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Guided Imagery as a Therapeutic Recreation Modality to Reduce Pain and Anxiety

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Abstract

Guided imagery can be an effective intervention when used as a therapeutic modality for a variety of symptoms and conditions. It can improve health and enhance well-being, particularly through the reduction of pain and anxiety. The application of a specific type of guided imagery, integrative guided imagery, is presented through a case report and within the context of the therapeutic recreation process. Implications for the use of guided imagery in therapeutic recreation are discussed.

KEYWORDS: *Guided Imagery, Therapeutic Recreation, Anxiety, and Pain.*

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Guided imagery is a form of deliberate, directed daydreaming-a purposeful use of the imagination, using words and phrases designed to evoke rich, multisensory fantasy and memory. It is used to create a deeply immersive, receptive mind-state as a catalyst for desired change (Naparstek, 2004). For most people, imagery is an easy, user-friendly form of meditation that yields immediate results. Guided imagery has been used increasingly by healthcare providers in the medical field with impressive results (Utay & Miller, 2007). Indeed, given the last 20 years of research findings from various clinical trials, it is surprising that guided imagery is not more frequently prescribed as a universal, low-cost, preventative health tool.

Imagery as a clinical intervention has been associated with a variety of physical and psychological health outcomes such as improved mood and reduced symptoms of anxiety and depression (Dattilo, 2000). The connection between stress and health, as well as the potential impact of guided imagery on both, is an important consideration for therapeutic recreation (TR) practitioners (Brownlee & Dattilo, 2002). Typically, embedded in the rubric of stress management, TR practitioners often teach and provide complementary and alternative medicine (CAM) techniques such as aromatherapy, massage, yoga, guided imagery and tai chi to clients (Bonadies, 2004).

Mind-body interventions including guided imagery are emerging in response to a growing awareness that individuals can take more control of their health. Mind-body interventions constitute a major portion of the overall interest and practice of CAM techniques among the general public and within healthcare agencies. In 2002, mind-body techniques, including relaxation techniques, meditation, guided imagery, biofeedback, and hypnosis were used by about 17% of the adult U.S. population (Barnes, Powell-Griner, McFann, & Nahin, 2002). In a recent study, hospitals that offer CAM ranked guided imagery as fourth among other CAM therapies that are provided in inpatient settings (Ananth & Martin, 2006). As holistic health among consumers continues increase, the TR profession will have a clear opportunity to position itself as an important contributor to responsive health in the 21st century.

A holistic approach to health is embedded in TR. This approach involves accepting responsibility for becoming aware of and making choices to create a healthier lifestyle and striving to achieve a sense of balance between body, mind, and spirit (Coyle & Shank, 2002). As western medicine and health care begin to shift to a more holistic approach, TR practitioners will be challenged to provide more mind-body interventions such as guided imagery. Guided imagery is an effective modality for TR practitioners to use with different populations in a variety of settings. It can help individuals manage a variety of symptoms such as pain and anxiety, which can be barriers to a fulfilling leisure lifestyle.

The purpose of this paper is to describe current research addressing the use of guided imagery to determine if support exists for guided imagery as a TR modality. To start, relevant definitions and descriptions are provided. In particular, a more specific type of guided imagery, "integrative guided imagery", is presented. A review of the literature examines research on the use of guided imagery as a method of reducing anxiety and pain associated with stress and illness. Implications for implementing guided imagery in TR practice are discussed.

Definitions

Imagery is the deliberate formation of a mental representation while in a deeply relaxed state. Images can have several sensory qualities including visual, auditory, olfactory, and tactile. They also vary in clarity and intensity between people and within the same person. They may occur during dreams, fantasies, or during complete conscious awareness (Sodergren, 1992). The imagery may be receptive (that is, perceiving messages from the body) or may be active (that is, cognitively evoking thoughts and ideas; Achterberg, 1985).

Guided imagery is a gentle but powerful technique that focuses and directs the imagination. This is a therapeutic process that facilitates working with the power of the imagination and associated images to positively affect mental attitude, potentiate positive outcomes and actively innate healing within the body. Although guided imagery has been called "visualization" and "mental imagery", these terms are misleading. Guided imagery involves far more than just the visual sense. Instead, im-

agery involves all of the senses, and almost anyone can engage in guided imagery. It is also inaccurate to describe guided imagery as strictly a "mental" activity, because it involves the whole body, the emotions and all the senses, and it is precisely this body-based focus that makes for its powerful impact.

