Towards Advanced diploma in HP
and for
Accreditation towards UKCP registration

Dissertation - Advanced Psychotherapy Module
A consideration of the ethics of providing Guided Imagery by CBT trained staff without full and proper training in psychotherapy or full knowledge or training in Hypnosis and Hypnotherapy

By
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9/19/2011
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Introduction

I first became interested in Hypnosis, or guided imagery being used with CBT during training I did through The National college of Hypnotherapy and Psychotherapy on Post-Traumatic Stress Disorder with Geoff Ibbotson. Part of the reading material he gave out had a small paragraph saying that

Quote. Use of Imagery
The conscious mind processes using language whereas the unconscious mind processes using images. Hence, language expresses our conscious “reality” whereas imagery expresses our unconscious feelings. Thus positive suggestion using imagery is often more powerful than just using words
As we hear language, we process it using our own imagery. This is based on our own previous experiences and culture. This adds our own frame to the word – and this may be very different from that of the speaker. For instance the word boat may elicit an image (and hence meaning) of a rowing boat to one person and a Mississippi river boat to another. This point is of paramount importance in communication as we must realise that what we say may be interpreted in a totally different way by someone else. Cancer may mean a medical condition or an astrological sign!!
Images are created by all of our senses and are consequently not just visual. The technical terms are that imagery can be visual, auditory, kinaesthetic, olfactory or gustatory. Different people process in a different manner and tend to favour the different systems in different proportions. (VAKOG, 2008). An indication can be the language that they tend to use. © Geoff Ibbotson geoff@geoffibbotson Dr Geoff Ibbotson, from course material PTSD

Later on Dr Ibbotson asked the question - a therapeutic digression – some? Hypnotic use of imagery-

Dialectical Behavioral Therapy for BPD suggests the use of “Wise Mind” techniques. I would regard this as accessing the unconscious mind using self-hypnosis.

Compassionate Mind imagery is sometimes used in Cognitive Behavioural Therapy as a way of helping a client deal with self-criticism. The client is asked to close their eyes and make an image that represents their self-criticism. They then listen to what it says about a particular event when they were self-critical, and the feelings that that engenders are discussed. Usually the self-critical voice is angry or disappointed and gives rise to feelings of hopelessness or of being a failure. The client is then asked how they would react if a good friend of theirs was in trouble. The therapist then draws their attention to that caring, compassionate, supportive part of themselves that operates towards others in trouble but is rarely activated towards them self. Having made an image that represents the caring compassionate friend they listen to what that part of them self has to say about the event previously used to access the self-critical voice. The therapist then asks how that made them feel. Feelings of encouragement are commonly reported. We all know that encouragement gets better results than criticism and this exercise can be done regularly until it becomes established as an automatic way of thinking when something untoward occurs.

On looking into this further I became more aware of the wider use of hypnotic techniques being used in different areas of therapy such as under guided meditations where self-hypnosis is also promoted to users and practitioners.

What is Mindfulness?
Mindfulness is an ancient Buddhist practice which is very relevant for life today. Mindfulness is a very simple concept. Mindfulness means paying attention in a particular way: on

Guided Meditations http://mbct.co.uk/cd-set/

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purpose, in the present moment, and non-judgementally. This increases awareness, clarity and acceptance of our present-moment reality.

Mindfulness does not conflict with any beliefs or tradition, religious, cultural or scientific. It is simply a practical way to notice thoughts, physical sensations, sights, sounds, and smells - anything we might not normally notice. The actual skills might be simple, but because it is so different to how our minds normally behave, it takes a lot of practice.

I might go out into the garden and as I look around, I think "that grass really needs cutting, and that vegetable patch looks very untidy". My young daughter on the other hand, will call over excitedly, "Mummy - come and look at this ant!" Mindfulness can simply be noticing what we don't normally notice, because our heads are too busy in the future or in the past - thinking about what we need to do, or going over what we have done. ²

The Visitor - Mindfulness Exercise

Automatic Pilot
In a car, we can sometimes drive for miles on “automatic pilot”, without really being aware of what we are doing. In the same way, we may not be really “present”, moment-by-moment, for much of our lives: We can often be “miles away” without knowing it. On automatic pilot, we are more likely to have our “buttons pressed”. Events around us and thoughts, feelings and sensations in the mind (of which we may be only dimly aware) can trigger old habits of thinking that are often unhelpful and may lead to worsening mood.

By becoming more aware of our thoughts, feelings, and body sensations, from moment to moment, we give ourselves the possibility of greater freedom and choice; we do not have to go into the same old “mental ruts” that may have caused problems in the past.

Not dissimilar to

* Therapeutic techniques used during hypnotherapy include relaxation skills, desensitisation, imaginal exposure, aversion therapy, mental rehearsal, challenging unhelpful thoughts and behaviours, building on positive thoughts, ego-strengthening and self-esteem building, psycho-education, cue-controlled states and emotions (‘anchoring’), ego-state or parts therapy, regression techniques (as part of therapy), dissociation, future pacing, visualisation, modifying distressing memories using imagery, direct and indirect suggestions, and use of metaphors. ³

Until this point I had thought of hypnosis and cbt as being distinctly different in their approach, although I had been working in Hypno-Psychotherapy.

In order to find out more about it I began to research the methodology and at once began to see that CBT having made wide claims in its use across all mental health problems had begun to use “guided imagery as a technique to further develop the effectiveness of CBT.

Some of the claims in CBT as being the best form of therapy and ‘a one size fits all’ was promoted across the PCT and health authorities for a long time having been adopted because of its methods which are useful in providing outcomes that are recordable, thereby seen as scientific.

Since my initial findings I have done some more research on this and have found quite a bit of literature on the subject.

I have also completed training for a certificate in CBT for a number of reasons

2 Another example where CBT and self-hypnosis (meditation) guided imagery can be found on http://www.getselfhelp.co.uk/mindfulness.htm
3 http://www.guernseyhypnotherapy.com/

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1. to look at the training
2. to have a better understanding of CBT
3. to see if my concerns etc. were founded
4. I was also surprised to see students doing the Certificate in CBT without any previous knowledge or expertise in therapy work at all. Paid for through the organisations they worked for with the expectation that’s they would be able to provide cbt with clients afterwards.

I do on some level believe that in spite of the Increasing Access to Psychological Therapies (IAPT) programme meaning all therapies, it has a bias and that it promotes an increasing access to mostly CBT. This is borne out by the literature available from IAPT, NICE guidelines and from training and competency papers on what is best for clients with depression and anxiety (in particular.)

