

COGNITIVE THERAPY FOR PAIN MANAGEMENT

**Unedited Transcript of 90-Minute Workshop Presented by
Dr. Eimer at the American Academy of Pain Management Meeting
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Introduction

My name is Bruce Eimer. I'm a clinical Psychologist from Philadelphia. I'm in full-time private practice and I specialize in pain management. Pain management comprises about 50% of my practice. The purpose of today's course is to provide you with an introduction to cognitive behavior therapy for pain management. There are handouts. If you're compulsive about wanting to get as much information as you can, from a work-shop like I am, you'll be gratified to know that the handout has everything I'm going to talk about and much, much, much more. So every slide that you'll see and every transparency is in the handout, so you don't have to worry about taking notes, unless you find that that helps you to focus. The purpose of the slides is just kind of to help me sort of stay organized and on track. What I'm going to try to do this morning, we have about 90 minutes, I think I'm slated to relinquish this room at 11:10, if I'm not mistaken, so I think we'll have enough time to overview the material that I think is important for this kind of presentation and this length of time. I'm going to try to teach you some things in the next hour and a half that you can take home with you, back to your practice, and I'm also going to give you a gift, towards the end, if you are here at the end of the presentation, I shouldn't say that, of course, you're all going to be here at the end of the presentation and you're going to get a gift to take home with you, that you can have and I think you'll find quite useful that you can use for yourself, as well as with your patients and clients.

If you look at the transparency on the right wall, there is an outline or a course syllabus, and you have the course syllabus in your handout and it is numbered page III. So, this basically is an outline or a table of contents for your handout. There is much more in the handout than we're going to cover in this course.

A "roadmap": simplifying problems

I'd like to start out by telling you that my approach to both teaching and to stress management in my own life and pain management in my own life, and working with my patients is to try to reduce things into terms that are digestible and understandable, and to break things down in a way that gives people a clear road map for how to apply concepts and ideas and principles. In over viewing of the several of the different techniques that fall into the rubric of cognitive behavior therapy specifically applied to pain management, I'm going to reduce things for you and break things down, and they are broken down in your handout too, so you will be able to then apply these ideas.

Individualizing your treatment strategies

I want to emphasize that my bias has always been that people should, and this probably comes from that part of my clinical training that is psychoanalytically oriented, although I'm pretty much

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in a valid cognitive behaviorist, in my orientation, to doing therapy, but my psychoanalytic training kind of emphasize the importance of respecting the individual's individuality. While modeling and observational learning is an important part of education, of all kinds, I think it's important that you integrate all of your new learnings into your own personalities and your own ways of thinking and doing things, which you are going to do anyway. So, what I'm basically trying to say is, whatever verbiage I use in some of my examples, feel free to adopt to your own style what you wish to adopt and feel free, as well, to use your own words in applying some of the techniques that I'm going to go over, because you can't be anybody else, but yourself. I work pretty well with mnemonics and with algorithms, and so, therefore, you'll see in your handouts, when we go over some concepts, and in the slides, some cutesy little mnemonics that I have developed to help sort of jog my memory about some of these ideas and techniques.

The book Pain Management Psychotherapy: A Practical Guide

I want to just mention, and I do have an interest in this, I wrote a book entitled pain management psychotherapy, it's published 1998, John Wiley and Sons, in which all of the material and much, much more, in which, which I'm going to be talking about is covered. The reason I wrote this book, to be quite honest, is to help me learn more, and so that I could be a better pain management therapist. The truth is that when you write something, you learn it better, than the people who read what you write, and the purpose of the book was to put in one place, in an organized manner, a lot of different techniques for assessment and for therapeutic intervention, that were scattered in a lot of different places, and reviews of research, and so on, and basically to break it down, so that it's usable and so that it can be easily referenced.

The relevance of CT to pain management

The concept of cognitive therapy is really, really relevant to pain management because, one of the basic assumptions of cognitive therapy is that we all talk to ourselves. The concept of self talk is a very important concept, and it refers to the kinds of thoughts that we have about our experience that we play in our minds, in abbreviated words and abbreviated form, mental pictures, memories, images and so on. Our thoughts determine how we feel and how we let ourselves feel.

And I think that after spending the last three days here at this marvelous conference, which is an opportunity for people from a wide and desperate world of healing, to get together. What strikes me, and which is also consistent with much of the research in psychotherapy is that pretty much everything works, and why is that. There are people that claim that magnets heal directly and that healing is mediated through the meridians in acupuncture and so on.

Positive intention. My particular theoretical model leads me to believe that things work if there

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is positive intention, if the person who is experiencing the method or the technique believes in it, and if there's positive expectancy and positive self efficacy, and in any kind of therapeutic relationship, it is my very firm belief that the techniques cannot be applied in a cold and dry, and removed manner, and that whatever it is, whether it's acupuncture, or magnetic healing, or hypnosis, or psychotherapy, or biofeedback, or physical therapy, or chiropractic, or what have you, osteopathic manipulation.

The therapeutic context and the central role of thinking processes. If there's not a positive relationship, a good working relationship, that there is no fertile soil for the techniques to take rooting and for the methods to really work from. So there has to be a positive context for healing in which to take place. An example that I want to give you, as an introduction to my model of working, and this really highlights the importance of thoughts, the connections between thoughts and feelings, and feelings and thoughts, is the idea that if you think about yourself being in a wonderful environment, you can be in a place that's extremely beautiful and yet, feel miserable. You can go to a practitioner, who is physically is convinced that he or she takes away your pain, through acupuncture, or through magnetic healing, or hypnosis, or osteopathic or chiropractic manipulation, all of which are excellent modalities that are grounded in particular world views, and yet if you're thoughts are catastrophic, negative, miserable, horrible, depressogenic thoughts, you're not going to be able to, because of the mood state that you're in, you're not going to be able to appreciate the power of whatever it is that you just experienced. So think about it, I'm sure everybody has had the experience of being in a beautiful surrounding, perhaps on a beach, or sitting by a lake in the country, and the people that you're with may be having a good time, and for some reason, you're preoccupied with something that's bothering you, and you're not in frame of mind to really enjoy the beautiful benefits of where you are, of your environment. Or, if you go to a healer, and you're not in frame of mind to really appreciate what the healing that's going on, it's going to effect the efficacy of that process. So, all this, as an introduction to highlighting the importance of thoughts as a kind of determiner, a mediator of how we feel.

Now, if you turn to the pages II and III on your handout, you'll see, I kind of cramped into small print, so I could get everything in there, at a minimum of copying costs, you'll see a number of definitions, and I put some of those on slides, which I'm going to go over briefly because these form a basis for understanding some of concepts that I think are important.

