Interactive Guided Imagery\textsuperscript{sm} in Treating Chronic Pain

by

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Chronic pain has become the western world’s most expensive, disabling, and common disorder. It is estimated that 8-10\% of the population of most western countries suffer from chronic headaches. Arthritis afflicts over 50 million Americans, of whom 20 million require medical care. Low back pain generates nearly 20 million doctor visits per year and has disabled seven million Americans\textsuperscript{1}. Add facial and dental pain, neuralgia, cancer pain, chronic neck and shoulder pain, fibromyalgia, and other common pain syndromes, and it’s easy to understand why chronic pain is estimated to cost the nation’s economy $60 billion dollars per year. The cost in human suffering is incalculable.

Our focus in this chapter will be on the uses of a particular form of mental imagery, called Interactive Guided Imagery\textsuperscript{sm}, to relieve chronic pain, increase pain tolerance, reduce the emotional toll and amplification of pain, and relieve suffering. In the past 30 years of treating patients with chronic pain and other chronic illnesses, we have found Interactive Guided Imagery\textsuperscript{sm} to be unusually effective in relieving symptoms, enhancing tolerance, relieving feelings of hopelessness and helplessness, promoting healing, and increasing functional abilities in our patients.

WHAT IS INTERACTIVE GUIDED IMAGERY\textsuperscript{sm}?

Mental images, formed long before we learn to understand and use words, lie at the core of who we think we are, what we believe the world is like, what we feel we deserve, and how motivated we are to take care of ourselves. They strongly influence our beliefs and attitudes about how we fall ill, what will help us get better, and whether or not any medical and/or psychological interventions will be effective.

Imagery has powerful physiological consequences which are directly related to the healing systems of the body. Research on the omnipresent placebo effect, the standard to which we compare all other modalities (and find relatively few more powerful), has provided some of the strongest evidence for the power of the imagination and positive expectant faith in healing. It is well documented that from 30-55\% of all patients given inactive

\textsuperscript{1} Inventory of Pain Data from the National Center for Health Statistics, U.S. Government Printing Office, Washington, DC 20402
placebos respond as well or better than those given active treatments or agents.²

If people can derive not only symptomatic relief, but actual physiologic healing in response to treatments that primarily work through beliefs and attitudes about an imagined reality, then learning how to better mobilize and amplify this phenomenon in a purposeful, conscious way becomes an important, if not critical, area of investigation for modern medicine.

In addition to its potential for stimulating physical healing, imagery provides a powerful window of insight into unconscious processes, rapidly and graphically revealing underlying psychological dynamics that may support either health or illness. To the clinician, this “window” is invaluable for quickly identifying opportunities for positive change, manifestations of resistance to change, and ways to work effectively with both.

“Guided imagery” is a term variously used to describe a range of techniques from simple visualization and direct imagery-based suggestion, through metaphor and story-telling. Guided imagery is used to help teach psychophysiological relaxation, to relieve symptoms, to stimulate healing responses in the body, and to enhance tolerance to procedures and treatments.

“Interactive Guided Imagery(sm)” (IGI) is a service-marked term coined by the Academy for Guided Imagery to represent its highly interactive, non-judgmental, content-free style of using guided imagery to evoke patient autonomy. This approach allows patients to draw upon their own inner resources to support healing; to choose the most appropriate adaptations to changes in health; and to find creative solutions to challenges that they previously thought were insoluble. IGI is particularly useful in our current health care climate, where cost-effective mind/body medicine, improved medical self-care, and briefer yet more empowering approaches to health care are becoming more highly valued by patients, providers, and insurers alike.

Before explaining the principles and practices of IGI, let’s briefly examine some of the unique aspects of chronic pain that demonstrates why a sophisticated mind/body approach that utilizes techniques such as IGI is critical to long-term success.

**CHRONIC PAIN DEMANDS DIFFERENT TREATMENT THAN ACUTE PAIN**

Modern technology has created a huge variety of pharmaceutical products for pain relief, many of which are available over the counter. For acute or self-limiting pain, these agents are usually highly effective, for they provide temporary relief while the body heals itself. With the development of neural blockade and other modern anesthetic techniques, patients who undergo operative or other invasive procedures are generally spared all but the slightest degree of pre- or post-surgical discomfort.

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² Frank, Jerome, Persuasion and Healing, Schocken Books, NY, 1974
Yet, the pharmacological approaches which have proven so successful in the management of acute pain are often ineffective or even counter-intentional for controlling chronic or long-term pain. Although acute pain usually gets better by itself as the body heals, chronic pain typically becomes worse with time.

As a rough rule of thumb, chronic pain refers to any pain problem that lasts longer than six months. Its victims are referred endlessly from doctor to doctor, for even if temporary relief can be obtained, the pain inevitably returns.

For example, when analgesic medications are used over a prolonged period of time, pharmacologic tolerance begins to develop and effectiveness is progressively reduced. As tolerance develops, patients typically increase their dosages with the idea that "if a little is good, a lot will be even better." Unfortunately, higher dosages only produce greater amounts of side effects, for tolerance continues to develop. In addition, most of the more effective analgesic agents also carry a high risk of dependency.

As a result, it is common to find patients with chronic pain taking large amounts of ineffective medications that produce significant side effects, many of which even contribute to the pain experience. When patients or their doctors attempt to reduce these medications, withdrawal symptoms make pain even less tolerable, and they return in desperation to their former regimes.

