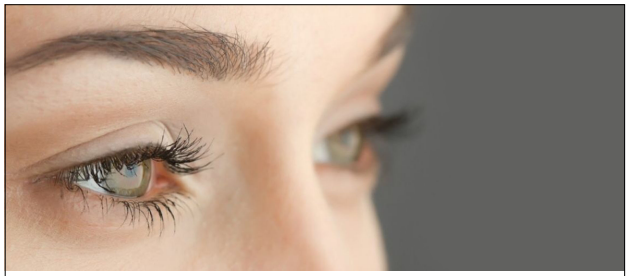

Somatic and Attachment Therapy for Chronic Pain and Illness

Part 1

Tyler Orr, LPC/MHSP

Day One

- 4:00-4:15 Introduction
- 4:15-5:15 The History and Science of Pain
- 5:15-5:30 Break
- 5:30-5:45 EMDR Research on Chronic Pain
- 5:45-6:15 Persistent Pain and Early Attachment
- 6:15-6:45 Pain-Informed History Taking
- 6:45-7:00 Summary and Questions

Day Two

- 9:00-9:30 Questions from Day One
- 9:30-10:30 Targeting and Reprocessing
- 10:30-10:45. Break
- 10:45-11:45. Demonstration Video
- 11:45-12:00 Summary and Questions

Chronic Pain and the AIP Model

The AIP model states that most pathologies are derived from earlier life experiences that are maladaptively stored in the nervous system.

As EMDR therapists, we see things like panic attacks, depression, and intrusive thoughts as symptoms—not the problem.

The same is true for chronic pain.

History of Pain Science

- Homer (8th century BCE) described pain as "arrows shot by the gods."
- Aristotle (384-322 BCE) stated that pain was due to evil spirits and that the gods entered the body through injury.
- The brain was not considered important for the experience of pain. Rather, the liver or heart was considered the center for pain control.
- Other influences: deities, energy fields, the moon, planets, and the stars

US Pain Stats

- Pain is the most common presenting symptom in medicine
- $560-$635 billion annually ($2,000 for EVERY person)
- Most common cause of disability (followed by anxiety/ depression)

- Low Back Pain:
  - 2nd most common reason for PCP visits
  - 80% of us will have it at some point
    - 30% of women; 25% of men CURRENTLY HAVE IT
  - 90% of cases resolve in 6 weeks, regardless of Tx
  - 90% of patients NEVER KNOW THE PRIMARY CAUSE!!

US Pain Stats

What we did…	What we got…
MRI's ↑ 300%	Disability rates ↑
Procedures ↑ 130-700%	Complications rates ↑
Surgeries ↑ +300%	No self-reported improvements
Opioids ↑ +700%	Costs ↑

	2000	2010	% Change
US Population	282 million	309 million	↑ 9.6%
Chronic Pain	45 million	100 million	↑ 122%

Western Medicine's Painful Beginnings

- Pain = Tissue Damage
- Pain as the "5th Vital Sign"
  - Just increase the opiates!
  - "True pain" = addiction is impossible
  - Medicalization of Symptoms
  - Doctors…"Oh, I can fix that…!"
  - Patients… "Doc, make it stop! Fix me!"
- Mechanic model
  - Pain as a Diagnosis (Fever as a Diagnosis)
  - Time/economic crunch, politics, Big Pharma
  - High Responsibility + Low Efficacy = BURNOUT!
  - Low Efficacy + Frustration = HOPELESSNESS!

Porter and Jick "Paper"

"Recently, we examined our current files to determine the incidence of narcotic addiction in 39,946 hospitalized medical patients who were monitored consecutively. Although there were 11,882 patients who received at least one narcotic preparation, there were only four cases of reasonably well documented addiction in patients who had no history of addiction. The addiction was considered major in only one instance. The drugs implicated were meperidine in two patients, Percodan in one, and hydromorphone in one. We conclude that despite widespread use of narcotic drugs in hospitals, the development of addiction is rare in medical patients with no history of addiction." (1980)

- One researcher, writing in 1990 in Scientific American, called Porter and Jick an "extensive study."
- A paper for the Institute for Clinical Systems Improvement called Porter and Jick "a landmark report."
- Time magazine in 2001 story titled "Less Pain, More Gain," called Porter and Jick a "landmark study" showing that the "exaggerated fear that patients would become addicted" to opiates was "basically unwarranted."

Western Medicine's Painful Beginnings

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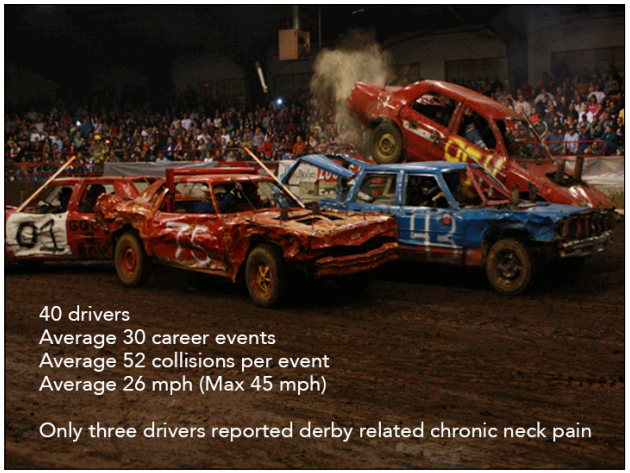
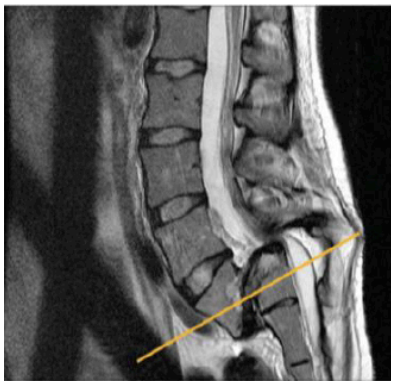
Age-specific prevalence estimates of degenerative spine imaging findings in asymptomatic patients

