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Oxford Guide to Imagery in Cognitive Therapy

Ann Hackmann
James Bennett-Levy
Emily A. Holmes

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Oxford Guide to Imagery in Cognitive Therapy

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Dedications

To Willem, Anneke, Corinna, and Dylan
- A.H.

To Judy
- J.B-L

To Alan and Astrid
- E.H.

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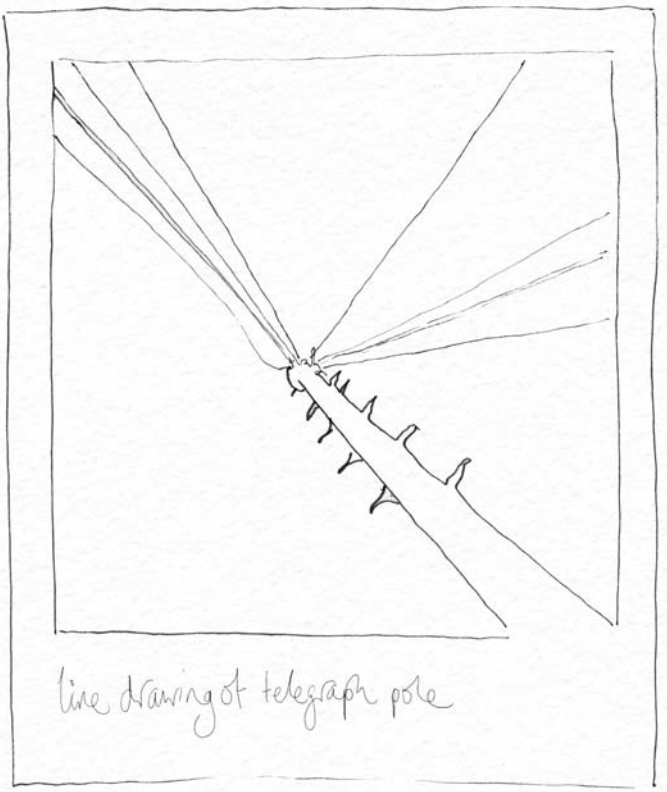
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About the authors

Ann Hackmann has been one of the leading clinical researchers on imagery in psychopathology during the past 15 years. Her research includes studies on intrusive memories in depression (with Jon Wheatley and Chris Brewin), in PTSD (with Anke Ehlers) and on early memories in social phobia (with Jennifer Wild and David Clark). In 2004, she edited a special edition of the journal *Memory* on imagery with Emily Holmes. Ann has worked as a therapist in many randomized controlled trials with the research teams of David Clark and Anke Ehlers, and recently worked with Mark Williams researching mindfulness-based cognitive therapy in depression and other disorders. She was one of the editors of the *Oxford Guide to Behavioural Experiments in Cognitive Therapy* (Bennett-Levy, Butler, Fennell, Hackmann, Mueller, and Westbrook, 2004), and has co-written *Cognitive Therapy for the Anxiety Disorders: Mastering Clinical Challenges* (2008) with Gillian Butler and Melanie Fennell.

James Bennett-Levy is an Associate Professor at the University of Sydney, in the University Centre for Rural Health (North Coast). He has played a leading role in co-editing two key clinical texts: the *Oxford Guide to Behavioural Experiments in Cognitive Therapy* (Bennett-Levy, Butler, Fennell, Hackmann, Mueller, and Westbrook, 2004) and the *Oxford Guide to Low Intensity CBT Interventions* (Bennett-Levy, Richards, Farrand et al., 2010). He has specialized in the teaching and dissemination of key therapeutic skills for CBT practitioners, and has published a number of empirical and theoretical papers on CBT training over the past decade. His interest in imagery—and behavioural experiments—has stemmed from an ever-growing appreciation of the power of experiential interventions to produce significant shifts in clients' experiences of life and ways of being.

Emily A. Holmes is a Clinical Psychologist with a PhD in Cognitive Neuroscience, based at the University of Oxford's Department of Psychiatry. Dr Holmes is known for her clinical expertise and research in mental imagery—particularly trauma memory— with current work also reaching into depression and bipolar disorder. Her research into experimental psychopathology seeks to understand cognitive mechanisms underlying distress across psychological disorders, focusing on mental imagery. She is currently a Senior Research Fellow and a Wellcome Trust Clinical Fellow. She was awarded the 2010 British Psychological Society Spearman Medal. Dr Holmes has received research grant support from the Wellcome Trust, Royal Society, Economic and Social Research Council (ESRC), the John Fell OUP Research Fund, and the Lupina Foundation. At Oxford, she has established the research team "EPACT" (Experimental Psychopathology and Cognitive Therapy). For further details see: http://www.psychiatry.ox.ac.uk/epct/publications/index_html

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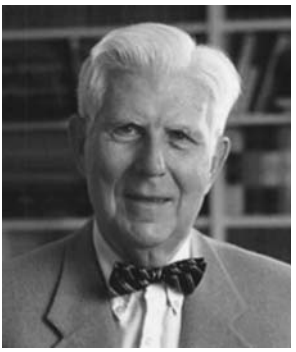
Foreword

Aaron T. Beck



My approach to developing a cognitive theory of psychopathology initially relied on my patients' ability to share their inner cognitions; a process that was significantly aided by imagery (Beck 1970). In this sense, imagery contributed to the evolution of cognitive therapy theory and practice. Despite the important role imagery played in elucidating the tenets of cognitive theory, it is only within the past decade that imagery-based research and practice have been critically examined.

The *Oxford Guide to Imagery in Cognitive Therapy* makes an important contribution to the field by synthesizing the significant developments, both empirically and clinically, in our understanding of imagery. Two of the authors, Ann Hackmann and Emily Holmes, are leading researchers and expert clinicians on imagery in cognitive therapy, and with James Bennett-Levy with his clinical and editorial expertise they have written an engaging and enthusiastic guide to imagery-based research and practice.

This comprehensive volume functions both as a practical guide for clinicians and a valuable reference for researchers in the field. The clinician with limited experience of imagery-based interventions will appreciate the accessible nature of the book. The numerous examples and illustrations allow the reader to become quickly familiarized with the empirically-based techniques. Additionally, there are plenty of opportunities for the clinician who is more experienced with imagery-based interventions to refine and deepen their skill set, or to learn how to expand their repertoire by learning how to apply imagery-based interventions to a new population or diagnosis.

With the increasing recognition of the importance of imagery in the development, maintenance, and treatment of psychopathology, this volume is a timely and essential guide to understanding the important concepts and ideas in the field of imagery. Furthermore, this seminal book will significantly influence experimental research on imagery in the fields of cognitive psychology and cognitive neuroscience for years to come.

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Preface

Imagery is one of the new frontiers of cognitive therapy. In our experience, imagery is a hugely exciting area for clinicians and researchers, and holds rich promise for the treatment of clients. The *Oxford Guide to Imagery in Cognitive Therapy* seeks to provide clinicians and researchers with a contemporary view of imagery research and practice in cognitive therapy. We have written this book firstly to assist clinicians to expand their imagery skills, and to be more confident using them in their clinical practice; and secondly, to inspire more research in this burgeoning area. We also want to share our enthusiasm for what we believe to be such a fascinating and rewarding field.

We are aware that many therapists have little knowledge about imagery research, and may use imagery only rarely in their clinical practice. Other therapists may use imagery more frequently, but lack the resources to enhance their practice. Our hope is that this book will both inform and guide: inform practitioners about the multitude of ways in which imagery can be of value, and guide them to use imagery creatively and effectively with a range of clients and situations.

In the 1950s and 1960s, imagery played an important role in the behavioural treatments of systematic desensitization and flooding, and in Lazarus's multimodal therapy. When cognitive therapy first developed in the 1970s, imagery's importance was noted at the outset by Beck. In the late 1980s and early 1990s, therapists such as David Edwards, Jeff Young and Mary-Anne Layden started to provide fuller descriptions of the application of imagery-based techniques within a cognitive therapy framework. However, it is only in the last decade that clinicians and researchers have placed imagery more fully under the microscope to illuminate the central role that it plays in human cognition, psychopathology, and therapeutic change.

The start of the twenty-first century has been a particularly exciting time for the study of imagery. We have witnessed a major expansion of imagery-based theory, understanding, and treatments; and we anticipate a further mushrooming of imagery research and practice within cognitive therapy and other psychotherapies in the next decade. It has therefore seemed timely to bring our current knowledge together and produce a book that can be of value to clinicians and researchers at all levels of experience.

One of our principal aims has been to develop a guidebook for clinicians. To date, imagery in clinical practice has largely had the appearance of a fascinating potpourri of observations and techniques. The clinical phenomenology has been articulated to varying extents in different disorders. Imagery-based treatment techniques feature strongly in some treatment protocols, while being largely absent (at the present time) in others. We have sought to introduce a greater degree of coherence by creating a book with a transdiagnostic emphasis; by focusing on the *process of therapy* rather than specific disorders; and by highlighting the links between experimental research, theory, and clinical practice.

In doing so, we hope that the book will be as valuable for the clinical researcher, as for the clinician. Imagery is such an exciting field, ripe with opportunity. Therefore, it is a further aim of this book that it attracts future researchers, and inspires innovation.

We have tried to steer a not-always-straightforward course between:

1. grounding the book in a rapidly developing clinical and experimental science of imagery;
2. creating a manual for therapists based on this science;
3. illustrating the book with many clinical examples to give clinicians a 'feel' for the creative ways in which imagery can be used in clinical practice.

What started out as a small book has inevitably grown. We have had to make decisions about what to feature in the book, and what not to. One of the decisions has been to put the emphasis on contemporary and future directions, rather than past. Therefore, the book does not focus on systematic desensitization or flooding, which played such an important role in the early stages of behavioural therapy. Rather, it gives greater emphasis to emerging approaches; for example, the use of metaphor in cognitive therapy, and compassion-focused therapy.

Another decision that we made was to place our emphasis on the *process* of imagery interventions, rather than *types* of therapy. Therefore, although we acknowledge the value of therapies such as schema-focused therapy, mindfulness-based cognitive therapy, metacognitive therapy and eye-movement desensitization and reprocessing (EMDR), which all have a strong imagery component, we do not describe them in any detail. This would be beyond the scope of the present book. Rather, with our focus on theory, processes and techniques, we have highlighted some key aspects of these therapies throughout these pages—for instance, we emphasize the importance of metacognitive beliefs, mindful states, and reliving techniques to access and work with childhood memories, and memories associated with trauma.

As a precursor to the main body of the book, we are privileged to have an *Invited Essay* by David Edwards, *From ancient shamanic healing to 21st century psychotherapy: The central role of imagery methods in effecting psychological change.* As Edwards so ably demonstrates, imagery has played an important part in human consciousness and healing for at least 20,000 years, and its value was recognized from the earliest stages in the development of psychotherapy.

The main body of a book is divided into five parts. Part 1, *Imagery in context*, provides the historical, theoretical, phenomenological, and research platform on which the remainder of the book is based. Chapter 1 illustrates the ways in which the study of imagery and related therapeutic techniques fit within the theoretical and philosophical context of Beckian cognitive therapy. Chapter 2 looks at imagery's varied manifestations across different disorders; and examines its sometimes baffling phenomenology, which has only recently started to make sense in the light of new developments in memory theory. The last part of the chapter provides guidance around definitions and use of terms in the book. Chapter 3 reviews recent experimental evidence on imagery. It highlights

imagery's links with emotion, and thus the relevance of imagery-based interventions for clinical practice. Chapter 4 examines theory and research, in particular focusing on the question: What are the effective components of imagery interventions? The answers help to frame the structure for Parts 3 and 4 of the book.

Part 2, *Preparation for imagery interventions* is covered by three chapters. Chapter 5 is a highly pragmatic chapter for clinicians, which sets out some general principles, and 'dos and don'ts' when introducing imagery-based interventions with clients. Chapter 6 focuses on methods to assess client imagery and its impact, and is the logical precursor to Chapter 7, *Micro-formulation of imagery.* In this chapter, we introduce a new type of cognitive therapy formulation, "micro-formulation", which specifically focuses on the role that imagery plays in the client's clinical presentation.

Part 3 and Part 4 focus on therapeutic interventions. Typically, clients who come for cognitive therapy present with negative disturbing imagery (e.g. intrusive images, memories, or nightmares). Part 3, *Imagery interventions: Removing and transforming negative imagery,* takes as its starting point the negative image and addresses the means to transform its contents and meanings. The chapters in Part 3 address day-time intrusive imagery (chapter 8); imagery which is recognized by the client to be directly derived from memories (chapter 9); night-time imagery, including dreams and nightmares (chapter 10); and metaphorical imagery (chapter 11). We have endeavoured to provide clear guidance for readers by using the same framework to divide each of these chapters into definable stages and processes. These stages/processes are:

- Socialization
- Evocation and Assessment
- Micro-formulation
- Manipulation
- Discrimination
- Transformation
- Making an Emotional Bridge to the Past
- Creation

Our hope is that this framework will help to clarify what on first acquaintance can seem a bewildering array of types of intervention.

Part 4, *Imagery interventions: Creating positive imagery* contains two chapters: one addresses *Creating goals, developing new skills and problem solving* (chapter 12); the other *Creating new ways of being* (chapter 13). Both chapters start from the position of creating positive imagery *de novo,* rather than attempting to transform negative imagery. Chapter 12 shows how imagery can potentially enhance conventional cognitive therapy techniques (e.g. goal setting) that we might use with all clients. Chapter 13 specifically addresses the value of imagery-based interventions for clients with more long-term chronic difficulties (e.g. clients with low levels of self-esteem or self-compassion, or diagnoses of personality

disorders). Such clients often do not have access to any positive beliefs or images about themselves. Therefore therapy focuses on building new positive images *de novo.*

Part 5, *Concluding comments,* consists of one chapter that examines potential future directions. As we hope this brief chapter makes clear, we have only just started to explore the potential of imagery as a psychotherapeutic intervention. It is a field brimming with possibility for creative minds in the future.

This book has brought us many pleasures. One of the greatest is being honoured with a Foreword by the founder of cognitive therapy, Dr Aaron T. Beck. At the outset of cognitive therapy, Dr Beck demonstrated a prescience—in this case about the importance of imagery—that we are only slowly catching up with some 30 years later. His inspired observations set the scene for the present book, as we illustrate in chapter 1.

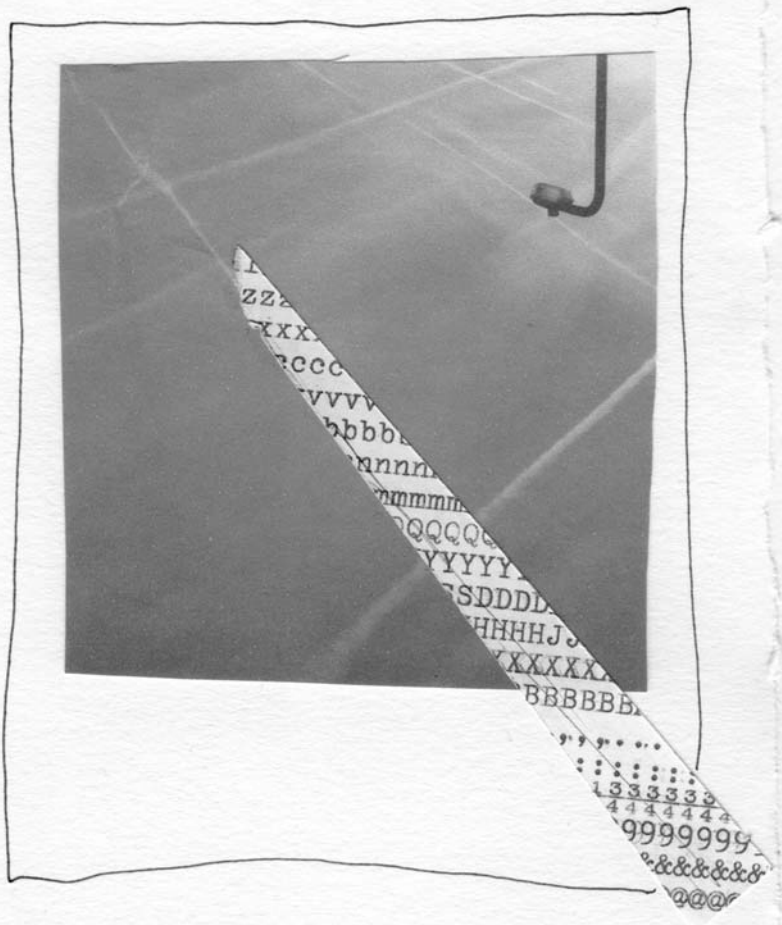
We also wanted to honour another man who has made a significant contribution to 'putting imagery on the map' in cognitive therapy, David Edwards. We are grateful to David for his Invited Essay that follows this Preface. It is an extremely well researched historical introduction to imagery.

We would also like to thank Charlotte Holmes for providing the art work. She has beautifully illustrated the book with a set of plates, each reflecting her own artistic view of the topic covered in the accompanying chapter.