When properly constructed, imagery has the built-in capacity to deliver multiple layers of complex, encoded messages by way of simple symbols and metaphors. Imagery has the capability to mobilize unconscious and pre-conscious processes to assist with conscious goals. It can bring to bear much more of a person's strength and motivation to accomplish a desired end. So, subtle and gentle as this technique is, it can be very powerful, and more and more so over time (Naparstek, 1994).

Another method of guided imagery is a more customized one-on-one approach termed integrative guided imagery (Stein, 2007). In this type of imagery, both the client and practitioner interact with each other, and the client interacts with images she or he creates. As a more client-centered type of imagery, the purpose of the practitioner is not to provide images, but to help the client find his or her own images.

Because these images come directly from the client, they can be more meaningful and can provide insight about barriers, unspoken fears, and intuition about what is needed. In addition, because these images are often so deeply entwined with emotion, consciously changing the images themselves can have a powerful effect on well-being.

Effects of Guided Imagery on Pain

Approximately 50 million Americans suffer from chronic pain, including pain from lower back problems, arthritis, cancer, HIV/AIDS, repetitive stress injuries, headaches, fibromyalgia, and other ailments (Dillard, 2002). Mind-body interventions such as guided imagery have been applied to various types of pain. Clinical trials indicate that these interventions may be a particularly effective adjunct in the management of arthritis, with reductions in pain maintained for up to 4 years and reductions in the number of physician visits (Luskin, Newell, & Griffith, 2000). When applied to more general acute and chronic pain management, headache, and low-back pain, mind-body interventions show some evidence of effects, although results vary based on the patient population and type of intervention studied (Astin, Shapiro, & Eisenberg, 2003). Guided imagery has been found to reduce abdominal pain (Weydert et al., 2006), chronic pain (Baird & Sands, 2004), post-operative pain (Huth, Broome, & Good, 2004), cancer pain (Syrjala et al., 1995) and burn pain (Fratianne et al., 2001).

Researchers from Children's Mercy Hospital in Kansas City, Missouri, evaluated the therapeutic effects of guided imagery on children with recurrent abdominal pain (Weydert et al., 2006). Twenty-two children with recurrent abdominal pain, aged 5- 18 years, were randomized to either a group for learning breathing exercises alone or a group that taught guided imagery with progressive muscle relaxation. Both groups had four weekly sessions with a therapist. Using a daily pain diary, the children reported the numbers of days with pain, the pain intensity, and the amount of missed activities due to abdominal pain. Monthly phone calls were also conducted to assess the same information. Depression, anxiety, and somatization were measured in both children and parents at baseline. Children who learned guided imagery with progressive muscle relaxation had significantly greater decreases in the number of days with pain than those who learned breathing exercises alone. The authors concluded that guided imagery with progressive relaxation has therapeutic efficacy for recurrent abdominal pain in children; and that, although this technique is unfamiliar to many pediatricians, it is a simple, noninvasive therapy with potential benefit.

Baird and Sands (2004) conducted a longitudinal, randomized clinical trial pilot study to determine whether guided imagery with Progressive Muscle Relaxation (PMR) would reduce pain and mobility difficulties of women with osteoarthritis. Twenty-eight older women with were osteoarthritis randomly assigned to either the treatment or the control group. The treatment consisted of listening twice a day to a 10-to-15-minute audio taped script that guided the women in guided imagery with PMR.

Repeated-measures ANOVA revealed a significant difference between the two groups in the amount of change in pain and mobility difficulties they experienced over 12 weeks.

The treatment group reported a significant reduction in pain and mobility difficulties at week 12, as compared to the control group. Members of the control group reported no differences in pain and non-significant increases in mobility difficulties. The results of this pilot study justify further investigation of the effectiveness of guided imagery with PMR as a self-management intervention to reduce pain and mobility difficulties associated with osteoarthritis

Another study of post-operative pain with children investigated the effectiveness of imagery when used alongside routine analgesics for reducing tonsillectomy and/or adenoidectomy pain and anxiety after ambulatory surgery (AS) and at home (Huth, Broome, & Good, 2004). Seventy-three children, aged 7-12, were recruited from five AS settings. Thirty-six children randomly assigned to the treatment group watched a professionally developed videotape on the use of imagery and then listened to a 30-minute audio tape of imagery approximately 1 week prior to surgery. They also listened to the audio tape 1-4 hours after surgery and 22-27 hours after discharge from AS. The videotape, given to patients during the 3 weeks prior to surgery, taught deep breathing and imagery techniques, while the audiotape included deep breathing and muscle relaxation exercises, music, and suggestions for picturing a favorite place.