	Age (yr)						
Imaging Finding	20	30	40	50	60	70	80
Disk degeneration	37%	52%	68%	80%	88%	93%	96%
Disk signal loss	17%	33%	54%	73%	86%	94%	97%
Disk height lost	24%	34%	45%	56%	67%	76%	84%
Disk bulge	30%	40%	50%	60%	69%	77%	84%
Disk protrusion	29%	31%	33%	36%	38%	40%	43%
Annular fissure	19%	20%	22%	23%	25%	27%	29%
Facet degeneration	4%	9%	18%	32%	50%	69%	83%
Spondylolisthesis	3%	5%	8%	14%	23%	35%	50%

Brinjikji et al., 2015



Asymptomatic Grade IV Spondylolisthesis



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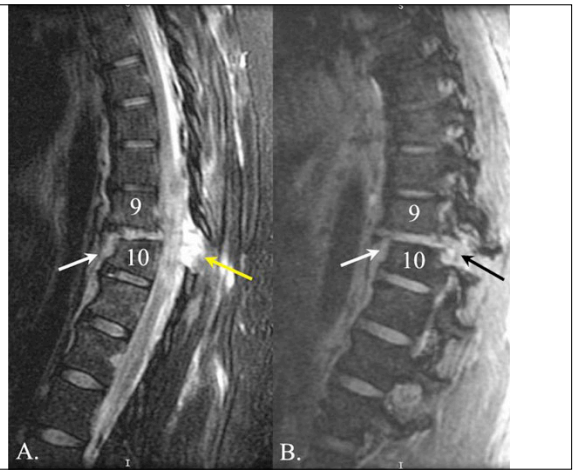
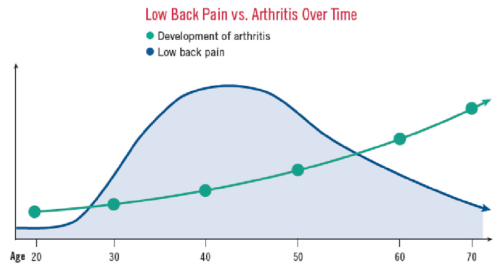


Arthritis and Pain



Pain Defined

Dictionary.com

1. Physical suffering or distress, as due to injury, illness, etc.
2. A distressing sensation in a particular part of the body

International Association for the Study of Pain

"Pain is an unpleasant sensory AND emotional experience associated with actual or potential tissue damage, or described in terms of such damage."

Lorimer Moseley

"Pain is produced by the brain after a person's [nervous system] has been activated and concluded the body is in danger and action is required."

YouTube TED Talk:
TEDxAdelaide - Lorimer Moseley - Why Things Hurt

Pain does not come from the body.

It comes from the brain.

All pain is a matter of perception—how the person's nervous system perceives what is happening.

Sometimes the perception can be incorrect, causing pain to persist beyond the necessary time for damaged tissue to heal, and/or exist even in the absence of detectable damage.

Low Back Pain Disability

- '64–'94 LBP disability rates ↑14 x population ↑
- Structural imaging = WEAK

Strong predictive factors:
- Psychosocial: SES, low social support/stability
- Abuse: childhood and adult (PTSD)
- Psychiatric Comorbidities
- Pain Beliefs / Maladaptive Coping
- Genetic/Epigenetic

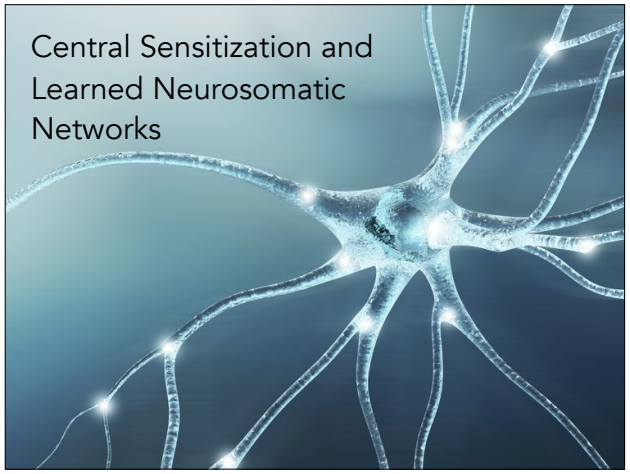
Most predictive factor ?

PTSD and Pain

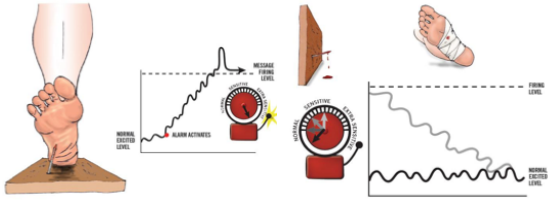
- FM, CFS, & IBS are strongly associated with depression, anxiety, and PTSD
- 55 % of fibromyalgia patients had PTSD
- FM + PTSD = More pain, emotional distress, life interference, and disabilities.

"We believe that here is a key to what in mainstream epidemiology appears as women's natural proneness to ill-defined health problems like fibromyalgia, chronic fatigue syndrome, obesity, IBS, and chronic non-malignant pain."