The uses of metaphor being adopted or more extensively promoted seemed to me to be important in a number of ways in that it is:

1. Acknowledging that CBT is not perhaps as effective as it was first thought to be, and other research has identified this.  
2. CBT is now using other methodologies in order to maintain its position as a therapy of choice while subtly changing the tools that it used to increase the effectiveness of that therapy.  
3. Trainees in level three Certificate in CBT were not trained or did not have to be trained in other forms of therapy or in the uses of hypnosis or guided imagery techniques to use CBT with clients.  
4. Providing tools for use that newly qualified practitioners of CBT who may then also be encouraged to use guided imagery without any background knowledge or training in its full use.  
   (Such as an awareness of abreactions, levels and depth of hypnosis, the uses of ideomotor responses etc. (or indeed any ethical considerations and contraindications to its use.)

CBT seems more about the here and now while Hypnosis is dealing with the unconscious and perhaps core beliefs, CBT in my training at certificate level says that it does not work with core beliefs.

**Review**

While I can understand that CBT is a set way of working, and is recommended in many instances by the PCT (one of the reasons I undertook this extra training for myself and to help me have a deeper understanding of the process.) CBT is recommended because it is not (or should not be anecdotal) but is evidence based and therefore measurable and is seen as controllable. It is run and works alongside support planning and other outcome based works such as outcome star developed by triangle training.

I have worked across many different organisations in the course of my career through QAF and audits through English and Welsh authorities. The evidence based quality control systems are very well established which is why I believe CBT is accepted and used more commonly those other therapeutic systems. The private sector has developed and used other systems which encourage and use visualisation and psychotherapy (although I might be a bit sceptical in thinking that’s cbt at certificate level is more in line with coaching certificate which also uses a method of asking questions and pulling and pushing, techniques, use of homework and goal setting.

So my concerns on completion of a certificate in coaching are similar in that people are given skills (which is good) based on techniques used in counselling without previous knowledge of perhaps where this work may lead both them and the person they are working with.

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4 The final Chapter of Robin A Chapman is called becoming a practitioner of CBT and Hypnosis is focused on training appropriately. His focus but I feel that it is still that CBT is the most important part of his attention

5 http://www.outcomesstar.org.uk/

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During the course of doing research for this study I was initially side tracked by the information that is available for low intensity workers and high intensity workers within the PCT. The uses of forms and tables that seek to measure and record at all levels the type of therapy that’s should be completed with clients who exhibit particular symptoms and would be diagnosed with depression, anxiety etc.

See appendix 1

This breaks down everything that a practitioner would need to know. I have a problem here because often the people who come through the medical treatment system cannot afford to go to a private practitioner are often the people who have the most difficulties, long term mental health issues and drug and alcohol abuse (unless as a private practitioner one is able to provide therapy that is based on earnings or benefit levels)

Often they are dependent on and become used to having things done to them and for them when they as clients become ‘medicalised’.

Behavioural management and medical considerations of course have to be taken into account (e.g. physical symptoms from long term alcohol and drug use.) (I would like to highlight that perhaps those self-medicating and mal-adaptive strategies that people who have suffered a trauma or have long mental health issues adopt are because they have not been addressed by the available service provision in other ways and can provide the individual with an autonomous and anonymous way of dealing with their own anguish, depression etc.

Using medical services and health authorities because we have a national health service is a good way for people with little or low income to access medication and treatment etc. but on each visit one as a patient is accountable to the GP or hospital and the institution who is then accountable when that treatment is provided. Regulation is and should be a good thing, but for those whom regulation and record keeping provided a barrier no real provision is made.

It cannot provide autonomy (with some understandable reasons, such as a lack of appropriate funding, and/or patients who might choose a therapy or treatment based on what they want rather on what it is felt they need), however this leads the patient (not as a client) but to become dependent on those services in many ways, in the same way as they may be on alcohol, illegal and prescribed drugs.

Professor Marmot commented on the findings in his review:

The evidence of the Marmot Review is borne out by the recent work of Richard Wilkinson and Kate Pickett, which emphasises that it is not only the poor who suffer from the effects of inequality, but the majority of the population. (*2


For example, rates of mental illness are five times higher across the whole population in the most unequal societies compared to the least unequal societies in their survey. One explanation, they suggest, is that inequality increases stress right across society, not just among the least advantaged.

Which led me to look at and perhaps question how on the one hand it is clear that the IAPT programme is all about increasing access (presumes choice by me) in real terms it restricts availability

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* Taken from the original reports referencing -http://www.ukpha.org.uk/media/17359/manifesto_colour_online.pdf
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of those services and/or techniques; provided for those people coming through the NHS, for those who are dependent on those services and for those who are in a position of having little choice. Taken from Nice guidelines

The lessons in this module encourage students to think about the relationships among knowledge, choice, behavior, and human health in this way:

**Knowledge (what is known and not known) + Choice = Power**

**Power + Behavior = Enhanced Human Health**

And in assessing competencies it says that

Therapy cannot be delivered in a ‘cook book’ manner; by analogy, following a recipe is helpful, but it doesn’t necessarily make for a good cook. This domain describes some of the procedural rules (all shown in white) (e.g. Bennett-Levy, 2005) that enable therapists to implement therapy in a coherent and informed manner and to apply an intervention in a way that is responsive to the needs of each individual client.

This may not seem to be relevant for this study however for me it is relevant because by the promotion of only particular therapies, it becomes in the best interest of the organisation (or authorities) to ensure that those therapies are effective, especially when it had done so because of the emphasis on providing therapy which is measurable results that are to be obtained throughout the process.

The wider use of guided imagery, is indicative of fitting and changing the therapy for better results (good for the client/patient) but not sticking to the identified this can be measured (outcomes based therapy) which CBT is revered for. *(For further information see Appendix 2)*

I may be judging the situation harshly but as I have stated I have worked in many organisations and have seen how policies have been adopted and put in place and where staff are expected to complete work within guideline and in relation to quotas based on results which look good but do not give a full picture of what is going on, that the sometimes anecdotal evidence which is not taken into account can be very illuminating. As an aside we cannot measure the mental image that the client has, nor can we measure the intensity of that image, (we can use a best guess!) We cannot measure if any other senses are stimulates in relation to a particular image through the process of guided imagery. We must rely by default on the anecdotal evidence from the client as to images and on the outcomes/results from these.

*(FROM)* CHAPTER FOUR
the unjust distribution of psychotherapy

We argued in chapter three that psychotherapy addresses basic needs, and we suggested that its distribution should not be determined by the ability to pay for it. It is our belief that in this respect psychotherapy should be regarded, like basic health care and education, as something that should be equally available to people according to need. This follows from the Principle of Equal Respect.

This Principle is really about well-being or flourishing, and it states that people should not be disadvantaged on arbitrary grounds. Of course, natural differences, which from a moral point of view are arbitrary, mean that it is not possible for everyone to flourish equally… The crucial point is that scarce essential services should not be distributed on an arbitrary basis.

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9 Assessing Competences against the Cognitive Behavior Therapy Framework. Self-Assessment Tool, [www.ucl.ac.uk/CORE/](http://www.ucl.ac.uk/CORE/)

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To distribute health care or education simply according to ability to pay is to do an injustice to those whose needs for the services are great, but whose financial resources are small. 10

While in the UK we are not required to pay for health service, what services we can access is controlled, by restraints and by various means. Decisions are made based on medical guidelines as to who is deemed suitable for a particular treatment. (prohibitive things such as cost of treatment).