Finally, we would like to thank colleagues, mentors and friends, too numerous to mention, who have been fellow travellers on the path. Some of these colleagues have been generous enough to contribute the spicy clinical vignettes that flavour the pages of the book at regular intervals. We have appreciated both their vignettes and the substantial contributions that each has made to putting imagery firmly on the map of evidence-based psychotherapy practice. We hope the extensive reference list at the end of this book inspires readers to further exploration of their work.

Most of all, we look forward to a new edition of this *Oxford Guide* in ten years' time. Even with our belief in the value of imagery, we are dubious whether we can even begin to imagine the advances that will be made in the next decade!

Images have been the basis for healing practices going back at least 20,000 years



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Invited essay:

From ancient shamanic healing to twenty-first century psychotherapy: the central role of imagery methods in effecting psychological change

David Edwards

The use of imagery in the psychotherapeutic setting has a vast, rich history, as well as existing still in the contemporary fore *(Achterberg 1985, p. 149)*.

The use of imagery to change conscious and unconscious cognitive processes has been the basis for shamanic healing practices going back at least 20,000 years (Achterberg 1985). Dream incubation methods were employed in the ancient Egyptian temples of Imhotep and, from the fifth century BCE, flourished in the ancient Greek temples of Asclepius (Meier 2003; Oberhelman 1983), where the bed on which the person lay was called a *cline*, origin of the term 'clinic' and an attendant was called a *therapeutes*, origin of the term 'therapist.' Meditative visualization of deities in Tibetan Buddhism goes back to at least the 8th century CE (Beer 2004; Samuels and Samuels 1975). In Christian Italy, the Spaniard Ignatius of Loyola (1491-1556) promoted the popular practice of the visualization of inspiring episodes in the lives of saints (Haraguchi 2009). In Western philosophy and medicine, the term 'imagination' was used by such key figures as Aristotle (384BCE-322BCE), Galen (129CE-199CE) and Paracelsus (1493-1541) to refer to personal meanings whether in the form of beliefs, attitudes, or images. Galen, as a young man served as a *therapeutes* at the temple of Asclepius at Pergamum, and Asclepius appeared in some of his own dreams (Oberhelman 1983). The concept of imagination gave a psychological dimension to explanations of experience and behaviour, which otherwise had to be understood in terms of physical factors such as the balance of fluids in the body, or by the nineteenth century, the activity of the nervous system (Achterberg 1985; Jackson 1990; Samuels and Samuels 1975). In his *Anatomy of Melancholy* (1621), Robert Burton (1577–1640) drew on contemporary and ancient sources to document the power of imagination to fuel intense and disturbing emotions. He also recognized how imagination could be used in healing, referring to the 'principle of contraries,' already

described by Thomas Fienus (1567–1613), whereby the physician would seek to counter disturbing aspects of the imagination by inducing 'an opposite sort of image that it might bring about an opposite passion' (Jackson 1990, p. 347). The means for this was probably not today's guided imagery methods but spells or charms or some sort of dramatized enactment that created an expectancy that healing would take place.

From 'animal magnetism' to psychotherapy

In the late eighteenth century Franz Anton Mesmer (1734–1815) popularized healing methods involving the induction of altered states of consciousness which yielded a range of vivid imagery including reliving of traumatic events. However, Mesmerists attributed cures to a force field called 'animal magnetism' rather than to imagination. In 1813, two Dutch physicians who were experimenting with 'magnetic treatments' worked with a maidservant whose fatigue, panic states, indigestion, and muscular spasms followed her nursing an elderly woman for several months till she died. She was plagued by nightmares of the deathbed and, while undergoing treatment over a six month period, relived, in the 'magnetized' state, 'the last agonies of her lady with greater precision and detail as to time and place than would have been possible in the waking state.' Her physicians, however, attributed her progress to magnetism and ruled out imagination as playing any role (Vijselaar and Van der Hart 1992, p. 2). Although Mesmer was discredited, these methods were increasingly taken up in medicine and psychiatry where they were rebranded as hypnotherapy and understood in terms of imagination and suggestion. The work of Bernheim (1840–1919) in Nancy, France was particularly influential (Ellenberger 1970; Pintar and Lynn 2008).

Throughout the nineteenth century, the role of psychological factors in psychopathology was widely recognized (Ellenberger 1970, Van der Hart and Horst 1989). Probably the first documented case of a therapy in which a clinician explicitly recognized that treatment involved enabling the client to reintegrate traumatic experiences was in Holland in 1851(Van der Hart and Van der Velden 1987). Rika, aged 22, had been 'insane for 5 months' (p. 264) with a range of symptoms including suicidal command hallucinations after she broke off her engagement and her ex-fiancé had drowned himself. Her severe symptoms were resolved after almost daily sessions over a year, in which she relived a series of childhood traumas as well as the events surrounding her ex-fiancé's death.

From about 1880, Pierre Janet in France worked extensively with trauma reliving under hypnosis and provided comprehensive clinical descriptions of dissociative psychopathology. His theories and treatments anticipated much of today's theory and practice (Ellenberger 1970; Van der Hart, Brown and Van der Kolk, 1989). He recognized that identifying and reliving a trauma, and even converting it into a narrative memory was not necessarily enough to bring about a resolution of symptoms. To neutralize the impact of traumatic memories, he worked session after session using a range of interventions, several of them involving imagery. In his 1890 treatment of Justine, who, as a child, had seen the corpses of two cholera victims, and was now preoccupied with the fear of dying of cholera herself, he used a psychodrama dialogue method.

> . . . the patient cried, 'Cholera! He will take me!' . . . Janet then asked, 'Where is he, your Cholera?' to which she would reply, 'Here! See him, he's bluish and he stinks!' Janet could then begin a dialogue with her and was able to carry it on throughout the crisis and gradually transform the crisis into an ordinary hypnotic state. (Ellenberger 1970, p. 367).

Janet also worked to substitute neutral or positive images for traumatic ones. He helped a woman with traumatic grief to replace an image of her dead children with one of blooming flowers. In 1897 he reported the treatment of Marie, who had symptoms related to several traumas, each of which he addressed by transforming imagery. He resolved a longstanding conversion blindness in one eye, which began after she shared a bed with another child whose face was infected with impetigo. He had her visualize that the other girl was a kind person whose face was not infected and to imagine stroking her face. She had felt deeply ashamed at her first menstruation and eventually tried to stop the menstrual flow by plunging into cold water. Her menstruation had stopped for 5 years and when it resumed was accompanied by shaking and trembling and other severe symptoms. He had her rewind to before her first menstruation and imagine that she felt no shame and the menstruation proceeded normally (for a fuller account see Edwards 2007; Ellenberger 1970; Janet 1914).

In the late nineteenth century, the widespread description and investigation of dissociated states and altered states of consciousness (including associated paranormal phenomena) 'led to major psychotherapeutic developments in the scientific understanding of dreams, visions, hallucinations and normal mental imagery' (Taylor 2000, p. 1030). The term 'psycho-therapeutics' was first used in 1872 and the term 'psychotherapy' in 1891 (Shamdasani 2005, p. 2). By the turn of the twentieth century, psychotherapy was being practised in Europe and North America and drew on a mix of fairly pragmatic interventions derived from pastoral counselling, a range of what we would now call cognitive and behavioural methods, and hypnotherapy techniques developed for a range of medical and stress-related problems including dissociated states. Many clinicians were keen observers of imagery. Morton Prince described the precipitating event of a woman's panic attacks. Under hypnosis she recalled a childhood incident where as the witness of a distressing family scene, she received an emotional shock and nearly fainted.

> [Looking in a mirror], she saw in place of her features a . . . 'round white object with two black dots' representing the eyes. The fearful thought flashed into her youthful mind: 'Could this be death?' (Prince 1909 ch4/5 p. 421).

He mentions that she 'was cured by appropriate psycho-therapeutics,' so although the exact intervention was not specified, it is clear that imagery methods were being used both in assessment and treatment at the birth of psychotherapy.

Trauma reliving in the twentieth century

Throughout the nineteenth century, there were vigorous debates about working with trauma memories which have repeated themselves through the twentieth century. Many of the debates are still alive today. Is the discharge of pent-up emotion in what, in 1892,

Freud had termed 'abreaction,' healing in itself, or does resolution depend on cognitive change (Van der Hart and Brown 1992)? Is it better to strengthen people so they can put trauma memories aside, or must therapy focus on cognitive integration? Despite his initial enthusiasm, Freud had realized that simply recovering the trauma memory or even converting it into a narrative was not enough. Anna O, Breuer's famous case, found only temporary relief in this manner, and when Breuer withdrew from treating her she was admitted to a sanatorium for four months and had further hospitalizations over the following years (Kimball 2000).

Freud followed Bernheim in inducing imagery by holding the patient's head or pressing on the forehead and giving a firm instruction to produce an image (Ellenberger 1970). However before 1900 he had abandoned this method and, as he focused more and more on *verbal* free association, eventually moved away from working with imagery altogether. Ferenczi (1924, 1950) did not accept this development and described ways of enhancing imagery and emotional connection to the imaged material. In his method of 'relaxation and neocatharsis', cases were conceptualized in terms of a thorough developmental understanding of clients' current problems, and treatment included reliving traumatic childhood episodes and working with them using dialogue methods and a reparenting approach (Ferenczi 1930, 1955). However, it was Freud who defined what passed as psychoanalysis (Shamdasani 2005) and, in this tradition, the production of imagery by the patient came to be seen as a form of resistance (Suler 1989) and an interference in the process of analysing the resistance and the transference (Silverman 1987). Nevertheless there would be regular excursions into the territory of imagery and regression to childhood trauma from this tradition, for example by Clark (1925), who described reconstituting the mother-child relationship in infancy and Reyher (1963, 1978), whose 'emergent uncovering' approach has much in common with the work of the hypnotherapists to be described below.

Trauma reliving and age regression continued to be used by hypnotherapists many of whom, like Janet, realized that procedures were needed to integrate the trauma memory into what we now call autobiographical memory. At a symposium on the treatment of traumatized soldiers in the First World War, Brown (1921, p. 19) implied that the abreaction was itself healing, but also emphasized:

> the great therapeutic effect produced by the intellect in the analytic review of past memories . . . The method . . . does produce a readjustment of emotional values among the patient's past memories . . . The progress is one from a state of relative dissociation to a state of mental harmony and unity.

At the same symposium, McDougall (1921, p. 25), more concerned about the precise mechanism of healing, concluded that: 'the essential therapeutic step is the relief of the dissociation . . . the emotional discharge is not necessary to this although it may play some part in contributing to bring it about.' Debates about the relative role of emotional discharge, recovery of dissociated episodes and cognitive integration repeated themselves during the Second World War and in the later literature on dissociative identity disorder (Van der Hart and Brown 1992; Watkins 1992, chapter 4).

Kline (1968) and Watkins (1992) use the term 'hypnoanalysis' for the use of hypnotically induced age regression to access painful childhood episodes, followed by work to resolve and integrate them drawing on a psychodynamic case formulation. In common with the earlier work of Janet and Ferenczi, they used a range of imagery techniques. Kline (1952) describes work with a disowned part of the self in a woman who could not sit alone in the dark because she sensed a looming figure, which she vaguely saw as a witch, her face hidden by a hat. Under hypnosis she was asked to look closely at the figure and saw that the witch was herself. The therapist invited her to dialogue with the witch who revealed that she represented all the things she desired to do but was afraid to because of her mother's punitiveness. Work on integrating this disowned part of herself led to the therapist suggesting a merging of the images of herself and the witch, so that by the end of the therapy she could say of the witch, 'I guess she is a thing of the past since I am now the "witch" and I like it' (p. 166).

In an article originally published in 1961, John Watkins (1971) described the 'affect bridge' technique (termed 'emotional bridge' in the present book, see chapter 6). A client focuses on a current distressing feeling and uses that to bridge back to an earlier memory. The therapist makes suggestions like: 'You are going back, back, back into the past . . . You are going back to some time in your life when you first felt this . . .' He illustrated it with a case of a woman who was overweight because of uncontrollable bingeing to show how the identification and gratification of unmet infant needs could resolve symptoms. Use of the affect bridge led to a regression to a time when she was lying in a cot wanting to suck her thumb, 'but Mama has tied a cloth on it with bitter black medicine.' The therapist allowed her to gratify the unmet need and she lay sucking her thumb for fifteen minutes until she said she did not want to suck any more. This and another regression led to remission of her craving and rapid weight loss. Mary Watkins (1984) described other active techniques for restructuring, including having a female client imagine pushing back a child molester and protecting herself, or reparenting by imagining oneself as an adult taking the child's hand and showing her that she now has nothing to fear. The hypnotherapy literature is rich in these kinds of applications of memory and dialogue work (Dowd 2000; Kline 1968, 1976; Murray-Jobsis 1989), and the ancient principle of contraries appealed to by Fienus, Burton, and Janet is explicitly stated by Watkins (1992, p. 66). 'If a veridical memory causes symptoms . . . then its replacement by a more benign recollection is in the interests of our patient's welfare.'

Metaphoric imagery and imagery journeys

Imagery has other applications besides processing trauma memories. Aspects of psychological life can be projected into imagery just as it can into painting, sculpture, dance, and other art forms. Carl Jung's (1977) interest in imagery was fuelled by his own vivid dreams and waking imagery. His method of active imagination developed from a variety of influences including his research on dissociated states and paranormal phenomena and reading Silberer's (1909) account of how he was able to sustain a state between waking and sleeping in which a problem would translate itself into a metaphorical image (Swan

2008). Jung (1916/1960, p. 82) would invite a client to focus on a feeling or mood and to let an image emerge which would provide 'a kind of enrichment and clarification of the affect.' A scene would be allowed to develop and evolve, sometimes using dialogue between imagined characters. In Jung's case, rather than reflecting his personal history, much of the content was symbolic and transpersonal (what Jung called archetypal), e.g. his conversations with Philemon, a kind of spiritual guide (Jung 1977). Hannah (1981) documents the unfolding of active imagination over several weeks or months in a series of cases. However, in contrast to today's imagery rescripting methods she explicitly recommends against working with images of real people and she also recommends that it should be done alone at home and reported to the therapist.

Influenced by Jung's approach, Jellinek (1949) reported a range of imagery interventions in her work with stuttering and other speech problems. Clients would be guided to find an image associated with calm or competence (in one case an image of walking in the rain, in another an image of sitting on a throne holding a sceptre) and subsequently to bring up this image whenever they felt anxious or threatened. One client visualized two selves, a shabbily dressed poor speaker, and a smartly dressed good speaker, and learned to keep 'the well-speaking boy always beside him' (p. 386). A similar intervention is part of current cognitive therapy for social phobia (Clark and Wells 1995). Jellinek (1949) described another client who felt that his stuttering was chasing him. Asked to visualize this, he saw a dwarf on his shoulder. 'If you speak slowly, you will starve the little demon and it will die,' she told him (p. 380). Another saw himself on a road covered in a dark cloak and she guided him to see a sunny area ahead, to walk into it and to see the cloak change to a brilliant white (for a similar intervention see Fromm 1968). Jellinek also describes clients going through a series of imaginal scenes with mythic content, sometimes accompanied by intense emotional expression.

In the 1930s Carl Happich and Robert Desoille exploited the metaphorical aspects of imagery through guided daydreaming. The deliberate visualizing of a scene such as a meadow, a mountain or the mouth of a cave would be the beginning of an imagery journey through a landscape that might pose challenges or obstacles, or in which there would be meetings with figures (animal, human or spiritual), which might be threatening or wise and helpful. Desoille (1965) saw this as part of a comprehensive change process which involved an assessment of the patient's 'maladaptive dynamic patterns . . . the deconditioning of these maladaptive patterns . . .[and] the establishment of new and appropriate dynamic patterns' (p. 21). Desoille's (1945) book influenced Hans Carl Leuner (1969, 1978), whose method of Guided Affective Imagery was applied to a range of clinical problems. Roberto Assagioli's (1965) psychosynthesis also drew on these imagery techniques and, from the 1960s his organization disseminated them not only to therapists, but also to those interested in the application of experiential methods to personal and spiritual development (Gerard 1961; Crampton 1969).

Metaphorical imagery is reported by hypnotherapists too. Van der Hart describes two cases of metaphorical imagery that resolved amenorrhea (1985b), a single session imagery journey which was followed by dramatic lifestyle changes in a vagrant (1985a), and

successful treatment of a woman with generalized anxiety, social withdrawal, and emotional instability who saw herself in a corset and worked with loosening it, then taking it off for a while, allowing her backbone to grow (Witztum et al. 1988). Metaphorical imagery also plays an important role in modern cognitive therapy. Chapter 11 demonstrates how, when used today, there is an emphasis on eliciting metaphors from the client and exploring the personal meanings that they portray as a prelude to instigating change.

