities
- Hot and cold stimulus, auditory etc

Adjunctive interventions (Cognitive)

- Meditation (Breath awareness, focused attention)
- Imaginal (pain + antidote imagery)
- Hypnotic;
 - Awareness (just noticing)
 - Alteration (breathing + imaginal antidote)
 - Avoidance (distraction, engagement other)
 - Alleviation (breathing + suggestion)
- Attentional telescope exercise
- Positive self-talk (adult – child ego-states)

Manuals and books



<https://www.youtube.com/watch?v=v4yQPzvfS64>

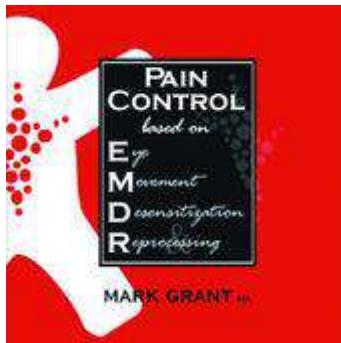
Apps and audio



Anxiety Release based on EMDR



Calm and Confident based on EMDR



Pain Control based on EMDR

www.overcomingpain.com

- Books and audio
- Apps
- Workshops
- Research
- Free pain resources

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10

EMDR Pain Protocol

EMDR PAIN PROTOCOL SCRIPT

My EMDR pain protocol is an adaptation of Shapiro's (1999) basic trauma protocol. Changes include the option of targeting sensory distress in the absence of a traumatic memory, the use of continuous BIs, allowances for incomplete processing, partial positive cognitions and the use of antidote imagery for managing on-going pain. This protocol has been tested and by myself and others with a variety of chronic pain populations including CLBP, headaches, accident pain, fibromyalgia pain, somatization disorder etc. Other, not dissimilar protocols have been used with phantom limb pain. It is likely that pain will be the next application of EMDR to be empirically validated.

Pain and the Adaptive Information Processing Model

Begin by explaining chronic pain in terms of the Adaptive Information Processing model. E.g.,

“Pain can occur for many reasons. We generally understand pain as a signal that something is wrong physically. However, sometimes pain can continue longer than expected, despite medical treatment. Pain can persist because of fatigue, stress, and biochemical and neurological changes. As a result of these changes, the pain becomes “locked” in the nervous system. EMDR is a way of stimulating the nervous system to facilitate healing. Even though we might not be able to completely eliminate your pain, EMDR often stimulates feelings of relaxation, which always reduces pain.

We can’t predict how your nervous system will respond to the EMDR stimulation, so try and adopt an open mind and just notice the sensations of your pain as best you can. Initially, the intensity of the pain may not seem to change, or it may even increase, this is just the pain response shifting in response to the stimulation. In the unlikely event that the pain increases to an intolerable level, just raise your hand like this (show stop signal). Remember your nervous system knows what to do, so there’s no need to try and make it happen, just notice and just let whatever happens happen.

What we will be doing often is a simple check on what you are experiencing. I need to know from you exactly what is going on, with as clear feedback as possible. Sometimes things will change and sometimes they won’t. There are no ‘supposed to’s’. Just notice and just let whatever happens happen.”

EMDR Target

Develop target based on whether pain is trauma-related or not.

a) **Traumatic Pain**

“When you think of the incident that led to your pain, what picture do you get?”

b) Non-Traumatic Pain

“Can you describe the pain in terms of how it feels physically?” (suggest size, color, etc if client needs help describing their pain)?

Where clients are really unable to find words or images to describe their pain, ask them to draw a picture of their pain. Do not be put off by clients’ objections that they are not artists; even a dark angry line can be a helpful tool in focusing the client and concretizing the pain.

The point of getting the client to describe their pain is to help them connect with it in preparation for the desensitization state. Once this has happened, there is no need to ask the client to describe it any further - in fact there is a risk the client will go into an intellectual mode or other form of avoidance.

Negative Cognition (NC)

“What does the pain (or memory) make you believe about yourself?”

Pain Control with EMDR - Treatment Manual

If client reports a positive difference, elicit details and re-stimulate using what they reported as a target.

“That’s fine, just go with that.”

Continue Bls and review until a relatively stable level of improvement is achieved.

Responses like *“It feels better,”* are okay, but asking for more details will elicit better target for reprocessing, as in the following:

“But how does it feel better? What feels different about it?”

