A Multi-Modal Approach

Based on EMDR

by Mark Grant MA

This is an outline of a psychological treatment approach to chronic pain, integrated with medical treatment, based on EMDR.

EMDR consists of a combination of various elements of standard approaches to pain management, together with innovations such as dual focus of attention and bilateral stimulation. Although EMDR initially utilized bilateral eye-movements (EM's), bilateral tones and tapping are now also utilized. One of the central elements of EMDR is a desensitization procedure in which the patient is assisted to focus on the negative thoughts feeling and sensations associated with their problem, whilst simultaneously attending to a bilateral stimulation (visual, auditory or tactile). This is frequently followed by change in the level of distress associated with the problem (Shapiro, 1989, 1995).

It is generally agreed that a comprehensive history should be taken prior to commencing psychological treatment of pain (Salerno & Willens, 1996; Turk & Meichenbaum, 1989). Given the extent of mismanagement, this should include a review of previous medical investigations and treatments, the existence or otherwise of a medical diagnosis, and the psychological effects of medical treatment.

Drawing on parameters set by the International Association for the Study of Pain, (IASP, 1995) the author has developed a 'task-oriented' approach to pain management, which delineates 5 tasks of psychological pain management designed to ensure that both the medical and psychological needs of pain sufferers are met (Grant, 1999). The first two tasks address the psychological effects of medical treatment. Tasks three to five involve facilitating changes in pain sensations and developing new coping strategies.

The five tasks of pain management are:

1. Insure pain is within tolerable levels of severity.

2. Review medical diagnosis and patients attitude to their diagnosis.

3. Identify and prioritize "targets" for EMDR reprocessing.

4. Facilitate relaxation and change in pain sensations.

5. Develop psychological pain-management resources.

The first task is to check that the pain is being adequately managed. It is necessary to distinguish between tolerable and intolerable levels of distress. Patients with excessive levels of physical discomfort are frequently anxious and dysphoric (Gatchel & Turk, 1996) which may mitigate against their ability to engage in psychological treatment. Thus the first task of the psychologist is to ensure that the patient's pain is under adequate control. Patients in extreme pain, with significant emotional distress, may be unable to perform the focusing and concentration that psychological pain-management requires.

The presence of a medical diagnosis, together with the patients attitude to it, must be considered. The presence of a diagnosis has been found to be a strong predictor of recovery (Brown, 1998) and is an often over-looked variable in the experience of pain. Since there is no adequate medical explanation in up to 85% of cases of chronic pain (Deyo, et.al., 1998) the presence or absence of a medical diagnosis must be considered. Patients with anxiety associated with uncertain diagnosis will have limited motivation for psychological treatment. Once it is established that the patient's pain is within tolerable limits and they are accepting of their diagnostic status, it is appropriate to commence psychological interventions to change their pain experience.

The third task of treatment marks the beginning of psychological attempts to transform the pain experience. This begins with the identification and prioritization of specific issues to be addressed in treatment. Chronic pain sufferers are invariably seeking pain relief, better control over their pain and relief from suffering associated with pain, however, each patient has different priorities according to their personality, life circumstances, degree of suffering and distress etc. It is thus necessary to elicit each patients priorities according to their individual needs.

The fourth task is the desensitization and reprocessing stage. Here the patient focuses on their pain whilst also attending to the bilateral stimulation. Following each set of bilateral stimulation the therapist helps the patient notice whatever changes have occurred and facilitates cognitive interpretation of those. For example, following bilateral stimulation the therapist asks the client "what do you notice now?". The client might report feeling the pain is softer or smaller, their belief about their ability to control their pain might change from 'I'm helpless' to 'I can learn to control my pain'.

The fifth and final task is to integrate the changes in physical sensations the patient has reported cognitively. This is achieved by inviting them to create associations between the feelings of relief and memories of situations or things that remind them of the feeling. The author has designed a set of questions designed to facilitate these associations. These include; "So what's there now where the pain was before?" and "What does that feeling remind you of?" For example, in response to noticing the pain feels softer, a patient might think of cotton wool.