Psychodrama, Perls, and the humanistic movement

Moreno's psychodrama, developed in the 1930s, has many parallels with imagery methods as we can see from this excerpt from his work with a woman with a psychotic illness. She lies on the floor, eyes closed, and says, 'now I am in a box. I am dead and safe on the bottom of the sea . . . (she cries like a baby) . . . O the box begins to rise . . . I rise with it higher. The box opens, I am reborn. I am an infant . . . There is an open window. a beautiful tree full of leaves. The sun is so warm' (Moreno 1939, pp. 12-13). Similar methods were prominent in Fritz Perls' Gestalt therapy (Edwards 2007). Towards the end of his life, Perls ran workshops in which a volunteer would sit in the 'hot seat' and work intensively using imagery and dramatization. In working with dreams, clients would be asked to be different figures from the dream and to speak out their experience (Edwards 1989). This might lead to dialogues between the figures. He would also ask the client to focus on their moment-to-moment experience and let it emerge as an emotion, phrase, or image, in anticipation of what Gendlin (1978) would call 'focusing.' These methods evolved out of Perls' keen interest in the expressive arts. As a young man he was involved in developments in German experimental theatre (Perls 1969) and was exposed to Moreno's work. Gestalt therapist, John Wymore, told an interviewer: 'The empty chair was not originated by . . . Fritz Perls. In Europe, Perls knew a lot of theatre people, including Jacob Moreno' (Madewell and Shaughnessy 2009, p. 2).

Verbatim transcripts of some of Perls' workshop sessions were influential in popularizing these imagery and drama methods during the 1970s, not only among therapists but also within the humanistic movement which encouraged self-exploration and experiential learning (Perls 1971, 1973). The present author's introduction to these was in 1978 through John Heron's work in adult education at the University of Surrey. He was one of many using and disseminating what were widely referred to as 'Gestalt techniques.' In his manual of the co-counselling method (Heron 1974—now available online: Heron 1998) and his manual for co-counselling teachers (Heron 1978) he described how to use imagery and other methods to connect emotionally with past distressing events and how to use dialogue and drama methods to bring about resolution.

Imagery in behavioural and cognitive psychotherapy

Meanwhile, imagery-based methods played a major role in the emerging behavioural and cognitive psychotherapies. Lazarus (1977) describes how he learned to train clients in visualization in South Africa in 1955 as Joseph Wolpe taught him to do systematic

desensitization. Lazarus was the first to use the term 'behaviour therapy', and systematic desensitization was an important part of this emerging identity. Lazarus' broad cognitive-behavioural approach, called multimodal therapy, employed imagery not only to desensitize anxiety but also for rehearsing new habits of assertiveness, mastering problematic situations, coping with anticipated challenges (see also chapter 12 of this book), and ameliorating stress-related conditions such as hypertension, spastic colon, and dermatitis. In the 1970s, Cautela systematically applied several conditioning procedures through imagery (Cautela and McCullough 1978). In covert sensitization, problematic behaviours were associated with distressing consequences. Clients who could not control their eating would imagine eating a sweet cake and becoming nauseous and vomiting, or clients arrested for sexual exhibitionism would imagine exposing themselves and being instantly arrested and jailed (Cautela 1967).

Already Singer (1974) could review a large number of studies of imagery in the emerging cognitive and behavioural therapies. These included implosive therapy (Stampfl and Levis 1967), in which clients with phobias visualized their worst fears very vividly and were encouraged to exaggerate catastrophic scenarios. Although framed within learning theory as a means of extinguishing problematic emotional responses, psychodynamic principles were used in developing emotionally intense scenarios and, later, Silverman (1987) reported effective use of implosive imagery within a psychoanalytic framework. Imagery rehearsal techniques were also reported in the hypnotherapy literature. Fromm (1968) worked with an acrophobic client who learned to visualize a competent self, merge with it and go to high balcony and look out over Lake Michigan, and commented, 'In trance we develop a stress situation for the patient and then let him experience that and how he can handle it with increasing skill' (p. 177).

Imagery within contemporary integrative approaches

All this was part of 'an explosion of interest in mental imagery' in the 1970s and early 1980s (Suler 1989, p. 347), such that 30-40 years ago there were already several comprehensive books documenting the application of imagery techniques to a range of psychological as well as somatic problems (Achterberg 1985; Singer and Pope 1978; Samuels and Samuels 1975, Sheikh 1984; Shorr 1983; Singer 1974). In the 1990s, the potential for restructuring implicit levels of cognition by means of what would soon be called imagery rescripting using drama and dialogue methods began to be recognized within CBT. The present author was one of several cognitive therapists trained by Beck who were influenced by experiences with Gestalt therapists; others were Jeff Young, who was developing schema therapy, and Merv Smucker who developed imagery rescripting and reprocessing therapy. By the early 1990s a significant integration of these methods into cognitive therapy was taking place (Beck et al. 1990; Edwards 1989, 1990, 2007; Layden et al. 1993; Smucker and Dancu 1999; Young 1990). They are now an important resource within several contemporary integrative approaches to psychotherapy including schema therapy (Young et al. 2003), emotion-focused therapy (Greenberg 2004), and compassion-focused therapy (Gilbert 2009).

This review shows that several of the imagery methods to be described in this book have been part of psychotherapy since its emergence in the late nineteenth century, and that, long before then, imagery methods played a role in healing practices based on the principle that change of emotional and physical symptoms could be achieved by effecting a change in the imagination. Fienus' principle of contraries was the basis for techniques in which dramatizations organized by the healer would lead a person to a more positive belief. Thus priests in the ancient Asclepian temples were believed to dramatize visits from deities, which would evoke a positive change in the mind set of those who came for healing, and such methods are reported by healers in many traditions. The same principle lies behind the use of imagery replacement methods, used by Janet and later hypnotherapists, and which have evolved into today's very detailed and focused methods of transforming imagery, through rescripting and other methods such as those described in chapter 8.

In the nineteenth century, there was increasing recognition of the contribution made to psychological difficulties by memories of past traumatic events. Even before Janet and Prince, it was recognized that it was necessary to undo the dissociation of such memories from the rest of the cognitive system, and techniques to recover traumatic memories and resolve the dissociation were described and discussed extensively in the late nineteenth century and on into the twentieth. These methods prefigured current use of imagery techniques in the treatment of traumatic memories as described in chapter 9. During the twentieth century, hypnoanalysts continued the work of Janet and Prince by evoking distressing childhood memories and working actively with them in various ways. The emotional bridge method described in chapter 6 goes back to nineteenth century hypnotherapy. Heightening awareness of a current emotional state and evoking an image was the basis of Jung's (1916/1960) active imagination, and Gendlin's (1978) method of focusing and using it to bridge back to a childhood memory was, as we have seen, referred to as the 'affect bridge' by Watkins (1971).

Work with parts of the self also has a long history within psychotherapy, appearing in Jung's active imagination, Moreno's psychodrama, and, in the second half of the 20th century, in the hypnoanalytic work of Kline, Transactional Analysis (Barnes 1977; Goulding and Goulding 1979), Watkins' ego state therapy (Watkins 1978; Watkins and Johnson 1982), and Perls' Gestalt methods, which have now been integrated into contemporary cognitive therapy. Although some of the techniques involve psychodramatic enactment on a stage, or using chairs for different parts, many of them use imagery. We have also seen how other forms of metaphorical imagery have been a regular feature of the psychotherapy landscape, often in developments of active imagination, guided daydreaming, and hypnoanalysis (e.g. by Fromm 1968; Jellinek 1949; Leuner 1978; van der Hart 1985a, 1985b). Finally, although cognitive and behavioural applications of imagery methods for desensitization, sensitization, and rehearsal of new skills and habits emerged from the late 1950s, these kinds of methods were also used by hypnoanalysts and probably go back to the turn of the twentieth century.

Two factors distinguish the early years of the twenty first century with respect to our understanding of working with imagery in psychotherapy. First, the exceptional ease of communication means that knowledge of these methods is more widespread and easier to obtain than in the past, where imagery techniques were used by some groups of therapists while others had little or no exposure to literature about them. Second, the development of research into evidence-based practice means that we no longer have to rely on informal clinical vignettes to assess the effectiveness of imagery techniques. There is a growing literature demonstrating the important role of imagery methods within empirically grounded clinical interventions (Salkovskis 2002) that are supported by experimental research, systematic clinical observations, and controlled trials. This book provides an update on how these methods, so long a part of many psychotherapy traditions, are being used today within contemporary evidence-based approaches to address a range of challenging psychological problems.

CASE VIGNETTE

Finding a frightened child behind a case of (adult) panic disorder

David Edwards, *Rhodes University, Grahamstown, South Africa*

Tariq's panic attacks began after his sister was hospitalized with schizophrenia. He was terrified that he too was going insane. Standard cognitive therapy brought improvement, but did not alleviate his fear.

I relaxed him and suggested he see an image of the part of him that was insistent on maintaining the fear. He saw a little demon that enjoyed worrying him. I asked it to reveal what it was that this demon needed us to take seriously. A series of memories arose, mostly from ages 6-7: going to his parents' room at night, telling them his stomach hurt–it didn't, but they wouldn't listen if he said he was feeling scared . . . alone in a car, feeling terrified he would be attacked and kidnapped, while his Dad fetched something . . . left in the house, feeling responsible for protecting his sisters should any catastrophe happen, and feeling inadequate . . . and several incidents in which his parents deliberately scared him in a misguided attempt to protect him and enforce discipline. Tariq had also experienced police raids on the home.

This information led to a revised developmental case formulation. As a child, filled with fear and shame, he had compensated by developing a tough unshakeable self with which to face the world. With his sister's hospitalization, the compensation collapsed and it was as if the frightened little boy had now returned. This was followed by two guided imagery sessions with inner child work and rescripting, following which he left the country. He described the last three sessions as the most meaningful part of therapy.

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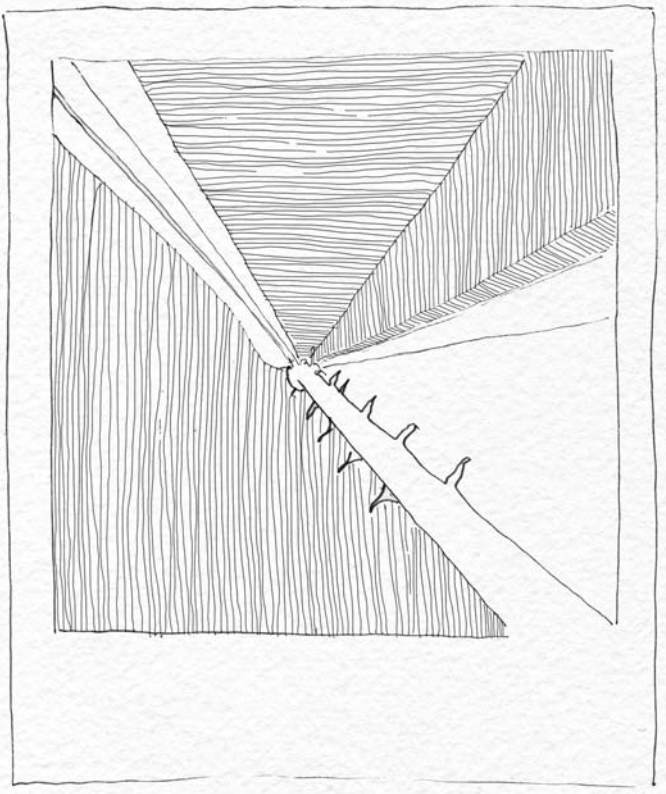
Part 1

Imagery in context



Beck saw imagery as important and crucial to our understanding of human distress

Chapter 1

Imagery in the tradition of Beckian cognitive therapy

'Imagination is more important than knowledge.'
Albert Einstein, Saturday Evening Post, 26th October, 1929.

Images are one of the key ways in which thoughts manifest in the human stream of consciousness. Imagery encompasses a range of mental representations with sensory qualities. From the outset of cognitive therapy (CT), the psychiatrist Aaron T. Beck regarded imagery as crucial to our understanding of human distress (Beck 1970, 1971; Beck et al. 1985). The meanings (appraisals) we give to our experience are a central focus of CT, and Beck (1971) suggested that images, fantasies, memories and dreams are among the most important means of accessing appraisals.

In this chapter, we demonstrate that Beck's philosophy and clinical observations make the perfect case for including work on mental imagery within the remit of CT. To support this contention we look at the ways in which Beck has embodied the attitude of the scientist–practitioner: espousing method rather than theory, systematically collecting data, attempting an integrative approach to psychotherapy, remaining curious and pragmatic about a wide range of phenomenology in psychopathology, and developing strategies that work for clients.

Beck's early research

Beck trained as a psychiatrist and psychoanalyst. His initial research was on dreams, and he inherited a proto-experimental approach from his psychoanalytic mentor Leon Saul, who had himself inherited it from Franz Alexander (see Rosner 2002).[1] Initially using methodology from the social sciences, he tested psychoanalytic hypotheses about dreams in depression, finding evidence that seemed at first to support the idea that depression was characterized by the masochistic wish to suffer. However, the epistemology of experimental science led him to trust data more than theory, and ultimately he concluded that, whilst the dreams of depressed people did feature themes of suffering, loss, and failure, there was no evidence to support the notion of a *wish* to suffer (Beck and Hurvich 1959; Beck and Ward 1961). He also noted that the themes in the dreams of people with depression were similar to those observed in their negative automatic thoughts in the day-time.

[1] We are indebted to Rosner's article for much of the biographical information about Beck's career.

In 1971 he wrote a paper on cognitive patterns in dreams and spontaneous daydreams, concluding again that the same cognitive themes were apparent in studies of various client groups (Beck 1971, reprinted in the Special Issue on Cognitive Therapy and Dreams, Rosner et al. 2002).

An integrative approach

During this formative period, Beck continued to present his findings in psychoanalytic circles, aligning himself with neo-Freudians such as Karen Horney and Alfred Adler. Adler's work encompassed techniques for working with early memories and metaphor, not dissimilar to techniques used by cognitive behaviour therapists, as described later in this book. Beck's approach achieved some recognition in the psychoanalytic context, but garnered much more from the behaviour therapy community, where he played an important role in the development of CBT. He hoped to promote an integrative approach, in which CBT could encompass a variety of techniques drawn from different therapeutic schools (Beck 1991).

Beck formed lively relationships with behaviour therapists such as Arnold Lazarus and Joseph Wolpe (see Rosner 2002). Apparently he found Wolpe's use of imagery in desensitization rather restrictive. He was more interested in Lazarus's use of imagery modification techniques such as 'time projection with reinforcement', in which the depressed client is encouraged to form positive images of the future, which may impact on motivation and behaviour (Lazarus 1968). Beck wrote a comprehensive article on 'fantasies', suggesting that 'a theoretical construct that may explain this continuity among ideational phenomena is that they are the derivatives of the same hyperactive cognitive pattern' (Beck 1970, p. 13). In the same article he asserted that there is clinical evidence that 'unrealistic pictorial images exert significant influence not only on affect and motivation but also on the patient's overt behavior' (Beck 1970, p. 15). Simultaneously he continued to collect data on cognitive themes in a variety of disorders, using material derived from negative automatic thoughts, fantasies, 'day-dreams' or the dreams of clients.

Dual belief systems

In 1985 Beck and colleagues produced the first text on the cognitive therapy of anxiety disorders, *Anxiety Disorders and Phobias: A Cognitive Perspective* (Beck et al. 1985). Within this book there is an eloquent description of what the authors called 'dual belief systems'. They made the astute clinical observation that, when we consider belief systems, we need to recognize that away from a potential source of danger, a person may rate the chances of a feared catastrophe occurring as low. However, as the person approaches the perceived danger, it will seem much more likely that a catastrophe will occur. This distinction—between belief ratings away from, and in the presence of, a perceived danger—gives rise to the notion of 'dual belief systems'.

Beck also noted that when a person is exposed to actual sensory triggers (e.g. loud noises, or racing heartbeat), disturbing imagery begins to arise, appearing to signal current threat (e.g. imminent car crash, or impending stroke). At this point, affect and belief

ratings that the catastrophe will happen may become elevated. These observations prefigure our modern emphasis on examining and seeking out the triggers for distress (either real or imaginal) in order to better understand negative appraisals and beliefs. Triggers often enable rapid access to 'hot' cognitions with high emotional content, which are encapsulated in negative imagery.

Beck continued to pursue the idea, prevalent in psychotherapy more generally, that there are two systems for processing information: one more rational, and the other more immediate and primitive. He argued (Beck 1971) that in psychopathology the more primitive system is relatively easily activated, leading to a range of cognitive responses, which formed a continuum from the verbal to the visual: from automatic thoughts to spontaneous day dreams, drug induced hallucinations, and dreams. Potentially other types of imagery including flashbacks and hallucinations in psychosis could be included here. He suggested that dreams could provide a sort of 'biopsy' of the person's distorted appraisals, away from what he called 'the press of reality'. These appraisals could then be considered from a wider perspective in therapy.