Defining "pain". First of all, the IASP, which is the International Association for the Study of Pain, defines pain, this is the accepted definition by the Premier World Organization that sets standards for pain treatment and pain management, and the definition is that pain is an unpleasant

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sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage. This definition is important because it highlights that pain is an unpleasant experience with both sensory and emotional aspects, and when we think of emotional aspects of pain, what we think of is the suffering component, that pain is not just pain, pain includes, not only the sensory aspect, but it includes the emotional and the cognitive aspects of how it's being interpreted by the individual.

"Cognitive therapy". This definition for pain underscores the relevance of psychotherapy and especially cognitive therapy for pain management, because cognitive therapy is a form of therapy in which patients or clients are taught skills for identifying evaluating and responding to their self defeating or dysfunctional thoughts, and it employs techniques to change thinking mood and behavior. It's relevance to pain management is that the basic tenant of the cognitive model is that people are upset not as much by the things that happen to them, as by their interpretations of personal events, and this principle is relevant for understanding the experience of physical pain because the personal meaning that an individual that suffers from physical pain, makes of the pain plays a major role in determining a person's suffering.

Pain and "Negative Thoughts". Most pain patients, pain patient being defined as somebody with persistent pain that comes to treatment with the chief presenting complaint of being pain and the chief goal of seeking pain relief, most pain patients, given the nature of pain, and that pain is noxious stimulation, nociceptive stimulation, most pain patients have negative thoughts related to pain, because certain stimuli are more likely than others to activate negative thinking, and persistent noxious input is was such stimulus. So constant or frequent bombardment with pain is going to obliterate homeostasis, it's going to obliterate a comfortable steady state, and it's going to make a person more vulnerable to thinking negatively because having to live with a mantel of pain is going to block goal oriented behaviors and siting Freud's idea, is it's going to interfere with the realization of the pleasure principle. So that because people with chronic pain live with persistent pain, it increases their proneness to interpreting a myriad of events in negative terms, which if not looked at and refuted can make their pain worse by increasing the negative emotional component and increasing their suffering. So, this is the basic, let us say, assumption or basic rationale for talking about applying cognitive therapy to helping people achieve relief from pain.

Classifying pain. Several quick further definitions. I'm sure that all of you can differentiate between the terms acute pain and chronic pain. There are different classification systems for differentiating different kinds of pain, chronic pain is generally thought of as pain that doesn't

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respond to treatment that lasts for more than three to six months and that is persistent and remains with an individual. Pain can be also kind of subclassified in terms of it being objective or logical, which means that pain that can be associated with an objective or logically identifiable physical cause and pain that can't. Although the distinction between psychogenic and physical pain is often too much of a black and white absolute kind of distinction. Then there's chronic benign pain, which is pain that's not associated with any kind of malignancy, and chronic malignant pain, and pain that's progressive, such as associated with certain diseases, which are verifiable and get worse.

The connection between "suggestibility", thoughts, and physical reactions. This cartoon shows a man reading a newspaper and he hears that the pollen count is 126 today, and he starts to sneeze and sneeze his head off. I thought this cartoon was kind of cute, somewhat relevant here because it underscores the role of suggestibility in creating physical reactions. In other words he hurt it and subconsciously it just caused the physical reaction in his body and he started sneezing.

The problem of "obsessing" about pain. Okay, moving on, I think this is kind of a cute cartoon, this is a Charlie Brown cartoon. Linus is sitting there and he says oh no, not again and Lucy says, what in the world is the matter with you, and Linus says, I'm aware of my tongue. She says, your what? Linus says, I'm aware of my tongue. It's an awful feeling, every now and then I become aware that I have a tongue inside my mouth and then it starts to feel all lumped up. She says, that's the most stupid thing that I've ever heard and he says, I can't help it, I can't put it out of my mind. I keep thinking about where my tongue should be and where it would be if I weren't thinking about it and then I feel it pressing against my teeth. Now it feels all lumped up again. The more I try to put it out of my mind, the more I think about it. And Lucy says good grief and then suddenly she gets the thought oh no, as she starts to get all preoccupied with the feeling of her tongue. And then she goes I ought to knock your block off. Again, you know, I think this is kind of relevant to what we often deal with, when we're talking about pain, because one of the key factors that promotes misery, if you suffer from continual or persistent pain is, focusing on it, thinking about it, and not being able to free yourself from attending to it.

My Intake Evaluation Format

What I'd like to do is I'd like to move on and I'd like to go through with you briefly an intake format that I use when I evaluate people that come to my practice with pain complaints. It starts on page V of your handout and it's something that you might want to feel free to use in your own practice, use it as a guide or adopt it as you see fit. Basically, at the outset of the interview, I get some basic non-threatening demographic kind of information. I gather some basic information

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about who the person that I am talking to for the first time lives with and what their living environment is, and I gather some family history about relevant medical conditions, and then I move on to doing the pain history.

The pain patient's "Basic I.D."

I organize the pain history based on a model I borrowed from a psychologist by the name of Arnold Lazerus, who practices what he calls multi-modal therapy. He's developed a system for evaluating and treating individuals which he calls the "BASIC I.D.". The basic I.D. basically divides personality functioning into seven basic modalities. I'm putting up here on the overhead, you also have this in your handout, and I think that when you look at this, you find that you can break down a person's functioning, you can think of our experience in the world as being dividable, if you will, into these seven dimensions. There's the behavioral dimension, B, the basic ideas and acronyms, so B stands for behavior, the things that we do. So this involves assessing what a person does before, during, and after they have severe pain. A in basics, stands for affect, so this has to do with emotions, a person's emotional reactions to being in pain. S stands for sensation and that has to do with the sensory aspects of pain. I stands for imagery, the mental pictures that people make in their minds. C stands for cognitive which has to do with the kinds of beliefs, automatic thoughts, attitudes, opinions, that people have about their experience of pain. I stands for the I and I.D?? stands for interpersonal, which refers to the interactions that the individual has of other people and D stands for drugs, which basically is an encompassing term that stands for the biological physical and medical aspects of the person's functioning. Now, you can intervene at any one of these levels. You can intervene on any one of these dimensions. So if you take a look at this slide, what I've done is, I've just basically code the most important, the most prototypical kinds of problems that individuals with chronic or persistent pain have in each one of these modalities. Under behavior, people with chronic pain tend to emince large amount of avoidance of activities that they used to do, as a result of pain. There may be and often is a lot of withdrawal, and there may be a tendency to over compensate for the avoidance and the withdrawal and to overdo things at times when they feel a little bit better, which then kind of restimulates the cycle, because when they overdo things and don't pace themselves, they reinjure themselves, and it's kind of like a dual edged sword because many people with chronic pain are caught in this trap where there is a lot of anger and resentment, which goes under the affective dimension because, you know, they feel that people really don't understand what they're really experiencing and what they're going through and the struggle that they have, they feel that people just pay lip service to that struggle because when you're hurting all the time, it really does put a damper on your life and the enjoyment of being on that beautiful beach or that beautiful surroundings by the lake, and there is a tendency to kind of shuttle, you know, kind of from one