The 37 children in the attention-control group received standard care. Pain and anxiety were measured at each time-point in both groups. Measures of sensory pain were the Oucher Pain Scale and amount of analgesics used in AS and home; affective pain was measured with the Facial Affective Scale (FAS). Anxiety was measured using the State Trait Anxiety Inventory for Children (STAIC). Children in the intervention group reported significantly less pain and anxiety after listening to the audiotape immediately after surgery: 28.3% less sensory pain, 10.5% less anxiety and 8.5% less affective pain. Although the difference was no longer statistically significant when measured in the home, the intervention group still exhibited 18.6% less sensory pain, 9.2% less anxiety and 8.2% less affective pain. The use of analgesics, both opioid and non-opioid, did not differ between groups.

The study concludes that appropriately trained health care providers could use imagery to reduce post-operative pain following tonsillectomy and/or adenoidectomy in the ambulatory setting. In addition, it suggests that teaching parents about adequate home administration of analgesics may increase the effectiveness of imagery at home.

Research examining effects of guided imagery on abdominal pain, post-operative pain, cancer pain and burn pain has shown an increase in mobility, reduction in pain and discomfort such as anxiety.

Effects of Guided Imagery on Anxiety

Another common use of guided imagery is for the management of anxiety. Studies have confirmed the effectiveness of guided imagery in reducing anxiety (Tusek, Cwynar, & Cosgrove, 1999). The following studies found guided imagery as an effective modality in managing anxiety. Caruso and Helge (1999) found that when comparing guided imagery and progressive relaxation with chemotherapy patients, guided imagery performed significantly better than progressive relaxation, in reducing depression and anxiety. In addition, there is support for the use of guided imagery to reduce anxiety in people with cardiac catheterization (McCaffrey & Taylor, 2005), breast cancer (Nunez et al., 2007), surgical procedures (Tusek, Church, & Fazio, 1997), multiple sclerosis (Macquire, 1997) and wound healing (Holden-Lund, 1988).

McCaffrey and Taylor (2005) reviewed the literature to see which complementary therapies could effectively reduce anxiety before diagnostic cardiac catheterization. The authors cited music therapy, massage, guided imagery, therapeutic touch and stress management instruction as modalities that have been used successfully to decrease patient anxiety prior to diagnostic cardiac catheterization, providing better patient outcomes.

In a study with breast cancer patients, Nunez et al. (2007) examined the effects of guided imagery on psychological distress, cortisol levels, and immunological parameters of breast cancer patients undergoing radiotherapy. Their results showed guided imagery was effective in reducing stress, anxiety, and depression (all $p < .05$). The researchers concluded that the intervention was able to attenuate the

emotional distress presented during radiotherapy treatment.

Macguire (1997) determined the efficacy of imagery for influencing attitudes and moods in multiple sclerosis patients. Thirty-three patients were both assigned to the imagery group and control group. The imagery group demonstrated significant reductions in state anxiety and significant alteration in their illness imagery because of feedback obtained during the study. They concluded that the use of the relaxation/imagery protocol led to clinically significant reductions in state anxiety. Imagery may be assessed through drawings that allow for positive modification of the imagery material to increase its utility and power.

Holden-Lund (1988) conducted a study to determine the effects of an audiotape series employing relaxation with guided imagery (RGI) on the psychophysiologic stress response and wound healing in surgical patients. Twenty-four patients undergoing cholecystectomy were randomly assigned to either RGI or control (quiet period) conditions and measured against three indexes of recovery: state anxiety, urinary cortisol levels, and wound inflammatory responses. An analysis of variance for repeated measures revealed that the RGI group demonstrated significantly less state anxiety, lower cortisol levels one day following surgery, and less surgical wound erythema than the control group. Thus, the RGI tapes demonstrated stress-relieving outcomes closely associated with healing.