Beck's observations about information processing were elaborated in two important articles on emotional processing by Rachman (1980, 2001). Rachman highlighted the importance of intrusive negative thoughts, images, memories, dreams and nightmares, and described them as some of the markers of a lack of 'emotional processing' (Rachman 1980, 2001). He suggested that we need some objective measures of change during therapy, and the decrease or disappearance of these intrusive phenomena is one such measure. A variety of techniques can be utilized to bring about changes in emotional processing. In his review of emotional processing 21 years after his seminal 1980 paper, Rachman (2001) celebrated the progress that had been made both through behaviour therapy and latterly through the 'cognitive revolution'; in particular, he made special reference to progress made in the treatment of PTSD, where intrusive memory images are targeted.

The scientist–practitioner approach

We now return to our focus on Beck as an exemplar of what David H. Barlow et al. (1984) called the 'scientist–practitioner'. Beck, like George Kelly (1955) before him, brought hypothesis testing into the therapy room. His approach has been to see researchers, therapists, and clients as all engaged in the processes used by scientists, involving observation, reflection, testing hypotheses, and arriving at new theories. For the client, this involves making detailed observations of their own cognitions, affect, and behaviour, and reflecting on their appraisals, planning to test them against reality, testing them, and reflecting again on their validity. The therapist and client work together in a spirit of collaborative empiricism. These processes epitomize what has been called the 'experiential learning circle' (Kolb 1984), a framework that has been used to provide a valuable description of the therapeutic process in behavioural experiments in cognitive therapy (Bennett-Levy et al. 2004), and is used as a core construct in this book.

The same principles can be applied to our work on imagery in cognitive therapy. We encourage the client to observe imagery that is triggered either by imaginal or real life

cues, and to reflect on its contents, its encapsulated meanings, and the metacognitive appraisals of its significance. The validity of the meanings and appraisals can then be tested against reality in a variety of ways. The results of these tests are then reflected upon, and new belief ratings are noted. For a fuller exposition of this concept see chapter 4. Measures can be made of the outcome, in terms of characteristics of the imagery (its vividness, its frequency, the distress associated with it, belief ratings, etc.) and other measures of symptomatology.

Meanwhile, therapists and researchers have built upon the foundations laid by Beck, and have looked in detail at phenomenology involving imagery in a wide range of disorders. Researchers have also examined connections between intrusive imagery and memory in psychopathology, the relationship between imagery and emotion, and the effects of targeting imagery, directly or indirectly, on efforts to change cognitions and affect.

Conclusion

Working with imagery in cognitive therapy fits well into the framework conceived by Beck. We now have numerous studies focused on the phenomenology of imagery in different disorders (see chapter 2), and a range of research findings on the relationship between imagery and other cognitive processes (see chapter 3). We have an understanding of some of the common components that seem to be helpful when tackling distressing imagery (see chapter 4). We also have a wide range of possible techniques that incorporate different combinations of these underlying components, and the start of an evidence base examining the efficacy of various treatment packages that target imagery (see chapters 5–14). These are the areas we explore in the rest of the book.

CASE VIGNETTE

Developing a realistic image of the future (to allay anxiety)

Judith Beck, *Beck Institute for Cognitive Therapy and Research and University of Pennsylvania, Philadelphia, Pennsylvania, USA*

Beth, a single mother, was growing more and more anxious. Her eight-year old daughter, Emily, had mild mental retardation and Beth had daily spontaneous, disturbing images of Emily at age 21, sitting alone in a dark room, crying, feeling isolated and lonely. Beth discussed a more realistic scenario with her therapist, including the concrete steps that Beth could take, and the resources she could call on, to make this more positive scenario come about. After this discussion, Beth's anxiety decreased. She was able to see that Emily's future did not rest wholly on her shoulders. She could ask for help from family members, friends, parents of Emily's classmates, school personnel, Emily's physician, her county social service department, and even from people she had not yet met.

In their next session, her therapist helped Beth create a specific image of Emily in the future. Beth imagined, in great detail, a typical day in 21-year old Emily's life, from the time she woke up in the morning until she fell asleep at night. She saw Emily waking up in her nicely furnished bedroom in a group home, getting dressed, eating breakfast, and interacting with the kindly staff and other residents. She imagined Emily catching a bus with another resident to a nursing home, where she worked in the dining room. Beth continued this image until she saw Emily, feeling reasonably satisfied, getting in bed for the night.

For weeks, Beth practiced this image daily, adding more and more detail. She also described the image to family members and friends, who offered helpful suggestions to improve the image. Thinking about a realistic scenario for Emily helped her anxiety; practicing a specific image reduced it much more.

Imagery contains distressing material from memory

Chapter 2

The phenomenology of imagery in clinical practice

'Where there is no imagination there is no horror.'
Arthur Conan Doyle, 'A Study in Scarlet' (1888).

Introduction

As we saw in Chapter 1, Beck et al. (1985) noted the centrality of imagery in the anxiety disorders. They described what they called 'dual belief systems', observing that an anxious person can have contradictory beliefs about a situation. Well away from danger, the probability of a catastrophe seems small, but as proximity increases, it rises dramatically, and imagery and affect emerge. The anxious person begins to experience in fantasy the catastrophic consequences that he or she fears.

> Beck et al. (1985, p. 128) describe a woman with a fear of heights, who, when accompanied to the top of a hill felt 'dizzy, began to sway, and "felt" a force pulling her over the edge. On the fortieth floor of a sky scraper she "felt" the floor tilt to a steep angle'.

This text makes important observations about imagery: it can be triggered by cues in the environment, it feels real and compelling, it may involve modalities other than the visual modality, and it can be accompanied by strong affect and elevated belief ratings. As we shall see in this chapter, these are general observations across many diagnostic groups, not just in anxiety.

The study of mental imagery in psychopathology is a new field of enquiry, which has been developing rapidly over the past 20 years. For both clinicians and researchers, there is now a body of fascinating findings, which can shed light on some of the phenomena we typically find if we ask clients about their imagery (e.g. why clients' images are frequently experienced as so distressing and real). These findings give rise to testable hypotheses concerning ways in which imagery may be involved in the development and maintenance of disorders. In this chapter we look in some detail at the phenomenology of imagery, as it presents in everyday clinical practice. The chapter is divided into four sections:

General features of imagery

We report on research that addresses the general features of imagery, including:

- How imagery is frequently vivid and distressing

- How imagery often seems real and important
- How imagery can be positive or negative
- How imagery gets triggered
- How imagery affects behaviour
- How 'perspective-taking' in imagery impacts on emotional experience
- How imagery can be experienced in different sensory modalities
- How engaging with imagery can lead to new insights

Specific content of imagery in different disorders

Imagery takes varying forms in different disorders, and images are often linked to past autobiographical memories of specific events. In this section, we examine the phenomenology of imagery in anxiety disorders, mood disorders, eating disorders, body dysmorphic disorder, childhood trauma, and psychosis.

Metacognitive appraisals of imagery

It is not just the content of imagery which is important; so is the meaning that people attach to having images in the first place (e.g. some people may think that having negative images mean that they are 'going mad'). In the third section of the chapter, we examine some of the unhelpful meanings and beliefs that clients may have about having images, which may need to be addressed in therapy.

Definitions of imagery

In the final section, we define what we mean by imagery, and identify some distinctions between the different types of imagery that feature in the rest of the book.

General features of imagery

Vivid, frequent, and distressing imagery reflects clients' specific areas of concern

Recent studies have shown that in a range of different disorders, clients' specific areas of concern (e.g. body image) are accompanied by vivid, frequent, and distressing imagery (e.g. vivid images of 'being fat'). This is even more pronounced in severe cases. For example research findings suggest that:

- In PTSD imagery is especially vivid, distressing and accompanied by a sense that what is in the image signals what is about to happen again now (Ehlers et al. 2002). At its most extreme, imagery can take the form of a full dissociative flashback during which the person loses all awareness of their current situation, and literally relives what happened during the trauma.

- People with spider phobia have more vivid, distressing, spontaneous or deliberately evoked images of spiders than control subjects, but their butterfly images were not different (Pratt et al. 2004).
- Among snake phobics, those who are the most fearful and avoidant have the most vivid and frightening images (Hunt et al. 2006).
- In obsessive compulsive disorder (OCD) intrusive imagery is associated with more ritualizing, avoidance and distress than verbal thoughts (Speckens et al. 2007). Obsessions occurring with high frequency in the form of images are accompanied by higher appraisals of guilt and responsibility than are obsessions occurring more frequently as verbal thoughts (Freeston 1999). The frequency of intrusive images increases during stressful periods in clients with OCD (de Silva 1986; Rachman and Hodgson 1980).
- The severity of depression is related to the frequency of intrusive memories (Brewin et al. 1998; Kuyken and Brewin 1994). Negative interpretations of intrusive memories are correlated with depression severity in depressed undergraduates (Starr and Moulds 2006).
- In bulimia nervosa (BN), clients have more vivid, upsetting appearance-related images than dieting or non-dieting controls (Somerville et al. 2007).
- In body dysmorphic disorder (BDD), clients have more vivid, distressing imagery of their appearance than controls (Osman et al. 2004).

A successful course of therapy can result in decreases in the frequency, vividness and distress of intrusive imagery. Some examples are the impact of CBT on intrusive memories in PTSD (Hackmann et al. 2004; Speckens et al. 2006), and the impact of imagery rehearsal therapy on nightmares (e.g. Germain et al. 2004; Krakow and Zadra 2006).

Imagery can also reflect current everyday concerns:

- An increase in stress level has been shown to increase the frequency of distressing images. For example, parents whose children need an operation have increased images compared to a control group, before and during the operation, but these quickly subside afterwards (Parkinson and Rachman 1981).
- Indirect exposure (e.g viewing traumatic events on television) may be followed by intrusions. For example, recurrent intrusions were experienced in a proportion of London children some months after the attack on New York on September 11th, 2001. Notably these images were more likely to occur in children who believed they were in danger at the time (Holmes et al. 2007c).

Imagery frequently seems both real and important

Perhaps because of their sensory qualities and the accompanying affect, images can seem compellingly real, leading Conway (2001) to describe them as 'experience near'. This is particularly evident in PTSD where the sense of current threat is partly determined by the sense of 'nowness' accompanying the intrusive imagery. The sense of 'reality' can be totally compelling during full dissociative flashbacks and in psychosis.

Because imagery often seems to signal important things about the past, present or future, and feels real and true, it frequently triggers behavioural responses.

> One client had images of her parents' house, where she was often left alone at night as a small child. These images were triggered by feeling cold. At such times, she would often rush out to seek an inappropriate casual sexual partner to deal with the terrible cold, lonely feeling that accompanied the image. The comfort she obtained was in contrast to her 'felt sense' as a child, left alone at night in an unheated house, whilst her parents were at work.

It is perhaps precisely because imagery can feel real and compelling that the generation of new, constructive imagery can have powerful beneficial effects on appraisals, emotion and behaviour.

Imagery may be positive or negative

Imagery can be positive or negative. Intrusive (i.e. unwanted) images are very common in psychopathology, and are an obvious target for imagery-based interventions (see chapters 8–11). Additionally, clients often experience an absence of positive, adaptive imagery. For example, happy, predictive images of the future are often lacking in depression (Lazarus 1968), and generalized anxiety disorder (Borkovec 2008). See in particular chapters 12 and 13 for strategies to generate positive images.

Even positive images may not always be beneficial. Holmes et al. (2007b) have shown that images of future suicide may be experienced somewhat positively by depressed clients, and be accompanied by feelings of comfort and relief (as well as distress), making suicidal behaviour more likely. Also, Holmes et al. (2008a) argued that highly positive imagery (e.g. imagining oneself as an award-winning author) may drive mania. Seeking to accomplish mania-related goals (e.g. writing a novel in a day and not sleeping) could lead to burn out. Further, people with bipolar disorder have the highest rate of suicide of all psychological disorders. Holmes et al. (2008b) suggested that if clients with bipolar disorder have particularly compelling images of how to commit suicide or of its 'comforting' consequences, then the drive to act on such imagery may be one reason behind the high levels of suicidality in this group.

Research has also suggested that maladaptive positive images often occur in situations where there is craving or desire (May et al. 2004). Clients with addictions may deliberately elaborate the attractiveness of the imagery, leading to negative emotions and increased craving when the desired outcome does not materialize (May et al. 2004).

From the above, it can be seen that clients frequently see the images that they experience as meaningful, real and important. Therefore, appropriate targets for therapy may be an excess of intrusive negative imagery or unhelpful positive imagery, or a lack of positive adaptive imagery. We illustrate these possibilities throughout this book.

Imagery can be retrieved deliberately, or involuntarily by exposure to situational cues

Conway and Pleydell-Pearce (2000) have distinguished between 'deliberate retrieval', where the client deliberately focuses attention on bringing an image to mind, and 'direct retrieval' where a memory is triggered spontaneously and involuntarily. Imagery may be

deliberately evoked, for instance when wishing to imaginally rehearse a newly acquired skill such as responding to criticism (see chapter 12); or it may be spontaneously triggered by low level sensory cues (e.g. bright lights in a shop, reminiscent of headlights approaching during a previous car crash) or by meaning cues (being criticised by the boss bringing back childhood memories of being bullied). Spontaneously triggered imagery often appears to signal a sense of *current* threat (Ehlers and Clark 2000; Martin and Williams 1990), and the trigger may not be consciously perceived.

> A woman with PTSD felt unaccountably upset in a restaurant, until she realised that her table was facing a man who had a moustache and resembled her assailant.

If the imagery has been triggered spontaneously, this may help explain why it is sometimes difficult to realise that the image actually contains material from memory, rather than being a signal of current or future threat. For clients, this distinction between memory ('that was then') and current experience ('this is now') has important therapeutic implications (see chapter 9).

Imagery and its effect on behaviour

Intrusive negative imagery significantly affects clients' behaviour and cognitive strategies. Typically, cues that are known to trigger negative intrusive imagery may be strenuously avoided, suppressed or neutralized.

For instance, a client with PTSD will avoid any situations which may trigger memories or flashbacks. Alternatively, negative images can be suppressed, using distraction strategies, or side stepped—at least in the short term—by verbal worry or rumination. It has been suggested that the predominantly verbal activity of worry suppresses emotional imagery in generalized anxiety disorder (Borkovec and Inz 1990). Rumination could also function as motivated avoidance of distressing images and memories. Depressed clients with intrusive imagery have high levels of rumination that decline when the intrusive memories fade following imagery rescripting (Brewin et al. 2009). Clients can also try to deal with negative imagery by attempting to neutralize it, or carry out other safety behaviours (Muse et al. in press; Speckens et al. 2007).

Not all intrusive images are avoided. As we saw above, unhealthy positive images (such as those accompanying cravings, or those depicting relief from future suicide) can be purposely elaborated, and followed by impulsive behaviour. The links between imagery, appraisals and behaviour will be explored further in chapter 6, which covers assessment, and chapter 7, which addresses micro-formulation.

The perspective taken in imagery may be clinically significant

It has long been noted that the emotional impact of remembering is modified by the vantage point from which memories are recalled (e.g. Nigro and Neisser 1983). Memories from a first person 'field' perspective are seen as if through one's own eyes. Those recalled from an 'observer' perspective are seen as if seen through the eyes of another.

Observer perspective imagery plays an important part in psychopathology. Wells and Clark (1997) place a negative, distorted, observer perspective image of the self at the heart of their model of social phobia. Self-images of this type are more common in people with

social phobia than in people without the disorder (Hackmann et al. 1998). Observer-perspective images are also reported in clients with body dysmorphic disorder, in contrast to those of controls who typically describe images of the self as if seen in a mirror, rather than through the eyes of others (Osman et al. 2004). The proportion of observer perspective images is higher in depressed than in non-depressed adults (Lemogne et al. 2005) and adolescents (Kuyken and Howell 2006). A recent study suggests that even positive imagery, seen from an observer perspective, can have negative effects on mood. Participants in an interpretation training experiment became sadder rather than happier when attempting to imagine positive outcomes from an observer perspective (Holmes et al. 2008a).

Such findings may have important clinical and theoretical implications. In social phobia it appears that holding a negative, distorted, observer perspective image in mind has unfortunate effects. Several studies have demonstrated that an observer perspective leads to increased anxiety, and poorer performance in the eyes of the client and of others, compared to holding in mind a more neutral self-image (Hirsch et al. 2003, 2004). These studies indicate a causal role for observer perspective imagery in social phobia, and possibly in other disorders. In general, clients who report observer perspective imagery often complain that this robs them of a sense of agency, leaving them feeling helpless, alienated, and more like an object than a person. In therapy, clients can be encouraged to move their attention away from their observer perspective imagery, and instead adopt a first-person field perspective, seeing events, memories, and images through their own eyes.

Imagery may be in any sensory modality (not just visual)

The HarperCollins (1995) dictionary definition of imagery highlights the visual modality. However, imagery may involve any or all of the sensory modalities (Kosslyn et al. 2001, see chapter 3). Different sensory modalities, encompassing sights, sounds, tastes, smells, and somatic sensations (sometimes subdivided into organic, cutaneous, tactile, and kinaesthetic), are more or less salient in different disorders. In most disorders, visual and somatic modalities are most prominent. Less commonly, there are auditory intrusions, and more rarely, tastes or smells.