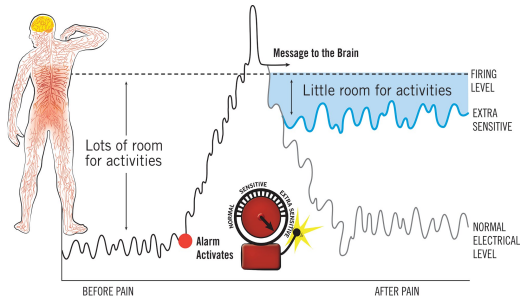
Central Sensitization and Learned Neurosomatic Networks



Pain Is Like an Alarm



Pain Reframed - The Body's Living Alarm System



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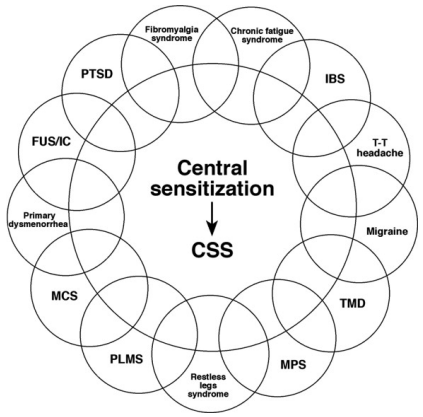


Central sensitization syndromes
Chronic functional syndromes
Psychophysiologic disorders
Tension myoneural syndrome (TMS)
Mindbody syndrome
Autonomic overload syndrome
Amplified pain syndrome
Somatic symptom disorder
Stress illness
Medically unexplained symptoms

Neurosomatic Sensitization

Sensitizing Factors

Central:

- Neuroplastic changes to nociceptive networks of central nervous system
- Inflammatory co-morbidities (e.g., autoimmune disorders, diabetes, heart disease, etc.)
- Inflammatory lifestyle (e.g., diet, sleep, etc.)
- Psychosocial risk factors (e.g., stress, powerlessness, trauma, emotional health, fear, etc.; most highly correlative factors to pain chronicity)

Peripheral:

- Injury
- Regional inflammation
- Neuromuscular guarding
- Repeated postures and movements
- Structural changes/ degeneration (least relevant, most of the time)

Those with early trauma and attachment disruptions are especially susceptible to the type of pain where there is no detectable tissue damage or reliable medical reason for the pain.

Clients need to know

- Your symptoms are real.
- You're not doing this to yourself.
- All pain is real. There is not real pain and imaginary pain.
- Pain is a complex process that involves more than just the tissue of your body.
- Pain can be triggered by tissue damage and also by neurosomatic pathways, even in the absence of tissue damage.
- All pain is generated by the brain.
- Your symptoms are real, but they will not harm you.
- Your brain has been sensitized and is creating symptoms.
- Most people experience this at some degree.
- You can get better.

Your client's back pain may not be rooted in the tissue of his or her back after all. Rather, it may be rooted in earlier experiences in the client's life that are presently stored in his or her system.

EMDR in the Treatment of Chronic Phantom Limb Pain (Schneider, Hofmann, Rost, & Shapiro, 2008)

- 38-year-old male with severe case of phantom limb pain after losing his leg in an accident
- Three years of unsuccessful treatment
- Eliminated pain and reduced opioid use after nine sessions of EMDR
- Decrease in PTSD and depression symptoms
- "The patient has renewed his ability to enjoy life and to explore new ways of making use of his time."

An Abortive Treatment for Migraine Headaches (Marcus 2008)

- 43 individuals diagnosed with migraine headaches
- Treatment outcomes suggest that EMDR may be an effective approach for aborting migraine headaches

EMDR in the Treatment of Medically Unexplained Symptoms (Van Rood & De Roos 2009)

- Systematic review of 16 studies on EMDR in the treatment of medically unexplained symptoms: 13 case studies, two uncontrolled clinical trials, and one randomized control trial
- EMDR might play a role in the treatment of medically unexplained symptoms

EMDR in the Treatment of Chronic Pain (Mazzola, Calcagno, Goicochea, Pueyrredòn, Leston, & Salvat, 2009)

- 38 patients suffering with chronic pain received 12 EMDR sessions over a 12-week period
- Treatment focus was to desensitize the emotional and somatic aspects of the pain experience
- Decrease in pain reports and medication intake
- Decrease in anxiety and depression
- "EMDR may function by desensitizing emotional aspects of the pain experience, allowing the patient to separate painful somatic perception from emotionally linked memories and allowing changes in the way pain is perceived and remembered."

Effects of Eye Movement Desensitization and Reprocessing (EMDR) Treatment in Chronic Pain Patients (Tesarz, Leisner, Gerhardt, Janke, Seidler, Eich, & Hartmann, 2014)

- Systematic study: Two controlled trials
- EMDR may be a safe and promising treatment option for chronic pain conditions
- Length of treatment may influence outcome—six or more sessions is favorable
- Therapist's training level may influence outcome
- No severe safety concerns were reported

Studies report that EMDR shows promise for treating chronic pain, but there isn't enough research to provide sufficient evidence.

"The results of this study indicate that EMDR therapy can be effective in the treatment of chronic pain and its effects in a heterogenous group of pain sufferers. Although most of the research regarding EMDR treatment of pain points to it being more effective with pain which is associated with trauma, studies have suggested that EMDR might prove to be effective in patients with high emotional distress but without a history of trauma because of the many similarities between chronic pain and trauma. Significantly, six of the nine subjects with clinical levels of PTSD symptoms and pain experienced a reduction in both PTSD symptoms and pain. However, all subjects in this study reported decreased pain following EMDR therapy (Grant, 2014).

The Answer

How we learned to stay safe and connected.