The above quote was written in 1998 so is quite old but I think the sentiment still stands. The focus on the main provider of mental healthcare in the country to one form of therapy does this.

Given the numerous reports on mental health and well-being, which identify the best way forward for the population, to decrease inequalities and provide more access. It seems more important to evaluate what sources of help from private and independent practitioners might be available and are being overlooked. At the present time we know that by working together and developing strategies that are based on the co-operation of new and innovative ways of supporting the whole of the population, would seem to be the best way forward but this is in direct contradiction to a one size fits all therapy that CBT I believe has become. A therapy that now looks to use other therapies without full recognition of the roots of those therapies or of the ethical boundaries that need consideration.

One might not see how or where the two strands of my study meet or if they are indeed related. This I hope will become clearer as I look at the inter-relation between the two.

My research for hypnosis and CBT resulted in information on mindfulness and after following these links and searching for mindfulness on the NHS, I was able to see other research that is being completed with the focus on mindfulness (using meditation for self-hypnosis)11

I am concerned that any therapy provided will become a watered down versions (such as guided imagery and hypnotherapy) in order to provide access (as in the IAPT guidelines), and (as identified earlier) an easy fix that seems to be cost effective. Which, at the risk of repeating myself, in the long run equates to further inequalities within the population based on that access to and availability of therapies that are outside of the ones adopted though Health Trusts and Primary care Trusts.

This article on mindfulness states 12

“By simply refocusing our awareness, we reshape our experience”.

A study by researchers in Wales, Toronto and Cambridge found that in cases of recurring depression it reduced the risk of relapse by 50%. As a result, the National Institute for Clinical Excellence (Nice) adopted it in its guidelines as a recommended intervention in cases of chronic depression. Recent studies have shown that the technique can have other significant benefits, including boosting the immune system and encouraging left-field brain activity – the side most associated with feelings of wellbeing.

The impressive experimental results have led to a surge in interest and increasing demand that the practice be made more widely available. Research centres have sprung up across the country and there has been an explosion of mindfulness courses in non-clinical settings.

However the article also cautions

10 Questia, a part of Gale, Cengage Learning, www.questia.com
11 http://www.crd.york.ac.uk/crdweb/ShowRecord.asp?LinkFrom=OAI&ID=12007907418
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Some psychologists are cautious about overselling the benefits or applying mindfulness too zealously outside a clinical setting. Florian Ruths, who runs a mindfulness meditation programme at the Maudsley Hospital in south London, argues that the technique’s very success in becoming part of the psychological mainstream could lead people to view it as a quick-fix solution. See also 13

While continuing to look and research information for Hypnosis on the NHS I also came upon teaching and learning self-hypnosis.

"It was clear that anxiety was a problem," says Dr Walters. "High levels of adrenalin make it difficult to sleep." Dr Walters says the self-hypnosis techniques, which all involve imagery, are adapted to the individual's own strengths. 14

Another NHS website brought this up

**Complementary and alternative therapies**

There is very limited evidence that acupuncture is effective for treating insomnia, and there is no good quality evidence that hypnotherapy is effective.

Certain herbal remedies such as chamomile and passionflower have had some reported positive effects, but have not been thoroughly clinically investigated to support their use and long-term safety. 15

This information by its proximity links hypnosis with other alternative therapies as not particularly helpful and does not recommend it as part of a wider psychotherapy or with cbt.

The site recommendations for insomnia can be found in **Appendix 3** Initially this looks at good sleep hygiene and then recommends sleeping tablets after medical examination prior to other forms of therapy or help.

Recommendations for therapy are focussed on CBT for long term insomnia only and include having this from your GP who can give this or from a clinical psychologist. These are not very wide ranging recommendations and still promote the use of CBT through medical pathways.

On this site there is no model for the use of CBT and hypnotherapy or guided imagery, it offers instead a negative to any prospective client.

Also on the site like many others it asks the question - Are there any natural remedies for insomnia?

It is possible that some complementary and alternative medicines are effective in managing conditions that cause insomnia (for example, pain or anxiety) but there are no alternative approaches to insomnia that have been proven to be as effective as sleeping pills or CBT. 16

This site is readily available for all to see not a difficult search to get to it. Further research proffered up the opposite description which is quoted here: -

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13 http://www.guardian.co.uk/society/2011/jan/02/mindfulness-meditation-meg-ryan-goldie-hawn
14 http://www.nhs.uk/Livewell/insomnia/Pages/hypnosis.aspx
15 http://www.nhs.uk/Conditions/Insomnia/Pages/Treatment.aspx
16 http://www.nhs.uk/Conditions/Insomnia/Pages/Questionstoask.aspx#CBT

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Modern cognitive hypnotherapy is an enjoyable and relaxing experience allowing you to access your full potential with relatively little effort and in a short time. You are in control all the time and... It feels great!

CBT with Hypnosis - a powerful combination

Combining (CBT) Cognitive Behavioural Therapy with Clinical Hypnotherapy creates a powerful treatment solution that can help with a wide range of issues. CBT has the strongest evidence base for effectiveness of any "talking therapy". Hypnotherapy too has a strong record of brief, effective treatments. Together CBT with Hypnosis allows for deep, effective and rapid treatment.

Most issues are a result of excess tension combined with unhelpful/poor thinking habits - leading to negative emotional states. With a systematic approach to relaxation and changing those thinking habits, using CBT and hypnosis, you will enjoy freedom from those negative emotional states and experience greater ease and empowerment in your life.17

There are many more and the effectiveness and usefulness of many of these sites cannot be examined any deeper here and are not within the scope of this study. However I have used them to illustrate how information can be confusing and contradictory depending on what criteria is used to look for help or to find a therapist. Ethical considerations can differ greatly from one organisation to another and even between different health authorities. Funding plays a big role on what is adopted or not.

I can also give many examples from my own working experiences where new ways of working has been introduced based on new ways of thinking, for example under the community care act . It was only after the policy had been implemented that some contraindications appeared and it became apparent there were some causes for concern and adaptions needed to be made.

In a document called The Introduction to the Recommended Terminology for Hypnotic Practice from the National Guild of hypnotists (founded in Boston, Massachusetts 1950 in America) they clearly state that they are not psychologists or therapists. They do not diagnose or provide treatments instead.

As hypnotists do not independently work with medical or mental disorders we advise practitioners to avoid even casual use of the common language versions of therapeutic language. We provide an alternative here. Before working with a client who may informally use therapeutic words to describe his or her problem, the hypnotist should be careful to restate the client’s issue in non-therapeutic terminology and to use this terminology in all records.18

The use of hypnosis is not shown be used as therapy

**Guided imagery, Hypnotherapy and hypnosis**

As this study is to do with ethics of lay people using guided imagery and the last section ended with looking at how sometimes the cart is put before the horse. I would like to focus on some contraindications. I would like to raise some concern if those practitioners who may be trained in using basic CBT without full therapy training are now to be charged with using guided imagery as a matter of course.