Summary

Positive effects of guided imagery on anxiety have been shown with cardiac catherization, breast cancer, surgical procedures, multiple sclerosis and wound care. Results of these studies have demonstrated the far-reaching effects of guided imagery as an intervention. The field of nursing, in particular, has investigated the use of guided imagery as a means of reducing anxiety and pain. A substantial body of research in the nursing literature consistently has reported significant positive results (Atcherberg, Kenner, & Lawlis, 1988; Baird & Sands 2004; Frank, 1985; Holden-Lund, 1988; Huth, Broome, & Good, 2004; King, 1988; Macquire, 1997; Nunez et al., 2007; Rees, 1995; Speck, 1990; Stephens, 1992; Thompson & Coopens, 1994; Weydert et al., 2006). As such, guided imagery appears to be a legitimate modality for the reduction of pain and anxiety among various client populations.

Despite the abundant research supporting the effectiveness of guided imagery across these various potential applications, no scientific studies investigating guided imagery in therapeutic recreation could be located. Because TR practitioners and other health care professionals are using guided imagery, there is a significant need for further scientific knowledge regarding this practice and its effective use as a therapeutic recreation modality.

A Case Report of Integrated Guided Imagery in TR

The following is an example of the use of an integrated-guided imagery session conducted by the author in his agency. The agency is a 206 bed residential health care facility on the northeast region of the United States that integrates traditional medical approaches with complementary and alternative medicine in the treatment of AIDS. The interdisciplinary team on each of the resident care units included a physician with a specialty in HIV/AIDS, and professionals from nursing, therapeutic recreation, social work, substance abuse counseling, physical therapy, occupational therapy, speech therapy, nutritional services, and pastoral care. Various disciplines such as psychiatry and psychology are also provided on a consultant basis when needed. Complementary therapies such as yoga, acupuncture, acupressure, reiki, meditation, guided imagery, breathing techniques, music therapy, and art therapy are provided to the residents upon referral by the interdisciplinary team.

Resident profiles are similar to people with AIDS across the United States. The resident population at the agency consisted of 55% African American and 30% Latino individuals. Typically, about 80% of the residents are male. As much as 75% of the resident population has a history of substance abuse and 60% have a history of mental illness. Facility data has indicated 45% of the population experience pain. While 57% of these residents have one or more pain syndromes, further examination indicates 24% have two pain syndromes and 5% experience three or more pain syndromes. In addition, 67% of these residents experience chronic pain. The data suggests the prevalence

of neuropathic pain to be around 40-45%. Despite the use of traditional approaches such as pain and anxiety medication, many of the residents still complain of high levels of pain and anxiety. The use of complementary therapies such as guided imagery for symptom control is very commonly recognized in the facility.

Assessment

My client was a 52-year-old Hispanic male with a diagnosis of AIDS, poly substance abuse and depression. He was on a regime of antiretroviral medication and several pain medications for his lower back pain. The pain in his lower back had affected his ability to walk; therefore, he used a cane for ambulation. To help manage his pain better the interdisciplinary team referred the client to me, the CTRS. At our initial meeting the client was hyperverbal and appeared very anxious. He stated: "I'm lost with my pain, I can't get rid of it". As I continued to speak with him, I had a sense that his pain had taken a real emotional toll on him. At times he seemed distraught and in despair about his pain. To assess his pain level I used the Numeric Pain Rating Scale. He reported a pain level of an 8.

Plan

At this point, I asked my client if he would like to try an imagery session with me to help him relieve his pain. I then went on to describe what imagery is, and in particular the nature of integrated guided imagery. He agreed to give it a try. The client had no previous experience in imagery, but had recently tried acupuncture and massage for his lower back pain with minimal relief. I suggested we use an imagery technique referred to as the "Pain Intensity Scale". I then went on to explain the technique to him and he agreed to give it a try.

Intervention

With the client's permission, we started the relaxation response by using a body scan and deep breathing. A body scan is a relaxation technique that introduces to the client simple deep breathing exercises that relax the body and calm the mind. The TR practitioner guides the client to relax each muscle group of the body, usually starting at the head and ending at the toes. I suggested to the client that he lay on his back on his bed in a comfortable position and close his eyes. It was apparent after a few moments that the client was becoming very relaxed, as indicated by his facial muscles softening. After the completion of deep muscle relaxation, I asked the client to let me know when he felt relaxed by either a nod of his head or with a "yes". Deep muscle relaxation involves using the imagination or suggestions of the facilitator to relax the various muscle groups of the body by using cue word(s). Usually this is done by starting at the top of the head and then working down through the body, as if relaxation were being poured over the head and flowing down over all of the body. Various cue words can be used such as heaviness, softness and warmth.