When medications fail, patients are often told, "Nothing more can be done. You'll have to learn to live with it." But in our opinion, there is always hope for someone in pain. Until every therapeutic approach has been attempted, no one should ever be told, "Nothing more can be done."

This statement has two iatrogenic implications: First, it destroys the most significant healing asset that the victims of chronic pain possess -- namely, hope or positive expectant faith. Secondly, it conveys the subtle message that if you "have to learn to live with it," the only time you won't have it is when you are no longer alive. This adds to the significant suicidal ideation already experienced by many people in chronic pain.

The way we communicate with patients in pain has important effects and implications. As we'll discuss below, such negative communications may actually retard the body's intrinsic healing abilities, while more positive, imagery-based suggestions may enable patients to unlock the door to the most potent and varied pharmacy yet discovered -- the one in our own brain.

THE IMPORTANCE OF THE PAIN EXPERIENCE

One of the greatest challenges in researching and treating chronic pain is to resolve ambiguity in the terms and concepts we use to describe it.

For example, it is helpful to distinguish between a painful sensation (mental awareness of an unpleasant stimulus) and the pain experience (the total subjective experience of pain). Furthermore, it is important to recognize that there is not necessarily any direct relationship between the sensation and experience of pain.
This is seen in a study reported by Beecher, who found that soldiers seriously wounded in battle reported only mild discomfort compared to civilians with similar injuries; for they were elated to learn that the war was over for them and they were to be sent home. In contrast, patients with phantom limb pain often report agonizing discomfort even though the entire stump has been anesthetized.

Many individuals think of pain primarily as a tangible thing, much like a splinter is a thing -- that is, an object or substance from outside that infiltrates the body. Thus, if you accidentally strike your thumb with a hammer, you might say you that you “feel pain in your thumb which is radiating to your hand.”

Such a notion is totally inaccurate, for there is no pain “in” your thumb, any more than there is pleasure “in” your mouth when you eat something that tastes good. You probably wouldn’t say, “Umm. My mouth is full of pleasure which is radiating to my stomach.”

When you injure your thumb, you stimulate neural receptors that send a barrage of electrical and chemical messages up through the nerves in your hand and arm to your spinal cord and brain. Whether or not a given sensation becomes “painful” depends upon the way it is interpreted by the nervous system.

If you’ve ever scratched an itch really hard, you know that sometimes it’s hard to tell if something hurts or feels good. If, for all sorts of reasons, the nervous system decides that the messages from the thumb are urgent and require immediate action, it creates an experience of pain that is identified with the thumb so that you’ll give it proper attention. However, it is important to note that the main pain receptor is between the ears, and that’s where pain resides.

Like many perceptions, pain is well known to be influenced by learning and early developmental predispositions. For example, animals raised in a pain-free environment show insensitivity to noxious stimuli in later life. Social, cultural and ethnic differences in the experience of pain also are well documented. A vivid example are the elective initiation rituals of many primitive tribes, which would be considered nothing short of torture if practiced by members of Western cultures.

Aristotle was the first to suggest that "pain is an emotion," as pervasive as anger, terror, or joy. The emotional component of pain is inexorably bound to other aspects of the pain experience; for anxiety and agitation are the natural consequence of a painful sensation that tells higher cognitive centers that "something is wrong." If the "something" can be clearly identified and appropriate corrective action can be taken, the (acute) pain experience is terminated.

However, for most patients with chronic pain, the "something" is vague, and fear of continued pain in an unknown future produces even greater anxiety. On a physiologic level, sympathetic hyperactivity develops, as manifested by increased heart rate, blood pressure, respiration, palmar sweating, and muscle tension. In patients with musculoskeletal pain, this
increased muscle tension often augments the sensation of pain, which
further increases anxiety, which, in turn, produces even greater muscular
tension and more pain. The amplifying relationship between pain and
anxiety is well known to clinicians, for treatment of one frequently provides
relief of the other as well.

Over time, exhaustion of sympathetic hyperactivity is inevitable, and
more vegetative signs and symptoms soon emerge, such as feelings of
helplessness, hopelessness, and despair, sleep and appetite disturbances,
irritability, decreased interests and libido, erosion of personal relationships
with family and friends, as well as increased somatization of complaints.
Thus, acute pain and anxiety become chronic pain and depression.

It is well known that the most notable emotional change in patients
with chronic pain is the development of depression. This may be overt or
masked to both patient and health practitioner alike. In a sense, depression
can be considered a type of emotional pain, and when it is effectively treated,
the chronic pain experience is also often relieved.

It is important to emphasize the psychophysiological basis of chronic
pain, for it is a complex subjective experience that involves physical,
perceptual, cognitive, emotional, and spiritual factors. When a patient with
low back pain complains that “my back hurts,” his/her pain experience also
may involve anxiety or depression (producing insomnia, loss of appetite, and
decreased sexual desire), drug dependence or addiction, separation from
work, family and friends, loss of avocational interests and hobbies, numerous
secondary gains, and a host of other problems. These may remain indelibly
associated with the experience of back pain, even after the entire spine has
been chemically anesthetized.

Thus, it is easy to see why no simple pill or shot can cure chronic
pain. The most common error made by clinicians is to evaluate and treat
only the physical aspect of the problem, for they assume that the objective of
therapy is to treat pain in people. To us, however, the objective of therapy is
to treat people in pain, which takes a much broader perspective. From this
point of view, it is nonsensical to wonder if a patient has "real" versus
"unreal" pain, "organic" versus "psychologic" pain, or "legitimate" versus
"hysterical" pain. Pain is an intensely subjective and personal experience,
and even if no physical explanation for it can be found, all pain is real.