A number of therapeutic methodologies that have developed in mindfulness as discussed earlier, one source also included the following information:-

**Abnormal results**

17 [http://www.hypnotherapy-success.co.uk/](http://www.hypnotherapy-success.co.uk/)

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Guided imagery is not used in isolation but as a part of a therapeutic formulation and is appropriate for a range of problems and disorders. It is, however, thought that some techniques—such as imagery used in rational-emotive therapy—can trigger high levels of anxiety in some clients. Therefore, caution should be taken when using these techniques if clients have the following conditions:

- asthma attacks triggered by stress or anxiety
- seizures triggered by stress or anxiety
- cardiac condition or related conditions
- depression with suicidal ideation
- hysteria
- pregnancy
- severe psychiatric disorders

In these instances, other strategies and techniques that do not trigger high levels of anxiety, such as relaxation exercises or coping imagery should be considered. When working with clients with these conditions, the therapist should be in consultation with their medical provider. 19See Appendix 4

Also from the same source: -

Definition
Guided imagery therapy is a cognitive-behavioral technique in which a client is guided in imagining a relaxing scene or series of experiences. 20

It comes down to different practitioners calling the same or similar methodology by a different name. Access can be available and can be provided and these systems are advertised as a therapy. Where guided imagery is advertised tapes can be available to anyone who has not had any training or face to face therapy with a practitioner or has prior knowledge of hypnosis or hypnotherapy

This in itself may not be a problem but where can a client go to ensure that he/she is not being given something that may not be helpful to them. The option to have access to other therapies and in the case of this study a fully trained hypnotherapist would not be an option under NHS recommendations. As highlighted earlier the system does better at increasing inequality and dependence by providing what is thought to be best for them! And Us! (Does he take sugar come to mind)?21

Another concern I do have is that guided imagery is usually seen as a gentle and relaxing method and a pleasant experience; however this may not always be the case where a practitioner is not fully trained :-

Such issues such as how to deal with an abreaction,(mentioned earlier) or how to provide safety mechanisms against false memory syndrome, the use of these guided imagery techniques for people in groups, anywhere that underlying anxieties or phobias are not known could well be contraindicated. Assessment may not (most likely) have been carried out beforehand and work on one particular problem without knowledge of any other underlying problems or recourse to other methodologies could be unethical by its nature.

The power of the mind to bring up information and images not always related to what is being worked through or discussed is possible. My experience as a practitioner has shown that sometimes surprising

19 Read more: Guided imagery therapy - children, functioning, person, people, used, skills, effect, theory, health http://www.minddisorders.com/Flu-Inv/Guided-imagery-therapy.html?ixzz1VhOa3K1
20 Read more: Guided imagery therapy - children, functioning, person, people, used, skills, effect, theory, health http://www.minddisorders.com/Flu-Inv/Guided-imagery-therapy.html?ixzz1VhLBAmzZL
21 http://everything2.com/title/Does+He+Take+Sugar%3F

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results are brought about and one needs to be focussed and have the skills to deal with these situations.

**Guided Imagery** is a method of recognizing the imagination as a way of knowing. Imagery is the natural language of the unconscious mind and guided imagery is a powerful modality to help a person connect with the deeper resources available to them. This process is capable of bringing about profound psychological and physiological change, as it simultaneously empowers and educates the user.

This lens will provide descriptions, explanations, examples, links, and support products to facilitate the use of guided imagery and help to spread the word about this powerful but accessible modality.

No music is needed, no sound effects, just the knowledge of the guide and their ability to guide the listener through the process of opening a cognitive communication between the conscious and subconscious mind to perceive and recall senses and events that are already familiar to the listener.

Guided Imagery and Meditation. High quality MP3 downloads for adults and children

This sounds great, but what happens when the images being provoked or brought up are not pleasant, are distressing (see previous notes on this) it makes it sound as if there would be no problems.

**Is guided imagery safe?**

Guided imagery is safe. No known risks are associated with it. Guided imagery is most effective when the person teaching it has training in guided imagery techniques.

Always tell your doctor if you are using an alternative therapy or if you are thinking about combining an alternative therapy with your conventional medical treatment. It may not be safe to forgo your conventional medical treatment and rely only on an alternative therapy.

In a study to check for false memory syndrome

Participants were asked what they remembered about each event. If they could not recall an event they were asked either to form a mental image of the event and describe the image to the experimenter (the guided imagery condition), or they were simply asked to quietly think about the event (the control condition). This procedure was repeated on each of 3 consecutive days. The major result was that the guided imagery condition produced more confirmed false memories than did the control condition. (p83).

This recognises the need for caution and for understanding how asking questions or for information can change the event or add an event that did not exist previously. In inexperienced hands these methods could lead (as it has done in the past) to accusations being levied against people for abuse it is important to be aware especially where this maybe being done with vulnerable people where new
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supports (as protectors) are overzealous in there interpretations. There is now much research on this and how to recognise when a memory maybe true or false.

There is much research on this already. See these two sights http://www.fmsfonline.org/ and http://www.bfms.org.uk/

From the Royal college of psychiatrist website in the questions and answers page

Is CBT-based Hypnotherapy safe?
CBT-based Hypnotherapy is completely safe when carried out by a professionally trained and skilled therapist. 26

They also go on to say that

Nobody can be hypnotised against their will. Even when hypnotised, people can still reject any suggestion that they choose not to accept. When in a trance you do not loose control and are able to hear everything that is said.

Hypnosis is one of the world’s oldest healing techniques, having been used since the sleep temples of ancient Egypt and is a naturally occurring state of mind. Trained therapists can use it to help guide patients into an understanding of the root causes of their disorders. Once such insight has been achieved, hypnosis can then be used to provide the patient with tools to allow them to achieve their goals.

By combining the two techniques, CBT-based Hypnotherapy teaches people to deal with the past by focusing on the present. The result is a uniquely powerful tool for therapists and a rapid and effective treatment for patients. 27

The emphasis is on professionally trained and this leads me to the question what constitutes professionally trained? Described as a powerful tool for therapists it suggests that it should not be used by people who are not either professionally trained or classed as a therapist.

At Inspired Hypnosis I combine the two most powerful psychological therapies: Cognitive Behavioural Therapy and Clinical Hypnotherapy; offering you the most effective and proven therapy currently available. Indeed such is the effectiveness of this combined therapeutic approach that we believe that Cognitive Hypnotherapy (also known as Hypno-CBT) will become the treatment of choice in the NHS over the next five years.

How does CBT-based Hypnotherapy differ from ordinary hypnosis?