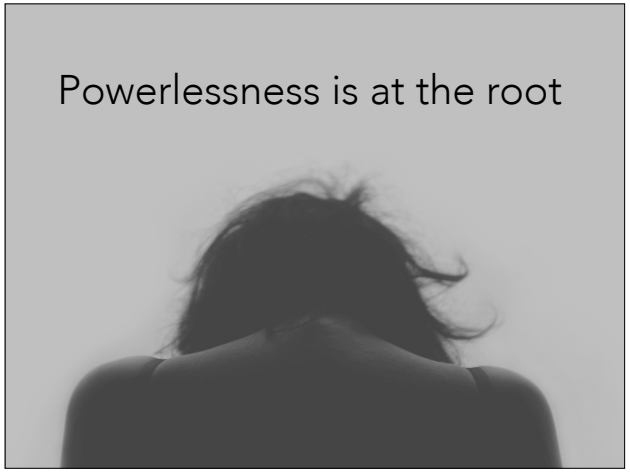
Examples:

- A child learns that emotions are a weakness and logic is encouraged by parents-
  - Good at thinking things through and being logical.
  - Not as good at connecting with emotions or being able to express feelings.
- A child learns to be good at noticing how other people are feeling and taking steps to make other people "happy."
  - Good at perceiving how others are feeling, pleasing others.
  - Not as good at tolerating the distress of others.

These character traits are commonly seen in people with chronic pain:

- Low self-esteem
- Perfectionism
- High expectations of self
- Wanting to be good or liked
- Guilt
- Dependence on others
- Conscientiousness
- Being hard on yourself
- Overly responsible
- Taking on responsibility of others
- Excessive worry
- Indecisiveness
- Helplessness
- Rule following
- Difficulty letting go
- Cautious, shy, or reserved
- Represses thoughts and feelings
- Lack of safety/ hypervigilance
- Harboring rage or resentment
- Not standing up for yourself

Powerlessness is at the root



These "Answer" character types are commonly seen in people with chronic pain:

- The rock
- The invisible one
- The emotional one
- The nice/non-threatening one
- The doer
- The hero

Two common factors of those with chronic pain:

1. Childhood abuse and/or neglect.
2. Overdeveloped personality traits

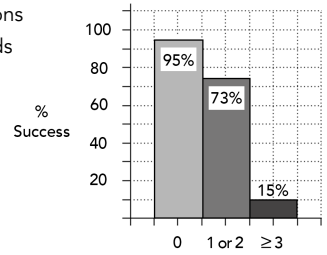
Even mild degrees of dysregulation rooted in childhood experiences can be enough to trigger symptoms.

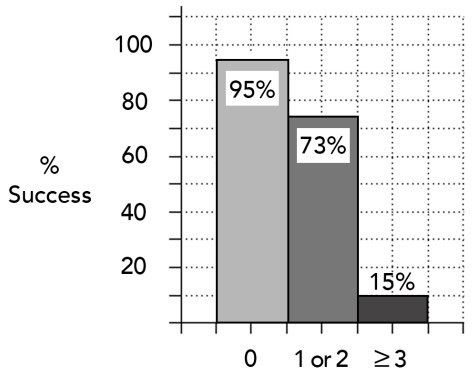
Regardless of the level of childhood stress, it's important to explore:

- How these previous experiences are currently being stored in the client's system
- How "The Answer" to these previous stressors are getting in the client's way
- Which past experiences are at the root of the client's pain

Lumbar Surgery Failure

- Failure = repeated surgery, continued disability, persistent opioids, repeated MRI/epidurals
- Consistent population, same indications/MRI's, same surgeries, same surgeons
- Childhood trauma leads to adult pain
  - Physical abuse
  - Sexual abuse
  - Emotional neglect
  - Abandonment
  - Parental drug use





Schofferman, Anderson, Hines, Smith, & White, 1992

ACEs Include

- Physical abuse
- Sexual abuse
- Emotional abuse
- Physical neglect
- Emotional neglect
- Mother treated violently
- Substance misuse within household
- Household mental illness
- Parental separation or divorce
- Incarcerated household member

Adverse Childhood Experience (ACE) Questionnaire
Finding your ACE Score as last 10-24-98

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often** …
   Swear at you, insult you, put you down, or humiliate you?
   or
   Act in a way that made you afraid that you might be physically hurt?
   Yes No If yes enter 1 _____

2. Did a parent or other adult in the household **often** …
   Push, grab, slap, or throw something at you?
   or
   Ever hit you so hard that you had marks or were injured?
   Yes No If yes enter 1 _____

3. Did an adult or person at least 5 years older than you **ever** …
   Touch or fondle you or have you touch their body in a sexual way?
   or
   Try to or actually have oral, anal, or vaginal sex with you?
   Yes No If yes enter 1 _____

4. Did you **often** feel that …
   No one in your family loved you or thought you were important or special?
   or
   Your family didn't look out for each other, feel close to each other, or support each other?
   Yes No If yes enter 1 _____

5. Did you **often** feel that …
   You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
   or
   Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   Yes No If yes enter 1 _____

6. Were your parents **ever** separated or divorced?
   Yes No If yes enter 1 _____

7. Was your mother or stepmother:
   Often pushed, grabbed, slapped, or had something thrown at her?
   or
   Sometimes or often kicked, bitten, hit with a fist, or hit with something hard?
   or
   Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?
   Yes No If yes enter 1 _____

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
   Yes No If yes enter 1 _____

9. Was a household member depressed or mentally ill or did a household member attempt suicide?
   Yes No If yes enter 1 _____

10. Did a household member go to prison?
    Yes No If yes enter 1 _____

Now add up your "Yes" answers: _____ This is your ACE Score

ACEs and Headaches

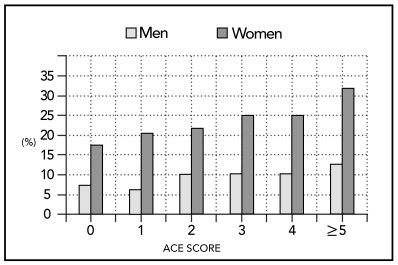


Figure: Prevalence of frequent headaches by Adverse Childhood Experiences (ACEs) score and gender. Estimates adjusted for age, race, and educational attainment; trend in increasing prevalence by ACE score is significant for both men and women.