PAIN VERSUS SUFFERING

In our culture, pain is usually considered an enemy to be fought and
overcome, and our first approach is to search for a “pain killer.” This overlooks
and ignores the survival value of pain, which can be a warning signal, a
protector, a potential teacher, guide, motivator, or even an incentive for change.
While some believe that chronic pain is a symptom that has lost its meaning,
this is the result of our health care system’s tendency to medicalize and
externalize symptoms rather than to examine their meaning in a holistic
context.

Whatever the cause, when one cannot tolerate or cope effectively with
pain, he or she suffers, which is manifested as an inability to sleep, eat,
work, or fully enjoy one's life. Life, in the most personal, meaningful sense, stops. As we'll discuss below, suffering is primarily an epiphenomenon of one's attitude and beliefs, and we are convinced that it is possible to have pain, and yet not suffer, depending upon how we relate to the pain we experience.

In the more traditional psychological literature, a distinction is often made between pain sensitivity and pain tolerance. To illustrate the clinical importance of pain tolerance when teaching fellows and residents at UCLA, one of us (DB) found it helpful to compare x-ray films of two patients with knee pain.

The first patient was a professional football player who had undergone six prior knee surgeries. While reviewing his films, we wondered how this individual could walk, much less continue to play football. However, he reported little pain or discomfort, took no pain medications (since they made him "feel less ferocious"), and only desired treatment that would increase stability and range of motion in his knees.

The second patient was injured on-the-job and had filed extensive worker's compensation litigation. Although his knee x-rays were completely normal, he suffered greatly and was unable to climb stairs, drive a car, or sleep for more than two to three hours at a time. He was totally disabled, despondent and depressed, and dependent on his family, four medical doctors, and seven different pain medications.

The first patient had significant pathology but high tolerance and barely complained of pain. The second had minimal if any pathology, but little tolerance to the pain he experienced.

In the clinical situation, we often confront limitations in our ability to reverse severe physical pathology (e.g. degeneration of cartilage in a joint). However, our ability to help patient's enhance their tolerance of pain seems to have no upper limit. Thus, practitioners who help patients embrace a more positive attitude about pain can be successful in helping to reduce suffering and enhance tolerance, even when "nothing more (medically) can be done."

Increasing pain tolerance is, after all, the basis of effectiveness of our most potent pain medications. When a patient is given an injection of morphine (which mimics the effects of endorphins), he or she will often state that "it still hurts, but it doesn't bother me." This represents enhanced central tolerance, not reduced sensation, yet it enables the patient to become more highly functional.

The extent to which a patient's suffering can be reduced through psychophysiological approaches such as IGI depends upon many complex variables including the patient's belief systems and attitudes, early life experiences, the degree of physical pathology, and perhaps most importantly, the meaning of pain in the context of the patient's life.

THE MEANING OF PAIN

Since the dawn of creation, pain has provided critically important
information concerning our relationship to our inner and outer environments. Pain strongly conveys the message that "something is wrong," and it encourages the body to take action to prevent further injury. From an evolutionary point of view, it is one of the most powerful ways to insure the survival of an organism in a dangerous world.

While most authorities acknowledge the positive aspects of acute pain, many believe that chronic pain is a "biological mistake" or "obsolete symptom" that serves "no useful purpose." In order to correct this "mistake," they recommend strong drugs or surgical procedures to obliterate the sensation of pain. It’s interesting to note that the exact technique utilized will depend more upon the type of specialist consulted than upon the patient’s unique needs.

For example, an internist may prescribe medication; a psychologist, psychotherapy; an acupuncturist, needles; a chiropractor, manipulation; and so forth. Abraham Maslow used to say, "When all you have is a hammer, you tend to look for nails."

In our opinion, the best long-term interests of the patient often are not served when the major goal of therapy is to artificially mask or suppress pain without attempting to understand its ultimate message. To do so is like responding to a ringing fire alarm by cutting its wires to stop the annoying clamor, rather than by leaving the burning building.

We invite patients to consider the notion that like the oil light in a car, their nervous system is generating the experience of pain for a reason. We invite them to explore the possibility that chronic pain is usually not a disease or “mistake” but a symptom generated through the wisdom of the body.

We then teach them about the extraordinary self-balancing, regeneration, and repair systems of the body and remind them that symptoms are the way that the body tries to heal itself or prevent further injury. Like the oil light and the fire alarm, once their message is heard and appropriate action is taken, symptoms usually will disappear, for they are no longer needed.

Much of contemporary medicine is based on a "symptomatic adjustment model" of therapy designed to reduce or suppress symptoms. If a patient has high blood pressure, anti-hypertensives are prescribed to reduce it. If a patient is unable to sleep, medications are given for sedation at night. If a patient has excessive anxiety, tranquilizers are often utilized. But why does a given patient have hypertension, sleep disorders, or anxiety neurosis? What is the message that the symptoms are trying to convey? Exploring this question in a non-judgmental way can be the key to relieving or modulating many symptoms, including chronic pain.

Pain is a message that alerts us to danger. Through the primitive, survival-oriented wisdom of the nervous system, it motivates us to correct the situation by changing and adapting to the shifting demands of the world in which we live. Through pain, we are warned about all of the dangers we face, and if we continue to ignore them, the intensity of pain will increase in
an attempt to get our attention and/or elicit some change.