CBT-based Hypnotherapy combines the efficacy of hypnotherapy with the self-awareness gained from the well-proven psychological technique of CBT. Research has shown that this approach is up to 80% more successful than either straightforward hypnotherapy or ‘standalone’ CBT 28

29 Is a link for another of what is guided imagery, and shows how the two, that is guided imagery and hypnosis are linked together. That guided imagery uses hypnotic skills and I suppose I wanted to

http://www.rcpsych.ac.uk/
http://www.rcpsych.ac.uk/
http://www.hypnotherapy-success.co.uk/hypnotherapy.htm

What is Guided Imagery?
Guided Imagery/Visualisation is the use of hypnotic skills. One of the easiest ways to use guided imagery in therapy is to start with a relaxation induction. There are a number of ways to induce relaxation. For example, a relaxation induction can be initiated, which requires the practitioner to count from 1 to 20 combined with a basic breathing exercise, which helps the client experience a state of relaxation.

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emphasise this because looking through some of the information on CBT it seems that the techniques are not seen as encompassing the skills of hypnotic inductions. - That guided imagery to help clients/patients can be seen as something that is only a gentle and relaxed state that anyone can use without any concern-.

It is clear that specific training is being made available for Hyno-CBT, and cognitive Hypnotherapy within the private sector and my hope is that this will be part of training and not adopted into or grand parented into the existing work done by staff previously trained only in using CBT at a basic level.

I have found little evidence at this time to show that this is presently or in the process of being done within the IAPT programme, even though there is evidence that is now emerging across many platforms.

Supervision for IAPT work force

It is assumed that experienced therapists already in post or newly recruited to services will have the skills to supervise. The principle is that the supervisors should be trained practitioners in the therapy that they are supervising. Such supervisors might be drawn from a range of professions and include nurse therapists, counsellors, psychologists, psychotherapists, etc. When IAPT services offer a greater choice of NICE recommended evidence base therapies in addition to CBT, it will be important that some supervisors are familiar and trained in these therapies. See Appendix 5

I would like to add that in the private sector it is not presumed to have to skills to provide supervision. Evidence of training is needed for this

More links to further information, other documents and guidelines re the IAPT programme can be found in Appendix 8

Other considerations

Quote

From 2011, its focus has broadened, following publication of Talking Therapies: a four-year plan of action , one of a suite of documents supporting No health without mental health, the cross-Government mental health strategy for people of all ages.

In the four years to April 2015:
the nationwide roll-out of psychological therapy services for adults will be completed a stand-alone programme for children and young people will be initiated models of care for people with long-term physical conditions, medically unexplained symptoms and severe mental illness will be developed.

Evidence shows this approach can save the NHS up to £272million and the wider public sector will benefit by more than £700 million.
By 31 March 2011:142 of the 151 Primary Care Trusts in England have a service from this programme in at least part of their area and just over 50 per cent of the adult population has

Most clients enter therapy with a degree of emotional distress or anxiety and the use of guided imagery during these initial stages can produce immediate relief from such emotional and physical symptoms, thus helping the client to calm down.

Clients that feel anxious or distressed prior to or during therapy should note that it is impossible to be relaxed and anxious at the same time. If a client has experienced guided imagery or hypnosis during any aspect of therapy they are likely to discover and appreciate that therapeutic change can be experienced quite early in the process. Most clients are also likely to feel encouraged that their problem or concern can change through the process of therapy.

From http://www.harleystreetpsychology.co.uk/phd/p1.aspx?openerpages/tenharley?opendocument&part=2
30 www.csl.nhs.uk/Publications/.../Responsibility%20and%20Accountability.pdf
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access 3,660 new cognitive behavioural therapy workers have been trained Over 600,000 people started treatment, over 350,000 completed it, over 120,000 moved to recovery and over 23,000 came off sick pay or benefits between October 2008 and 31 March 2011 (latest figures available)

The programme began in 2006 with Demonstration sites in Doncaster and Newham focusing on improving access to psychological therapies services for adults of working age. In 2007, 11 IAPT Pathfinders began to explore the specific benefits of services to vulnerable groups.

Relevant for this discussion is the No Health without Mental Health document which looks at physical illness and mental illness and which promotes the linking of both in order to treat the whole person. The feedback in this document form research studies completed show that a person’s physical health can affect their mental health and vice versa.

I think this is important for the use of guided imagery and hypnosis which has long recognised the link between physical and mental illness. Its use for PTSD, which can be the result from a person having to be sectioned under the mental health act and which can be a very traumatic event is noteworthy. For those people who have been hospitalised on many occasions, Guided imagery and Hypnotherapy can be very effective, perhaps from a being child when they have had a longstanding physical illnesses that can lead to depression or anxiety and phobia.

Which treatments can help?

NICE recommends that patients found to be depressed or anxious should be treated with conventional pharmacotherapy. Cognitive-behavioural programs that focus on relaxation and changes in thinking are also thought to be effective, with one study suggesting that as little as a 2 hour session of cognitive behavioural therapy can reduce anxious and depressive symptoms.

A systematic review of 37 randomised control trials showed that collaborative-care models were significantly more effective than treatment in primary care alone; they increased treatment compliance and reduced depression for 2 to 5 years. (Page 36)

Part 1: The Link between Physical and Mental Health

Approximately one quarter of people with physical illness develop mental health problems as a consequence of the stress of their physical condition. In these cases, the process of adjustment fails, and people develop depression, anxiety, panic or some other form of mental disorder. Depression is characterised by a persistent and severe low mood which is qualitatively different from ‘normal distress’. Anxiety is characterised by severe agitation and apprehension which is qualitatively different from ‘normal worry’. Both have major effects on the ability of the individual to function, including the ability to sleep properly, concentrate, socialise, care for others, work and carry out normal daily activities. (Page 9)

Under the recent well-being strategies, and healthy communities there are other considerations that come into play

How can individuals and communities be enabled to thrive, to be healthy and resilient to illness, to live within sustainable carbon limits - and to have these enhanced levels of

31 http://www.iapt.nhs.uk/about-iapt/
32 http://www.rcpsych.ac.uk/pdf/No%20Health%20without%20Mental%20Health%20Evidence.pdf
33 http://www.rcpsych.ac.uk/pdf/No%20Health%20without%20Mental%20Health%20Evidence.pdf
34 http://www.rcpsych.ac.uk/pdf/No%20Health%20without%20Mental%20Health%20Evidence.pdf

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...wellbeing more fairly distributed across social groups at the same time as public resources are diminishing? See Appendix 6 for specifics.35

Like the nice guidelines and IAPT programmes here we also find areas highlighted that need attention. The wellbeing programmes in many ways is on the de-medicalising of illness and looking instead at mental health not mental illness and the ability to thrive.

With its focus on the steps (originally12) that have been shown to improve the nations mental health and wellbeing, 9such as access to green space, exercise, it provides in some ways a contrast to the IAPT programme because it is recognising that mental health can be promoted with non-medical intervention.