Once the client indicated to me that he felt very relaxed, I then initiated the "pain intensity scale" technique by suggesting that he imagine in his mind an intensity scale from 0 to 10. I went on to suggest that the scale could be seen in several different ways, like numbers on an electric blanket or numbers on a radio. I even suggested he could just imagine numbers in the corner of his mind if he wanted. Whatever the image, it was important that the client create his own, as this is a distinguishing characteristic of integrated guided imagery.

I then asked the client to spend a few moments clearly focusing on this scale and to particularly focus on the number that related to his pain at the moment. Next, I suggested he begin to decrease the number and to continue to lower the number as the pain decreased. I encouraged the client to take as much time as he needed. I continued to guide the client to lower the number to the point where he felt the pain was tolerable or completely gone.

When the client reached a number that was "right" for him, I suggested that he lock in this number. I gave him an example of visualizing the use of a key and a latch, or any way so that the number remained fixed in his mind. Again, I encouraged him to create his own personal image. As the client locked in his number, I reminded him that he could use this technique at any time to tap into his inner ability to manage his pain. He could, with practice, become better at lowering the number. It was also at that time I told the client that, when he felt ready, to come into the present by slowly opening his eyes, still feeling sense of calmness and comfort. The entire intervention lasted approximately 20 minutes.

Evaluation

I asked how he was feeling. He stated: "In a lot less pain". He began to smile as he realized how well this technique worked for him. The client then reported that at the start of the session his number was an 8. When asked about the nature of his imagery, he reported that he imagined the numeric scale on his spinal cord. Starting with the number 8 at the top of his spinal cord, he began to lower the number slowly to a 4 until he reached his lumbar area. I asked if he had learned anything from today's session and he replied: "I can reduce the pain, lowering the number in my imagination". He also came to the awareness that he could use this technique whenever he began to feel that the pain was becoming intolerable.

Follow-up

I conducted three more imagery sessions with my client during his stay at the facility. He reported a lower pain level at the end of each of the three sessions. The client also used other non-pharmalogical interventions such as acupuncture, reiki, art therapy, exercise and psychotherapy to manage his chronic pain condition. At times, his pain would intensify, but he was able to reduce his pain level by participating in the above modalities including guided imagery. When I was unavailable to conduct an imagery session with him, he would very often listen to a guided imagery CD or perform the imagery himself.

I also noticed that, as the client began to effectively manage his pain, he became more involved in his daily routine. He would wake up earlier, attend to his ADL's without assistance from staff, leave his room more often, participate in various facility activities, and visit other clients in the facility. In summary, the client's quality of life began to improve with the use of guided imagery and other medical and non-pharmacological interventions.

Guidelines for the Therapeutic Recreation Practitioner

TR practitioners use almost any activity-based intervention to help clients improve functional skills and to meet various psychosocial needs (Coyle & Shank 2002). Teaching and assisting a client to use guided imagery meets the definition of a TR intervention. It is a readily taught and learned skill used to achieve the outcome of symptom relief as well as other issues that may be barriers to full leisure involvement. The TR practitioner can initiate guided imagery after recognizing that it may be appropriate in a particular situation to enhance a client's leisure functioning. It does not require a medical order or sophisticated technology. Guided imagery remains under the control of the person using it. The TR practitioner also assesses the appropriateness for and evaluates the effectiveness of guided imagery and decides to modify or discontinue the intervention. These characteristics place guided imagery within the realm of TR practice.

The TR practitioner is essential in enabling the client's integrated guided imagery experience and has two main roles: (a) to provide overall help for the client's imagery journey and (b) to assist the client to access and interact with his or her images (Henschel, 2002). To do this effectively, the TR practitioner's characteristics must include a genuine human-to-human caring and competence, both of which are needed for the TR practitioner to be considered trustworthy. Two important elements of competence are allowing the client to make choices and providing a balance between structure and nonstructure for the client's imagery journey (Henschel)

Every aspect of TR clinical practice pivots on the relationships that therapists have with their clients (Coyle & Shank, 2002). An effective therapeutic relationship is one of the primary elements to TR practice. Creating an open and relaxed environment or climate that will be supportive of the clients' needs – especially the need to inquire about and understand their surrounding circumstances and feelings-is essential for use of any modality, including guided imagery (Carter, Van Andel, & Robb, 2003). It is helpful that the TR practitioner educate clients and colleagues about the process and effects of guided imagery before using this technique. The comfort of the client is vital. The TR practitioner should always indicate that guided imagery is a very gentle, normal and permissive technique and that the client is always in control during the imagery process.

