

Guided Imagery for Pain Control

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Evidence-based practice is integral to the delivery of effective and efficient nursing care. However, translating evidence into practice remains a challenge in health care. To overcome this challenge, the Oncology Nursing Society developed a program, the ONS Foundation Institute for Evidence-Based Practice Change, to provide nurses with the tools they need to translate evidence-based practice to their units. This article reviews the process of implementing the evidence-based practice of guided imagery for pain management on a medical oncology inpatient unit at a comprehensive cancer center.

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Pain is a significant burden to patients with cancer and one of the most feared symptoms of the disease (Swarm et al., 2010). In a systematic review of 28 epidemiologic surveys of cancer pain, 14%–100% of patients reported pain symptoms (Goudas, Bloch, Gialeli-Goudas, Lau, & Carr, 2005; Montgomery et al., 2007). Because pain is so prevalent in the cancer population, organizations, such as the National Comprehensive Cancer Network ([NCCN], 2013), have developed guidelines for appropriate evidence-based cancer pain management (Swarm et al., 2010). These guidelines suggest rating pain intensity, determining goals of treatment, and instituting pain-management methods that primarily focus on pharmacologic interventions. Nonpharmacologic interventions for pain management are recommended by the NCCN (2013), National Cancer Institute ([NCI], 2012) and the American Cancer Society (2014).

Guided imagery is considered a non-pharmacologic modality as well as complementary and alternative medicine, as listed by NCI. NCI (2012) describes it as “imagining scenes, pictures, or experiences to help the body heal” (Mind-Body Medicines section). A typical guided imagery intervention uses relaxation techniques and a description of mental images (Astin, Shapiro, Eisenberg, & Forsy, 2003). Significant evidence exists to support the use of guided imagery in the management of cancer-related pain (acute and chronic), as well as cancer treatment-related anxiety, nausea and vomiting, and depression (Kwekkeboom, Cherwin, Lee, & Wanta, 2010; Portenoy, 2011; Roscoe, Morrow, Aapro, Molassiotis, & Olver, 2011). A comprehensive meta-analysis by Deng and Cassileth (2013) found evidence of efficacy in the use of guided imagery as adjunct therapy for disease- and treatment-related cancer symptoms.

Problem Identification

Managing pain is a top priority for oncology nurses. Pain medications, as a single mode of therapy, may fail to eliminate pain; a combination of approaches is needed for relief (Gatlin & Schulmeister, 2007). Therefore, adjunct methods are frequently recommended (Pasero & McCaffery, 2011). The policy and procedure on pain control for the authors’ institution notes, “Use non-drug interventions such as exercise, positioning, heat/cold, music, imagery, etc., as part of the pain relief program” (City of Hope, 2013, p. 4). To evaluate how well pain is managed, the authors conducted a periodic pain survey throughout the year of 2012. As a part of this survey, inpatients were interviewed and asked questions about how well their pain was managed while in the hospital, and the survey showed that 42% of patients were offered non-medication options for pain relief. This question prompted interest in offering guided imagery to patients. When asked why alternative methods were not being offered, some nurses stated that they were aware of other methods to control pain but were uncertain of how to implement them. Nurses expressed a desire to learn about alternative modalities. Recognizing this knowledge deficit as a barrier to evidence-based practice, the authors developed the pilot program described in the current article.

Methods

The authors’ aim was to test the feasibility of a nurse-led guided imagery intervention on two medical oncology inpatient units. Seven nurses responded to an email invitation and volunteered to participate in the pilot. The project

content expert, a certified hypnotherapist, developed a curriculum for the guided imagery training. The one-day course was held in a classroom setting with interaction and hands-on practice, and it focused on (a) the biologic basis for guided imagery, (b) the evidence supporting the use of guided imagery for pain control, (c) the technique of delivering the intervention, and (d) practice time to deliver the intervention to other course participants.

At the end of the course, nurses were able to provide a 15-minute guided imagery intervention. An intervention binder was developed and kept on each medical oncology unit to hold the pilot materials. The guided imagery binder included (a) a scripted introduction to explain the guided imagery intervention to the patient, (b) a 15-minute guided imagery intervention written out for the nurse to read, (c) a short data-collection tool to document pain levels, (d) a handout to give patients describing guided imagery, and (e) a laminated “please do not disturb; relaxation in progress” sign to hang on the patient’s door.