There is the other question, does it actually matter?

The Equivalence Paradox. Stiles, Shapiro, and Elliott have dubbed the above two apparently contradictory findings "The Equivalence Paradox" (Stiles, Shapiro, & Elliott, 1986): most therapists believe strongly in their model, and do best if they stick to it and hone it, yet outcome is not crucially dependent upon which model it is. We shall offer three explanations for this apparent paradox.

First, there is the issue of "non-specific factors" in therapy. All effective therapies, whatever their orientation, contain elements that include, implicit hope, an attempt to understand and make sense of psychological stress, and respect and concern for the patient as a human being. If these were predominant in determining outcome, then one would expect the personal qualities of the therapist to be important, but it but it would not matter which model she followed.

A second explanation might be that, psychologically speaking, all roads lead to Rome. This follows from the way in which mental states are organized hierarchically with reciprocal feedback between levels. To oversimplify: behaviour is linked with specific plans and strategies, which in turn connect with deeper patterns of feelings and attitudes. Change at one level has inevitable effects at another. Masters and Johnson's behavioural sex therapy, for example, directs partners to spend more time stroking one another. This in turn is likely to lead to increasing trust and improved emotional communication, and this may ultimately influence deeper levels at which basic attitudes towards relationships between the sexes may begin to change. Conversely, analytic therapy will start at the "basic attitude" end of the hierarchy and hope that this will ultimately be reflected in enhanced sexual communication. Behaviour therapy may have more immediate impact, and so work faster, but possibly with less reverberative and so less lasting effects. Cognitive therapy occupies an intermediate position, tackling "basic assumptions" as well as encouraging patients to change their behaviours. Analytic therapy may have less immediate impact, but greater resonance. Each kind of therapy is appropriate to its own circumstances; neither is definitely superior.

A third possible explanation of the Equivalence Paradox is that it is a research artefact. Outcome studies necessarily give standard treatments to groups of diagnostically different cases, which one might expect, on average, to give similar results irrespective of treatment modality. In clinical practice, following an assessment interview, therapists try to find the best match between patient and problem, available therapies and therapists. In group therapy, for

35 Full manifesto can be found at Manifesto from the UK Public Health Association, http://www.idea.gov.uk/idk/core/page.do?pageId=71665
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instance, more extrovert individuals do better with behavioural methods while introverted types fare best with analytic approaches. (page 40) 36

One thing that stands out for me in relation to this quote and because of the research I have done for this study is the part of text that I have highlighted - finding the best match… for… available therapies and therapists. - The evidence can only be based on that premise and if the only available therapy is CBT and only available therapists, are people trained in CBT then any further development towards using guided imagery on a regular basis will be given via those pathways.

The arguments for increasing access, while following prescriptive and restrictive training programmes, the research that shows physical illness will also have an impact on mental health and the promotion of non-medical intervention shows that the information is readily available. That this could be pulled together into a comprehensive service regulated but not restricted would be of some benefit, one that could work in unison and provide a well-balanced multi-faceted service for all that has fewer inequalities.

An interesting thing to note that I had not come across previously when looking at hypnosis and may be relevant to this study

Hypnosis is used for clinical purposes… If hypnosis can affect these functions therapeutically, then it can do so pathogenically. And if that is the case, it is potentially dangerous (P187) 37

Ethics of Psychotherapy

Where is the foundation for my concerns re guided imagery while there is so much evidence to say that it is safe? For me it can also easily become a question of… if it comes under the authority, it is ‘more’ safe?’

Although it may be impossible literally to force someone to undergo psychotherapy, there may, however, be situations where the main reason for offering a patient psychotherapy is not to serve the patient's best interests, but to promote the goals of society, to solve a social problem (P193) 38

I have worked as a behaviourist and with behaviourism in context and seen how non aversive techniques can be helpful, however they are usually helpful to the both the patient and the environment

In evaluating behaviour therapy in prisons and other coercive contexts, it is necessary to make distinctions between the different ways in which it can be used. The least problematic is where the prisoner consents to a positive reinforcement schedule. (P194) 39

In the same way that a prisoner giving consent could be questionable… ensuring that a prisoner's consent to treatment is genuine (196) 40. I have argued that members of the population having access to

36 Questia, a part of Gale, Cengage Learning. www.questia.com
37 Questia, a part of Gale, Cengage Learning. www.questia.com
38 Questia, a part of Gale, Cengage Learning. www.questia.com
39 Questia, a part of Gale, Cengage Learning. www.questia.com
40 Carolyn Sinclair – Dissertation for Advanced DipHP, 10,899 words which include quotes, not including footnotes or appendices
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only those therapies that are made available are not making informed choices or given the right to exercise their freedom to choose the therapy that they may feel is right for them.

The whole picture become difficult for me reconcile, more so than if providing guided imagery is ethical, more about the whole process of availability in the first place.

The natural reinforcement of compliant behaviours given through using hypnotic techniques and with a CBT practitioner with basic training providing it, who is under pressure to provide positive results based on numbers of people seen, outcomes based reports, and evidence based forms and records and the strain on workers to produce results against a sea of evidence that says CBT it the appropriate method to use, could in the long run be setting up many people to have no access at all to any kind of therapy.

Compliance to accepted protocols on the part of the patient/client and the therapist, leaves little space for development of therapy.

While CBT can be used creatively by a competent and experienced therapist I would suggest that basic trainees would be practicing within strict boundaries and this could lend itself to frustration for the both the patient/client and for the practitioner who may not have previous training in therapeutic tools to fall back on.

The use of cognition and behavioural techniques based on the individual recognising their own unhelpful thoughts is a very helpful tool, but, could easily be used by less skilled in way that would further demoralise a client, if a practitioner is too overzealous or concerned with getting quick results given the premise that unhelpful thought maintain our depression or anxiety, phobia etc.

The treatment of people after a diagnosis of borderline personality disorder led originally with many people being told there was not treatment or help for them. I have had direct experience of supporting people with this diagnosis so speak with that knowledge. Where the GP and provided no support or explanation after the diagnosis. This denies access to those people who may be difficult to support and for whom more resources may be needed and exacerbates their feeling of isolation.

There is evidence that previously accepted treatments for PTSD are not as effective, and this to some extent goes across the board for many treatments as more is learned and new research has been completed.