When you get a response that is something concrete, such as, *“softer, smaller”*, you have a better target with which to continue processing.

Then say, ***“Notice that.”***

And re-stimulate.

Never accept responses like *“Nothing”* or *“It’s the same”*. These are analyses rather than direct reports, and give you nothing to reprocess.

Say, ***“Yes, okay, but I need to know exactly what you are experiencing, like when you described it before we started.”***

Chapter 10 - EMDR Pain Protocol

NB. Stop the Bls if it is making the pain worse, use other methods (e.g., hypnosis, imagery, pacing, emotional containment techniques, support, etc.) to manage the pain.

As long as the pain is changing, keeping saying, ***“Notice that.”*** after each set of Bls

Continue Bls and reviewing the clients’ responses until the clients’ SUD has decreased to an acceptable level for the clients before proceeding to the Installation Phase. An acceptable level of pain may be anywhere between zero and a four or five. The best way to determine this is to ask clients whether they think they can achieve any further improvement or not and whether they feel like continuing.

Say, ***“On a scale of 0 to 10, where 0 is no disturbance or neutral and 10 is the highest disturbance you can imagine, how bad does it feel now?”***

1	2	3	4	5	6	7	8	10
(no pain)							(highest pain)	

“Does it feel like you can achieve any further improvement?”

When the number is higher than zero ask:

“What prevents the number from being a zero?”

Or

“If you focus on the number ____ (state the number given), what is behind it?”

“Go with that.”

Pause and ask client what they notice now. If they report feeling better ask,

“Do you want to continue?”

Also look for physical signs of progress such as changes in posture, facial expression, and so forth. If you are ‘in-tune’ with your client you should be able to sense their energy levels and capacity for further work versus needing to finish.

Note: If the client has a medical condition, you need to understand the implications of this when deciding how low the pain SUD’s can go. a zero may not be realistic.

Installation

When working with pain control, depending on whether the pain is trauma-related or not, positive cognitions and/or antidote imagery are installed to assist in controlling pain. The most effective antidote imagery is derived from mental associations based on how the client feels rather than suggestions from the therapist.

“Think of something that reminds you of that feeling of relaxation or pain relief.”

“What is it?”

The idea is to link the feeling of relief to a memory association. Clients will say things like “a wet blanket,” “a pac-man,” “an absorbent sponge.” Once clients have identified a healing image, ask them to think of a word that goes with that image and install it by pairing it with DAS.

“Now think of a word that goes with that image and go with that.”

Pain Control with EMDR - Treatment Manual

“So what’s come in the pain’s place? What’s there now where the pain was before?”

Sometimes, when the pain doesn’t change of its own accord, it may be necessary to instruct the client to do the following:

“Think of something that could take the pain away or make it better, don’t worry about whether it seems realistic or not, just let your imagination run wild”.

Once you obtain something concrete, (e.g., smooth, softer, smaller, etc) re-stimulate. If change continues, after a couple more sets, ask the following:

Say, *“What’s that like? What does it remind you of?”*

Pair a word with the metaphor and install.

Chapter 10 - EMDR Pain Protocol

“Is there a word that goes with how you feel when you think of that image?”

Resume DAS until the client reports stable link between the image and the trigger word.

Note: The last two steps can be used as an alternative to eliciting the positive cognition prior to the desensitization (as per normal trauma protocol).

Note: quite a bit of review and reinforcement of pain-management skills may be necessary before the client is ready to endorse the positive cognition.

VoC

“When you think of the pain now, how true do those words ____ (clinician repeats the positive cognition) feel to you now on a scale of 1-7, where 1 feels completely false and 7 feels totally true?”

1 2 3 4 5 6 7

“Is there another positive statement or cognition that fits better now? If so, what would it be?”

Body Scan

If clients report, “No change” following the DAS, use a cognitive interweave as in the following:

“Are you sure it is really no different?”

If the client answers ‘yes’ say,

“OK, do you have any idea about what’s stopping the pain from changing?”

When the client reports no pain or it is apparent that the client cannot improve any further, *“Close your eyes and keep in mind the original memory/image and the positive cognition. Then bring your attention to the different parts of your body, starting with your head and working downward. Any place you find any tension, tightness or unusual sensation, tell me.”*

Closure

“Now that you are feeling better you are probably wondering how long the effects will last. Experience suggests that these changes can last anywhere from a few hours to being permanent. Even if the pain comes back, it is often weaker because of the way EMDR effects memory. The most important thing is to just have an open mind and pay attention to what you are feeling in the present. Many people find that EMDR helps them feel more in touch with their feelings and this can lead to increased self-care and reduced stress and pain flare-ups.