The client's non-verbal communication can provide important information to the TR practitioner during the imagery intervention. Noticing facial gestures, respiration, skin col-

oring, muscle tension, tears, perspiration, etc. can all be connected directly to the client's imagery (Naparstek, 2004). These non-verbal signs could be areas to discuss and process with the client after the imagery session, which may lead to valuable information about the client. An example of this is that during the guided imagery intervention the TR practitioner may notice a tear running down the client's face. The TR practitioner may explore this further by asking the client, "I noticed a tear running down your face during the imagery session, do you want to tell more about that?"

Although research has shown that guided imagery is a very safe technique to use, not all individuals are appropriate for guided imagery. Individuals with organic brain syndrome, psychosis or pre-psychosis are not the most suitable clients for guided imagery. Using a more simple relaxation technique such as deep breathing may be more appropriate.

Individuals in a state of acute anxiety will also not be appropriate. Guided imagery is most effective when an individual is in a relaxed state (Naparstek, 2004). The TR practitioner may not be very successful in facilitating the relaxation response with their client if the client is in a high state of anxiety. Individuals who have a tendency to fall asleep during or just before the guided imagery process may be sleep deprived. It would be essential for the TR practitioner to emphasize to the client that they may need more sleep in order to have guided imagery become more effective.

When assessing an individual's appropriateness for guided imagery it is necessary for the TR practitioner to explore with the client any experiences they may have had with imagery and/or other relaxation techniques (Dossey, 1995). Understanding and being aware of the client's experiences with imagery may indicate to the TR practitioner the level of comfort or difficulty the client may experience in their attempt to engage in imagery.

Appropriate tone and quality of the TR practitioner is another important consideration during the guided imagery intervention (Naparstek, 2004). As important as the words are in guided imagery, the quality of the TR practitioner's voice and the intention behind it is critical. When first practicing the technique of guided imagery, the TR practitioner's voice may be high-pitched, words come out too fast and too forced, but with some practice the TR practitioner can slip into a relaxed cadence and a gentle flow of their own natural rhythm, which is essential to effective guided imagery. The most important consideration for TR practitioner to remember when providing guided imagery is to speak naturally, just as if in a relaxed quiet conversation. The voice is low and soft.

One last caution for the TR practitioner, when providing guided imagery intervention, is that not all guided imagery experiences are positive. In some cases a client may experience fear, agitation, and anxiety. If the client appears in distress at some point during the imagery session, the TR practitioner can ask the client to go to a safe and pleasant place in their imagery, and from there continue the imagery intervention. Despite the amount of training and experience a TR practitioner may have in imagery, in a few instances the guided imagery may become negative. It would be essential for the TR practitioner to process the client's feelings about the imagery session assuring that the imagery intervention resulted in a positive experience. Processing the imagery experience with the client is paramount and may require the TR practitioner to refer the client to a trained mental health professional if the implications are beyond the TR scope of practice. The TR practitioner's skills in listening, reassuring and providing support will in many cases provide a positive effect.

General Format for a Guided Imagery Session

The basic steps in using guided imagery are as follows (Naparstek, 2004). First, the client attempts to reach a relaxed, altered state. The client assumes a comfortable position, either sitting or lying down, eyes open or closed, preferably closed.

After several, slow relaxing deep breaths, the client consciously notes and relaxes any areas of muscular tension. When ready, the client remembers or visualizes a safe, peaceful place and intensifies it by focusing on sights, sounds, smells, and other senses. When relaxed, the client follows a tape of suggestions or the TR practitioner's suggestions (See figures 1 and 2 for session scripts and sample protocol) and forms an image of the symptom (such as pain or anxiety). The client imagines something

FIGURE 1.

SUGGESTED GUIDED IMAGERY SCRIPTS

Dimensions of the Pain

Purpose: Controlling acute or chronic pain, both physical and psychological.