I have not up to this point been able to put my hands on any ethical guidelines for the use of guided imagery and for the most part it does look to a benign treatment, practice. But there are contraindications through NICE for specific disorders See Appendix 10

The following is also taken from the guidelines and shows how prescriptive the nice guidelines can be

If PTSD sufferers request other forms of psychological treatment (e.g. Supportive therapy, non-directive therapy, hypnotherapy, psychodynamic therapy or systemic psychotherapy), inform them that there is no convincing evidence for a clinically important effect.P13 41

The next quote written in 1996 illustrates where guided imagery is helpful and where it is not, and shows that his experience tells him when it is best used and when it is not. It is part of a wider therapy

40 Questia, a part of Gale, Cengage Learning. www.questia.com
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and says that guided imagery can help where there is an overreliance on intellectual understanding. For further reading see Pages 356 -359 in Appendix 11

Not all clients are well suited for guided-imagery therapy. Clients must exhibit an interest in an experiential and alternative form of therapy. Otherwise, the client will be too sceptical and distrustful to benefit from this approach. Many clients have participated in some form of conventional, verbal psychotherapy before seeking guided-imagery. The majority benefited from traditional therapy but eventually reached an impasse in their progress, probably owing to an overreliance on intellectual understanding. If a client is receptive to developing and discussing her internal images, I proceed quickly to guided-imagery therapy.

There are certainly contraindications to the use of this therapy. Sound ego structure is imperative. Even if a client appears motivated to use an alternative approach, attention must be given to a well-formulated diagnosis. Clients with borderline personality disorders or psychoses are not appropriate. Any client with boundary issues must be evaluated closely because of the intensified closeness and intimacy with the therapist involved in guided-imagery.

In his book Lindley 1998 looks at the question of ethics and some of these argument still stand today. See Appendix 12

Codes of ethics are available now across the board for psychotherapists, counsellors’ et al. The arguments and discussions continue on the best way forward for registration compulsory or voluntary (most recent http://www.psychotherapy.org.uk/article1181.html)

From ‘Enabling Excellence: Autonomy and Accountability for Healthcare Workers, Social Workers and Social Care Workers’. Section 4.4 states:-

To this end, the Government proposes to enable a system of assured voluntary registration to be developed for professionals and occupational groups which are currently not subject to statutory professional regulation. At present, there are a range of voluntary registers, but no system which allows the public, employers or professionals to gauge whether they operate effectively and to high, or common, standards. A system of assured voluntary registration is a more proportionate way of balancing the desire to drive up the quality of the workforce with the Coalition Government’s intention to avoid introducing regulation with its associated costs wherever possible.

Section 1.13: -

It is noticeable that major systemic failures in both the health and social care sectors are often characterised by insufficient attention paid to professional standards within teams and by employing/commissioning organisations, a lack of support for staff and a weak professional voice in management decisions.
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This link to the HPC standards of proficiency document relates to psychologists and counselling psychologists but not to the newly trained IAPT workforce 46

The UKCP website states that

2007 White Paper that psychotherapy and counselling should be subject to statutory regulation. We also note that the preferred solution for the government is 'assured voluntary registration' but that two possible mechanisms for achieving this are proposed.

The Council for Regulatory Excellence (CHRE) - now to be called the Professional Standards Authority for Health and Social Care - has been given powers by the Health and Social Care Bill 2011 to accredit the voluntary registers of others, e.g. professional bodies.

Alternatively, the nine health statutory regulators, including the Health Professions Council (HPC), have been given powers by the Health and Social Care Bill 2011 to establish voluntary registers for those professions which are not regulated. Thus, the HPC will have the powers, not to accredit other registers, but to set up its own voluntary registers including, if it so determined, a register for psychotherapy and counselling.

The IAPT website’s List of accredited courses show them to be available through three organisations, The British Psychological Society, The British Association for Counselling and Psychotherapy and The British Association for Behavioural and Cognitive Psychotherapies.

There are ten modules that are on the website with links to go through each module it is web based learning in modular form with learning outcomes and a log not dissimilar to NVQ layout and the certificate in CBT. It is a comprehensive learning programme but does state that the student can learn independently also working with others is preferred.

For example

Welcome to Module 1. This module introduces you to the Ten Essential Shared Capabilities (ESCs) learning materials (CD-ROM and print version) and explains how you can get the most out of them. It starts with a general description and then divides into two sections:

- Notes for learners.
- Notes for facilitators and managers.

At the end of the module you will find brief biographical notes on the authors and editors of these learning materials. 47

46 http://www.hpc-uk.org/assets/documents/10002963SOP_Practitioner_psychologists.pdf For a list of ethics from different organisations see the following link: - http://www.psychotherapy.org.uk/cgi-bin/showpage.fcgi

47 http://www.lincoln.ac.uk/ccawi/esc/esc_web/assets/mod1_home.html

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Under module 2 reference to ethics is as follows its focus is more on good practice (best practice) words such that have also been used under the QAF (Quality Assessment Framework) used to regulate service providers in housing and under the supporting people grant system. 48

3. Practising Ethically

Recognising the rights and aspirations of service users and their families, acknowledging power differentials and minimising them whenever possible. Providing treatment and care that is accountable to service users and carers within the boundaries prescribed by national professional, legal and local codes of ethical practice.

‘There is a concern that many mental health professionals understand neither the legal rights of service users under their care nor their own legal and professional obligations to service users. Under this capability would come issues of informed consent, effective communication, de-escalation, and control and restraint.’

(Department of Health 2004)

What this means is: Recognising the rights and hopes of service users and their families and treating people as equally as possible. Keeping to good practice guidelines and working within the law.

As far as ethics goes this is very basic and would not constitute a code of ethics that I work within at the moment.

Guided imagery practitioner requirements

In the United States, there is no formal licensing process for guided imagery practitioners, although many schools have training programs that lead to certification in guided imagery. Some of these programs are specifically intended for people who already have a state-issued license in a health profession, such as nursing or psychotherapy. Training hour’s requirements can range from 90 to 200 hours.

You can find a qualified guided imagery practitioner through the Academy for Guided Imagery. The Academy trains and certifies health professionals in guided imagery, requires 150 hours of training, and has a website featuring a U.S. database of its certified practitioners 49

Conclusions and Other considerations

I have done a lot of research during this study and for the most part I have found a lot of information on hypnosis, hypnotherapy, and guided imagery, with the result that I believe the words and terminology used are interchangeable. Where one organisation will call it mindfulness, another will use the terms guided imagery or hypnotic techniques

Hypno-Psychotherapy is not dissimilar to Cognitive Hypnotherapy although in the second (CH) the only methodology used is CBT. (HP is much wider in its approach. CBT claims to work with the here and now and this gives us a clue to type of guided imagery that it seems likely to be employed: Imagery that is focused on the here and now and not for regression work or for a deep hypnotic states

49 http://www.breastcancer.org/treatment/comp_med/types/imagery.jsp
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or using direct hypnotic suggestion. However most of findings do indicate that practitioners should be appropriately trained in using any of these techniques.  

Looking through the contraindications I do believe that we cannot be aware of how our words will be taken. To re-iterate previous sentiments; that without full training a member of staff using guided imagery techniques would not have skills to work through a situation where a client becomes extremely upset or distressed. Because guided imagery is not seen as being the same thing as hypnotherapy or hypnosis the practitioner may not be aware of techniques that are helpful in removing or working through that abreaction, or use disassociated states with the client so he/she is not engaging in but is watching from afar an incident that has caused distress.