The goals of the pilot were to provide guided imagery to 20 medical oncology patients and to use pre- and postsurvey information to assess the success of the intervention. The authors presented the project to the medical oncology interdisciplinary team during medical oncology rounds. The team was supportive of the project and referred patients who could have benefitted from the intervention. This project was carried out as quality improvement and did not meet the definition of research per the U.S. Department of Health and Human Services (2009); therefore, institutional review board approval was not required or requested.

Findings

Guided imagery was conducted by the trained nurses and documented for a total of 24 sessions during the pilot. Three sessions were excluded from evaluation because the guided imagery intervention was used for a symptom other than pain relief (i.e., anxiety and dyspnea). Despite training seven nurses, only three nurses were able to commit to providing the intervention. The average time spent with the patient was 17.4 minutes (range = 10–30, SD =

4.6). The script was translated into Spanish, and two nurses were able to deliver the intervention in Spanish. Family caregivers were encouraged to stay and participate in the guided imagery intervention in the patient’s room.

The primary aim of the pilot study was not to test the efficacy of guided imagery because that has been previously documented in the literature (Astin et al., 2003; Deng & Casileth, 2013; Kwekkeboom et al., 2010; Portenoy, 2011). The aim of the project was to test the feasibility of a nurse-led guided imagery intervention. Patient pain levels were measured preintervention, immediately postintervention, and one hour postintervention (see Table 1). On average, patients experienced a decrease in pain level immediately postintervention, and, in some cases, the effect was sustained one hour later.

In addition, patients were asked about the experience of guided imagery. Of the 47 comments offered by the participants, the majority of the comments were positive. When asked what could improve the experience, most stated that it should be done more often or for a longer duration and available on demand. Only one patient commented that it was hard to focus and did not find it helpful. Based on this feedback, guided imagery and relaxation sessions have been recorded in English and Spanish and have been added to the inpatient television at the authors’ institution. They are available on demand and include relaxing music and scenic images.

The nurses who provided guided imagery stated that their experiences were positive and that they noted a reciprocal benefit from guided imagery that included personal calmness and relaxation, as well as a feeling of internal satisfaction from providing high-quality care to patients. They also expressed satisfaction and benefit from participating in the intervention.

Barriers to Implementation

Only three of the seven trained nurses participated in providing guided imag-

TABLE 1. Pain Scores Pre- and Post-Guided Imagery

Variable	\bar{X}	Median	SD	Range
Preintervention (N = 21)	5.12	5	2.31	0–9
Immediately postintervention (N = 18)	3.39	3.75	3.09	0–10
One hour postintervention (N = 18)	4.69	4.75	1.58	2–8

Note. Scores ranged from 0–10, with higher scores indicating more pain.

Note. Patients were also administered analgesics during this time.

ery. The other four nurses did not have adequate time to complete the intervention. The average implementation time for providing the intervention was 17.4 minutes, and nurses cited a lack of time during their shift. No formal communication system existed, making it difficult to contact a nurse trained in guided imagery. Some patients who were approached for guided imagery were not interested in the intervention. Some physicians wanted to be notified prior to the nurse offering guided imagery to their patients to ensure that the patients were well suited for the intervention. This created delays and often prevented that patient from receiving guided imagery.

Discussion

The authors were able to implement evidence-based practice in nursing care. The intervention was supported by the interdisciplinary team, and most patients were receptive to the intervention. In retrospect, the efforts to bring guided imagery to patients in the authors’ institution could have been improved. Time to provide the intervention was not always allocated, and a clear mechanism for referral and contacting the trained nurses did not exist. Solutions to these barriers could include obtaining a beeper for a trained nurse to be contacted or creating a schedule of when a guided imagery nurse was available. The authors had strong leadership support, and the institution’s culture was supportive of the efforts. The program provided critical reflection and a development experience for nurses. The pilot resulted in a mechanism to bring guided imagery to all patients via the inpatient television system.