You can also use the bilateral stimulation by yourself to control your pain. I am going to give you a recording of this sound. Whenever you need relief from pain (or stress, or even insomnia) just play this CD and concentrate on the negative feelings you want relief from, just like you did here today. The more you practice the more you will succeed. Of course if your pain persists beyond what you feel you can cope with you should always seek medical help ”

Clients with on-going pain, will need resources to help control that pain. You may teach them visualization strategies such as healing light or anaesthetic mist (both of which are on my pain control with EMDR CD) or you can use the positive changes following DAS/BlS to construct antidote imagery. I prefer the latter because it is more grounded in the clients

Chapter 10 - EMDR Pain Protocol

own sensory experience. Resource development can happen anytime the client has achieved a reasonable stable change.

Re-evaluation

Each session should begin by reviewing client's experience of their pain and related stress or trauma over the period since the last session. Changes in sleeping patterns, physiological arousal and activity levels need to be screened for, identified and feed-back to clients to avoid a false perception that nothing has changed.

“So what have you noticed about your pain since our last session?”

If the client says nothing, ask more direct questions.

“Have you noticed any changes in your sleeping pattern?”

“Have you noticed any changes in your activity levels since last time?”

“Have you done anything different or unusual?”

Have you noticed any changes in your mood since last time?”

Inquire about specific areas of the client's life that they have identified as problematical or affected by their stress, trauma or pain, such as sleep, relationships, activity levels etc.

“Tell me about _____ (state problem areas) since the last session. What have you noticed?”

It is not uncommon for clients to fail to notice changes because of depression, alexithymia or negative thinking. Asking detailed, change-oriented questions helps the client recognize those important changes, exceptions and new trends. The therapist needs to check with clients for any changes in how they have been feeling in terms of the material that was processed at the previous session and use this as a basis for constructing new targets for EMDR reprocessing. It is not uncommon for the image of the pain to change between sessions, as the clients experience changes, particularly if progress is being made.

EMDR treatment of chronic pain is often less ‘successful’ in terms of the kinds of dramatic treatment gains that can be expected from EMDR treatment of simple PTSD. This is not surprising; chronic pain is maintained by injury processes which are not as amenable to change as mental or emotional phenomena. Where the client is left with residual pain to any significant degree, EMDR may need to be supplemented by adjunctive pain management strategies such as sleep management strategies, exercise, resilience building etc. Chapter 11 covers some of these strategies, plus the client handouts from the client resources chapter.

This protocol is based on the original EMDR trauma protocol, as developed by Francine Shapiro Phd.¹

Pain Protocol variations (from standard trauma protocol)

Different problems often require variations to the standard EMDR protocol, and pain is no exception. Below is a summary of the variations to the basic protocol for working with pain, together with the rationale for each variation and any precedents or other applications.

Conceptual differences between trauma and pain

Pain vs Trauma

Trauma is typically conceptualized as a memory which involves somatic aspects

Chronic pain is a present somatic event which involves memory (of previous pain or of event which caused pain) which can maintain and exacerbate pain.

Pain protocol variations

1. Targeting pain first

Rationale: if pain is viewed as a kind of affect-management problem, then the option of targeting the pain first helps with client's stabilization (sense of mastery) and preparation for trauma work. This option is offered when the pain is assessed as the primary presenting problem, whether or not trauma is present, but the client should be offered the choice.

Caution: To avoid triggering trauma, use the pain target option in the protocol and keep the client focused on present affect, (ie; OFF the trauma track) and track physical changes closely.

2. Continuous Bls

Rationale: Continuous Bls keeps the client "on the track"- this is important for clients who have avoidant tendencies or a tenuous connection with affect. The longer duration of Bls also gives clients with low sensory receptivity (eg; alexithymic clients) more time to attune to Bls and notice its effects.

Chapter 10 - EMDR Pain Protocol

3. Auditory Bls

Rationale: Sandra Paulson has suggested auditory Bls is more visceral than eye movements which she feels are more cognitive, more cortical. Paulson feels that sounds or tapping are more subcortical, subliminal, affective.