Perhaps this is why many chronic pain patients receive only temporary relief after symptomatic treatment. Although the nervous system can be fooled for a short time by drugs or surgical treatment, if it believes that some subtle danger still remains, pain will attempt to break through and, over time, continue to return until the message is heard and properly responded to.

**PRINCIPLES OF INTERACTIVE GUIDED IMAGERY**

(1) Healing Benefits from Respectful Attention

Although no one really knows what "consciousness" is, we believe that it is critically related to the process of attention, for we only experience what we attend to. There is an old saying that “whatever you give your attention to grows,” whether it be your garden, your children, your worries and fears, or your pain.

Over the years, most of us learn to give our attention to the conscious, verbal part of our mind that narrates a linear logical, rational, analytic monologue describing its perspective of the world and how we think about it. It’s the “little voice inside your head” that talks all the time, the “person” who most of us think we are.

However, who we really are is much more than just what we “think.” We are also the richness of our intuitions, emotions, feelings, memories, drives, fantasies, goals, appetites, aspirations, expectations, ambitions, values, passions, beliefs, perceptions, and sensations. Any or all of these aspects of self may require and even demand attention, finding ways to compete by intruding on everyday consciousness through physical, cognitive, emotional or even behavioral symptoms, if need be.

Rather than suffer the results from neglecting these parts of ourselves, we can focus attention on them in a relaxed state of mind and invite images that represent them to “come to mind.” By properly dialoguing interactively with these images, we can reconnect with important and powerful inner resources that are deeply dedicated to protecting us and improving the quality of our lives.

(2) Imagery is the Primary Encoding Language of the Body’s Healing Systems

Imagery can be thought of as one of the brain’s two higher-order information processing and encoding systems. The system we are most familiar with is that which uses sequential information processing, and it underlies linear, analytic, and conscious verbal thinking. Most health professionals are highly educated and highly rewarded for their abilities in using this mode of information processing.

Imagery serves a simultaneous information processing system, which underlies the holistic, synthetic, pattern thinking of the unconscious mind, and can reveal to us how seemingly disparate areas of our lives are intimately related.
A brief clinical example from Dr. Bresler’s practice serves to bring the importance of this relational quality to life.

“A fifty-two-year-old cardiologist named John was suffering from excruciating low back pain following treatment for rectal cancer. Although surgery and radiation therapy apparently had eradicated the cancer, he described the pain that remained as unbearable. Because the area had been so heavily irradiated, neither repeated nerve blocks nor further surgery could be used to help relieve his terrible discomfort, and he had long ago developed tolerance to his pain medications.

When John first came in, he already had narrowed down his personal alternatives to three: 1) successful treatment; 2) voluntary commitment to a mental institution; or 3) suicide. John was convinced that under no circumstances could he continue to live with pain and, at the same time, maintain his sanity.

In reviewing his medical records, I noticed that during a psychiatric workup, John had described his pain as "a dog chewing on my spine." This image was so vivid that I suggested we make contact with the dog, using guided imagery. With his training in traditional medicine, he thought the idea was silly, but he was willing to give it a try.

In John’s case, our initial goal was to have the dog stop chewing on his spine. Over the next few sessions, the dog began to reveal critically important information. According to the dog (named Skippy), John never had wanted to be a physician - his own career choice was architecture - but he had been pressured into medical school by his mother. Consequently, he felt resentment not only toward his mother, but also toward his patients and colleagues. Skippy suggested that this hostility had in turn contributed to the development of his cancer and to the subsequent pain problem as well.

During one session, Skippy told John, "You're a damn good doctor. It may not be the career you wanted, but it's time you recognized how good you are at what you do. When you stop being so resentful and start accepting yourself, I'll stop chewing on your spine." These insights were accompanied by an immediate alleviation of the pain, and in only a few weeks' time, John became a new person, and his pain progressively subsided."

This type of experience demonstrates how powerfully the imagery process can reveal meaning in a supposedly "meaningless" symptom, and show the way to healing. While imagery does not always lead so dramatically to relief, and disease remission from such dialogues does not always occur, they almost always lead to better self-understanding and enhanced coping skills for dealing with a chronic illness or condition.

(3) Imagery Has Physiological Consequences

Numerous research studies have shown that imagery is able to affect almost all major physiologic control systems of the body, including
respiration, heart rate, blood pressure\textsuperscript{3}, metabolic rates in cells, gastrointestinal mobility and secretion, sexual function, and even immune responsiveness.\textsuperscript{4}

Imagery is essentially a way of thinking that uses sensory attributes, and in the absence of competing sensory cues, the body tends to respond to imagery as it would to a genuine external experience. For example, imagine that you have a big, fresh, yellow, juicy lemon in your hand. Experience it in your mind’s eye until you sense its heaviness and fresh tartness. Now, imagine taking a knife and slicing into the lemon. Carefully cut out a thick, juicy section. Now take a deep bite of the lemon slice and imagine tasting the sour lemon juice, saturating every taste bud of your tongue so fully that your lips pucker and your tongue begins to curl.

If you were able to imagine this vividly in your mind’s eye, the image probably produced substantial salivation, for the autonomic nervous system easily understands and responds automatically to the language of imagery.

Here is the crux of the matter: \textbf{If imagining a lemon makes you salivate, what happens when you imagine you’re a hopeless, helpless victim of chronic pain?} Doesn’t it tell your nervous system to give up? Isn’t it likely to create neural and biochemical signals that goes along with being defeated rather than actively healing? And in the other direction, might not resolving serious life problems, improving communications and relationships, and learning to modulate pain create healthier and more functional physiology in the body?