It can be of particular interest to explore the bodily experience of imagery with the client. For example, in PTSD it has been noted that when traumatic memories are evoked, people often report 'body memories', and once again feel pain, heat, cold, or the feeling of faintness or nausea that they experienced during the trauma (van der Kolk 1994; Rothschild 2000).

> During a flashback to an accident where a lorry hit his car, Bill experienced himself as tiny, and the road as vast. He had a sense of being knocked around, just as he had been at the age of four, when his father hit him and bounced him off the walls.

In many other disorders the somatic modality conveys more than the symptoms of high affect. For example, in clients with social phobia who have somatic imagery, the felt sense of the body is often distorted (Hackmann et al. 1998, 2000).

When socially anxious John felt as if he weighed 15 stone again, as he had as a teenager—yet he was a slim young man.

Paul felt as if there was nothing in the space where he should be: he experienced himself as 'a nothing'.

In a study of health anxiety one client experienced herself '*spiralling down to hell*' when she feared she was dying. This was a physical sensation.

In obsessive-compulsive disorder, images can be in any modality, e.g. *feeling semen sticking to me; seeing myself as covered in faeces, urine and wrinkles*; *hearing my mother scream that I should never have been born; the smell of baked beans, when my dad put my head in my dinner*; or *tasting a hair in a sandwich at my boyfriend's house, and feeling sick* (Speckens et al. 2007).

Brewin and Patel (2010) have reported that the hearing of voices is not unique to psychosis. They found that hearing voices with repetitive, critical content is common in PTSD, and to a lesser extent in depression. This study highlights that if we do not enquire about imagery in detail we may be missing the whole picture (see also chapter 5). Brewin and Patel's clients were specifically asked if they ever experienced auditory imagery. Many reported hearing voices in parallel with their deliberate thinking processes. These voices had significant emotional impact and produced shifts in the sense of self. The clients (unlike psychotic clients) were fully aware that the voices were produced by their own minds.

Modalities in imagery have not often been examined in mood disorders. Birrer et al. (2007) compared the intrusive memory images of clients with PTSD with those of clients with depression who had experienced either a trauma or another critical but non-traumatic event. Modalities in the images were similar, except that the two groups who had experienced traumatic events were more likely to report the visual modality than the other depressed clients.

Hallucinations in schizophrenia frequently involve the auditory modality (e.g. Aleman et al. 2002; Morrison 1995; Slade and Bentall 1988). Morrison et al. (2002) report that the majority of psychotic clients identify visual images that occur simultaneously with their auditory hallucinations and/or delusions (e.g. imagining a face when hearing a voice, or having an image of being attacked when having persecutory ideation).

Engaging with imagery can lead to the emergence of insights

It is intriguing that new material may emerge when one approaches imagery rather than avoids or ignores it. As Jung (1935, p.193) remarked 'When you concentrate on a mental picture, it begins to stir, the image becomes enriched with details, it moves and develops'. This is true of all types of imagery, including that reflecting past, present or future reality, and also metaphorical or symbolic imagery, including dreams.

When fully evoked, imagery can often be more vivid or detailed, and may be accompanied by more emotion than expected. Aspects of events not previously recalled may be retrieved. The imagery sometimes reveals encapsulated meanings, of which the individual might have been unaware, and that may be seen as obviously distorted on reflection.

Evoking imagery and reflecting on the content can trigger an autonomous cognitive shift through which clients may become aware of their cognitive distortions, or of

possible solutions. This process may also lead to the realization of an association between an image and earlier memories of related experiences. There are many examples in this book of therapeutic change arising from simply holding imagery in awareness. For a more detailed description of the effects of holding imagery in awareness and experiencing spontaneous shifts in meaning, see chapter 4.

Specific content of imagery across disorders

Many studies now indicate that negative imagery is a widespread cognitive feature in psychological disorders. Interestingly, though, the content of imagery is often disorder specific. Examples of themes and content of imagery in a range of disorders are presented in Table 2.1. Some of the studies from which these observations are drawn are referenced in the table. For a more detailed general review see Hackmann and Holmes (2004), and for a review of imagery in the anxiety disorders see Hirsch and Holmes (2007).

It is clear from these studies that each disorder investigated has characteristic patterns of content and meaning, although there is substantial individual variation. The frequency and vividness of imagery comes and goes, in line with the strength of the client's current concerns and proximity to threat and stress.

Links between imagery and autobiographical memory

The link between imagery and autobiographical memory is particularly obvious in PTSD. Clients report recurrent imagery of moments when the meaning of the traumatic event changed, usually for the worse (Ehlers et al. 2002). These usually map onto the most emotionally laden moments of the trauma, which have been described as 'hotspots' (Holmes et al. 2005). Research studies and clinical observations suggest that intrusive memories and images are also found across other disorders. Distressing past experiences are often encapsulated in recurrent intrusive images, which function rather like the 'hotspots' in PTSD.

Many of the studies referenced in Table 2.1 have sought to trace the historical source of the current imagery. Clients are asked when in their lives they remembered having an experience like the one in the reported image. This is explored using the 'emotional bridge' technique described in chapters 6 and 8. Clients frequently associate their present-day imagery with specific memories from the past, which often share some similar sensory content and meanings, and which still have important implications for them in the present. Memories of past events that still colour current experience have been described as 'negative self-defining moments' (Conway and Pleydell-Pearce 2000; Conway 2001), a topic explored more fully in chapter 3. We now consider the links between imagery and memory in a variety of disorders other than PTSD.

Anxiety disorders

Studies of social phobia, agoraphobia, health anxiety, and OCD reveal that frightening recurrent images are common, and are often associated with significant upsetting memories from the past, with similar thematic content. For example, in social phobia typical themes in recurrent images and associated memories are of humiliation, bullying, criticism

Table 2.1 Examples of problematic intrusive images across disorders

Disorders and some selected references	Core concern	Type of images	Illustrative examples
Post-traumatic Stress Disorder *Ehlers* et al. 2002, 2004 *Grey and Holmes* 2008 *Holmes* et al. 2005 *Krakow* et al. 2001b *Speckens* et al. 2007	Threat to physical or psychological self	Flashback to moment in past trauma, e.g. a moment of physical danger, or of extreme humiliation Nightmares	The sight of someone beside the bed, knife in their hand Lying on the floor with the gang all towering over me and mocking my weakness Replicative or thematically linked nightmares of the trauma
Social Phobia *Hackmann* et al. 1998, 2000	Fear of showing signs of anxiety and embarrassing or humiliating oneself	Observer perspective image of self doing something that will cause rejection	Seeing myself lurching awkwardly, and making strange noises at a party
Panic disorder *Ottaviani and Beck* 1987	Fear of physical or mental catastrophe	Self suddenly collapsing or losing control	Image of self collapsing with a heart attack
Agoraphobia *Day* et al. 2004 *Hackmann* et al. 2009	Fear of being in places or situations where escape may be difficult or embarrassing in the event of a panic attack	Self being unable to cope with the consequences of impending mental or physical catastrophe, such as being trapped, intimidated or abandoned	Image of self collapsing, being put in a straight jacket, and being taken to hospital. Never released
Obsessive Compulsive Disorder *de Silva* 1986 *de Silva and Marks* 1999 *Rachman* 2007 *Speckens* et al. 2007	Fear of being contaminated or being responsible for harming someone	Obsessional images that are unpleasant and ego-dystonic	A sexually provocative image of the Virgin Mary Self covered in germs
Simple phobia *Beck* et al. 1985 *Hunt* et al. 2006 *Pratt* et al. 2004	Fear of external source of danger	Horrific images of phobic objects Images of catastrophes in certain settings	Large hairy spider, evil look in its eye Snake sinking teeth into one's face Losing control and jumping off a cliff Suffocating in a lift that gets stuck

(Continued)

Table 2.1 (Continued)

Disorders and some selected references	Core concern	Type of images	Illustrative examples
Health Anxiety *Muse* et al. 2010 *Wells and Hackmann* 1993	Preoccupation with possibility of developing a serious illness, or fear of having one already	Negative images about self, illness and death	Image of being dead but aware of being trapped in own body Image of own serious illness or funeral, and distraught relatives
Depression *Beck and Hurvich* 1959 *Beck and Ward* 1961 *Brewin* et al. 1996 *Holmes* et al. 2007b *Kuyken and Brewin* 1994	Sense of failure, loss, guilt, humiliation	Negative memories of events that now carry over-generalized, negative meanings Negative images of past events recurring in a similar manner Dreams with themes similar to images and memories Flash-forwards to future suicide	Memory image of self not knowing what to do when parents were fighting Image of ex-husband breaking into new house, and verbally abusing her Dream of failing my exams again Suicidal images, including positive and comforting aspects
Bipolar disorder *Holmes* et al. 2008b	Exaggerated ideas about potential positive and negative life experiences	Imagery serving possibly as an 'amplifier' of negative or positive mood	Possible severe negative events Suicidal images, including positive and comforting aspects Self gloriously winning in a casino
Eating disorders *Shafran* quoted by *Rachman* 2007 (p. 403) *Somerville* et al. 2007	Preoccupation with shape and weight	Images of negative, distorted body image	Rolls of fat around my back. Flesh spilling out over my underwear. I hear myself say 'You are disgusting'
Body Dysmorphic Disorder *Osman* et al. 2004	Serious concerns r.e. appearance of self	Negative, observer perspective images of the self	Whole body out of proportion; self looking two heads taller than anyone else.

Table 2.1 (Continued)

Disorders and some selected references	Core concern	Type of images	Illustrative examples
Childhood Trauma *Arntz and Weertman* 1999 *Layden* et al. 1993 *Smucker* et al. 1995	Negative schemas about the self, other people and the world	Recurrent multi-sensory images and 'felt sense' linked to traumatic early memories Intrusive early memories	Self feeling small and totally pathetic Abuse memories Early memory of mother telling her she was evil
Psychosis *Morrison* et al. 2002, 2004	Threats to the self and others, of many kinds	Images of being attacked, verbally abused, or of many other potentially negative scenarios Hallucinatory voices	Image of being attacked Image of white van coming to get me Image of a face accompanying a hallucinatory voice Recurrent images often linked to past events
Craving and substance abuse *May* et al. 2004	Desired outcomes from substances that are craved for	Spontaneous images of desired substance, and what it would be like to ingest it Intrusions elaborated, but produce negative affect when deficit is appreciated	The smell of coffee, and what it would be like to drink it Pouring myself a nice cold glass of wine, and tasting it

or rejection, which frequently date from teenage years (Hackmann et al. 2000). The meaning carried by the images and memories involves themes of unlovability and probable rejection. Most clients report that their social phobia started or worsened after the distressing events.

In clients with agoraphobia, recurrent images and associated memories include not only representations of actual physical catastrophes, but also separation events, neglect, or lack of protection (Day et al. 2004; Hackmann et al. 2009). Typical themes involve beliefs that no-one will help them, or they will be ridiculed, or separated from people they love, if they become ill. In Day et al.'s (2004) study, several clients were struck by the fact that their recurrent 'image' reflected the same content as a disturbing memory, although they had not been aware of this before. The authors speculated that this insight may have led to a change of perspective on their anxiety problem, as there was a small but significant drop in the average avoidance score for the group following the interview study (Day et al. 2004).

In clients with health anxiety, reported memories may involve parental neglect, or a dogmatic, punitive religious upbringing. These memories appear to colour later appraisals of the likely consequences of illness or death, echoed in intrusive future images of being alone or of being neglected or punished when ill, or even in an afterlife (Wells and Hackmann 1993). Clients may also report memories of their own past illnesses, or illness or death in the family. Some of this content may appear in recurrent images of their own possible future illness or death, and the possible devastating effects on others (Muse et al. 2010).

Speckens et al. (2007) studied recurrent images in obsessive compulsive disorder (OCD). Their clients were asked whether the image was an *actual* autobiographical memory; one third of clients responded that this was the case. The majority of other images were considered by clients to be abstractions from associated distressing memories, encapsulating similar content (Speckens et al. 2007). More than half of the clients reported that they had no OCD symptoms before the key event described, and the remaining clients described their symptoms worsening after this event. These results echo previous observations by other authors who have highlighted the possible role of traumatic experiences in the genesis of OCD (de Silva and Marks 1999; Janet 1903; Pitman 1993).

Thus anxiety disorders are often characterised by key memories of past events that were given over-generalized distressing meanings, this material being echoed in recurrent imagery of future catastrophes and their likely consequences.

Mood disorders

Imagery also plays an important role in mood disorders, which will be explored further in chapter 9. However, in most studies of mood disorders, researchers have not enquired initially about images (as in many of the studies on imagery in anxiety). Instead, they have asked whether clients have experienced *intrusive memories*.

Depressed clients, like those with PTSD, report high levels of intrusive (sensory) memories of stressful events (Brewin et al. 1996). For instance, in matched samples of depressed

and non-depressed cancer clients, depressed clients report significantly more intrusive memories (mostly concerning injury, illness or death) and more preoccupation and hopelessness (Brewin et al. 1998).

Intrusive memories in depression may involve childhood abuse (Kuyken and Brewin 1994), or more recent stressors, such as death, illness, or family disputes (Brewin et al. 1996). In addition to sadness, clients' memories may be associated with emotions such as guilt, shame, humiliation, or fear. However, in contrast to PTSD, intrusive memories in depression impart less sense of 'nowness' though they still have important implications for the present (Birrer et al. 2007).

As we shall see in chapter 9, imagery rescripting of memories can be an effective therapeutic intervention in depression.

Eating disorders

In bulimia nervosa (BN) (Somerville et al. 2007), distorted intrusive images of the self are common and frequently linked to distressing childhood memories, suggesting some similarity between the function of imagery in the eating disorders, and that observed in anxiety disorders. Somerville et al. (2007) investigated spontaneous imagery of clients with BN, and dieting and non-dieting controls. They found that BN participants reported more spontaneous appearance-related images than the non-dieting group. Images were mostly recurrent and, compared to those of the two control groups, were significantly more negative and anxiety provoking. BN images were frequently linked to distressing childhood memories, with high ratings of similarity between the image and memory.

Body dysmorphic disorder

In body dysmorphic disorder (BDD), the results follow a similar pattern. For example, Osman et al. (2004) reported that the BDD body images are more detailed than controls, and are linked to stressful memories, with a mean age of onset at about 11 years. They involve themes of being teased for being ugly, or of feeling self-conscious about some aspect of their experience. For example, one client reported asking a boy why he didn't like her and being told that *'It's because you are ugly'*. Another described seeing her reflection in a window and commented that '*My whole face and body seemed out of proportion, and I was about two heads taller than everyone else.'* The memories reported as being associated with intrusive images in the control group were of less distressing and more recent events.

Childhood trauma and long standing interpersonal issues

There has been much interest in the role of traumatic childhood experiences and intrusive memories in the genesis and maintenance of personality disorders. Layden et al. (1993) hypothesized that the age at which the child was traumatized may have an effect on the way in which information is stored. Very small children (1–2 years old) may first encode experience in a form which the authors call 'the cloud', encompassing sensations like warmth or coldness, comfort or pain, and tones of voice. Over the next 1–2 years, they may encode and process information predominantly in the visual modality.

Once language develops, children start to encode linguistically. Therefore Layden et al. (1993) suggested that to identify schemas formed very early in life, it is important to inspect the imagery (in any modality) that accompanies disturbing affect. If this imagery is held in awareness, it may be possible to access memories that had similar sensory and meaning components, even those formed at a very early age. This material may be utilized in treatment. Similar techniques for identifying maladaptive schemas and disturbing memories by reflecting on imagery and affect in the present are described by Beck et al. (1990), Edwards (1990) and Young et al. (2003).

Authors have made frequent reference to the lack of positive images in people with long-standing difficulties, suggesting a dearth of pleasant memories (e.g. Gilbert 2005a; Layden et al. 1993). The use of positive imagery to create 'new ways of being' is addressed in chapter 13, where we discuss compassionate mind training (e.g. Gilbert 2010; Lee 2005), old system-new system work (Padesky and Mooney 2005) and COMET training (Korrelboom et al. 2009) for use in cases where new 'minds in place' (Teasdale 1997) need to be ushered in. Here there may be little pre-existing positive experience for clients to draw upon when forming new images, so they have more work to do to create positive imagery and new ways of experiencing events.

Psychosis

Hallucinations in psychosis are often associated with high affect, like intrusions in PTSD (Nayani and David 1996). As all clinicians will recognise, clients who experience psychotic symptoms may not recognise their images as mental events, but consider them to be real.