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pull to other, or one extreme to the other, in other words, there's one extreme of feeling really miserable and this goes along with feeling depressed, and not wanting to do anything and being apathetic and kind of inert, and then when you're feeling a little bit better or you're really kind of getting angry at yourself for not doing anything for a period of time, shuttling to the other pole which is overdoing it, overdoing work in the garden and you know, spending three hours planting your seeds and then ending up, you know, with a severe, severe flare up and being in bed for the next week and being depressed about it. So this tends to be a pattern that we all see when we work with people with chronic pain.

The "Six Dysfunctional D's of the "Chronic Pain Syndrome"

Now, affectively speaking, I think that people that present with chronic pain syndrome, which is kind of a term that I've defined in your handout somewhere on the page on definitions, when we talk about chronic pain syndrome, we talk about depression, we talk about distress, we talk about disability, we talk about deficits in functioning, we talk about disrupted sleep and I've coined this kind of idea of the six D's of chronic pain syndrome and those are five of those six D's, I can't remember the sixth right now. All of that is connected with a tendency to have very extreme mood states or extreme affects. Having depression rather than disappointment, rage versus annoyance, apathy and withdrawal, and all this is associated with the experience of living with chronic unremitting pain. Under the sensory area, two things that stand out with a lot of chronic pain patients, with exceptions, of course, is the experience of allodynia which refers to basically experiencing painful sensations when being stimulated by none painful stimuli, in other words being touched becomes very painful for somebody that has reflex sympathetic dystrophy. Sitting in a chair can be extremely painful for somebody who has a low back syndrome. Hyperaesthesia, which is also an exaggerated response to painful stimuli.

Pain Imagery. Under imagery, how many people, raise your hands, have had chronic pain patients that you've evaluated or treated, who make extremely morbid, horrific mental pictures of their life and their situation, raise your hands if you experienced that. Okay, and that is a very important component of this basic idea of the pain patient, that begs for attention if you're going to do effective treatment.

Definition of "cognitive distortion". Under the cognitive dimension, we talk about cognitive distortions and in a minute I'm going to put a slide up that shows a list of some of the most common cognitive distortions that pain patients evidence. Let me just say something about cognitive distortions. There is some precise definitions that you can get for cognitive distortions, when you read some of the cognitive therapy textbooks, but basically, we all distort, don't we.

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I mean, if you're a cognitive therapists, or if you're a therapists, I think that with experience, kind of come to the view that everybody has their unique take on the world, that whatever reality is and I believe that there is reality out there, okay, that we don't see reality directly and we only can see reality through our own constructs and our own belief systems and our own ways of interpreting things. So we kind of filter reality through our own headsets. So we selectively distort information because it's adaptive, it's an adaptive mechanism. Right now, your sitting here listening to me and up until now you probably haven't been aware of the feeling of your back leaning against the back of the chair, and I'm sure you haven't thought about the feeling of your feet in your shoes until I bring your attention to it. If you sit here and you try to pay attention to what I'm telling you and you focus on everything about me, you know, if you focus on my shoes and my tie and my belt and my movements all at the same time and at the same time focus on the feeling of your back against your chair and the feeling of your feet in your shoes and your swallowing, and if you focus on Linus and Lucy's feeling of the tongue in your mouth, and all these things at once, which are all happening all at the same time right now, you're going to get kind of confused aren't you, you're going to get kind of disoriented and your not going to be able to focus. So distortion and selectively abstracting what's important and what's relevant is adaptive, but the definition of cognitive distortions that's useful is to say that a cognitive distortion is a thought about an event that is self defeating that cannot be backed up by the particular reality that makes sense in that context. Okay. So that if you think one way now, here in this classroom in this lecture, it hopefully is an adaptive thought about your here to learn something to pick up some knowledge that you can bring back to your practice, and that would be an adaptive thought. On the other hand, and you know, think of this perhaps, as a subtle suggestion to you, if you were instead focusing on one thing that I said or one thing that I did that you didn't like and you didn't hear all the other things that I'm saying that are worth while and that are useful, then certainly you have a choice to do that, but it's going to interfere, isn't it, with your being able to pick up useful information from it. In complementarily, I'm standing up here, and you know, a few people left the lecture, and if I were to become preoccupied with the possible reasons why they left, then I would become much less effective in giving you useful information, wouldn't I.

In fact, one of the key cognitive distortions that people with persistent pain engage in is the distortion of personalization, where they take things personally. They go to the doctors office and they're waiting for 15 minutes and they're in pain and maybe the chair is uncomfortable and they kind of maybe distort that and say, they kind of move that through their mental filter and conclude that the doctor really doesn't care about them. You could all probably think of your own or better examples. Another example of distortion that's germane to this same idea of personalization is

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making the error of thinking as if you're a mind reader or mind reading, and that would be thinking that you can really read somebody's mind, really know what they're thinking and what they're intending. So that, you know, if I were to say to myself, this would be my negative self talk that the couple of people that walked out of the lecture walked out because they didn't like me or they didn't think that what I had to say was useful, that would be mind reading, because I've been to a lot of different lectures over the last 3 days that I've walked out of, even when I thought that the lecture was very important and the speakers were great because I had to attend to something else. But mind reading is something a lot of pain patients engage in as a distortion.

I'm going to give you a few others a little bit later that I think are important to kind of be aware of. The interpersonal dimension is the I in the basic idea and that refers to the kinds of interactions that people who have persistent pain have with significant others and not so significant others in their lives, and I think that what's significant about this is that pain patients often tend to perceive their interactions of other people as being punitive, as being lacking in reinforcement. Well, they may not think of it in terms of reinforcement, but as a clinician, I think of it in terms of not getting a lot of goodies, a lot of positive reinforcement in their lives anymore.

Under the drug dimension, which is kind of like an all encompassing term for the physical medical aspects of pain, we can talk about the abuse of medicines, we can talk about muscle bracing and splinting and poor postural habits, we can talk about shortened irritable muscles, we can talk about myofascial trigger points, we can talk about asymmetries in the muscles and the musculoskeletal system, we can talk about the sleep disorder, which is so very often associated with persistent pain syndromes, especially fibromyalgia.