\textbf{(4) Imagery is the Language of the Emotions}

Imagery is a powerful tool in the healing arts also because of its close relationship to the emotions. Imagery is the expressive language of the arts -- poetry, drama, painting, sculpture, music, and dance, and thus of the emotional self. Emotions show us what’s personally important to us and they can be either potent motivators or barriers to changing lifestyle habits. As clinicians, we have concluded that, by and large, if an issue doesn’t affect you emotionally, it probably won’t make you sick nor is it likely to help you get well.

Emotions motivate us to action and they also produce characteristic physiologic changes in the body, including varying patterns of muscle tension, blood flow, respiration, metabolism, and neurologically and immunologically reactive peptide secretions. Modern research in psychoneuroimmunology points to the emotions as key modulators of neurotransmitter secretion by the brain, gut and immune systems.\textsuperscript{5}

\begin{footnotes}
\footnote{Sheikh, A, Kunzendorf, RG, Imagery, Physiology and Psychosomatic Illness, in International Review of Mental Imagery, Volume 1, Human Sciences, Press, NY, 1984, pp.95-138}
\footnote{Pert, CB, Chopra, D, Molecules of Emotion: Why You Feel the Way You Feel, Scribner, NY 1997}
\end{footnotes}
Patient Autonomy is Most Supported by Using a Two-Way Interactive Guiding Style

One key to the extraordinary clinical effectiveness of Interactive Guided Imagery is the unique interactive communications component that it incorporates. By working interactively instead of simply reading an imagery script, the Interactive Imagery Guide ensures that the experience has personal meaning for the client, and that it proceeds at a pace determined by the client’s actual needs and abilities rather than the guide’s “best guess estimate.”

For example, an Interactive Imagery Guide might ask, “Of all the different problems, symptoms, and challenges now going on in your life, allow an image to form that represents the single most important and critical issue for us to work on now, and then describe it to me.” The guide can then facilitate a dialogue between the client and the image to find out what the image wants, needs, and has to offer.

Since the content, direction, and pace are set by the client, not the guide, it is the client who actually (unconsciously) guides the process to the resources most needed to support healing, change, and positive therapeutic results.

Patient Autonomy is Most Encouraged by Using Content Free Language and Non-Judgmental Guiding

We often like to say that “the guide provides the setting, while the client provides the jewel.” Whenever possible, the Interactive Imagery Guide uses non-judgmental, content-free language, because it encourages clients to tap their own inner resources to find solutions for solving their own problems. Figure 1 illustrates the four major combinations of interactivity and language that occur in guided imagery with examples of each. While all can be useful, we feel strongly that when a content-free, two-way interactive style such as IGI is used, the client is most powerfully encouraged to progress along the diagonal axis representing increasing autonomy.

At a time when there is so much concern about “false memory syndrome,” this type of content-free guiding also insures that the client’s experience is not unduly contaminated or influenced by the suggestions of the guide. (INSERT FIG. 1 HERE)

Patient Autonomy is Encouraged by Specific Qualities and Skills Utilized by the Guide

There are important personal qualities that the Interactive Imagery Guide brings to the therapeutic experience, including a non-judgmental attitude, patience, and trust in the client’s own abilities. The consistent

emphasize on resources and solutions, the repetitive inner focus as a source for solutions and strengths, and the modeling provided by the guide’s belief that the client has within them more resources than they had imagined, leads to minimal transference, greater opportunities for effective client self-care, an enhanced sense of self-efficacy, and the rapid development of patient autonomy.

**PROVIDER-PATIENT/CLIENT INTERACTIONS**

**Patient Assessment Procedures**

The Interactive Imagery Guide must first decide whether there are any contraindications to introducing imagery to the patient, such as a medical or surgical condition requiring emergency treatment, or mental illness precluding its use. Having decided that imagery may offer benefit, a history is taken regarding the client’s prior experience with imagery, hypnosis, relaxation, meditation or related approaches. This allows the guide to utilize prior positive experiences or to address relevant issues in the case of negative experiences.

If the client has no prior experience with relaxation or imagery, the guide usually invites them to relax while being guided through a brief relaxation technique. The client is then invited to imagine themselves in a beautiful, safe and peaceful place and then to describe what they see, hear, smell, and feel there. The guide may suggest that this “special place” has other qualities that might also be uniquely helpful to the client. For example, a fearful client might be encouraged to imagine themselves in a “powerful place,” a “sanctuary,” or a “place where you are completely safe and beyond harm.” A client who feels they are too exhausted to deal with a situation might be encouraged to imagine a place of “great energy and vitality,” or “a place of rest, renewal, and refreshment.”

Imagining a quiet, safe place is one of the quickest ways to teach most people to relax and it powerfully illustrates the profound effects a simple imagery experience can have.

Occasionally, a client cannot imagine such a place, or gets more anxious as they close their eyes and begin to relax. If this anxiety doesn’t respond to reassurance that they are in control, and gentle encouragement to see what comes next, it may be a signal that the person has not had such an experience or that relaxing their vigil may be psychologically dangerous to them. Relaxation-induced anxiety may also be a marker for early trauma, as is the experience of having an imaginary safe place suddenly turn dangerous or foreboding.

Alternatively, the client may be invited to turn their attention to specific symptoms, to allow images to form for them, and to invite healing imagery to come to mind. They may be invited to have an imaginary dialogue with an image of a symptom, or with a kind, wise “Inner Advisor” who can provide previously inaccessible information about their issues or illness.
In this relaxed state, we can invite images to form for almost anything we want to know more about, and systematically explore the images to expand awareness and identify new options that promote healing.