Childhood Stress: A Predictor of Pelvic Pain

- Blinded observational study
- 25 women with chronic pelvic pain compared to 30 women being seen for tubal ligation or infertility with no pain
- Diagnostic laparoscopy showed no significant differences in severity or type of pelvic pathology
- Chronic pelvic pain patients showed significantly higher prevalence of major depression, substance abuse, somatization, and history of childhood sexual abuse.

Procedural Learning

These repetitive tension patterns, gestures, postures, and movements become the blueprints for the way you learn to move and hold your body throughout life. They become procedurally learned habits that endure into adulthood.

The patterns we display were formed because they were initially adaptive. However, later in life, when conditions have changed, the procedural learning remains in operation even if they are no longer appropriate responses to your current reality.

Just like symptoms such as anxiety or depression can become associated with a memory network, so can tension, posture, or pain.

Once these neurosomatic pathways are formed, they may be stimulated by present-day events that are similar to the previous event. Over time the neurosomatic network that contributes to the experience of pain can be strengthened, sensitized, and wired into the circuitry of the client's nervous system.

"Neurons that fire together wire together."
—Donald Hebb

Pain and "The Answer"

Many studies show that adverse childhood experiences can lead to an overly sensitized nervous system, which can lead to chronic pain later in life. These childhood stressors strongly influence and prime how a person's system responds to stress, how he or she perceives safety and attachment, and the character traits that become overdeveloped as "The Answer" to these stressors.

Phase 1

Check for symptoms and when they first occurred

- Heartburn, acid reflux
- Abdominal pain
- Tension headaches
- Migraine headaches
- Irritable bowl syndrome
- Unexplained rashes
- Anxiety
- Panic attacks
- Depression
- Fibromyalgia
- Back pain
- Neck Pain
- Repetitive stress injury
- Trouble sleeping
- Carpal tunnel syndrome
- TMJ
- Chronic tendonitis
- Facial pain
- Numbness/Tingling sensation
- Chronic fatigue
- Chest pains
- Irritable bladder syndrome
- Pelvic pain
- Muscle tenderness
- Tinnitus
- Dizziness
- PTSD

- When did the symptoms start?
- What was going on in the client's life around the time of the onset?
- What emotions were the client feeling around the time of the onset?
- Did the onset change how the client felt about him or herself?
- How did the onset of symptoms change the client's life?
- What diagnoses have been given previously?
- Medical procedures, hospital events, unpleasant doctor's visits, invasive or unwanted medical interventions
- Related losses

Investigate the client's childhood

- ACE Questionnaire
- How would you feel if someone you loved grew up the way you did?
- Look for more than just what happened. Look also for what didn't happen or ways in which the client had to hand over personal power.
- Explore how the client's personality traits where formed early in life.
  - What were these traits an "answer" to early in life?

How does the client guard him or herself from pain?

- What did he or she used to do that they can't do now?
- How has the experience of pain changed his or her life over time?
- What does the client do now to prevent or manage symptoms?
- What has the client tried already?

Signs there's something deeper at the root

- Symptoms shift from one location in the body to others
- Occurrence of a significant number of symptoms in the past
- History of adverse childhood events (ACE scale)
- Personality traits of self-criticism, self-sacrificing, perfectionism, need to please, etc. (personality traits checklist)
- Onset of symptoms coincide with significant stressful life events
- Onset of symptoms do not coincide with an obvious or recent injury
- Symptoms are in a distribution pattern inconsistent with a structural disorder, such as symmetric or one whole side of the body, or the whole arm or leg
- Symptoms have persisted after normal healing would have occurred

- Symptoms are bilateral in distribution
- Symptoms vary with time of day, place, or activity
- Symptoms are absent with a certain activity or exercise, but then occur later in the day or the next day
- Symptoms often begin or occur in the middle of the night or upon awakening
- Symptoms are correlated with stressful situations or the anticipation of stressful situations, such as family visits or work stress
- Physical exam does not reveal clear objective signs of pathology; no evidence of injury and a normal neurological examination
- Lab studies and imaging reveal normal or "normative" findings, such as degenerative disc disease or bulging discs frequently found in patients without pain
- Symptoms are triggered in the office when discussing stressful events

Neurosomatic Sensitization Checklist

Symptoms shift from one location in the body to others
Occurrence of neurosomatic symptoms in the past
History of adverse childhood events
Onset of symptoms coincide with stressful life events
Onset of symptoms do not coincide with an obvious or recent injury
Symptoms are in a distribution pattern inconsistent with a structural disorder. Example: one whole side of the body or the whole arm or leg
Symptoms have persisted after normal time for healing to occur
Symptoms are bilateral in distribution
Symptoms very with time of day, place, or activity indiscernible patterns
Symptoms often begin or occur in the middle of the night or when waking up
Symptoms are absent while doing certain activities, but then occur later
Symptoms coincide with stressful situations or the anticipation of stressful situations
Medical exam does not reveal clear objective signs of pathology
Lab studies and imaging reveal normal findings frequently found in patients without pain, such as degenerative disc disease or bulging discs
Symptoms increase in the office when discussing stressful events
Personality traits:

- Low self-esteem
- Perfectionism
- High expectations of self
- Wanting to be good or liked
- Guilt
- Dependence on others
- Conscientiousness
- Being hard on yourself
- Overly responsible
- Taking on responsibility of others
- Helplessness
- Rule following
- Difficulty letting go
- Cautious, shy, or reserved
- Represses thoughts and feelings
- Lack of safety/hypervigilance
- Harboring rage or resentment
- Not standing up for yourself
- Indecisiveness
- Excessive worry

Additional Notes: _____

Common Conditions of Neurosomatic Sensitization

- Tension headaches
- Migraines
- Back pain
- Neck pain
- Foot pain
- Whiplash
- Fibromyalgia
- Temporomandibular joint (TMJ) syndrome
- Chronic abdominal and pelvic pain
- Chronic tendonitis
- Vulvodynia
- Sciatic pain syndrome
- Repetitive stress injury
- Myofascial pain syndrome

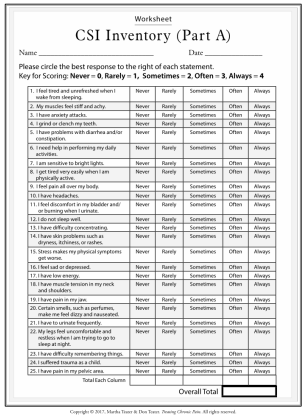
Autonomic Nervous System Related Disorders

- Irritable bowel syndrome
- Interstitial cystitis (irritable bladder syndrome)
- Postural orthostatic tachycardia syndrome (POTS)
- Inappropriate sinus tachycardia
- Chronic regional pain syndrome (CRPS)
- Functional dyspepsia or gastroesophageal reflux disease (GERD)

Other Syndromes:

- Insomnia
- Chronic fatigue syndrome
- Paresthesias (numbness, tingling, burning)
- Tinnitus
- Dizziness
- Spasmodic dysphonia and/or globus hystericus
- Chronic hives
- Periodic limb movements of sleep (PLMS)
- Multiple chemical syndrome
- Female urethral syndrome
- Interstitial cystitis
- Post Traumatic Stress Disorder (PTSD)
- PMS

- Adverse Childhood Experience (ACE) Questionnaire
- CSI Inventory (Part A and B)



Worksheet

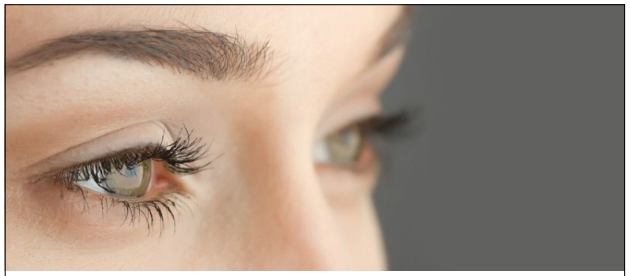
CSI Inventory (Part A)

Name _____ Date _____

Please circle the best response to the right of each statement.
Key for Scoring: **Never = 0, Rarely = 1, Sometimes = 2, Often = 3, Always = 4**

1. I feel tired and unrefreshed when I wake from sleeping.	Never	Rarely	Sometimes	Often	Always
2. My muscles feel stiff and achy.	Never	Rarely	Sometimes	Often	Always
3. I have anxiety attacks.	Never	Rarely	Sometimes	Often	Always
4. I grind or clench my teeth.	Never	Rarely	Sometimes	Often	Always
5. I have problems with diarrhea and/or constipation.	Never	Rarely	Sometimes	Often	Always
6. I need help in performing my daily activities.	Never	Rarely	Sometimes	Often	Always
7. I am sensitive to bright lights.	Never	Rarely	Sometimes	Often	Always
8. I get tired very easily when I am physically active.	Never	Rarely	Sometimes	Often	Always
9. I feel pain all over my body.	Never	Rarely	Sometimes	Often	Always
10. I have headaches.	Never	Rarely	Sometimes	Often	Always
11. I feel discomfort in my bladder and/or burning when I urinate.	Never	Rarely	Sometimes	Often	Always
12. I do not sleep well.	Never	Rarely	Sometimes	Often	Always
13. I have difficulty concentrating.	Never	Rarely	Sometimes	Often	Always
14. I have skin problems such as dryness, itchiness, or rashes.	Never	Rarely	Sometimes	Often	Always
15. Stress makes my physical symptoms get worse.	Never	Rarely	Sometimes	Often	Always
16. I feel sad or depressed.	Never	Rarely	Sometimes	Often	Always
17. I have low energy.	Never	Rarely	Sometimes	Often	Always
18. I have muscle tension in my neck and shoulders.	Never	Rarely	Sometimes	Often	Always
19. I have pain in my jaw.	Never	Rarely	Sometimes	Often	Always
20. Certain smells, such as perfumes, make me feel dizzy and nauseated.	Never	Rarely	Sometimes	Often	Always
21. I have to urinate frequently.	Never	Rarely	Sometimes	Often	Always
22. My legs feel uncomfortable and restless when I am trying to go to sleep at night.	Never	Rarely	Sometimes	Often	Always
23. I have difficulty remembering things.	Never	Rarely	Sometimes	Often	Always
24. I suffered trauma as a child.	Never	Rarely	Sometimes	Often	Always
25. I have pain in my pelvic area.	Never	Rarely	Sometimes	Often	Always
Total Each Column					