I want to make a point to you which I think is pretty important and that is that can you see how, by kind of breaking this down in basic I.D. terms, that practically all of what you might have encountered this weekend, here at this conference, can be considered part of this and that all of it is relevant, but it's really important to have a systematic model of framework for basically not being all over the place. I've said a number of times here this weekend that you can't do everything. Certainly you can't and you can't be an expert in all of these areas, but I think it's important to be aware of each of these areas and then to focus your efforts in those particular dimensions that you have expertise in and then to be able to talk intelligently with some of the other people from other disciplines, who hopefully are treating your pain patient that you understand some of what they're doing and some of the other dimensions.

"Unconscious" determinants

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Lastly, I added to the Lazarus BASIC I.D. model, the area of unconscious determinants and what I want to just say about this is that, let me see if I can bring up the slide. What I'm going to go through in the next few minutes is all on your handout and it's actually on page IV, so if you want to look at that, you might see that better than the slide. This is the armor stages of treatment model that I kind of invented, you know, as a way of thinking about the stages of pain treatment.

Basically, in doing cognitive therapy or psychotherapy with pain patients, the first thing to do is to assess the patient. The handout that I gave you is a very detailed framework, the intake format, for doing the assessment based on the basic I.D. that I just went over with you in a very overview terms. So that the pain intake form that I gave you, I invite you to use it, and it's organized in terms of those eight dimensions that I summarized before.

The "A.R.M.O.R." model for staging the treatment

The first step is assessment and then after you assess, it's necessary to do some education, it's necessary to do some, what is called in the literature, what in fact Dennis Turk talked about in his 1983 book on pain and behavioral medicine socializing the patient to the cognitive behavior model of the world. Or the cognitive behavior model of pain treatment. Then, the R in armor refers to relaxation and self control training, and basically I think that it's important after you develop some rapport with a pain patient, when you're doing psychotherapy, and you've done an assessment, and you've given feedback, and you've given them some understanding of pain mechanisms, that you teach them some methods for learning how to be more comfortable. We are going to go over one such method before the end of this session, and I'm going to give you a gift that you can use to experience this method yourself here, and take that home with you.

Relaxation is a very, very important component of pain management psychotherapy because you can't be relaxed and anxious at the same time. Relaxation is an antidote to anxiety and anxiety is associated with being in pain and suffering. So by relaxing, it helps to ameliorate anxious feelings and it also counters muscle spasm which makes pain worse. Learning how to relax, learning an appropriate method of relaxation, which you select from the many different approaches to relaxation based on your basic I.D. assessment of the patient, you teach that to the patient at this stage in the treatment and it helps to stabilize the patient, it helps to give them a safe place to go to, to use that metaphor. It helps to teach them some self control, which is a very, very important experience.

The M in the acronym armor, stands for mental imagery and cognitive restructuring, and basically, I have a bias, which is that all effective treatments that word and are effective with pain patients, or, in fact, with any kind of patient, work if they promote a change in that individual's cognitions,

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or beliefs, or opinions and interpretations of their problem, that all roads lead to cognitive restructuring, all roads across that basic I.D. lead to cognitive restructuring. Mental imagery is a very, very important modality for doing this, and, in fact, in meta analyses that have been done of the cognitive behavioral and the psychotherapeutic research with patients in pain, which has been reported by Karen Sejola? out of the Fred Hutchinson Cancer Center in Washington State, that imagery is one of the most key factors that mediates the efficacy, or the success of the various cognitive behavioral and psychological treatment programs, and I'm going to just briefly spend some time with you, in a little while, on an imagery exercise, that you can adopt and adapt to your own style of working with patients with pain, to help them develop more awareness with relief of their persistent pain.

Now, the O in Armor stands for origins of the pain, or uncovering work, and I think that it's very important to acknowledge the importance of providing a safe place for chronic pain patients to talk about all of their bad and traumatic experiences of the past, that they've had, that are associated with their continued suffering, and some pain patients, there's evidence that a certain percentage of pain patients have histories of trauma in their backgrounds. There's no question that living in persistent pain can be traumatic and can create trauma. Going through medical procedures, going through surgeries, failed surgeries and so on, can be very upsetting and traumatic, and I think that it's important for you, if your doing psychotherapy to provide an invitation to the patient, that lets that patient know that you consider it important to listen to their story and to help them to kind of put that story in a place where it won't be as prominent and as bothersome as it has been up until this point, which then of course increasing their suffering. It's important to be able to communicate that and then to follow through and do that.

Then the last letter in Armor is R and stands for rehearsal of coping strategies, and there are a myriad of coping strategies that you can teach a pain patient, that work. There's a lot of different techniques to select from, and in your handout I've written and summarized several.

The "D.I.A.G.N.O.S.E." model for the initial evaluation of the pain patient

This is kind of useful acronym that I have kind of developed. I can't take credit for the ideas, other than I simply am pretty good at coming up with mnemonics because it helps me to remember these things I read about in the literature. The mnemonic is diagnose, so if you can remember this mnemonic, you don't even have to have a pain intake sheet in front of you, when you are doing your intake, you know you can kind of use the steps in the diagnose work as your guide to gathering the most important kernels of information about a person's pain, if you're going to do psychotherapy for pain management. If we were doing a day long workshop, which we're not,

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or even a half day workshop, I would do some demonstrations.

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Some relief for some kind of acute or chronic pain, and basically, for those of you that are listening to the tape and for posterity, the diagnosed model is like so.

D stands for description of the pain, and, of course, I think that the most important thing that you have to get if you're going to try to understand somebody's pain is, how do they perceive it, and what kind of terms do they use to language it, to interpret it, to experience it, to communicate it, because for sure folks, how they communicate their pain to you is going to be related in a significant way to how they talk to themselves.

The I in Diagnose stands for images of the pain, and I said earlier that imagery has been associated to be a very key factor in the rated efficacy of psychological pain treatments in the meta analyses studies, and basically it's not just a statistical observation, but it's also a very individual one that you can verify in each individual case, and that when you're talking with a patient, you know, gathering information up front about their pain, you want to find out about how do you see your pain, what does it feel like, what mental pictures come to mind when you're in pain, when your pain gets worse, what does it feel like, what do you picture in your mind's eye and if you can please describe it. So that gives you some important material, then, to work with when you design an intervention.