Typically, a patient is initially seen one to three times to explore the potential benefits of working with IGI. After three sessions, the client may have solved their problem, may have found a successful way to work it out by themselves, may have identified an issue that will require additional work, or may have found that the method or practitioner is not suitable for them.

While imagery may bring psychological material to light that wasn’t previously perceived to be part of the medical equation, it can also provide ways to work with this material that does not create unnecessary dependence on a therapist. Many medical or nursing professionals will work with patients if the situation looks like it will yield to a brief course of teaching and counseling, while referring those with more complex issues to therapists who are more highly trained in the method.

Treatment Options

Since imagery is a natural way we think, and since it can almost always be helpful, there are virtually an unlimited number of situations where it can be used in health care settings. For simplicity, it may be helpful to consider three major categories of use:

(a) Relaxation and stress reduction, which is easy to teach, easy to learn, and almost universally helpful;

(b) Visualization, or directed imagery, where the client/patient is encouraged to imagine desired outcomes in a relaxed state of mind. This affords the patient a sense of participation and control in their own healing, which itself is of significant value. In addition, it may also relieve or reduce symptoms, stimulate healing responses in the body, and/or provide effective motivation for making positive lifestyle changes; and

(c) Receptive or insight oriented imagery, where images are invited into awareness and explored to gather more information about a symptom, illness, mood, situation, or solution.

Another set of options to consider is whether the client will be able to use imagery most effectively as a self-care technique, in a group or class, or as part of an individual counseling or therapy relationship. Self-help books and tapes are another inexpensive option for many clients who are capable of utilizing these techniques on their own.

In practice, most patients and practitioners will explore all of the above options and utilize the ones that suit a given client the best, given the unique nature of the issue, their coping responses and approach to life, and the amount of time, energy, and funds they are willing or able to invest in the process.
Description of Commonly Used Treatment Techniques

The list of techniques utilized in IGI is quite extensive, and this approach has been applied to problems ranging from severe depression and chronic pain, to post-traumatic stress, to relationship conflicts, to enhance creativity, to the search for life purpose. However, some of the more basic techniques include:

(a) **Conditioned Relaxation**

This powerful, relaxation technique is based on Pavlovian classical conditioning techniques and utilizes imagery-linked breathing and body awareness techniques to train the patient to relax automatically by taking a special “signal breath.” Instead of tensing when pain starts to flare, patients become conditioned to relax and gently move the painful symptoms out of their body.

(b) **Symptom Suppression Techniques**

Symptomatic imagery techniques reduce the physical symptoms of pain without concern for their cause. They are a useful alternative to analgesic medications, and are particularly helpful when discomfort is so intense that the patient cannot concentrate enough to use other guided-imagery approaches. They include a wide variety of scenarios and techniques, such as “glove anesthesia,” a two-step imagery exercise in which patients first are taught to imaging developing feelings of numbness in the hand, as if it were being placed into an imaginary anesthetic glove. Next, they learn to transfer these feelings of numbness to any part of the body that hurts, simply by placing the “anesthetized” hand on it. Glove anesthesia often helps to “take the edge off” the pain sensation, thus permitting patients to explore other aspects of the pain experience more fully. In addition, glove anesthesia provides a dramatic illustration of the power of self-control. When patients realize that they can produce feelings of numbness in their hands at will, they recognize that they may be able to control their discomfort, too. This is profoundly therapeutic for pain sufferers who feel totally helpless and unable to affect their discomfort.

(c) **Symptom Substitution Techniques**

Symptom substitution is another symptomatic technique that permits the nervous system to move the discomfort to a new area of the body where it will be less disruptive. For example, patients can learn to experience their headaches in, say, their little finger instead of their head. This technique does not ask the nervous system to stop the experience of pain (or to cover up the message it is trying to communicate). Rather, it moves the symptom to a less traumatized area so that patients can work more effectively to identify what is wrong.
(d) **Interactive Imagery** Dialogue.

This interactive technique can be used with an image that represents anything the client or therapist want to know more about, and in many ways, it is the quintessential insight technique. We use it to explore an image of a symptom (whether physical, emotional, or behavioral); an image that represents resistance that arises anywhere in the process; an image for an inner resource that can help the client deal with the current problem; or an image of the solution.

When using Interactive Imagery, the point is not to analyze the images, but to communicate with them as if they are alive, (which of course, they are). This is not to say that they have an existence apart from the client, but rather that the images represent complexes of thoughts, beliefs, attitudes, feelings, body sensations, expectations, and values that at times can function as relatively autonomous aspects of the personality. These constellations have been referred to as “subpersonalities” by Assagioli, or ‘ego states’ by Watkins.

(e) **The Inner Advisor**

After relaxing in their safe place, clients are invited to dialogue with an imaginary figure that is designed to be both wise and loving, or as characterized in analytic terms, an “Ego Ideal.” We call this figure the “Inner Advisor”, and it is often referred to as the “Inner Guide,” “Inner Healer,” “Inner Wisdom,” “Inner Helper,” “Inner Physician,” “Higher Self”, or any other term that is meaningful and comfortable for the client. As the client is invited to imagine a figure that has these qualities, a dialogue with whatever figure arises is usually meaningful and helpful.

