

EMDR and Chronic Pain: An Integrative Pragmatic Approach Convergences and Complementarities with Ericksonian Hypnosis

Practice-based reflection

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Abstract

Chronic pain encompasses complex emotional, cognitive, behavioral, and traumatic dimensions beyond nociceptive transmission. This clinical perspective examines EMDR (Eye Movement Desensitization and Reprocessing) as an integrative tool in pain medicine, highlighting its striking convergences with Ericksonian hypnosis.

EMDR demonstrates efficacy across chronic pain conditions including musculoskeletal pain, headaches, and fibromyalgia. We describe a pragmatic approach treating current pain experience directly as a target, allowing spontaneous material emergence without imposed causal narratives.

EMDR and Ericksonian hypnosis share remarkable phenomenological similarities: altered consciousness states, mental imagery work, unconscious resource access, and therapeutic dissociation. Each offers complementary advantages—EMDR provides structured protocols; hypnosis enables creative flexibility and immediate sensory modulation.

This integrative perspective embraces epistemological humility regarding incomplete mechanistic understanding. In pain medicine, theoretical uncertainty becomes clinical freedom: pragmatic tool selection based on patient need rather than theoretical orthodoxy. What ultimately matters is clinical efficacy with patient's respect.

Keywords: EMDR, chronic pain, hypnosis, Ericksonian approach, trauma, pain management, integrative therapy

1 - Introduction

Chronic pain involves both nociceptive signal transmission and a complex clinical picture encompassing emotional, cognitive, behavioural, and sometimes traumatic dimensions that amplify and maintain suffering far beyond the initial injury. While medical hypnosis has demonstrated its efficacy in modulating pain experience [1,2], EMDR (Eye Movement Desensitization and Reprocessing) emerges as a compelling complementary tool. This article presents an integrative vision of EMDR in pain medicine, grounded in rigorous clinical practice and the critical thinking necessary when facing therapeutic dogmas.

2 - EMDR

EMDR is a structured psychotherapeutic approach initially developed by Francine Shapiro to treat post-traumatic stress disorders [3]. Its principle relies on reprocessing dysfunctional information through alternating bilateral stimulation (eye movements, tapping, auditory stimulation).

Here is a summary of the essential technique:

2.1 - It all begins with target identification - interconnected elements to reprocess

- The image of the most difficult moment. Not the entire film of the event, just the most painful instant. This is the entry point into the traumatic memory network.

- The negative cognition (NC), a toxic belief about oneself, always formulated in present tense and first person: "I am powerless", "I am in danger", "My body is broken". This is what the patient thinks about themselves when reconnecting to the event.

- The positive cognition (PC), the desired, realistic counterbalance: "I can cope," "I am safe now," "I'm doing my best," whose validity we assess using the VOC scale (Validity of Cognition) from 1 to 7.

- The emotion: fear, anger, shame, sadness, despair... We name it precisely and evaluate its intensity using the SUD scale (Subjective Units of Disturbance) from 0 (total calm) to 10 (maximum disturbance).

- The body sensation, where this emotion lodges in the body. Trauma, like pain, is physically inscribed: chest tension, stomach knot, throat tightness...

2.2 - The reprocessing process

Once the target is identified, the patient simultaneously focuses on these elements while the therapist induces alternating bilateral stimulation (generally 20-40 eye movements per set). After each set, we simply ask: "What comes up for you now?"

The patient may report new images, thoughts, emotions, or sensations. We repeat the sets until the material is exhausted and the SUD reaches 0-1. We then install the positive cognition (VOC 6-7) and verify through a body scan that no residual tension persists.

3 - EMDR and Chronic Pain

3.1 - Chronic pain often carries multiple traumatic layers:

The initial event: accident, surgical intervention, brutal diagnosis

Iatrogenic traumas: "we don't believe you," "it's in your head," medical odyssey

Repeated trauma: therapeutic failures, learned helplessness, progressive loss of autonomy

Pain itself as continuous trauma: unpredictable, uncontrollable, threatening

This traumatic dimension maintains a vicious circle: trauma amplifies pain, chronic pain becomes traumatizing, and so on. Studies have shown a strong association between post-traumatic stress and chronic pain, as well as between premorbid traumatic events and the development of chronic pain [4].

3.2 - EMDR efficacy in chronic pain

A systematic review by Tesarz and colleagues (2014) [5] concludes: "Although the results of our study suggest that EMDR may be a safe and promising treatment option in chronic pain conditions...".

Randomized controlled trials have demonstrated EMDR efficacy for various pain pathologies: chronic musculoskeletal pain, low back pain, headaches, phantom limb pain, fibromyalgia, and rheumatoid arthritis [6,7,8].

3.3 - Direct approach to the symptom: working without archaeology

Contrary to the prevalent and useful idea that one must trace back to a foundational event - often in childhood - it is possible to treat the current pain experience directly as a target in itself, the image of a trigger. The question of narrative causality is interesting, with all due attention to the risk of creating false retrospective causalities: "you have back pain because your father criticized you" may be a temporal correlation, not a cause. Memory is reconstructive, memories malleable. The therapist must avoid imposing their theories onto the patient's lived experience. What matters pragmatically: If treating a memory improves the current symptom, it's clinically useful. But this doesn't prove it was THE real cause.