Psychosis researchers have become interested in the relationship between trauma and psychosis. Most clients with psychosis report that the imagery associated with hallucinations and delusions is recurrent (Morrison et al. 2002). On specific questioning, clients may associate the content with particular past events. Morrison et al. (2002) concluded that traumatic events may give rise to some of the intrusive imagery in psychosis, but individuals may initially be unaware of the source. Images may be appraised as truly reflecting current reality, rather than being seen as mental events of dubious validity, perhaps with roots in past trauma. The key factor maintaining images in psychosis may be inaccurate metacognitive appraisals experiencing the images as 'real' phenomena (see below), rather than as intrusive imagery per se. For a case study see Morrison (2004).

Morrison et al. (2003) suggested that failure to identify intrusions as related to previous trauma may be a factor in the development of psychosis, which typically involves making external attributions for internal events (Bentall 1990). This could clearly cause distress, and could contribute to the positive symptoms of psychosis. One of the conclusions Morrison et al. draw is that, in therapy, examination of the relationship between imagery and reality may be beneficial.

Other researchers have also observed that individuals with psychosis may have faulty information processing, leading to prolific intrusive imagery. Their ability to integrate stressful experiences into a realistic wider context may be hampered by unusual

cognitive processes. See Steel, Mahmood, and Holmes (2008) for a review of the evidence, including a study by Holmes and Steel (2004) who found that in a non-clinical population high schizotypy (characterized by magical or superstitious thinking) was associated with more frequent intrusions of a traumatic film.

Thus, in psychosis recurrent imagery is common; images are perceived as 'real', meaningful and highly significant; and the content often reflects past trauma. Clients are unlikely to ascribe the imagery to a historical event, and may have schizotypal metacognitive beliefs about its significance. For example, fragmentary sensory memories of childhood abuse may be interpreted as being manifestations of a current attack by the Devil.

Metacognitive appraisals of imagery

Up until this point in the chapter, we have focused on the contents of imagery and its inherent meanings, which as we have seen have a powerful impact on the client's emotional state and symptoms. However, another important consideration in the assessment and treatment of image-based psychopathology is the metacognitive belief(s) that the client may hold about the significance and meaning of the images, as we have seen in psychosis.

Metacognitive beliefs may have a major impact on the course of treatment (Butler et al. 2008). For example, while some clients may be aware that their imagery is a product of their mind, others may experience it as something real (especially in the case of a dissociative flashback or a hallucination). The 'reality' of imagery, as experienced in an auditory hallucination, is captured in the DSM-IV definition of a hallucination as 'a sensory perception that has the compelling sense of reality of a true perception but that occurs without external stimulation of the relevant sense organ'.

Alternatively, clients may recognize the true source of their imagery, but may misconstrue its significance, and assume it is a premonition, or think that it could even affect reality for better or worse. Some examples of metacognitive beliefs that may need to be addressed in therapy are presented in Table 2.2, together with clinical observations about some of the disorders in which they may be observed.

The role of metacognitive beliefs in perpetuating intrusive imagery and maladaptive behaviour is addressed in chapter 6, which covers assessment, and chapter 7, addressing micro-formulation.

Definitions and terms used in this book

Before moving onto the main body of this book we need to define our terms. Horowitz (1970) defines imagery as 'mental contents that possess sensory qualities'. This definition embraces dreams and various types of waking imagery. Imagery is distinguished from mental activity that is purely verbal or abstract.

This definition is a wide one, covering the phenomenology of imagery as defined in this book, which includes literal and metaphorical images (or 'fantasies' in Beck's terminology), intrusive and other autobiographical memories, hallucinations, dreams, day-dreams, and nightmares, represented in any or all of the sensory modalities.

Table 2.2 Metacognitive beliefs, associated behaviours, and some disorders in which these are common

Metacognitive belief	Associated behaviour	Some disorders in which this is common
Image is a true reflection of reality, past, present or future	Focus on image rather than external reality, adjust behaviour in accordance	All disorders, including anxiety, mood disorders, BDD, eating disorders, psychosis, childhood trauma
Image is unwanted part of external reality	Avoid anything that triggers imagery. Execute safety behaviours	Psychosis, PTSD, childhood trauma
Image warns of future threat	Avoid situations in which threat might occur	All disorders
Image is a premonition	Feel helpless and hopeless, withdraw	Health anxiety, OCD, PTSD
Holding image in mind could affect reality for the better	Try hard to generate this particular image	OCD, health anxiety
Holding image in mind could affect reality for the worse (e.g. tempt providence, cause bad luck, etc).	Try to suppress or neutralize this image, distract self, avoid triggers	OCD, health anxiety, PTSD
Holding image in mind could cause madness, death or loss of control	Avoid triggers for image, refuse to evoke it, or talk about it	Agoraphobia, panic disorder, PTSD, depression
Facing the image would lead to permanent, overwhelming sadness, fear or anger	Avoid triggers for image, refuse to evoke it, or talk about it	PTSD, depression, GAD, agoraphobia, health anxiety, childhood trauma

The HarperCollins English Dictionary (HarperCollins 1995) defines an image as 'a mental representation of something (esp. a visible object) not by direct perception, but by memory or imagination'. As we shall see in chapter 3, Kosslyn et al. (2001, p.635) have strongly emphasized the connection between images and memory, by stating that 'mental imagery occurs when perceptual information is accessed from memory', or is 'created by combining and modifying stored perceptual information in novel ways,' giving rise to 'seeing with the mind's eye' or 'hearing with the mind's ear'. However, as we have seen above, clients often have images that appear to signal things about the present or future; they may be unaware that the content of the image is derived from past memories.

Imagery and memories: a pragmatic distinction

Sometimes it is difficult to make a distinction between *images* and *memories*, since mental imagery always involves perceptual information accessed from memory. What we think of as an 'image' of the present or the future may seem to signal current or future threat—yet inevitably it is woven from elements of past experience. As we have seen, recurrent images in various disorders can contain abstractions from memory, or may even be segments

of specific autobiographical memories without individuals at first being aware of their source.

In this book we have created a pragmatic distinction between intrusive images and memories, based on the client's understanding of the meaning and derivation of the image. The distinction we have made is that *intrusive images*, the subject of chapter 8, seem *to the client*—at least initially—to be about the *present or the future*, whereas *memories* are clearly referenced to *past events* about which the client is aware from the outset. Of course, what is considered to be an actual 'memory' may be different from what really happened, and could be wholly or partly something that was imagined, rather than directly experienced. The sensory content could be accurate, but the appraisal of this might be distorted. Therefore, while chapter 8 addresses intrusive images which the client believes represent the present and the future, chapter 9 addresses working with images that clients perceive to be memories.

Day-time and night-time imagery (including dreams)

Another distinction we make is between day-time and night-time imagery. While chapters 8 and 9 largely address day-time imagery, chapter 10 discusses working with night-time imagery, with a particular focus on dreams.

Literal and metaphorical imagery

A further distinction is between literal images (e.g. a car accident), and images which are more metaphorical (e.g. a dark void). Again, the phenomenology may be somewhat blurred. Even what appears to be metaphorical or symbolic imagery may have its roots in memory, although the person may not initially realize this. For instance:

> Elizabeth refused to discuss emotional topics, saying that if her therapist opened up such topics she was pushing her 'into the black'. This made sense once the therapist and Elizabeth realized that she feared losing consciousness as she had as a little child, during breath-holding attacks when she was very upset. These had occurred when she had been harshly treated by her stepmother, and had sometimes resulted in her having to be taken to hospital.

Where the historical roots of a metaphorical image are obvious, it is possible to work with the underlying memory. However, it is also possible to work directly with symbolic aspects of metaphorical images. We devote chapter 11 to metaphorical imagery.

Negative intrusive imagery and deliberately constructed positive imagery

Most of the imagery we describe in this book is negative imagery associated with psychopathology, and concerns events in the past, or imagined situations that we might wish to avoid in the future. However, we should not lose sight of another important function of imagery: as Taylor et al. (1998), Wells (2000) and Gilbert (2005) have pointed out, imagery can also be deliberately utilized in a positive sense to run through and simulate adaptive ways of experiencing and reacting to events; to create new ways of being; and to reflect on likely outcomes. This form of deliberate imagery is a property we will return to throughout the book, and is a major focus in chapters 12 and 13.

Conclusion

In this chapter we began by considering some general features of imagery:

- Links between symptoms and the vividness and frequency of imagery
- How imagery can seem really real and important
- The fact that imagery can be negative or positive
- Methods by which imagery can be retrieved
- The significance of the perspective taken
- Sensory modalities in imagery
- How engaging with imagery can in itself lead to the emergence of helpful insights

We then considered the specificity of imagery in different disorders, the links between imagery and autobiographical memory, and the importance of metacognitive appraisals of imagery, across disorders. Finally we have defined imagery as the overall topic for this book, subdividing it into images and memories, and day-time and night-time images, including dreams, all of which may have literal or metaphorical content. We have also alluded to the distinction between spontaneous intrusive images and deliberately constructed positive imagery. Having mapped out the territory in this chapter we move on in the next to look at research that supports the importance of imagery in our mental life.

CASE VIGNETTE

Imagery as chronic pain catastrophizing: a flash-forward to the 'worst' possible outcome

David Gillanders, *University of Edinburgh & NHS Lothian Chronic Pain Service, Edinburgh, UK*

Alexander developed chronic pain in his back, shoulders and neck. This had been going on for several years, and was likely due to a combination of wear and tear, a result of being extremely physically active through his work in the armed forces, and a specific injury to his spine from a road traffic accident. During the process of being medically retired from the services, in his early forties, he remembered being told by a military doctor that his spine was now vulnerable and that he should approach strenuous activities with caution.

As part of routine assessment for Clinical Psychology in the Pain Clinic I asked him what went through his mind when his pain flared up. He described a flashbulb like image of his spine cracking and then a picture of himself in the future, in a wheelchair. These images were associated with distress, muscle tension and spasm, and avoidance.

Even in that first session, he was able to use slow breathing and remain in contact with the images enough for his distress to reduce. Alexander spontaneously recognised that this image represented his greatest fear with regard to his pain, but that it was a possible rather than an inevitable future.

In this assessment example, simple exposure was enough for this patient to update his mental picture with a time code and an appraisal that this outcome was not inevitable. At the same time, the therapist learned that some of his appraisals were non-verbal.

Mental imagery has a special relationship with emotion compared to verbal processing

Chapter 3

Experimental research on imagery: implications for clinical practice

'When the imagination sleeps words lose their meaning'.
Albert Camus, 'Resistance, Rebellion and Death' (1961).

Introduction

Clinical wisdom has guided the development of imagery work in therapy. Until recently, our understanding of the basic scientific processes underlying mental imagery has lagged some way behind other areas. The topic of imagery has a long history of investigation and controversy in experimental psychology. Indeed, it has been argued that the study of imagery has seen more extreme fluctuation in terms of scientific respectability than almost any other topic in cognitive psychology (Baddeley and Andrade 2000), partly due, until recently, to its almost exclusive reliance on introspection. However, over the last decade, new experimental techniques and brain imaging studies have stimulated the development of a new body of experimental mental imagery research. Accordingly, imagery studies have been strengthened by the development of new methods of measurement, which have moved it away from its near-total reliance on introspection and increased the credibility of the research.

The aim of this chapter is to illustrate from experimental research why imagery forms such an important part of the phenomenology of psychological disorders, and why imagery interventions hold considerable promise as strategies for change in CBT. We will consider imagery in the context of empirical studies from cognitive psychology and experimental psychopathology. Why consider experimental research rather than only focus on clinical practice in this book? CBT aims to draw on an understanding of psychology and cognitive science in developing theory-driven therapy (Salkovskis 2002). It may therefore be particularly important to consider the psychological and theoretical underpinnings regarding imagery in order to both understand imagery phenomenology and to develop effective interventions.

In this chapter we will consider the relationship between imagery and other features of cognition such as memory and emotion. In particular, we shall focus on the assertion that imagery has a special relationship with emotion, compared to verbal processing. Indeed, this is a key reason why imagery is so important for cognitive therapy. In addition, we will consider experimental psychology and clinical theories about imagery and emotion,

and link this research to our understanding of some of the imagery techniques presented in other chapters.

The impact of imagery on emotion

Why is imagery so important? We argue that this is because imagery has a special relationship with emotion, and that emotional processing lies at the heart of what we are trying to do in therapy. It has long been assumed in both clinical and experimental psychology that imagery has a special relationship with emotion. Surprisingly however, research evidence for this assumption appears to have been lacking until recently. The most prominent theory of imagery is rooted in perception, and does not refer to emotion (Kosslyn 1980, 1994). Kosslyn, in his 1994 book *Image and Brain* argued that the next step for imagery research is to address emotion since 'imagery appears to play a special role in representing emotionally charged material' (pp. 405). Despite this assertion, it was another decade before this 'next step' was taken (see later discussion of experiments by Holmes and Mathews 2005; Holmes et al. 2006, 2008d).

From a clinical perspective, the experience of extreme emotion across a range of psychological disorders seems clearly to be accompanied by report of images (see chapter 2). A hallmark example is the intrusive images or flashbacks experienced in PTSD (American Psychiatric Association 1994; Brewin and Holmes 2003; Ehlers et al. 2002). In the treatment of many psychological disorders, clinicians have often assumed that imagery provides a particularly effective way to access and modify emotion in therapy. This is evidenced in therapy techniques that use imagery strategies ranging from imaginal desensitization for phobias (Wolpe 1958) to cognitive therapy in the present day (Holmes et al. 2007a).

However, researchers have been open to the criticism that theoretical claims about imagery and emotions appear to have been driven by clinical experience rather than empirical research. For instance, Watts (1997, p. 175) wrote:

> 'One of the most interesting issues that has been raised about the emotion-inducing properties of images and thoughts is their relative effectiveness in accessing emotion . . . It has also been suggested that material that is associated with painful or complex associations can be retrieved more readily in pictorial than in linguistic form. However, these claims have largely been based on anecdotal reports of clinical observations.'

Despite the widespread clinical assumption that imagery has a particularly strong impact on emotion compared to verbal thoughts, the research that did exist on imagery when Watts wrote the above words was dated, and was sparsely scattered across different research areas.

Early research on the impact of imagery on emotion

One research group that has taken a lead in imagery research is that of Peter Lang. The notion of an affect-laden image linked to physiology and behavioural responses was key to Lang's bio-informational theory of emotional imagery (P. J. Lang 1979) and his subsequent work. Lang's group have shown that people classified as 'good' rather than 'poor'

imagers exhibited greater physiological activity when imagining text-based, emotional scripts (Miller et al. 1987).

However, only one early study appears to have contrasted the impact of imagery on emotional responsiveness with verbal processing (our other key form of cognition in CBT). Vrana et al. (1986) manipulated the amount of information about physiological/behavioural responses in sentences describing various situations (e.g. a sentence about giving a speech with response information about one's heart pounding either included or not). The participants in the experiment were asked to repeat the sentence silently to themselves and then imagine the situation. Heart-rate was higher when imagining the fearful situation. This gives some indication that imagery processing of the sentences was more emotional than verbal processing. However, while physiological measures such as heart-rate may be associated with emotional responses, it would be useful to also have had people rate their emotion too. Further, a serious flaw in this experimental design is that all participants completed first the verbal condition and then the imagery condition. It could be argued that the results indicating a difference between the two may merely be attributable to the order in which the instructions were given (verbal then imagery). It therefore seems more evidence is needed—as we shall go on to discuss in a series of studies we have conducted.

Another line of research that has been concerned with imagery involves conditioning. Dadds et al. (1997) argued that it is commonly assumed that: (a) conditioning processes contribute to the development and maintenance of psychological disorders; and, (b) images (e.g. an image of a biting dog) can serve the same function in such conditioning processes as physical stimuli (a real scary dog). They reviewed the evidence for the latter premise. This indicated that images can substitute for both unconditioned and conditioned stimuli, and consequently that imagery is able to enhance or diminish the strength of classically conditioned responses.

Subsequently, in a survey of student participants, Dadds et al. (2004) found that, as predicted, high imagery ability was positively correlated with the frequency with which participants reported specific fears, such as aversions to food substances, people, and places. Applying a similar rationale to clinical emotion research, one can argue that the extinction of fear to a feared object could be achieved through imagining it. For instance, it has been shown that the use of exposure therapy in treating anxiety disorders is effective, whether exposure is to the actual feared object or done through imagination (Foa et al. 1980). Indeed, in their theoretical paper, Dadds et al. (1997) made a contrast between therapy for irrational fears using a 'representational approach' (i.e. imagery) with therapy using rational countering (propositional cognition). They argued that imagery is more likely to bring about emotional change and successful resolution of the problem.

In summary, we argue imagery should be important for therapy since it has an important relationship with emotion. However, research evidence for this assumption was lacking, and is suggested, but not proven, by the above studies. This issue has only been tackled directly in more recent experimental research.

Recent evidence about imagery and emotion

Given the lack of conclusive prior research, the overarching aim of a line of enquiry by Holmes, Mathews, and colleagues has been to investigate the impact of imagery on emotion, in comparison with the impact of verbal processing of the same material.