(f) **Evocative Imagery**

This state-dependent technique helps clients to shift moods and affective states at will, thus making new behaviors and insights more accessible to consciousness. Through the structured use of memory, fantasy, and sensory recruitment, the client is encouraged to identify a personal quality or qualities that would serve them especially well in their current situation. For instance, a client may feel they need more “calmness” or “peace of mind” in order to deal more effectively with pain.

The guide then invites the client to relax and recall a time when peace of mind was actually experienced. Through the use of sensory recruitment and present tense recall, the client is encouraged to

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7 Vargiu, J, Subpersonalities, Synthesis 1, Synthesis Press, Redwood City, California, 1974, pp.52-90

8 Watkins, JG, Watkins, HH, The Theory and Practice of Ego-state Therapy, in Short-term Approaches to Psychotherapy, Grayson, H., ed
imagine they are there again now, feeling that peace of mind. Once this peaceful feeling state has been well-established and amplified, the patient is invited to let the past images go, but to come back to the present, bringing the feelings of peace of mind. As they now become aware of their pain problem while strongly in touch with this feeling, they are usually able to tolerate it far more effectively.

Evocative imagery was researched by Dr. Sheldon Cohen at Carnegie-Mellon University and found to be highly effective in shifting affective states. Research aimed at assessing the effects of those altered affective states on subsequent behavior, problem solving and self-efficacy remain to be done and offers a fertile field for future psychological and behavioral research.

(g) Grounding: Moving From Insight to Action

This is the process by which the insights evoked by imagery are turned into actions, and increased awareness and motivation is focused into a specific plan for attitudinal, emotional, and/or behavioral change. This process of adding the will to the imagination involves clarification of insights, brainstorming, choosing the best option, affirmations, action planning, imagery rehearsal, and constant reformulation of the plan until it actually succeeds. It is often the “missing link” in insight-oriented therapies, for it connects the new awareness to a specific action plan. It’s where the “rubber meets the road,” and imagery can be used to enhance this process by providing creative options for action and by utilizing imagery rehearsal to troubleshoot and anticipate obstacles to success.

Treatment Evaluation

We refer to the time spent before entering into a formal guided imagery exploration as the “foresight” part of the process. Along with evaluating the appropriateness of using imagery with the client or patient, the guide works with the client to establish the desired goals and objectives for their work together.

As with any medical or psychological situation, goals can be defined in physical, emotional or behavioral terms, and a reasonable trial period of exploration is agreed upon. We often ask the patient to do three exploratory sessions and then decide whether this approach seems useful to them, whether they can best use it as self-care in a brief, time-limited period of work (10-15 sessions), or whether it looks like a longer-term piece of work will be needed.

Many physicians and nurses work for a defined period of time with patients in a psycho-educational or counseling model, with well-defined symptomatic or behavioral goals, and refer patients to mental health practitioners if their work becomes psychologically complex. At the same time, we urge that mental health practitioners take precautions to ascertain the medical status of any patient to make certain they are also aware of their medical options.

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9 Cohen, S, Personal communication
At the end of each session, and at the end the agreed upon time period, the goals of the work are reviewed and progress assessed (we call this phase “hindsight”). After this evaluation, an agreement is made to terminate treatment, to continue for another period of time, to refer to another practitioner, or to define a period of time in which the client will do “ownwork” and then return to report progress.

**Treatment Applications in Addition to Pain**

Since imagery is a natural language of the unconscious and the human nervous system, its potential uses in the healing professions are protean. We think that *imagery is essentially a way of working with the patient, rather than a way of treating particular disease entities.* Thus, it is almost always useful as an adjunctive therapy, while it is rarely, if ever, utilized as a sole therapy.

The following table lists some of the major applications of imagery in the healing professions:

(INSERT TABLE 1 HERE )

**Contraindications and Precautions**

1. Do not substitute imagery for necessary medical or surgical interventions

   The primary danger in using imagery to augment healing in medical situations is when it is used in lieu of appropriate medical diagnosis and/or treatment. We emphasize the necessity of an accurate diagnosis prior to using any psychophysiologic approach so that the patient is also aware of the medical options for treatment. At times, patients may decide that they do not have acceptable medical options available and will then choose to use imagery and mind/body/spirit approaches as their first line treatment. Although there are some situations in which this makes perfect sense, each situation must be evaluated individually to ascertain the patient's ability to judge for themselves and to make such choices.

2. Do not use imagery inappropriately with patients with unstable or unmanaged psychopathology

   There are several diagnostic categories of mental illness where the practitioner must use extreme care when utilizing exploratory receptive imagery techniques. In particular, patients who are psychotic or who are on the verge of psychotic breaks, patients with dissociative identity disorders, and patients with borderline personality disorders must be handled with care, and only by well-trained and experienced practitioners.

   While these diagnoses do not represent absolute contraindications for imagery work, they absolutely require treating health professionals to have appropriate training and expertise in these areas. While many clients with these diagnoses may benefit from certain uses of imagery (usually directed imagery scripts focusing on centering, calmness, self-control, safety, etc.), great caution should be taken when using potentially disorganizing receptive imagery techniques.

   In proper therapeutic hands, imagery techniques can be one of the most effective ways to work with clients who are survivors of traumatic abuse.
and who tend to pathologically dissociate. However, such treating practitioners must be well trained and experienced both in working with survivors of abuse and in working with exploratory IGI approaches.

(3) Do not confuse responsibility with blame

The fact that an illness can be helped through mental means does not necessarily mean it was caused by mental means. When using exploratory techniques such as the Imagery Dialogue With Symptoms, or Working With an Inner Advisor, there is a tendency to confuse the ability to learn from illness with blame for causing the illness.