The A in the word diagnose stands for anamneses, which I believe is kind of a highfalutin term that stands for taking a pain history. Doing the history and meaning that you have to gather or assess information about the onset of the pain. Very important is to gather information about the circumstances surrounding the origin of the pain and the onset of the pain. Both emotional and physical. You know, is the onset of the pain is associated with very marked emotional, negative emotional experiences which tend to imprint negative affect into the pain complex. This is important information to gather that's going to need to be addressed in the psychological treatment plan. Also, you want to know about the course of the pain syndrome over time, following it's onset. You want to know about other factors in the person's life and background. In your handout I gave you, in the intake form, there are a number of questions that you can ask the patient that address all of these kinds of things.

G stands for gets it better, gets it worse. Basically, this is just my attempt to kind of fit what information needs to be gathered into this diagnosed mnemonic. So basically, what we're talking about here gets it better, gets it worse, we're talking about what kind of antecedent factors make the pain better, make the pain worse. What kinds of activities make your pain better, make your pain worse. What kinds of thoughts do you have, when you're in pain, that make your pain worse,

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and what kinds of thoughts kind of make you feel better, make you feel stronger, make you feel more resourceful. What people in your life make you feel better, what people in your life make you feel worse. Where do you like to be, what's your safe place, what's your favorite pleasant peaceful place, where you feel more comfortable, where you can kind of retreat, that's what that refers to.

The "OPQRST" acronym. Okay thank you, just to repeat for those of you that might not of heard. The gentleman mentioned the OPQRST acronym, and familiar with the OPBQRST format of taking a history? No. If anybody's interested. The O stands for onset, P stands for provoking and palliative factors, Q stands for quality of the pain, the R stands for the radicular or radiation of the radiation of the pain, meaning the location, where in the body the pain is going to and felt, S stands for the severity or intensity of the pain and T stands for the time frame. Thank you.

Also, just to finish this diagnose piece. The O in my diagnose model stands for others. Of course it's important to assess the effect of the pain on important aspects of the individuals life. We are talking about the effects of being in pain on the person's vocation. The effect of the pain on the person's leisure activities. If there is any interference of sexual functioning, and the effects of the pain on one's relationships.

You're going to say that I skipped needles. I skipped needles, the N in diagnose stands for needles and that just a jogger, a mental jogger, a mental hook to remember to ask about past surgical treatments, drugs that have been taken, medical treatments, physical treatments, psychological treatments and so on. Nerve blocks or needles.

Okay, skipping O because we just did that, which stands for others. S stands for status and it's very, very important to do some assessment about functional status. You was to assess disability levels before and after the pain syndrome. You want to find out about premorbid functioning and compare that as best as you can to the patient's current level of functioning.

And lastly, E is a mental hook for the concept of secondary gains. In other words you want to find out from the patient, E stands for evens it up. So you want to find out a little bit about if there are some secondary benefits to having the pain.

Asking about "secondary benefits"

How do you ask about secondary benefits? I have to tell you that I always have a hard time giving a packed way of asking any question, because really how I ask any question is really kind of like

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based on the feelings that I'm getting from that individual when I'm with them. It's very patient centered and I won't ask a question the same way all the time. I know that some people tend to kind of remember sort of standardize kind of verbiage and ways of asking questions and argue for a standardized way of doing an assessment, where you're always doing the same thing with every patient, but I kind of individualize it, and I might just simply say or ask a patient, and I'm not going to ask it up front, you don't want to ask it until you've kind of shown a really good interest in the person and they feel comfortable and they've talked somewhat about themselves and the pain, and then at some point, you know, towards the later part of the interview I might throw in, you know, I really hear you about all of the terrible things that have happened to you and I really appreciate how vivid you've been able to be to give me an understanding of what you go through, but one thing that I find with a lot of people that I treat is that, like with anything, nothing is 100% bad, and sometimes there's a silver lining in a black cloud, and if you know what I mean, what I'm really kind of asking you, have you ever found a way to think about all this pain that you have as giving you some kind of leverage, some kind of advantage maybe, that helps you get something good, something that you want. I'm not implying anything, I'm just kind of asking, like you know, it helps you kind of get out of this, or get out of that, that kind of thing. So you kind of got to ask it real gingerly.

Pain as "unconscious punishment"

Okay, time for maybe a little cartoon here, to try to inject a little levity and humor. I'm not going to do anymore acronyms for you, because you have them all in your handout. I like this cartoon.

The fellow is thinking to himself as he has this back pain. If I can't get through to your conscious, says this little devil in his minds, that's pitch forking his back, the little devil says to him in his mind, if I can't get through to your conscious, let's see how you respond to some low back pain.

And very often, people who suffer from chronic pain, have some very, very, a lot of times it's unconscious, have some very, very punitive perceptions of the pain, that they view the pain as punishment for some misdeed. How can it not be if I'm suffering so much, I'm not being punished for some transgression that I've made in the past.

Need to look at the "whole person". I just want to take this moment to just throw in a bias that I have, it's not a bias, it's more of a kind of sort of a caveat, if you will, that there's a tendency, and I think there's a tendency in any kind of approach to treatment, that if you kind of have blinders on, and you don't look at the basic I.D., which is the whole person, and all you're looking at shortened irritable muscles, or all your looking at energy meridians, I think that you tend to miss other important things that need to be addressed. One of the things that I think is

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really important to address is this idea of the unconscious. You have to forgive me, it actually happened to me, this is good it only happened once, so far in this lecture, I actually lost my train of thought, and I was now it's unconscious, but I'm not going to punish myself about it, and I'm not going to blame myself about it, I'm going to use it and reframe it to teach you an important concept, which is that self blame is very, very destructive and it's important to assess this in pain patients and if you discover it, and they probably will deny it at the outset, but as you begin to work with a patient, you'll discover that there is self blame there, it's important to begin to understand and work with some of the beliefs here and try to refute them and change them, because it makes pain worse.

How cognitive distortions worsen pain and suffering

There's a fellow, a psychologist at GW University in Georgetown in Washington, DC, by the name of David Williams, whose a psychologist, a very active researcher in the pain field, and he's developed a scale, which I find very useful, which can be found in it's entirety in a number of places. It's called the pain beliefs and perceptions questionnaire. It's got sixteen items on it. This questionnaire can be found in a couple of places. I had his permission to reprint it in my book that I wrote, I wrote a textbook on pain management, called Pain Management Psychotherapy, a practical guide. It's published this year by John Wiley & Sons, and it's reprinted in that book, it's also available in the journal called Pain, I don't remember which issue it was, I think it's 1989's issue, and that's published by the International Association for the Study of Pain. It's also available in a series called Innovations and Clinical Practice published out of Professional Resource Press from Sarasota, Florida. Anyway, this scale I find very useful in my practice, because it tells me how a pain patient thinks about four very important issues, that have a lot of relevance for treatment planning. There's only 16 items and it gives you this information really quickly, it's quick and dirty.