Overall Total



Somatic and Attachment Therapy for Chronic Pain and Illness

Part 2

Tyler Orr, LPC/MHSP

Finding the Target: Getting to the Root Script

"Please tell me some way you feel limited in your present life or a current symptom or issue you would like to focus on."	
"When you___ (the presenting problem), what is difficult for you to do, especially with people closest to you?"	
"Let's look at times in your life when you tried to do what is more difficult and it didn't go well."	
"Please tell me a recent time that would be an example of this issue" (Moment in time)	Socially, Work, Intimate Relationships
"Can you give me an example of how this shows up in your life socially?" (Moment in time)	Present Trigger PT #1:
"Can you give me an example of how this show up in your intimate relationships?" (Moment in time)	Present Trigger PT #2:
"Can you give me an example of how this shows up in your life at work?" (Moment in time)	Present Trigger PT #3:
"As you bring up the worst part of this issue, what is the worst part of it now?	
"How disturbing is it now, on a scale of 0-10 with 0 being no disturbance and 10 being the highest disturbance you can imagine?"	SUD (Level of Disturbance) 0 1 2 3 4 5 6 7 8 9 10
"When you bring up this disturbance what is the negative belief you have now?"	NC:
"When you bring up the worst part of the present issue and the words _____ (NC) what is an earlier time you can remember experiencing something similar?"	Earlier Memory: Age:
"And what is an earlier time?"	Earlier Memory: Age:
"How about an earlier time?"	Earlier Memory: Age:
"How about an earlier time?"	Earlier Memory: Age:
"How about an earlier time?"	Earlier Memory: Age:
"How about an earlier time?"	Earlier Memory: Age:
Clinician keeps asking as long as the client keeps answering. Earliest is the "touchstone".	
We recommend going straight to phase 3-7 after getting the earliest memory. The earliest memory is considered the Target or Touchstone Memory.	

Script: Finding the Targets: Getting to the Root of Chronic Pain

Presenting Issue: The client's experience of pain, including sensation, thoughts, and emotions.

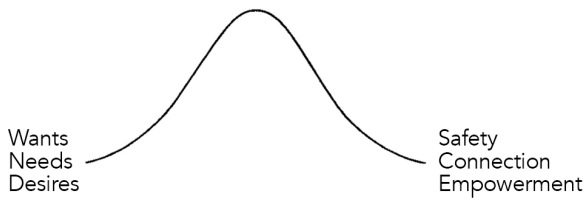
What's difficult to do?

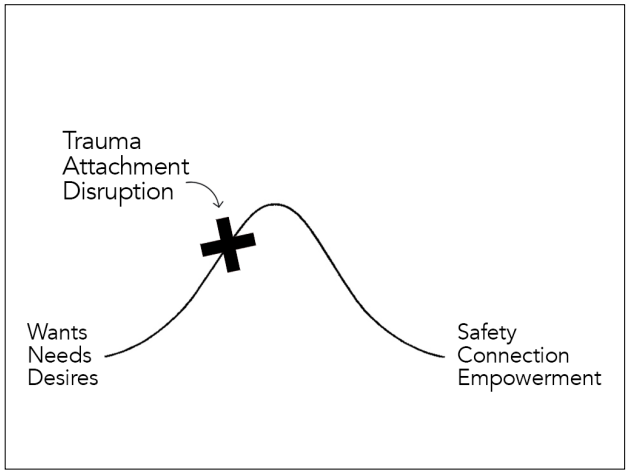
"When you are experiencing pain, what is difficult for you to do, especially with people closest to you?"

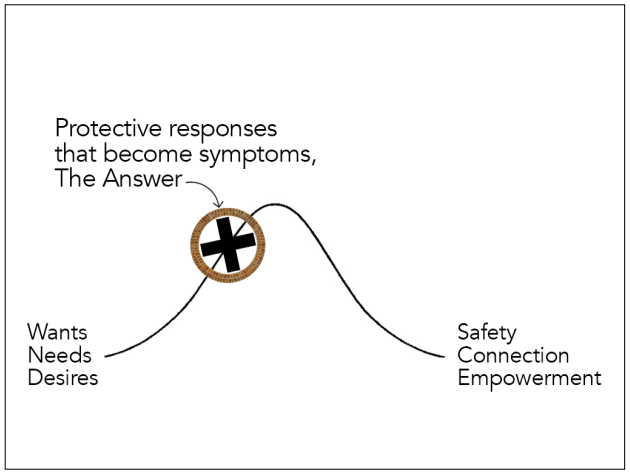
Example: "It's hard for me to feel like I belong."

Therapist: "Let's look at times in your life when you tried to do what is more difficult and it didn't go well."

Cycle of Wants, Needs, and Desires







What's difficult to do?

"When you are experiencing pain, what is difficult for you to do, especially with people closest to you?"

"When you are experiencing pain, what do you want or need that you aren't able to get?"

You are looking for wants, needs, and desires for safety, connection, and empowerment that are not being met.

Example: "It's hard for me to feel like I belong."

Therapist: "Let's look at times in your life when you tried or wanted to do what is more difficult and it didn't go well."

Present Trigger #1: *"Please tell me a recent time that would be an example of this"*

Present Trigger #2: *"Can you give me an example of how this shows up in your life socially?"*

Present Trigger #3: *"Can you give me an example of how this shows up in your intimate relationships?"*

Present Trigger #4: *"Can you give me an example of how this shows up in your life at work?"*

Worst Part:

"As you bring up the worst part of this issue, what is the worst part of it now?

Look for an emotional connection that goes beyond "It hurts."

Example: "I can't do things I enjoy with my family. I feel helpless."

SUD

"How disturbing is it right now, on a scale of 0-10 with 0 being no disturbance and 10 being the highest disturbance you can imagine?"

- "Disturbance" here is different than the typical "What's your pain level out of 10?"
- The SUD is a way of gauging the client's full experience of pain—mental and emotional upset surrounding the pain in addition to the level of pain that is experienced in the body.

Negative Cognition: *"When you bring up this disturbance, what is the negative belief you have about yourself now?"*

- Examples: "I'm powerless."