The first experiments were based on the work of Mathews and colleagues who developed the so-called 'cognitive bias modification' paradigm (S. Grey and Mathews 2000; Mathews and Mackintosh 2000; Mathews and MacLeod 2002). In the laboratory, participants were given 100 scenarios. The scenarios were devised to create a negative and a neutral condition; initially the scenarios appeared ambiguous to the research participants, but then they resolved in an either negative or neutral way. For example, someone in a negative condition would hear, 'you hear footsteps running up behind you and realize you ***might be attacked***'. Someone in a neutral condition would hear, 'you hear footsteps running up behind you and realize ***it was a friend approaching***'. One group of participants were asked to listen to the scenarios and think about the words and meanings (verbal condition). The other group of participants were asked to imagine the scenarios (imagery condition). The main result of interest is that those participants in the imagery group became significantly more anxious than those in the verbal group (Holmes and Mathews 2005), as illustrated in Figure 3.1.

In another experiment (Holmes et al. 2006), it was predicted that imagery would also have a more powerful impact on positive emotion. Positive scenarios were created for this experiment (Holmes et al. 2006), e.g. 'It's your birthday, and your friend reaches over to you with a present. You open it and feel . . . ***incredibly happy***'. The results showed that instructions to imagine *positive* events indeed led to greater increases in positive affect than did instructions to focus on the verbal meaning of the same descriptions. These are illustrated in Figure 3.2.

The two previous experiments indicate that imagery has a stronger impact on emotion than its verbal counterpart. It could be argued that this might only be shown in one kind of experiment, i.e. one when participants listened to scenarios, or that the imagery simply

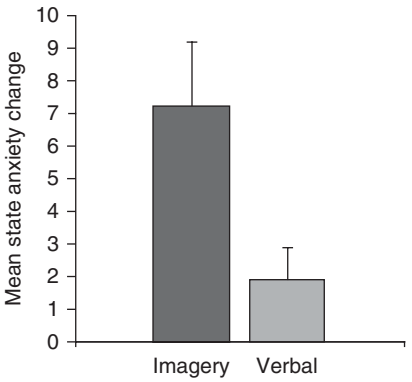


Fig. 3.1 Participants who imagined negative scenarios became more anxious than those who 'thought about the words and meanings' of the same negative descriptions (Holmes and Mathews 2005).

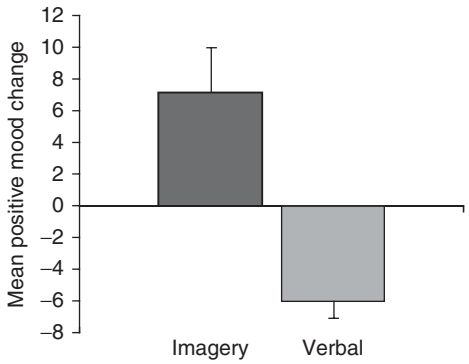


Fig. 3.2 Participants who imagined positive scenarios developed a more positive mood than those who 'thought about the words and meanings' of the same positive descriptions (Holmes et al. 2006).

'added' to the verbal story in the scenarios. To rule out this possibility, Holmes et al. (2008d) also tested the hypothesis using another type of experimental paradigm from a branch of research called 'evaluative conditioning'. In the new paradigm, participants were given pictures with one of two words: one that led to a negative interpretation of the outcome, or one that was benign (see Figure 3.3).

In the imagery instruction condition, participants were asked to 'imagine the combination of the next picture and word'. In the verbal condition, participants were asked to look at the same stimuli but 'make a sentence to combine the next picture and word'. The imagery instruction condition resulted in greater changes in state anxiety after negative picture–word combinations than the verbal instruction condition. In addition, for the *benign* picture–word combinations, there was now a significant difference in the *reduction* of anxiety between the imagery and verbal conditions. The results supported the prediction that imagery use is associated with higher ratings of emotion for both negative and benign picture–word combinations.

The convergent evidence from these two experiments (cognitive bias modification and the evaluative conditioning experiment) supported the overarching hypothesis that

Fig. 3.3 An example of a positive and a negative picture–word pair from Holmes et al. (2008d).

imagery has a more powerful impact on emotional response than does verbal processing of the same material, for both negative and positive stimuli. Indeed, these experiments provided the first systematic evidence to support this widely held experimental and clinical assumption, at least for anxiety and for positive emotion. These experiments therefore contributed a step forward in our understanding of cognitive processing and emotion. In particular, they provide experimental support for the clinical observation that intrusive images are frequently associated with high emotion, and are potential 'hotspots' for therapeutic intervention.

Why might imagery produce emotion?

We have now reviewed evidence that imagery invokes emotion more readily than verbal, language based processing. But why might this be? This issue has been reviewed by Holmes and Mathews (2010), who put forward several arguments about why this might be the case, as will now be discussed. It is possible that those systems involved in producing emotion might be particularly sensitive to imagery. One theory that may be relevant, at least in the context of fear and anxiety, has been proposed by Öhman and Mineka (2001). They argue that a so-called 'fear module' is more sensitive to evolutionarily older stimuli that are represented in perceptual form than more recently developed representational systems such as language. If mental imagery is similar to real perception (Kosslyn et al. 2001), then accordingly images may have more ready access to emotion than words. Further, as Conway (2001) has proposed, imagery may be the preferred form in which we remember highly emotional experiences, as clinical experience would suggest.

Imagery and perceptual representations

Images appear to share properties with perceptual representations derived from direct sensory experience (Denis et al. 2004; Kosslyn et al. 2001). If images have similar properties to actual percepts (Kosslyn et al. 2001), then accordingly images could have more ready access to emotion than for example, verbal language, as they could be responded to as if they were an actual threat object. As we have seen in chapter 2, the definition of mental imagery proposed by Kosslyn et al. (2001, p.635) emphasizes the link with perception:

> 'Mental imagery occurs when perceptual information is accessed from memory, giving rise to the experience of 'seeing with the mind's eye', 'hearing with the mind's ear' and so on . . . Mental images need not result simply from the recall of previously perceived objects or events; they can also be created by combining and modifying stored perceptual information in novel ways.' (Kosslyn et al. 2001).

The results of experiments using brain imaging techniques, as summarized in Kosslyn et al. (2001), have shown that imagery draws on much of the same neural regions as actual perception in the same modality. For example, Kosslyn et al. (1995) asked participants to visualize line drawings of objects at different sizes. In the brain scanner, participants kept their eyes shut to avoid any visual input. Imagining the line drawing resulted in activation in 'area 17' compared to a control condition using identical auditory cues

but no imagery. The early visual cortex comprises areas 17 and 18, and these are the first regions to receive input from the eyes. The results therefore indicate that imagining visual stimuli can result in brain activation in the same area as early visual perception. The results also showed that the specific locus of activation depended on the size of the imagined drawing. That is, imagining an object at a larger size shifted activation to more anterior parts of the calcarine sulcus (the principal anatomical landmark of area 17), a shift that is also found in the direct perception of larger objects.

Depending on the type of imagery task, different brain areas are activated. In another brain imaging study using fMRI, O'Craven and Kanwisher (2000) found activation in the fusiform face area (FFA) when participants were asked to imagine faces. However, when participants were asked to imagine indoor or outdoor scenes depicting a spatial layout, activation was found in the para-hippocampal place area (PPA). There was no activation of the PPA during face imagery, and no FFA activation during the spatial layout imagery. The areas of activation were similar to those found when the participants actually perceived visual stimuli of faces and places.

Kosslyn et al. (2001, p.641) therefore proposed a theory of 'functional equivalence', in which they argued that imagery can engage neural structures that are also engaged in perception, and that those neural structures can in turn, affect events in the body itself. They stated that 'visualizing the object has much the same effects on the body as actually seeing the object' (p.641). This claim is relevant to the hypothesis that imagery may have a special impact on emotion as 'body effects' or physiology are associated with emotional responses.

Imagery and autobiographical memory

What form do our own memories about ourselves take? The model of autobiographical memory proposed by Conway and colleagues makes a distinction between episodic memory that contains sensory perceptual information, and those memory structures that store conceptual knowledge of general events and life time periods (Conway and Pleydell-Pearce 2000). That is, specific emotional events (episodes) that have happened to the self (unlike generic classes of events or our memory for facts) can be stored in the form of images. This relationship between autobiographical memory and imagery has been proposed to account for the presence of intrusive, distressing imagery (i.e. 'directly retrieved' images—see chapters 2 and 4—associated with memories of negative experiences) across a variety of psychological disorders (Conway 2001; Conway and Holmes 2005; Conway et al. 2004; Conway and Pleydell-Pearce 2000). According to the sensory–perceptual episodic concept proposed by Conway (2001), imagery is thought to be the preferred form in which highly affective experiences are recalled. Imagery may therefore have emotional effects because it has privileged access (compared to verbal language) to representations of related emotional episodes stored in autobiographical memory. This view would suggest that imagery should be associated with greater affective responses regardless of the emotion involved, including more complex social–affective states such as admiration. Importantly, this work suggests imagery-based memories can be retrieved directly (rather

than deliberately built up), and when they spring into mind unbidden they 'hijack' our attention.

Conway and colleagues (Conway and Pleydell-Pearce 2000) have proposed that intrusive imagery, as experienced in psychological disorders, can have a profound effect on the person's sense of self and current experience. A key example of this is in PTSD (Conway and Holmes 2005; Conway et al. 2004). Presumably, one key reason such imagery could cause distress might be the relative ease of accessing negative emotion when processing information in the form of specific images (as in sensory perceptual episodic memories). In contrast, negative emotional information may be less easily accessed when information is processed in the form of verbal semantic knowledge about the self and an image is not brought to mind (Holmes and Mathews 2005).

Imagery's special relationship with emotion: summary of possible theoretical accounts

In summary, this section has explored possible explanations for why it might be that imagery elicits emotion more readily than verbal language based processing, at least for anxiety and positive affect. It was speculated that images have more ready access to emotion than linguistic representations for several reasons (Holmes and Mathews 2010). These include the similar properties of imagery with respect to perceptual representations, which implies that images may be responded to as if they were a real percept (Kosslyn et al. 2001). Further, autobiographical memory theory suggests that imagery may be the preferred form in which highly affective experiences related to the self are recalled (Conway 2001). Imagery may therefore have emotional effects because it has privileged access (compared to language) to representations of related emotional episodes stored in autobiographical memory. For instance, in terms of emotion encoding, it is possible that our fear systems respond particularly sensitively to perceptual stimuli like spiders, snakes, or snarling tigers (Bennett-Levy and Marteau 1984; Öhman and Mineka 2001). For evolutionary reasons, imagery may have special access to such emotions. It is likely that these alternatives are not mutually exclusive but have additive effects, and a combination of explanations is required.

Experimental psychology and clinical psychology models: the distinction between imagery and verbal modes of processing

The experimental findings reported above are paralleled by a long tradition of psychology models which suggest a contrast between nonverbal/imaginal and verbal modes of processing. For example in experimental psychology, Paivio's (1971) dual coding theory proposed that there are two independent yet connected systems for imagery and verbal coding. The multiple-entry, modular memory system (Johnson 1983; Johnson and Multhaup 1992) may be considered a more modern development, and distinguishes between perceptual and reflective memory systems. Of particular relevance to CBT, the Interacting Cognitive Subsystems (ICS) theory (Barnard 1999; Teasdale and Barnard 1993) has been usefully applied to depression and has the potential to model emotion and

imagery, as does the SPAARS (Schematic, Propositional, Associative, Analogical, Representation Systems) model (Power and Dalgleish 1997).

Simpler models of memory proposing independent image-based and narrative-based systems have been proposed by autobiographical memory theorists such as Brown and Kulik (1977) as well as Pillemer (1998) who suggested that intrusive images of highly emotional events (both positive and negative) are automatically activated by situational cues. These different verbal and imagery-based substrates of autobiographical memory are also a key feature of Conway's model of autobiographical memory—the self memory system—as discussed above.

Clinical models have made a similar division. The dual representation theory of PTSD (Brewin et al. 1996), although specifically developed to account for memory in the clinical condition of PTSD, takes a related approach. Brewin et al. (1996) proposed that trauma memories are processed in two systems and create two separate representations. Information that receives a relatively high level of conscious processing is laid down in a form that can later be deliberately retrieved, in the verbally accessible memory (VAM) system. The VAM system forms the basis of subsequent verbal accounts of the trauma. Information that is processed while the person is using conscious processing, but not to a sufficient degree to enter the VAM system, is stored in the situationally accessible memory (SAM) system. The SAM system primarily encodes detailed sensory information such as visuospatial input. Information in this system can be accessed automatically by exposure to relevant cues, and may be spontaneously re-experienced in the form of detailed visual images, affective responses, and emotion-laden flashbacks corresponding to moments of intense arousal during the trauma. However, this model and its subsequent versions does not explain why imagery may have a special relationship with emotion, but rather describes clinical phenomena, i.e. that emotional flashbacks in PTSD take the form of sensory images (rather than verbal cognitions) and how these might be triggered.

In their clinical model of PTSD, Ehlers and Clark (2000) proposed a related account. They suggested that processes at encoding might affect intrusive memory (flashback) development. Citing the distinction between 'data-driven' and 'conceptual' processing made by cognitive psychologists such as Roediger and McDermott (1993), they proposed that processing information in a predominantly 'data-driven' (image-based) manner was likely to increase intrusive memories of a trauma. Data processed more 'conceptually' (verbally) were less likely to intrude. This again is consistent with the proposal that imagery flashbacks are more emotional than verbal cognitions about a trauma. It is also consistent with the distinction between direct and indirect retrieval made in Conway's autobiographical memory theory (Conway and Pleydell-Pearce 2000).

Imagery's influence on the perceived probability of events

How do we estimate how likely it is an event will occur? Another feature of imagery with clinical relevance is how it impacts on our beliefs about the future. Mental imagery has been explored in the social psychology literature in terms of the subjective probability of future events occurring. Imagining one political party winning the next election, rather

than another, increases our estimates of how likely it is that that event will actually happen (Carroll 1978). Indeed, using imagery about oneself voting has been shown to be causal in determining whether people actually go ahead and vote in a general election (Libby et al. 2007). The ease of imagining the symptoms of a disease has been associated with subsequent likelihood ratings of contracting that disease (Sherman et al. 1985). If imagery increases the likelihood that people believe something will happen, or serves to increase the chance someone will act on the imagined event, then this may be of particular concern to us clinically. For example, Holmes et al. (2007b) have argued that if patients think about committing suicide in the form of an image (rather than just verbally) then this might increase the risk of them progressing from suicidal ideation to suicidal behaviour. Such images can vary from the actual act of suicide itself (e.g. taking tablets or jumping off a cliff) to the aftermath and its impact on others (e.g. a funeral). Imagery may also have a role to play in impulsivity in bipolar disorder (Holmes et al. 2008b; Goodwin and Holmes 2009). For example, in a manic state a person with bipolar disorder might imagine themselves gambling and winning heroically, thereby increasing the subjective probability of this outcome. Such imagery would thus be predicted to increase the likelihood of them gambling excessively.

Links between experimental research and imagery techniques in clinical practice

The findings about imagery and emotion discussed above provide some empirical justification for the use of imagery as a device to evoke—and also to modify—emotional responses in clinical conditions. These approaches broadly divide into techniques to encourage positive imagery (see in particular chapters 12 and 13) versus techniques to reduce the impact of negative imagery (see chapters 8–11). Such techniques are discussed in fuller detail throughout this book. The aim of this section is to link various techniques to the research and theory outlined earlier in this chapter.

We start with 'evocation' (see chapter 4). Well-established and successful imagery techniques for fear-based imagery include imaginal exposure (Foa et al. 1980) and systematic desensitization (Wolpe 1958). In imaginal exposure, the patient is asked to imagine the feared object/outcome in detail, as vividly as possible, without deliberately inhibiting their fear, and to focus on their images until their fear begins to subside (habituation process). This treatment strategy is consistent with the approach of Öhman and Mineka (2001), who argued that for successful treatment it is essential that patients with phobias confront their phobic stimuli to extinguish the automatic activation of the 'fear module', and that CBT aimed at the level of verbal beliefs about the phobic objects will be insufficient. Öhman and Mineka's discussion concentrates on actual fear stimuli such as real spiders or snakes. However, if the argument is made that images can be responded to as if they were percepts of real events (Kosslyn et al. 2001), then imaginal exposure to spiders and snakes should also be effective. Indeed, imaginal rather than *in vivo* exposure may be particularly useful for negative images which do not exist in reality (such as a constructed image of a terrifying spider-like creature) or images which represent a fear memory that

cannot be fully recreated *in vivo* (e.g. a traumatic physical assault). This rationale, following Öhman and Mineka (2001), has important ramifications for CBT, as it suggests that attempts to only verbally discuss 'negative thinking' (e.g. via negative verbal thought challenging) if a fear image is involved may be less effective, or indeed ineffective, compared to using imagery techniques. However, it has also been noted in the clinical literature that exposure alone may work less well for non-fear-based images such as those provoking shame and guilt (N. Grey et al. 2001). In such cases using an interwoven approach between imagery and verbal techniques, and specific strategies such as imagery restructuring, may be helpful.