Precedent: auditory Bls is a widely used alternative to EMS.

Research: I am currently (2013) coordinating a study with 6 other therapists in Australia which incorporates this variation of Bls in the treatment of pain. Initial results suggest auditory Bls is efficacious in the treatment of pain.

4. Self-use of Bls

For appropriate clients with on-going pain, self-use of Bls gives them a tool for alleviating pain, stress and insomnia which often persists in-between treatment sessions. Self-use should be introduced as a self-soothing strategy, (not DIY EMDR) AFTER the client has experienced positive effects of Bls (eg; relaxation etc) in session.

Precedent: I produced the first self-help Cd incorporating Bls in 1997 and have distributed thousands of these CD's with no ill-effects reported and the vast majority of people finding it very useful. See for example;

[http://www.amazon.com/Calm-Confident-CD-Mark-Grant/dp/B003156MSK/ref=sr_1_1?ie=UTF8&qid=1354181741&sr=8-1&keywords=calm+and+confident,-'customer reviews,'](http://www.amazon.com/Calm-Confident-CD-Mark-Grant/dp/B003156MSK/ref=sr_1_1?ie=UTF8&qid=1354181741&sr=8-1&keywords=calm+and+confident,-'customer+reviews,')

Pain Protocol variations and effects of bls menu

Different problems often require variations to the standard EMDR protocol, and pain is no exception. Below is a summary of the variations to the basic protocol for working with pain, together with the rationale for each variation and any precedents or other applications.

1. 'Present pain' as a target

If pain is viewed as a kind of affect-management problem, then the option of targeting the pain first helps with client stabilization (sense of mastery) and preparation for trauma work. This option is offered when the pain is assessed as the primary presenting problem, whether or not trauma is present, but the client should be offered the choice.

Caution: To avoid triggering trauma prematurely, use the pain target option in the protocol and keep the client focused on present affect, (ie; OFF the trauma processing track) and track physical changes closely.

2. Tracking and facilitating effects of bls

Be aware of the full range of possible effects of bls and take an active role in helping clients recognize the positive (increased relaxation, connectedness) and negative (decreased pain, distress) effects of bls. Use the menu (overleaf) to help client recognize possible changes they may not have consciously noticed. This is especially necessary when little or no change is reported but can still be helpful when processing seems to be proceeding well.

3. Continuous Bls

Continuous bls keeps the client "on the track" and gives intellectualized or anxious clients more time to attune to bls and experience its effects. You can check in with clients in the usual way ("what do you notice now?") without interrupting the bls. Cease bls when you feel some changes have occurred and or client appears tired. If you are not sure just ask.

4. Auditory Bls

Auditory bls may have a more visceral effect than Ems. EMDR expert Sandra Paulson feels that sounds or tapping are more subcortical, subliminal, affective. A 2015 study involving 11 chronic pain sufferers found that recipients obtained relief from trauma, pain and distress when this option was employed. Auditory bls can also be used by clients in-between sessions as a self-soothing device (see below).

5. Negative Positive cognition themes

Shapiro has categorized EMDR negative cognitions into different themes. Lack of safety/vulnerability, control/power, responsibility/feeling defective. When working with pain look for themes of responsibility and feeling defective in addition to control/power.

- Negative trauma-related cognitions; Lack of safety/vulnerability, control/power
- Negative pain-related cognitions; Responsibility/feeling defective, control/power

6. Self-use of Bls

For appropriate clients with on-going pain, self-use of Bls gives them a safe, effective tool for alleviating pain, stress and insomnia which often persists in-between treatment sessions. Self-use should be introduced as a self-soothing strategy, (not DIY EMDR) AFTER the client has experienced positive effects of Bls (eg; relaxation etc) in session. Self-use of bls is not recommended for severely dissociative clients. Always advise clients to discontinue self-use if they experience any adverse side effects.

Effects of bilateral stimulation menu

Physical:

- Decreased tension
- Decreased agitation
- Decreased heart rate
- Decreased breathing rate
- Decreased physical discomfort/pain
- Relaxation
- Feeling drowsy
- Feeling energized

Mental:

- Decreased anxiety
- Decreased worry
- Decreased thinking/mental activity
- Decreased emotional distress
- Decreased vividness of mental images
- More distant perspective on problem