The patients' responses are developed and reinforced by instructing them to 'think of that', whilst simultaneously attending to further bilateral stimulation. Typically patients report a strengthening of whatever positive changes previously noted. They are then instructed to practice at home by thinking of the anti-pain imagery whilst attending to bilateral stimulation (this may be achieved through self-stimulation in the form of tapping, or by listening to a tape of stereo bilateral audio tones provided by the therapist). Patients were instructed to practice only if they found this helpful, and to practice "a little, but often", perhaps only five or ten minutes at a time, several times per day.

Case Example

A 40-year-old mother of two was referred by her general practitioner for help coping with chronic pain caused by a work-related accident.

I obtained the following history from her at our first meeting. About two years prior to seeing me, Sue worked in a leather tannery. One day she went to remove a hide from a stand, and the stand toppled causing animal hides weighing about 1,000kgs to fall onto her. She was pinned to the ground by the legs and immediately felt excruciating pain. She suffered broken bones in her right foot and damaged nerves and tendons, and chronic pain in her legs. She had to quit her job and underwent various medical investigations and procedures, but nothing seemed to alleviate her pain. The family moved to the area where I worked, and she found work as clerk in a local hospital. She continued to suffer pain, and had trouble sleeping. The pain also restricted her ability to do things she used to enjoy outside of work, such as dancing. She was particularly upset at no longer being able to wear high heels on social occasions.

She had been prescribed pain-killers, but disliked taking pills and only took them if the pain became unbearable. Over a period of time, the chronic pain, disability, and uncertainty regarding when it would end, made her start feeling depressed and she told her general physician who referred her to me. She was quite anxious with me initially, and clearly had been having a hard time of it, but hadn't talked to anyone about how the situation had really been affecting her. My informal approach, whilst still obtaining necessary clinical data, soon put her at ease.

Towards the end of the interview, she admitted that she also experienced flashbacks and nightmares, in which she saw herself underneath all the hides, screaming. She had heart palpitations when faced with situations that reminded her of the accident. E.g.; having to get files down from high shelving at her office job. About mid-way through the EMDR treatment, it would emerge that she had also been sexually abused and had never dealt with it. She also told me that she had severe pain in her knee, but that the doctors hadn't paid any attention to it.

The issues in this case were:

1. inadequately managed pain

2. uncertainty about diagnosis

3. medical mismanagement

4. communication problems with doctors

5. medication issues (fear of addiction)

6. comorbid psychiatric condition (PTSD)

Although her medical investigations were not complete, and she had litigation issues, I decided to use EMDR with this patient because at least the trauma could be resolved, and maybe the pain.

The two 'targets' for reprocessing were the accident, and her pain. At the second session, I discussed her concerns about her diagnosis, and the pain in her knee, and she reported that she was due to see another specialist in a few weeks time, so we left it at that. She indicated that the thing she wanted to feel better about the most was the accident, so we made the trauma the first target for EMDR.

She could easily recall the picture of herself lying on the factory floor underneath all the hides. Her negative cognition was "I could have been killed" her subjective units of distress (SUD's rating) was 10/10 Her positive cognition was "I survived" with a validity of cognition (VoC) of 3/7. During EMDR, her SUD's went down to about 5/10 and her negative cognition changed to "I'm helpless". She also reported a significant reduction in the pain she'd been experiencing when the session commenced. The session had to be closed down before the reprocessing was complete. I gave her a relaxation tape that incorporates bilateral stimulation, for home use.

After her second session of EMDR, she reported feeling more relaxed when having to get things down from high places at work which had really been bothering her, but still having some anxiety when remembering the accident. She reported trying the relaxation tape and finding it helpful, but not nearly as effective as the therapy. But she reported that this week her pain had been much worse, 8/10.