These are the four issues. One is self blame. Does the individual blame themselves for their predicament. Are they self punitive, intra punitive.

A second issue is the issue of pain mysteriousness. Remember earlier I said that the first step in doing your pain treatment, after you do the assessment, is to begin to educate the patient and socialize the patient to your model of working. Help the patient to develop an understanding of pain mechanisms. Many patients come to me with a very poor understanding of their pain, in fact, they view their pain as being mysterious, and that has been associated with poor treatment outcomes. So it's important to assess this.

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The "constant pain syndrome" and psychogenic pain. A third factor that this brief instrument looks at is, the perceptions of the pain in time, so the issue is does the person think that their pain is constant. In other words, are you looking at somebody, here in front of you, who has what Dabney Yuhen?, a surgeon from New Orleans, calls constant pain syndrome. A very useful question that I ask people, which I learned from Dabney, is to ask them, do you always have pain. Are you in pain 100% of the time, and then I ask, do you also have pain when you sleep. There are patients that will say yes, yes and yes, and if they do, they have constant pain syndrome, which certainly, which invariably implicates very heavily psychogenic piece, psychological factors maintaining their pain. So the issue of pain constancy. Because certainly, you want to then help them to start to view their pain a little bit as being less constant, you want to kind of get them to begin to see their pain as variable, as less absolute, and you want to begin to help them to see that they're not always in pain. You want to change the perceptions of pain from constant to variable for intermittent. If somebody comes to you with a, you know, a kind of like acute recurrent pain syndrome, as opposed to a chronic pain syndrome where the pain is felt all the time, or constantly, such as somebody with low back pain, or somebody with a reflex sympathetic dystrophy, which has a constant pain component to it. Somebody with migraine headaches, you kind of think of as kind of like a chronic pain, but it's kind of recurrent and their episodes and it goes away, it comes back, that kind of thing. You want to begin to work with a patient to help them to begin to feel some control over the episodes, so that they can lessen the frequency and the intensity of episodes of pain.

And the last mentioned that this pain belief and perceptions questionnaire helps you to assess it, does the patient view their pain as permanent. And this particular dimension has been found in Dave Williams and Beverly Thorns' research to be the most toxic or nociceptive factor that predicts poor treatment outcomes, that people who come into treatment at the outset, who really believe that there is no cure for their pain, who believe that their pain is permanent and that where that perception is combined with the perception of pain being constant and mysterious present the most difficult cases to effectively treat.

I would like to move on into giving you a little information here on the cognitive distortions. I got to go through this to the end of the slides. The one thing that I didn't have in your handout, it was just an oversight, is a list of the cognitive distortions, so it's just in the slide.

Using the MPQ and Pain Rating Scales

Oh, this is important. This is take from Ron Melzack's McGill-Melzack Pain Questionnaire, and this is a simple scale for assessing the intensity or severity of pain. I think it's very important to keep in mind that people use different pain scales, people use 0 to 10, people use visual analog

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scales, people verbal numerical scales, which this is one of them, this is a 0 to 5 scale. I think it's very important to be sensitive though, when you're assessing pain.

Countering "absolutes". There's two factors I want to emphasize. One is, that's it's important to scale pain, because people who come to you, in pain, tend to think in very black and white, all or nothing terms, and it's important to change that perception both of their pain and the other events in their life, to the idea that there are gradations, and by asking somebody to give you a number or to give you an idea of how intense on a continuum their pain is, you are helping them to scale their pain, and it becomes a both a process measure and an outcome measure to evaluate the efficacy of what you're doing. But it's important to be, the caveat is sensitive to the fact that a lot of these patients that come with a lot of alienation and feelings that providers don't really understand what they're going through, they may have a tendency to poo-poo the scale and say, come on doc, how can a 0 to 10 scale really capture what I'm going through, and my report to that is well, it can't capture all of what you're going through, but it's just one way to help us get a handle on it, so that we can begin to work with it, and we can't do everything at once. But it's important to be sensitive to that and not kind of force people into a little box, but communicate the importance of scaling intensity.

I found that the present pain inventory, the PPI from Melzack's? scale is pretty helpful, it's pretty simple and easy to understand, it goes from 0 to 5, 0 stands for no pain, 1 stands for mild pain, 2 stands for discomforting pain, 3 stands for distressing, 4 stands for horrible and 5 stands for excruciating. So, I kind of find that helpful. The McGill Melzack? Pain Questionnaire is a very use test in my opinion for gathering information about how a person experiences their pain and it's available all over the place. There's so many places where it has been reprinted.

The types of cognitive distortions"

Cognitive distortions, distorted thinking, we all do this, I think that it's important in if your going to buy into the cognitive model to learn what some of these classes of distorted thinking are and kind of again, adapt these ideas to your way of working and your world view and then kind of communicate this in some appropriate manner to a pain patient to help them to begin to see that they do some of this distorting that may not be as helpful to them, they're not aware of it, it's kind of unconscious, kind of make them aware of some of the self talk that they engage in. This tends to be the hallmark of cognitive therapy, helping people to become aware of their negative self talk and then giving them a good rationale for responding to their negative self talk or refuting it.

You have such things as all or nothing thinking, or its also called black and white thinking. You know, basically a good example of this in somebody that suffers from persistent pain is, I'm either

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in pain or I'm not in pain. Things are either all good or all bad. There's no shades of grey, there's nothing in between. And you know if you think in such all or nothing terms, you may not be willing to accept anything less than 100% pain relief, and so it's important to begin to ask patients the question of how much pain relief to you expect, how much pain relief are you willing to accept as making this worth while for you. 90%? Would you be satisfied with 75%? How low can it go, if we can only relieve 30% of your pain, would you think this is worth while, that what we've been doing together has been worthwhile.

Disqualifying the positive is a cognitive distortion that we all engage in and we can relate it to pain patients in the sense that pain patients will often kind of view everything in terms of their pain, and so they'll disqualify anything positive in their life, because they're still in pain.

Selective abstraction, you know, I think that's called mental filter on the slide, mental filter. The concept basically here is, that people with chronic pain syndrome walk around with a negative pain halo or a black pain cloud over their head. Everything kind of gets filtered through that pain. Prevents them from enjoying things.

Perfectionism, I don't know, I think that I've seen a large share of individuals who premorbidly, before they develop their pain and disability tended to be over doers, tended to be over achievers, tend to continue to view things as having to be perfect, tend to be compulsive. I tend to suffer a little bit from that malady and I think that it unfortunately can result in stress and burnout and can make pain worse.