EMDR Pain protocol

"If your pain had a shape, a color, an image, what would it be?" (a pulsating red ball, a vice squeezing, lightning bolts...) similar to the reification technique in Ericksonian Hypnosis

"When you feel this pain, what negative thought about yourself comes up?" ("I am powerless," "My body is broken")

We identify the emotion (anger, despair, fear) and evaluate the SUD

We locate the body sensation, which often corresponds to the patient's expressed complaint

Then we launch bilateral stimulation, asking the patient to focus on this pain representation.

What often happens:

The quality of pain changes (less sharp, moves, becomes more bearable)

Memories emerge spontaneously (without our seeking them)

Repressed emotions surface

The meaning of the pain reveals itself

The fundamental advantage: We let things come, we don't impose dubious and potentially harmful causality. If the patient's unconscious needs to bring up a childhood memory, it will. Otherwise, no matter - we work with what's there, now.

3.4 - Current triggers

Beyond the source event and the pain symptom itself, there are triggers - present situations that reactivate pain or pain-related anxiety disproportionately.

Examples:

Returning to a place associated with the accident

Anticipating an activity formerly causing pain

Facing a medical situation (examination, consultation)

These triggers can be treated directly with EMDR, with promising results for reducing pain intensity and pain interference in daily life [4,9].

4 - Ericksonian Hypnosis

4.1 - Common ground and complementarity

Hypnosis and EMDR share several mechanisms

Altered state of consciousness: Although EMDR literature avoids the term "trance," bilateral stimulation clearly induces a state of focused attention, absorption, and increased permeability to unconscious associations [10]. The practitioner trained in Ericksonian hypnosis will immediately recognize these mechanisms: altered state of consciousness, work on mental imagery, therapeutic dissociation. If EMDR literature avoids the term "trance", the clinical phenomenology is strikingly similar.

Work on mental imagery: Both approaches use sensory representation and indirect suggestion.

Access to internal resources: Trust in the patient's unconscious wisdom, in their capacity to heal.

Therapeutic dissociation: Allowing observation of a painful experience without being overwhelmed by it.

4.2 - Hypnosis efficacy for chronic pain

Hypnosis has demonstrated solid efficacy for pain management. A meta-analysis by Thompson and colleagues [1] evaluates hypnosis efficacy in reducing, with some success, experimental pain in healthy volunteers. Interesting but insufficient when working in the field of chronic pain, which is not just a symptom but a disease in its own right.

Langlois's article [2] on chronic musculoskeletal and neuropathic pain revealed a moderate decrease in pain intensity, with optimal effects for treatments of at least 8 sessions. Hypnosis has also proven superior to standard care and other psychological interventions for chronic pain [11].

In any case, it's no longer about knowing whether one intervention is more or less useful than another - that's an outdated battle. We must always combine different therapeutic modalities to help chronic pain patients regain their footing and find daily comfort. Even if hypnosis were only 5% effective, it would still be an interesting therapeutic tool. Our obligation of means commits us to this path.

4.3 - An integrative approach in practice

Before EMDR reprocessing: Install a "safe place" using hypnosis - a resource anchor that the patient can use between sessions if difficult material emerges. This emotional self-regulation technique is essential before mobilizing traumatic material.

During reprocessing: The therapist trained in both approaches recognizes signs of trance, knows how to accompany altered states, can use comfort suggestions if necessary, and adapts the pace according to patient needs.

For pain management

- Hypnosis: immediate pain modulation, analgesia, reframing
- EMDR: desensitization of associated traumatic and emotional charge

The two don't oppose each other; they complement each other.

The therapeutic stance: observe without controlling

One essential phrase summarizes this integrative approach: "What does the patient need?"

Rather than mechanically applying a protocol, the therapist adopts a stance of attentive observation, inspired by Milton Erickson: observe, observe, observe. EMDR's structured framework (its stages, its scales) is not a rigid cage but a securing framework that allows the patient to let go.

The structured framework has a therapeutic function:

- For the patient: reassuring containment against traumatic chaos, predictability, sense of security
- For the therapist: guiding thread through complexity, protection against emotional over-involvement

5 - Conclusion

EMDR and Ericksonian Hypnosis share remarkably similar mechanisms: altered state of consciousness, work on mental imagery, access to unconscious resources, therapeutic dissociation. However, each approach has its specificities: EMDR offers a structured framework (8-phase protocol, validated scales) particularly adapted to traumatic reprocessing, while hypnosis allows creative flexibility and immediate modulation of sensory experience. Some patients respond better to one than the other for reasons we don't yet understand.

What is bold is recognizing that we don't know exactly why these methods work. The slow-wave sleep hypothesis is seductive but incomplete. Current theories illuminate certain aspects while leaving others in shadow. In pain medicine, this theoretical uncertainty is not a problem but a freedom: it allows us to use these tools in an integrative, pragmatic way, without dogmatism. The therapist trained in both approaches can recognize their kinships without confusing them, navigate between them according to patient needs, observe what emerges rather than impose orthodoxy.

The real boldness is not declaring that one method works better or worse than another, but accepting that we work with processes we only partially understand, and that this epistemological humility is precisely what allows us to remain in service of the patient rather than in service of our theories.

What matters: "It works - and that's already good to take." The rest belongs to future research.

Conflict of Interest: None declared

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