She indicated that although she wasn't totally over her PTSD, the pain was bothering her more and asked if we could try the EMDR on her pain.

I asked her to describe the pain, which she described as burning and pressure, and likened it to a tight elastic band, hot. Her negative cognition was; "there's something wrong" Her SUD's (pain rating) was 8/10.

I targeted the pain by instructing her to "just notice the pain the way you described it and follow my fingers." Following several sets of eye-movements, between which she reported decreasing pain and different images,, the pain intensity decreased to 1/10. I asked her to describe what sensations she now felt where the pain was before in order to elicit something positive to use to start constructing a healing resource. She said it felt cooler and like the pressure had eased. I instructed her to "think of that" and did another set of eye-movements. She reported that the feeling was stronger. I asked her to "think about what that feeling and what does it remind you of?" She immediately replied, "a block of ice", so I instructed her to "think of that" and followed this with a few more sets, until she had quite a strong association between pairing the block of ice and the feeling of comfort.

In the following sessions, we addressed her trauma and her pain alternately. She would report good pain relief following sessions, sometimes lasting up to 24 hours, but that it would gradually return. It also emerged that she was unhappy in her marriage, she felt ignored by her husband, who worked long hours, and she was sure he was sleeping around. She began to realize she was very unassertive.

By her fifth session, she reported a complete cessation of flashbacks about the accident, but had recalled being sexually abused as a child. This was a painful thing, involving her father, which she felt deep shame and guilt about. She had never told anyone, and had tried not to think about it all her life. In the following five sessions, we addressed both her pain and her abuse.

The pain would remit following sessions, but then return a day or so later. The antidote imagery was only of effective short-term. She was scheduled to see a medical specialist about the knee the following week. Nevertheless, I gave her 'the pain question', to see if this pain had any meaning to her in terms of physical pathology. I instructed her to "picture the injury that was causing the pain,". She was able to do this easily and said that it felt like something was broken, but not a bone. She also realized that she was unhappy with the medical treatment she had received, and that she didn't feel that the doctors had been very thorough in their investigations.

The following week, when she visited the specialist, he agreed to an MRI scan of her knee which detected a torn ligament in the knee. She realized with surprise how similar this was to what she'd imagined was wrong, even though she had no way of knowing exactly what was wrong with her knee. There was nothing medically that could be done for her knee, but knowing what was wrong helped her to be able to develop antidote imagery to relieve the pain associated with this.

Over the next few sessions, we developed antidote imagery until she finally settled on a " healing hot pack around my leg". Her ability to regulate her pain increased. By the end of treatment, (total of 12 sessions) she was able to have almost entire weeks pain-free although she accepted that her knee would need time.

Follow-up

I received a card the following Christmas (about 12 months later) in which she advised she continued to be able to manage her pain using the imagery developed in therapy. She reported that she was completely free of posttraumatic symptoms, both from the accident and her childhood abuse. She added that she had instigated legal proceedings against the man who had sexually abused her, a step she could never have imagined taking prior to therapy. She had also left her husband and enrolled in a management course. She added that she had found a new boyfriend "who treats me like a person" and "I have taken life with both hands and I am not going to let anyone else choose the path my life takes.." About 18 months after she first came to see me, I

telephoned her to ask permission to use her case, at which time she reported that the improvement had been maintained.

Exerpted from Pain Control with EMDR (by Mark Grant, Mentor Books, 1999)

This information is provided by Mark Grant to assist you to participate actively in your treatment and cope with chronic pain in the best way possible.

Mark Grant is a psychologist, specializing in the management of chronic pain and trauma. His advice is based on many years of clinical experience working with persons affected by chronic pain and trauma.

Mark has also conducted research regarding a multi-modal approach to pain management. He is the author of two self-help tapes which use accelerated learning principles for sufferers of chronic pain and stress: Calm and Confident based on EMDR and Pain Control, based on EMDR. He has also spoken at numerous international conferences and workshops about pain management.