I think I mentioned a few before, negative prediction, I didn't mention negative prediction. Negative prediction is also called the fortune teller error, which is the idea that you can predict the future. It's also something I refer to as the crystal ball phenomenon, that you have a way of predicting the future, and a lot of people think that when they suffer from pain that hurts terribly now, that they're always going to hurt, that it's going to be permanent, or they have these morbid horrific images that their spine is going to continue to fall apart and it's going to get worse and worse and worse. You know I worked with a lady a couple of years ago, who had these incredibly morbid images of her spine falling apart and deteriorating and desiccating and people, of course, tend to have these images based on the little knowledge that they have about what the doctors have told them, or what they've heard in passing.

Catastrophizing is a biggy. There's research by a lot of people in the field that's published that shows that catastrophizing which is a tendency to predict dire outcomes. A tendency to blow

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things up out of proportion as being awful, a tendency to kind of view things as oh my god, this is horrible. A tendency to see what's happening to you as being a harbinger of disaster. That pain patients who catastrophize tend to be more depressed and tend to have poor adjustment, and that needs to be addressed and that's why cognitive therapy is so very important and so very relevant.

One more distortion which I'm going to mention is called something that I have kind of coined myself I think, or at least I haven't read it anywhere else, I call it pain based emotional reasoning, and that is this. That basically, a lot of people that I have working with over the years, tend to view hurt as a indicator of harm. If we view pain as a signal that something is wrong in the body, this idea is useful for acute pain, but it doesn't continue to be a useful way of thinking about chronic pain. If it's been medically worked up and treated and we know that there is nothing going on that is occult or needs to be or can be addressed, you know, in a physical kind of cut it out manner, that sometimes chronic pain is not a signal, although there is a message to it, that people can be helped to learn to heed and to benefit from, but the notion that a lot of people have with chronic pain, that because it hurts, it signals that there is ongoing harm that is associated with it, and that's not always true.

Discriminating between "hurt and harm". I treated a lady that had carpal tunnel syndrome, she was a writing, and it really handicapped her a lot because she could not longer type on the keyboard and you know, she might type a little bit at a time and then she would feel these sharp shooting pains in her wrist and you know, she wasn't, before she began treating with this wonderful physical therapist and also with myself, she would basically just stop everything and not, as soon as she felt that first tinge of that shooting pain, that was it, because she would immediately think that it was hurt equals harm and she actually went through a chronic pain treatment program, a multi-disciplinary pain clinic, and she learned that hurt does not always equal harm and that helped her to begin to be prepared for a process of gradually shaping more activity levels and reconditioning herself.

Assessing cognitive distortions of pain patients with the PCI and the ATPQ.

Assessing associated stress symptoms with the SSCL.

The "R.E.A.D.S." model for cognitive restructuring.

Cognitive techniques for altering pain perceptions and reducing pain and suffering.

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Pain relief imagery (PRI) and the Awareness Release Technique ("ART").

The Zarren Marble Method: A kinesthetic technique for self-relaxation and self-regulation.

I'm going to give you that gift that I promised you. I'd like each person to take a marble, pass the jar to your neighbor, after you take one marble, and I'm going to teach you a method for relaxation using a marble that I think and I hope you'll find to be very relaxing and very useful, and also something you might want, if you like it, you might want to take it with you, not only literally, but you might want to take it with you into your practice and use this with people that you treat who have pain. I use big marbles with my patients, I have a big, big jar with marbles in my office and what I do is I, when the time is right, to begin to teach a relaxation technique and if this is the one that I'm going to use, I invite the patient to choose a marble out of the jar.

Now, the reason why I have a big marble here in my hand, and the reason why I use big marbles and your getting little marbles is because I really had a very little budget for this presentation. This technique is not my own technique, it was developed, it was created by a licensed clinical social worker, who is a masterful clinical hypnotherapist and psychotherapist out of West Palm Beach, Florida. His name is Jordan Zarren. He is very active in the American Society of Clinical Hypnosis. He is a friend of mine, and I learned this from him, and I find it very useful because it's a kinesthetic technique, and pain is a kinesthetic sensation, or kinesthetic perception, and it's important to do some kinesthetic things to counter noxious or nociceptive kinesthetic input, which pain certainly is, so therefore, it's a great thing, and it also, you'll see, gives you something that you can take with you, something that you can hold on to, and you maybe weren't noticing this because I was hiding the podium, but I was holding onto my marble during some key moments when I felt that I feeling not as powerful or when I felt that I was trying to find the right word, so I just found my marble and it gave me something to hold onto. It kind of was associated with strength. Does everybody have a marble?

Do you have suppliers of the large marbles? Yeah, I actually discovered a wonderful supplier and that is there is a chain of children's toy and computer software stores called Zainy Brainy. I don't know if there located down South, but they're located up in Pennsylvania where I'm from, and they sell these big marbles 3 for a \$1.99. So, you're talking about 65 cents or so a marble, which certainly you only give it to the patient once, it's a good investment. The first thing that I do whenever I do hypnosis with anybody, is I ask them, we're not going to do that now because I'm going to kind of give you and teach you this technique, but I always to an assessment of hypnosis, you know, in other words, have you ever been hypnotized, you know, have you ever used any relaxation techniques before, what do you do to relax, do you have any safe places in

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your mind, peaceful places that you like to go to, you know, in your pain intake form, you know under the sensory dimension and the imagery dimension and the behavioral dimension. There are questions that I ask about what kinds of thoughts are especially comforting. Are there any particular people in your life that you find especially soothing and comforting. Are there certain things you like to do that puts you at piece. Some people like to go fishing, some people like to meditate, some people like to work in their garden. What experience have you had with any kind of self control techniques, such as relaxation, or yoga, or biofeedback. Have you ever gone to somebody for hypnosis before. Do you pray, are you a spiritual person, assessing spirituality is a very important part of my intake, you know, what are your beliefs about you come from, where you go when you die, the meaning in life, the purpose of the world. Getting back to this here, have you ever used self hypnosis before, and if they say yes, the question would be, well do remember how you laugh, what helped to go into hypnosis. When it's appropriate then I will introduce the marble and I'm going to tell the person that we're going to do something a little different today, because this is something that you are going to do for yourself, and I want you to be able to do this for yourself and feel comfortable with it. So, I might ask you now to just think about what kinds of things do you carry around with you every day. Do you carry your keys, a pager, a cellular phone, and do you have any of that with you now. Perhaps you have a watch that you tend to play with, or a ring, and I'm going to give you that you can carry around with you in your pocket, you each have gotten a marble, I've already directed the patient to the marble jar, they've picked a marble that they find especially fascinating. I tell them that they've picked a great marble. Sometimes I'll tell them, oh, you know I got this batch of marbles from Zainy Brainy, but you know I also have some other marbles from places that I've visited. And I tell the person that what I do is I use the marble, I'm going to use the marble with your permission, to teach you a method of relaxation that you'll be able to do on your own. You'll be able to do it to help you relax, help you to become more comfortable, and as I'm talking to the person, I demonstrate, I'm going to grab a marble myself, and so let's all kind of, let me invite you to participate in this now. What I want you to do is I want you to hold the marble, just like I'm doing, kind of hold the marble in your hand like this, and when you look at it, you look at the marble, you kind of notice that it's not exactly smooth, you kind of notice the design in the marble. You may find that there's little imperfections, little pits and things in it. You can notice that it's not perfect, nothings perfect, there's no perfection in the world, and it's okay for it not to be perfect. Just continue to look at the marble, just continue to focus your eyes on the marble, as you listen to the sound of my voice and you may not necessarily hear all the words that I'm saying, just listen to the sound of my voice, and notice that when you hold the marble, I notice that when the jar was going around the room, that some of you kind of smiled. It kinds of brings back feelings from childhood, when you have a marble in your hand. It kind of brings you back to when you were