Earlier Memories: *"When you bring up the worst part of the pain and the words _____(NC) what is an earlier time you can remember experiencing something similar?"*

- *"How about an earlier time?"*
- Clinician keeps asking as long as the client keeps answering. Earliest is the "touchstone".

Float Back

deeper

- "As you bring up the recent experience of _____, notice the image that comes to mind, the negative belief you are having about yourself along with any emotions and sensations, and let your mind float back to an earlier time in your life when you may have felt this way before and just notice what comes to mind."

95

Affect Scan

deeper

"Bring up that experience, the emotions and the sensations that you are having now, and allow yourself to scan back for the earliest time you experienced something similar."

96

Future Desired State

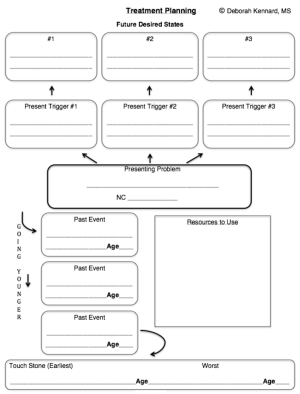
"Now I would like us to look at each present trigger and decide how you would like to react, behave, or feel in that situation when or if it happens in the future."

"As you think about the present trigger of_____, how would you like to be able to react, feel or behave when that or something similar happens in the near future."

"Now I would like us to look at each present trigger and decide how you would like to react, behave, or feel in that situation when or if it happens in the future." (This needs to be something you can imagine happening.)	Future Desired State:
One for each present trigger listed above. Present trigger 1: ***"As you think about the present trigger of_____, how would you like to be able to react, feel, or behave when that or something similar happens in the near future."***	Future Desired State:
Present trigger 2: ***"As you think about_____(name second present trigger), how would you like to be able to react, feel, or behave in the future?"***	Future Desired State:
Present trigger 3: ***"As you think about_____(name third present trigger), how would you like to be able to react, feel, or behave in the future?"***	Future desired state:

There may be more or less than 3 of each

Transfer the information to the one page sheet on the following page



Phase 3

1: Target Memory

- Target memory is a moment in time
- Always start with the earliest memory and work up in time.

"When you bring up that memory, what image represents the worst part?"

If there is no image: "As you think of the experience, what is the worst part of it?"

2. Negative Cognition

"What words go best with that picture that expresses your negative belief about yourself now?"

3. Positive Cognition

"When you bring up that picture (or incident) what would you like to believe about yourself now?"

4. VOC: Validity of Cognition

"When you think of that memory, how true do those words, (repeat the PC above) feel to you now on a scale from 1 to 7 where 1 feels completely false and 7 feels completely true?"

5. EMOTIONS

Identifying emotions associated with the targeted incident

"When you think of that memory, and the words_____ (repeat the NC), what emotion do you feel now?"

6. SUDS (SUBJECTIVE UNITS OF DISTURBANCE SCALE)

"From zero, which is no disturbance or neutral, to 10, which is the worst disturbance you can imagine, how disturbing does it feel to you now?"

7. PHYSICAL SENSATION

"Where do you feel it in your body?"

Phase 4: Desensitization Procedure

Transitioning from phase 3 to phase 4:

"I'd like you to bring up that image, those negative words_____ (repeat the negative cognition), notice where you are feeling it in your body, and follow my fingers." (or alternative bilateral stimulation, BLS)

- Stop BLS… "What are you noticing now?"
- "Go with that," or "Notice that."

Phase 5: Installation

- Purpose: To strengthen and link into more adaptive, positive networks
- Procedure: Strengthen validity of Positive Cognition
- Result: Positive Cognition and the Target Memory are linked
- BLS should not be slow. This is a reprocessing phase, not resourcing.

Phase 5: Installation

- Check the initial PC:

  "When you bring up the original incident, does your original PC ____ still fit? Or is there now a better statement?"
- Checking the Validity of the Cognition:

  "Think about the original incident and those words _____ from 1 being completely false to 7 being completely true, how true does it feel to you now?"
- Link the PC to Target and add BLS:
- "Hold them together. Those words_____ and that memory. " Do DAS.
- "On a scale of 1 to 7, how true do the words (PC) _____ feel to you now?" (After each set)

Phase 6: Body Scan

- Purpose: To process residual disturbance
- Procedure: Awareness on disturbing physical sensations
- This is a reprocessing phases, not resourcing
- BLS long and fast unless there is a good reason for another speed or length
- When working with pain, it is not a goal for the client to experience no pain to complete the body scan phase.

Phase 7: Closure

- "We are almost out of time and we will need to stop soon."
- "You have done some very good work and I appreciate the effort you have made. What feels like the most important thing you have learned about yourself or for yourself today?"
- "I suggest we do a relaxation (or a container) exercise before we stop. I suggest we _____."

If complete:

"The processing we have done today may continue after the session. You may or may not notice new insights, thoughts, memories, or dreams. If so, just notice what you are experiencing. Use the resources we have worked on to help manage any disturbance. We can work on this material next time. If necessary, you can call me.

Phase 8: Reevaluation

Check for what the client experienced between sessions:

- Assess if the client processed more between sessions
- Changes in symptoms—nuerosomatic symptoms and changes in what was difficult to do
- Changes in behaviors or patterns of relating
- Changes in reactivity or previous triggers
- Dreams
- New thoughts or insights

Assess the current state of the previous target:

- Is the previous memory still disturbing?
- Were other associated memories brought up?
- Were the present triggers more or less active?

Demonstration Video

Personal Transformation Institute

emdr-training.net

Insight
Pain Institute

insightpaininstitute.com

Tyler Orr

Licensed Professional Counselor
EMDRIA Approved Consultant

tylerorr.com

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