This issue needs to be handled with skill and sensitivity, and while the practitioner may not be able to prevent certain clients from self-blaming (this may be an important issue to address with them), they can help most people realize that using positive images to stimulate healing does not necessarily mean that their negative images caused their illness.

(4) Do not underestimate the holotropic principle and the innate resources of the patient

Imagery is a potent form of communication and suggestion. Whenever possible, we advocate using the patient’s own imagery and an interactive guiding style with the conviction that the client has within them a great deal of information, experience, knowledge and problem-solving resources that they are not yet using most effectively.

While there are certainly places and situations where a guide needs to supply suggestions and images, these are relatively rare when utilizing IGI, and they may even rob the client of the opportunity to learn an important way to help themselves. This creates or sustains a sense of dependency on the expertise of the guide, rather than attention to the inner abilities that have always been available to help them to help themselves.

SCOPE OF PRACTICE FOR INTERACTIVE GUIDED IMAGERY

This has been an important and problematic area for the Academy for Guided Imagery. As we considered the criteria for formal Certification in IGI, we decided to exercise caution and restrict Certification eligibility to professionals licensed to provide counseling services in their states of residence.

We soon found out that many states have no such licensing for therapists, and people of various levels of quality were providing counseling, psychotherapy, hypnosis, and guided imagery. As a result, we evaluate each candidate on an individual basis, assessing them for both competence and ethical standards as we observe them in clinical supervision as part of their Academy training.

Health professionals must practice within their scope of their licensure, education, experience and competence. Within these guidelines, Certification in IGI can significantly help make professionals more effective at what they already do. Using guided imagery or IGI does not turn a physician
into a psychotherapist, or a psychotherapist into a physician. Instead, it
gives each a greater range of skillfulness in working with issues that involve
both mind and body, and with issues involving emotions and behavioral
change.

Certified IGI practitioners must discriminate between psychotherapy
and psychoeducation, and between enhancing healing responses and the
practice of medicine. They must ethically practice each within their scope of
licensure, training, experience, and competence.

Since our approach is holistic, there is more crossover in these areas
than is immediately apparent. If we can effectively activate healing responses
through essentially psychological means, how does this affect the scope of
practice of mental health practitioners who are well versed in IGI? Shouldn’t
they be critical members of every primary health care team? We believe so.

**TRAINING, CERTIFICATION, & ISSUES OF COMPETENCE**

Many health professionals utilize guided imagery in their work, though
they may have only learned to lead someone by reciting a non-interactive
script. The quality of their training and competence with this approach is
highly variable. Since there is always the potential for doing harm when
these techniques are used inappropriately or without adequate skills,
standards of practice and quality control is an issue of critical importance.

The Academy for Guided Imagery has established specific standards of
competence and ethical behavior that must be met before Certification in
Interactive Guided Imagery™ is awarded. Quality assurance is based largely
upon direct observation of clinical work in small group and individual
supervision sessions during the training program. Over 52 hours of
supervision, four to six different faculty members carefully observe each
candidate, and provide specific feedback to enhance their skills. We know of
no other such standards of quality assurance established for imagery
practitioners.

**REIMBURSEMENT STATUS**

Imagery practitioners usually bill and are reimbursed for their work in
the same way they are for other professional services they render. Sessions
are usually billed as psychotherapy, counseling, stress reduction training, or
medical hypnosis. When applied for medical purposes, medical practitioners
may ethically bill for medical services, although insurance companies may
challenge this if services are lengthy and repetitious. There are currently no
separate billing codes for guided imagery or IGI.

**PROSPECTS FOR THE FUTURE**

When you look closely at almost every form of human therapeutic
interaction and communication, imagery is usually centrally involved,
primarily because it is a fundamental language of body’s healing systems. As
this is better recognized, we are hopeful that health professionals will learn
more about the best ways to utilize this potent form of thinking to support
optimal health and healing.
Feedback from the thousands of health professionals that have taken IGI training confirms that it is a rapid route to insight, growth, and change. One constant piece of feedback we get is that learning to use imagery interactively has improved the listening, communicating and therapeutic skills of our graduates, whether they are mental health professionals, physicians, or nurses.

We feel that competence in effectively yet respectfully guiding the imagery process should be a fundamental part of every health professional’s education and training, and the Academy for Guided Imagery is working toward that goal by co-sponsoring many of its professional training programs with well-established schools of medicine, nursing, and psychology.

In addition to professional training and Certification in Interactive Guided Imagerysm, the Academy for Guided Imagery is a resource for self-help books and tapes and reliable information on imagery. The Academy is also participating in research studies exploring the uses of imagery in pain control, surgical preparation and recovery, and cancer chemotherapy, and it recently established the non-profit Imagination Foundation to support further research in these and other areas. The Imagination Foundation is currently soliciting both funds and research proposals investigating imagery in healing.

Humans have always used their imagination to solve problems that threatened their survival. Our times demand that we now learn to use this powerful information processing and problem solving mechanism even more effectively to help heal ourselves, our families, our communities, and our planet. A sustainable future depends in part on our ability to imagine it in both personal and global terms, and we are committed to supporting the healing potential of this much underutilized resource -- the human imagination.

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10 Academy for Guided Imagery, 1-424-242-6369 or info@acadgi.com

11 Imagination Foundation, POB 2070, Mill Valley, CA 94942, www.imaginationfoundation.org