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a kid and you used to play with marbles. It's kind of a nice feeling isn't it. It's kind of a nice object. Just roll the marble around for a little bit and continue to look at it, notice it's beautiful colors, and also, notice how smooth and how cool it feels, maybe it begins to feel somewhat warmer as the warmth from hand begins to be absorbed into the marble. And as you continue to look at it, sometimes, you know, the colors that you're looking at that you're becoming absorbed in, seem to intensify, and as you do that you begin to find perhaps that your body begins to relax, just looking at the marble, holding the marble in your hand, perhaps you'd like to just now, just kind of let the marble rest in the very center of your hand, in the palm of your hand. Just continue to look at it, and just begin to notice that as you continue to look at it, as you continue to look at it, that you're body begins to relax, and as you continue to stare at it, perhaps you're eyelids begin to feel heavier, they may start to blink, if you continue to stare at the marble, you're hand may begin to feel heavy, and as your hand feels heavier, as you continue to look at the marble, as your eyes begin to feel a little bit more strained, you begin to feel more and more relaxed. And as you relax more and more and look at the marble as you hold it in your hand, you feel more and more comfortable, your breathing starts to become more even and regular, and your body starts to relax a little bit more, and eventually, I'd like to invite you to just gently and comfortably close your eyes, and close your hand, your fingers around the marble so that it doesn't fall out of your hand, and just concentrate on the feeling of the marble in your hand, once you close your eyes. Just concentrate on the feeling of the marble in your hand. Once you close your eyes, just leave them closed until I ask you to open them, don't squeeze them tight, just gently and comfortably leave them closed and if you want to put your head into a more comfortable position or adjust your body in any way that feels comfortable, that's perfectly alright to do so. Just concentrate on the feel of the marble in your hand. If you're mind wanders away from concentrating on the marble, the moment you realize you're thinking of something different, just bring it back, but concentrating on the feeling of the marble in your hand, and you notice as you do that, that you're mind wanders less and less, and you're body goes deeper and deeper into relaxation, deeper with each normal breath that you take, deeper with each word that I say, regardless of the meaning of those words, and the marble is the way that you're able to concentrate, without having your mind wonder very much, and as you do this, the doorway to your unconscious opens, and with your permission, I have the opportunity to talk directly to the unconscious and give it the information it needs to help you to change what you want to change to deal more comfortably and change the way you feel and change the way how you deal with your discomfort, to help you to feel more comfortable, and the marble is something that you can feel and imagine in your mind's eye. You can imagine the roundness, and the smoothness, and the colors, and the texture, and it's something that you can hold onto. It's yours that you can hold onto. In fact, you can take this marble home with and you can carry it around in your pocket, so if you feel, at any point, that you need to interrupt stress,

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you can just take the marble out and hold it in your hand and you will start to feel a sense of relaxation. But more importantly, you're going to find that the marble is what you can use to help you relax each evening, or each afternoon after work when you get home, or each morning before work, and the way you can do this is as follows. You go off by yourself someplace, sit in a comfortable chair, look at the marble the way you did, move it around in your finger tips, feel your body starting to relax, your breathing change, and your eyelids get heavy, and then you gently close your eyes and you close your hand around the marble so it doesn't fall out of your hand and just concentrate on the marble, it allows you to go deeper into relaxation, more and more relaxed, more and more relaxed. Now you can do that just sitting and relaxing and enjoying the experience for about 15 minutes everyday, even on weekends, and because you can do that, you can experience this nice relaxation, and this relaxation can last a long time afterwards, once you open your eyes to go about your business. So that by relaxing yourself, where before you used to do the things that you want to change, you now will no longer need to do the things that you used to do that you want to change. In other words, because you are relaxed from the relaxation, you will not have to do what you no longer want to do. Now, continue to relax and enjoy the experience, and I just want to give you a few suggestions about feeling more comfortable, you started feeling very uncomfortable perhaps a long time ago, because something might have happened that required that discomfort, as a signal to a part of you that something was wrong and needed help. We may know or we may not know, or we may never happened exactly what happened way back then. We do know that it is not happening now, because it is not happening now, you no longer need that alarm to tell a part of you that it needs help. You can now shut that alarm off or at least give yourself permission, if it's alright with you to reduce the noise, to reduce the intensity and the disruptedness of the alarm by giving yourself, you giving yourself permission to feel more comfortable. Remember, it's not happening now like it was happening then. And because it's not happening now, you have better things to do with the energy that was required to keep that discomfort in place, now you can let go and use the energy for healing. Now continue to relax and enjoy the experience, and when you want to awaken yourself from this deep relaxation, and I use the word awaken, because I don't have a better one, you're not asleep, just very relaxed and very comfortable, when you want to awaken yourself from this deep relaxation, all you have to do is count silently to yourself from 1 to 5, with the number 5 you open your eyes, you're feeling wide awake, you're feeling great, and you feel a great sense of relaxation throughout the rest of the day. Mellow and comfortable, yet with a lot of energy able to accomplish the things that you want to accomplish. So now I'm just going to leave you all in relaxation and when you're ready to, you can silently count to yourself from 1 to 5 and open your eyes with the number 5 feeling alert, relaxed, refreshed, comfortable, feeling great, at your own pace, your own time.

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Do you all feel that this is a neat technique. Raise your hand if you feel that if you'll be able to use this technique, use the marble for yourself. How many people think that you might want to, this technique is in your handout, by the way, Zarren's method of the marble induction technique is in the back of your handout. How many people think that you might want to apply it with some clients or patients.