In my experience the client has their own safety mechanisms but even as a qualified practitioner I have had clients develop imagery outside of any I have either suggested or we have been working within and this that has not been helpful but we have been able to work through this until the situation is able to be resolved.

A simple technique of bringing some back from the imagery can be troublesome in that the person appears to be fully aware but is still in the hypnosis state. My training allows me to test for this to ensure that this is not the case when the person leaves their session with me; Clients who fall asleep and who have taken a long time to come round and be fully aware, Clients who have sat up and opened their eyes but were still in the hypnosis state. My training enables me to work through these and then be able to understand what might be happening for that particular client.

Because guided imagery is not promoted at the level as hypnotherapy or hypnosis I think for the most part there may be no problems, however it could potentially be unhelpful or upsetting. Workers not trained appropriately may be working with people whose history would suggest a slower approach or the need to gather more information and develop the therapeutic alliance before using metaphor and imagery and because of the lack in training would not be able to recognise that. In many instance this knowledge and awareness has made a big difference in the work I have been able to do with individual clients. As a trained coach and AI assessor I am also aware of different learning styles and this too helps my hypnotherapy.

I have not been able to find information within the CBT training that I undertook on these styles although it was a part of my training as a Hypno-Psychotherapist. For some people the imagination is less accessible to them and the use of visual descriptions can be unhelpful, based on their own preferred way of learning and seeing.

I have also used different techniques with clients of different ages, having worked with a number of age groups from young people to older people. As stated I wonder if again guided imagery introduced with CBT and seen as this one size fits all and learned by rote so that the programme can be rolled out, with the focus on the numbers of people receiving therapy being the most important measure of success.

Some of the research on these techniques (CBT and hypnotherapy or hypnosis has been carried out by qualified and experienced therapists who have naturally come to use the techniques together realising they can be complementary. I have used through records (as in CBT) to identify unhelpful ideas and thoughts and gone on to develop and accept those balancing thought identified by the client through the hypnotic trance.

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I am trained in being flexible and creative in my approach and I believe this to be imperative when doing this work. That flexibility comes with practice, experience and continuous personal development.

The Future

I feel fairly hopeful that in time the use of guided imagery will become used on a much wider basis and that there is evidence to suggest that it can very powerful when used correctly. There is also evidence that indicate that proper training is needed and should be given before techniques are used widely. In line with best practice that those students of CBT have this as a part of their training and that they have the appropriate supervision, which is also invaluable in this work.

I have taken this study fairly wide and it led me to look at more than I first anticipated. Some of my concerns were overzealous but some I believe hold true in that to promote quality across therapies, appropriate training must be given.

The apparent closed shop of therapies available for people who cannot afford to pay does hold true but I wonder if the economic climate will do much to change this. Government paper s and recommendations all seem to promote working across and developing partnerships and I have been able to see where some of this is happening. However from experience I would suggest that this is more prevalent amongst government departments than across the wider private and voluntary sector. But I have not looked into this in any detail so that observation can only be anecdotal.

I would recommend both Roger A Chapman’s book the clinical use of hypnosis in Cognitive Behaviour therapy 51 and Assen Alladin book, titled Cognitive Hypnotherapy 52.

Two practitioners who are promoting this work. Both cite each others work and the books are extremely informative and would be good to be on the reading list of anyone thinking of working in this way.

Appendix 5

I have not yet discussed appendix five which is a copy of an article on GP’s promoting clinical excellence through their purchasing powers. This article is looking at the way GPs respond to the reviews and papers sent to them and if this would change if they had more spending power to make a choice.

There is no indication that these new powers will make any difference, that’s GPs will continue to follow guideline and recommendation that come through in the form of reviews and based on those same NICE recommendations.

Would GPs, not buying into the existing newly developed IAPT workforce, and not promoting the usual therapies such at CBT be an option? Appendix 5 seems to indicate that this would not happen either.

For my own opinion a program that includes imagery, relaxation, and behavioral changes can be a low cost, effective way for patients to actively participate in managing the symptoms of anxiety disorders if delivered with thought and diligence and co-operation.

51 http://minthrea.net/?p=1193
52 Cognitive hypnotherapy: an integrated approach to the treatment of emotional disorders
Assen Alladin, Publisher John Wiley and Sons, 2008, ISBN0470032472, 9780470032473 Length294 pages
Carolyn Sinclair – Dissertation for Advanced DipHP, 10,899 words which include quotes, not including footnotes or appendices
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The Richard Lindley book that has recommendations to have a regulatory body such as the UKCP was written in 1998. For the chapter on An ethics committee and codes of practice for psychotherapists See Index 14

A further proposal that could lead to more broadly educated psychotherapists, and away from rigid all-or-nothing types of training, would be a system of "credits" that a trainee would need to gain in order to become fully registered. These could be acquired from different courses and, if necessary, at different times. Thus, analytic psychotherapists might be required to gain one "minor" credit in cognitive therapy, and vice versa, and trainees could perhaps gain their "supervision" credit -- a mark of their ability to offer supervision in psychotherapy a -- two or three years after acquiring their "seminar" credit

This is an interesting book because it highlights the need for regulation for ethics and for properly trained therapists. It was written shortly after the UKCP came into force and while this is over 10 years old it illustrates for me similar thinking that has been at the for front of this study in that

It is against a rigid training that does not take account of wider issues or availability of other training. The focus is on having appropriate and full training and experience that can be developed over time.

While I am aware of the high levels of expertise available across the national Health Service by its very nature as an institution and the act of striving for quality and competence in its staff, it sticks to preferred and accepted ways of working and then provides a training that can be transferable from one area to another. This way is easier to promote, easier to manage, easier to regulate and hold to account. It develops competitiveness between providers that is not always healthy or helpful

Outcome based interventions are always favourable because there are records that show these. However the choice of recording does not take into account anecdotal, or information that might be initially hard to collect

Questions I have not answered

What is the drop out level of clients who have been given access to talking therapies, the numbers of people who because of funding and non-compliance with a compliant dependant system have no access at all?

Why is there a lack of funding for organisations who are not compliant with keeping records or rely on anecdotal and an informal approach in order to provide support for those vulnerable or people who are classed as being outside the system?.

The use of the private sector within therapy would utilise all the skills and training and experience that is already there instead of developing a new work force that could lead to further polarisation of the professions classed as medical and non-medical. And further decrease our ability as a whole profession to provide therapy across the board.

As ethics are different across different organisations I do believe that the health authorities do have provision to ensure its workforce is ethical in its approach. Personally I have worked at the forefront of new ideas and sometimes something that is new can take time to develop and for its planners to

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A consideration of the ethics of providing Guided Imagery by CBT trained staff without full and proper training in psychotherapy or full knowledge or training in Hypnosis and Hypnotherapy

recognise its inherent weaknesses or where that planning has been naïve. What will they do to rectify the situation?