Close your eyes let yourself relax... Begin to describe your pain in silence. Know that the pain may be either physical sensations... or worries and fears. Be present with the pain... Let it take a shape...any shape that comes to your mind. Become aware of the dimensions of the pain...What is the height of your pain...the width of the pain...and the depth of the pain? Where in the body is it located? Give it a color...a shape...feel the texture. Does it make any sound?

And now with your eyes still closed...let your hands come together with palms turned upward as if forming a cup. Put your pain in your hands. [Ask the following questions about each dimension and characteristic of the pain.] How would you change the pain's size [height, width, depth, etc]?

Let yourself decide what you would like to do with the pain. There is no right way to finish this experience...just except what feels right to you. You can throw the pain away...or put it back where you found it...or move it somewhere else. Let yourself become aware...of how your pain can be changed...By focusing with intention, you can change the pain.

Red Ball of Pain

Purpose: To decrease psychophysiologic pain and teach your client how to use distraction. Good for acute and chronic pain, as well as the discomfort or pain from procedures.

Scan your body...gather any pains, aches, or other symptoms up into a red ball. Begin to change its size...allow it to get bigger...just imagine how big you can make it. Now, gradually, make it smaller...See how small you can make it...Is it possible to make it the size of a grain of sand? Now allow it to move slowly out of your body, moving further away each time you exhale...Notice the experience with each outward breath...as the pain moves away.

Suggest that your client change the ball's size several times in both directions and imagine different ways to dispose of it-for example, tossing it in the garbage or letting the wind blow it away.

FIGURE 2.

GUIDED IMAGERY PROTOCOL

Title:	**Guided Imagery**
Purpose:	This program utilizes senses and memory to engage the imagination to manage pain. Guided imagery provides a story with several healing principles.
Staff Requirements:	One CTRS to one client preferably. One CTRS to four clients maximum.
Entrance Requirements:	Clients who exhibit symptoms from stress, anxiety and pain. Adaptable to clients in all stages who have the ability to follow directions and a minimal ability to think abstractly.
Exit Requirements:	Client's target symptoms decrease or client no longer wishes to participate.
Group Size:	1:1 or maximum group of 4
Duration:	15-45 minutes depending on the length of the guided imagery script.
Safety Considerations:	Avoid clients who have organic brain syndrome, severe dementia, acutely or on the verge of psychoses.
Facility and Equipment:	Small room away from noise, interruption or any distraction. Guided imagery scripts Optional: gentle, soft music without lyrics, journal book, pen/pencil or materials to color with.
Methods:	• Describe the guided imagery to the client and its benefits. • Assess the client's previous experience with guided imagery. • Inform the client that guided imagery is safe, gentle, they are always in control of the experience and they can stop the session at any time if they wish. • Before starting the guided imagery make sure the client is comfortable. • Suggest that the client closes his/her eyes and begin with 5-10 minutes of deep abdominal breathing, autogenic training or body scan to induce a further relaxed state. • When the client indicates that he/she is completely relaxed begin reading the guided imagery script. (See script). • When reading the guided imagery script to the client use a moderate tone of voice, with frequent pauses. • When the guided imagery script comes to an end, suggest to the clients to gently open their eyes. • Allow the clients to become oriented to their surroundings. Don't be concern to speak quickly, rather wait a few moments for the client to respond. • If the client doesn't respond verbally in an appropriate amount of time, ask the client if she would like to talk about the experience. • If the client wishes to talk about the guided imagery experience, do so but in a very permissive manner. • Suggested questions: How do you feel? What did you see, smell, hear or touch? Did the imagery convey any meaning or message to you? What did you learn from this experience and can you incorporate that into your life? • Another option if the client doesn't want to talk is to suggest writing or drawing about the experience. • Before concluding the session ask the client if he/she has any questions and if they would like to schedule another session in the future.
Possible Client Outcomes:	• Reduced anxiety • Reduced pain • Reduced stress • Learning a coping skill to reduce pain
References:	Dossey, B. (1995). Using Imagery to Help Your Patient Heal. *American Journal of Nursing*, 5, 41-46.

about the symptom to change it. For example, a headache that is a red, fiery color changes to pale yellow; or anxiety blows away with each breath. The TR practitioner encourages the client to describe the image of the sensation and/or whatever feels right to change it. After a few minutes, the TR practitioner instructs the client to return, when ready, to the safe, peaceful place and focus on being relaxed again. Following two or three deep, slow breaths, the client ends the imagery experience and returns to the fully conscious state. At first, each session may be only 10 minutes long. If the client wishes to, he or she may wish to process the imagery experience with the TR practitioner. During the processing phase the TR practitioner needs to take a very permissive role, gently encouraging the client to disclose feelings and thoughts that they feel comfortable sharing (Dossey, 1995). For example, a TR practitioner may ask the client during the processing phase to "Describe the imagery experience if you like." "What feelings, thoughts or messages arise from this experience?" It is important that the TR practitioner does not attempt to probe too hard but rather the opposite, to listen more and acknowledge the client's feelings. This technique will encourage the client to disclose more of the imagery experience (Dossey, 1995). If the client becomes uncomfortable or distressed at any time, the session ends without any attempts to try again. Fully acknowledging what took place and permissively encouraging the client to talk about the experience if he wishes. After two or three sessions with the TR practitioner, the client is usually able to perform the imagery alone. People can invent their own imagery, or they can listen to imagery that has been created for them. Either way, their own imaginations will sooner or later take over, because, even when listening to imagery that has been created in advance, the mind will automatically edit, skip, change or substitute what is being offered for what is needed. So, even a tape, CD or written script will be effective for the individual using imagery.

Resources and Training

TR practitioners should have the necessary knowledge and skill to utilize guided imagery in their practice. However continuing education is recommended for TR practitioners interested in learning more about guided imagery and developing a higher skill level. Training and education can be provided several ways. Minimally, TR practitioners can read literature on guided imagery or attend professional workshops or trainings. This will begin to provide a solid foundation of the principles of guided imagery and how it is used. Simple guided imagery techniques may be learned and performed easily to assist individuals in reducing pain, anxiety and other discomforting symptoms. These approaches can be used in collaboration with standard TR treatment protocols.

The use of guided imagery CDs or guided imagery scripts are the most common, inexpensive and easily accessible methods for TR practitioners to use with their clients. There are many healthcare practitioners who record guided imagery CDs and publish guided imagery scripts. One of the most recognized clinicians in the practice of guided imagery is Belleruth Naparstek. Her CDs are specifically scripted for various medical conditions and symptoms such as pain, anxiety and other conditions. Using guided imagery CDs and scripts requires minimal training; however, a TR practitioner must have the necessary interpersonal skills that are used to develop a trusting relationship with clients.

Advance training in guided imagery can be extremely useful to further enhance the TR practitioner skills in guided imagery. Two of the most widely recognized certificate training programs in guided imagery are the Academy for Guided Imagery and Beyond Ordinary Nursing Certificate Program in Imagery.

Conclusion

Health care is changing in dramatic ways, as is the TR practitioner's role. The use of guided imagery is a modality that can be utilized regularly in TR practice. It does no harm, it is non-invasive, it is time and cost effective, and focuses on client satisfaction. Perhaps most importantly, imagery offers TR a way to empower ourselves and our clients.

Complementary therapies, such as guided imagery, are being used increasingly by people suffering from pain or anxiety to help manage their symptoms (Lewandowski, 2004). Guided imagery appears, then, to have potential as a useful TR modality for chronic pain and anxiety. Although the use of guided imagery

should not be used in place of analgesic medication or anti-anxiety medication, it is useful as an adjunct to more traditional methods of pain and anxiety treatment, and can be offered to clients who are unable or refuse to take medication (Lewandowski, 2004).

The available research supports the conclusion that guided imagery is effective in reducing pain, and anxiety, and addressing other related health concerns, and can be used in a variety of settings with various populations. Guided imagery is especially applicable to therapeutic recreation because it acknowledges the wholeness of the person in both practicing the strategy and evaluating the effects. Although the specific technique of integrated guided imagery requires more extensive training, guided imagery in general can be learned and applied fairly easily to reduce stress, tension, pain, and anxiety.

By learning the basic techniques of guided imagery, the TR practitioner can assist people in preparing for leisure participation. TR practitioners who choose to use guided imagery as an intervention can help establish conditions that encourage people to participate in activities of their interest. As the use of CAM techniques continues to become more common in many health care facilities, it will only benefit the TR practitioner to take advantage of a modality such as guided imagery to assist in the self-management of illness and disease. Imagery is not only a set of tools for healing, but for preventing illness and living the highest quality daily life. It can help create a life of meaning, of purpose and of wellness.

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