In this book we also make reference to the importance of a client's '*metacognitive beliefs*' about imagery (e.g. see chapter 2 and chapter 8, manipulation section). Imagery is likely to make an event seem more real. This might make events that people realise 'logically' are improbable, such as a spider eating them with big teeth, seem particularly real or like a memory, even though that precise event may not have been seen in reality. If one of the reasons that imagery impacts on emotion is due to people responding to it as a 'real' stimulus (Kosslyn et al. 2001), then explicitly recognizing that a negative image is a mental representation per se, and not reality, could be helpful. Making this point explicit can be readily done within a typical CBT framework. Therapeutically this might also be achieved, e.g. via a metacognitive approach (Wells 2000) or mindfulness-based cognitive therapy (Segal et al. 2002). While Öhman and Mineka's (2001) approach suggests that imagery may have a direct and rapid impact on fear, it is possible that a further escalation of fear may be diminished using metacognitive techniques, which allow the patient to think differently about the experience of having emotion-provoking imagery. Future research might compare the relative effectiveness of, e.g. exposure versus mindfulness-based techniques for a given negative image.

Also, in chapter 4, we discuss the value of deliberately introducing incompatible information to help the client to develop new meanings in CBT-based imagery work. Such techniques include 'image transformation' plus rehearsal of the transformed image. In clinical practice, this is typically used for specific pre-existing negative imagery. That is, the patient is asked to mentally transform a problematic negative image to form a new benign or positive image, e.g. via 'image rescripting' (Arntz and Weertman 1999; N. Grey et al. 2002; Hackmann 1998; Harvey et al. 2000; Holmes et al. 2007a; Smucker and Dancu 1999). This may be particularly useful for repeated and stereotyped negative images, such as those held by patients who have recurrent images in PTSD or social phobia. Imagery rescripting is also a core component of the evidence-based schema therapy for borderline personality disorder developed by Arntz and colleagues (Giesen-Bloo et al. 2006).

If the creation of specific, alternative positive imagery is effective, this could be consistent with autobiographical memory theory. That is, the positive alternative may be taken to be equally genuine or believable to the negative alternative (which may or may not in itself be genuine). The reality monitoring literature has investigated participants' discrimination of real and imagined events (Johnson 1997). Hyman and Pentland (1996) asked participants to either to form an image of an event that had not happened to them (e.g. spilling a punch bowl as a child at a wedding) or to verbally 'think about' the same event.

Those participants who had been asked to use imagery were more likely to report in a follow-up session that the 'false childhood event' had actually happened. The imagined event may be 'mistaken' for a genuine memory as imagery shares phenomenological properties with autobiographical recall of specific episodes (e.g. Conway 2001; Mazzoni and Memon 2003; Garry et al. 1996). The reality-monitoring literature has largely focused on the negative impact of mistaken 'false memories' which were thought to be genuine (e.g. in alleged false claims of childhood sexual abuse). However, it is possible that similar processes could operate and be beneficial in therapy which deliberately transforms negative images to positive/benign images. Rehearsal of the transformed image may increase access to this non-negative alternative to the original negative image.

Future possible innovations from experimental research for imagery techniques

There are also some interventions that are under development and beyond the scope of treatment sections in the current book, but which are interesting to mention in this research context. For example, since negative imagery has a negative impact on emotion, then reducing the ability to hold a negative image in mind should bring about a reduction in affect. Imagery competition tasks (rather than distraction per se) could be useful in reducing the impact of intrusive negative imagery. For example, a concurrent visuospatial task (a task relying on mental imagery) could be used when unwanted images come to mind. According to a 'competition for resources' rationale, it is difficult both to hold a negative image in mind and perform a task which uses similar, limited cognitive resources (Baddeley and Andrade 2000; Holmes et al. 2004; Holmes et al. 2009a; Kavanagh et al. 2001). This may be useful to reduce the impact of negative imagery in situations where people find it hard to explicitly transform or challenge such imagery. One illustration from the laboratory that might be developed and applied to the aftermath of real trauma is that playing the computer game Tetris (a highly demanding visuospatial task using colour, shape and movement) can prevent the build up of flashback images after viewing distressing material (Holmes et al. 2009a). Another task used experimentally to reduce flashback frequency has been clay modelling (Stuart et al. 2006).

Imagery competing tasks have not yet been widely applied in clinical situations, but provide an interesting avenue of further investigation. Other than PTSD, there is exciting research emerging in the area of cravings for instance (Kavanagh et al. 2005; May et al. 2008, 2010). Importantly, the research to date indicates that, while imagery tasks may be helpful, a distracting verbal task can have the opposite and potentially harmful effect. For example, we have shown in experiments that verbal tasks can actually increase later intrusions (Bourne et al. 2010). This again highlights how images and verbal thoughts operate differently (Hagenaars et al. 2010), and that we need to pay attention to this distinction in CBT.

The research above regarding 'imagery competing tasks' may have a link to therapies such as EMDR (eye movement desensitisation and reprocessing therapy) (Shapiro 1996). EMDR has an evidence base for its use, for example in PTSD, but it has been difficult to

account scientifically for why it may work. It is possible that eye movements (and other spatial tasks) help to disrupt the negative imagery (Andrade et al. 1997). Indeed, we have found that an experimental eye movement task with PTSD clients during recall of their flashbacks has this predicted effect (Lilley et al. 2009). Overall, what this might mean for our clients is that if they experience a negative image, it might be dampened down by specific visuospatial tasks (but not by any distracting task) i.e. those which also use imagery such as drawing, knitting, visual computer games, clay modelling, and so on.

A recent development in experimental psychopathology has been the field of computerized cognitive bias modification or CBM (Koster et al. 2009; MacLeod et al. 2009). This paradigm assumes (as does CBT) that psychological difficulties are associated with biases in cognitive processing, e.g. a tendency to see a glass as half empty rather than half full if one is depressed, or that the future is hopeless rather than hopeful. CBM aims to shift negative biases in processing in a more adaptive way, through repeated learning trials via computer. Earlier in this chapter, an experiment was discussed in which participants were presented with ambiguous scenarios (e.g. 'you hear footsteps running up behind you and realize . . .) which were then resolved for example, in a positive way (e.g. . . . ***it was a friend approaching***) (Holmes et al. 2006). CBM results show that participants who are repeatedly trained to imagine a variety of scenarios such as a friend approaching (rather than a negative interpretation such as a mugger) have better outcomes, i.e. become more positively biased about other things too. Specifically, Holmes et al (2006) found that making these more adaptive resolutions using imagery, rather than verbal processing, had a more positive impact on emotion. Depressed mood is associated with the tendency to use a verbal ruminative style (Lyubomirsky and Nolen-Hoeksema 1995), and further with the inability to imagine a positive future (Holmes et al. 2008c). Thus it has been proposed that training people with depression to make more positive interpretations using imagery will be beneficial (Holmes et al. 2009b).

The CBM technique in these experiments can be used to do just this, i.e. to promote the more habitual use of positive and optimistic imagery (rather than a verbal style). We are developing CBM procedures first with non-clinical participants (Holmes et al. 2009c; T. J. Lang et al. 2009) and have some preliminary tests now with people with clinical depression and also psychosis (Blackwell and Holmes 2010; Steel et al. 2010). Initial findings suggest that to become happier, people need to use imagery from a first person ('field') perspective as if it is really happening to them, rather than a third person ('observer') detached perspective (Holmes et al. 2008a). Positive imagery CBM may be particularly useful for people who repeatedly generate negative interpretations in response to ambiguity in everyday situations (e.g. those with depression/anxiety). Positive imagery training may help the relatively automatic production of benign/positive imagery when encountering novel stimuli; that is, to start promoting a more adaptive 'rose tinted' way of imaging the world and an optimistic future (see chapter 13 for other examples of positive imagery training). While this area is at a young stage, it is exciting to think about imagery techniques not only involving the treatment of negative imagery but also promoting positive or more adaptive imagery as a more habitual style of thinking.

Conclusion

Considerable research remains to be done in bringing together developments in clinical psychology with those in basic cognitive psychology. We hope in this chapter that we have provided persuasive evidence to support the hypothesis that imagery has a more powerful impact on emotional responses than does verbal processing of the same material, for both negative and positive stimuli. Indeed, the special relationship between imagery and emotion is a key reason why mental imagery is so important for cognitive therapy. Experimental psychology and clinical theories about imagery and emotion have been considered. In particular, the reasons why imagery might impact on emotion have been examined, from links with real perception to the format of our important personal memories. Imagery can also increase our estimation of how likely it is an event will occur. Implications of this research are then taken up by making links to our understanding of some of the imagery techniques presented in other chapters. The chapter ends with an opportunity to think about research-led treatment innovations in the future. In summary, the findings from experimental research suggest that clinical imagery interventions should be targeted at reducing distressing unwanted negative imagery, and at promoting positive imagery.

CASE VIGNETTE

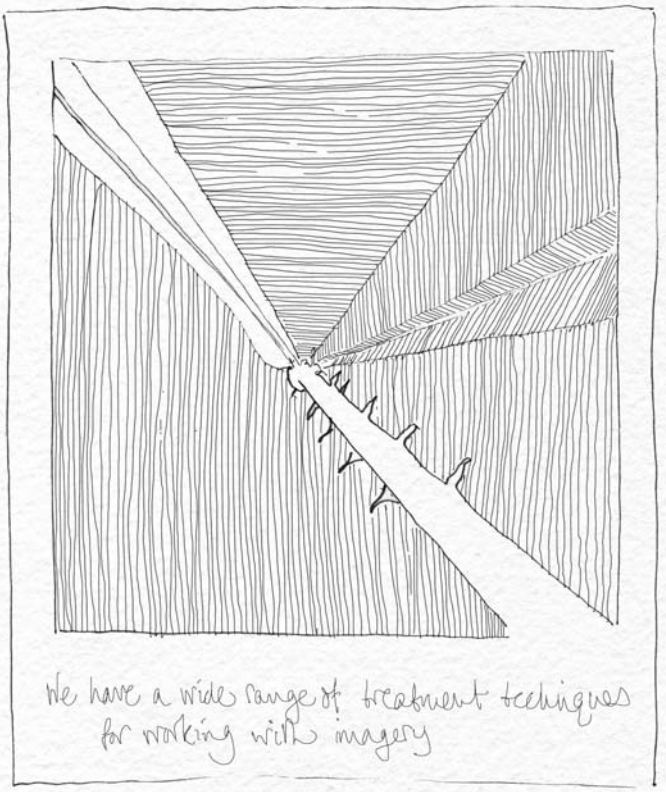
Using imaginal exposure to reduce intrusive memories of a negative life event in depression

Michelle Moulds, *University of New South Wales, Sydney, Australia*

Aaron was experiencing a major depressive episode subsequent to a relationship break-up. He reported two prominent daily intrusive memories of the break-up, one of the final argument with his partner that terminated their relationship, and another of an argument that occurred prior to the break-up. Aaron reported that the first of these memories was more intrusive and elicited a greater level of distress (i.e. 100/100). Whenever he experienced these intrusive memories, Aaron tried to actively suppress them and to distract himself by keeping busy. He endorsed negative interpretations of his intrusive memories: he believed that experiencing an intrusion indicated that he was inadequate and unable to cope.

Therapy involved Aaron reliving his most frequent intrusive memory. Consistent with the delivery of imaginal exposure (IE) in the treatment of PTSD, Aaron imagined the event and simultaneously verbalised a first-person narrative. He described in detail his emotional and physiological responses at the time of the event. Each IE session lasted for 50 minutes, and was repeated daily for homework. After three therapy sessions, Aaron's ratings indicated reduced frequency and distress associated with this memory.

Accordingly, IE addressed the next most frequent intrusive memory in the remaining therapy sessions. At post-treatment, Aaron had not experienced any intrusive memories in the preceding week. Six months later, Aaron reported that although he sometimes experienced intrusive memories of the break-up, they were infrequent and no longer elicited any distress (i.e. 0/100). In addition, he no longer appraised the experience of intrusions as evidence that he was inadequate or unable to cope.


We have a wide range of treatment techniques
for working with imagery

Chapter 4

The effective components of imagery interventions in clinical practice

'Thought is not a trick, or an exercise, or a set of dodges,
Thought is a man in his wholeness, wholly attending.'
D. H. Lawrence, 'Thought'.

Introduction

We have a wide range of treatment techniques for working with positive and/or negative imagery, in more or less direct ways. The difference between working directly or indirectly with imagery is akin to the difference between painting directly on the canvas, versus reflecting on the painting and seeing it from a new perspective. In the former case, the imagery is deliberately evoked before being worked upon; in the latter case, the frequency and impact of imagery may potentially be altered indirectly using techniques such as mindfulness-based cognitive therapy (Williams et al. 2007), or positive interpretation training (Holmes et al. 2006).

There is a bewildering array of so called 'imagery' techniques. We think it may be helpful to start by representing them along two dimensions: direct and indirect techniques, and negative to positive emotional valence (see Table 4.1). Going from top to bottom of Table 4.1, we have the notion of emotional valence. Working with imagery can involve addressing existing negative imagery (top) or promoting new positive imagery (bottom) or a mixture of both. See also Holmes et al. (2006) for further discussion.

In this book we focus mainly on a wide range of methods for working *directly* with imagery. These methods are listed on the left hand side of our preliminary taxonomy in Table 4.1, and include evoking and reflecting on imagery (imaginal exposure); manipulating imagery to change beliefs about its significance; learning to discriminate between imagery and reality; transforming images, memories and dreams; working with metaphorical images; and creating new positive imagery. On the right hand side of Table 4.1 we list some examples of more *indirect* techniques that may alter the frequency and impact of imagery, such as mindfulness-based cognitive therapy (Williams et al. 2007); other metacognitive approaches (Wells 2000); imagery-competing tasks (Lilley et al. 2009); or positive interpretation training (Holmes et al. 2006). As yet, we lack an adequate evidence base for the efficacy of indirect techniques, which involve basic changes in cognitive processing, rather than deliberate changes in imagery. Positive interpretation

Table 4.1 A preliminary taxonomy of imagery techniques

	Direct techniques	Indirect techniques
Address negative imagery	◆ Evocation (exposure) ◆ Manipulation of imagery ◆ Discrimination between imagery and reality ◆ Transformation of images, memories and dreams ◆ Working with metaphorical imagery	◆ Mindfulness-based cognitive therapy ◆ Other metacognitive approaches ◆ Imagery-competing tasks
Promote positive imagery	◆ Positive imagery of goals and skills ◆ Positive imagery of new ways of being	◆ Positive interpretation training via imagery

training is briefly described in chapter 3, and several other potentially useful indirect techniques are discussed in the final chapter.

In some CBT protocols that incorporate imagery the formulation and/or therapy techniques are clearly described, for example by Ehlers and Clark (2000) and Grunert et al. (2007) in PTSD; Clark and Wells (1995) and Wild et al. (2007, 2008) in social phobia; and Arntz and Weertman (1999) and Weertman and Arntz (2007) in personality disorder. However, where the evidence base is not clear, choosing strategies can be a challenge.

In this chapter, our primary purpose is to abstract the main treatment *components* required for bringing about cognitive and emotional change when working with imagery in CBT. We suggest that there are three main components: maintaining a reflective stance while working with imagery, evoking disturbing imagery, and deliberately introducing incompatible information to develop new meanings. These components are all aimed towards facilitating emotional processing, which is where we start the chapter. In parts 3 and 4 of the book, we provide a more detailed description of the range of effective strategies, combining these three components.

The purpose of imagery interventions

Following Rachman (1980), we suggest that an imagery intervention can be judged as successful to the extent that disturbing emotions have been successfully processed and transformed. In his seminal 1980 article, Rachman provided an operational definition of 'emotional processing'. He described Freud's account of Anna O., which illustrates how emotional experiences may reverberate for years. Her symptoms included many types of intrusive imagery such as flashbacks, images, nightmares, and memories with sensory aspects, which Rachman describes as 'out of context or out of proportion, or simply out of time' (Rachman 1980, p.51).

Successful emotional processing is defined as a process whereby emotional disturbance declines, so that other experiences and behaviour can proceed without disruption from symptoms like disturbing imagery. Rachman suggests a way to judge the success of processing: stimuli that previously triggered disruptive emotion and cognitions (such as intrusive imagery) should no longer do so. For instance, Bandura et al. (1977) observed that following treatment snake-fearful individuals reported relief from recurrent nightmares about reptiles.

Homage is due to Rachman, since these basic premises are still accepted. We can adopt a pragmatic definition of what we hope to achieve: our intervention has succeeded if intrusive imagery disappears, or becomes less frequent, distressing or disruptive.

This chapter draws together clinical observations and research findings from interventions that target intrusive imagery across a range of psychological disorders. This strategy is an application of the principle of parsimony, as suggested by Rachman (1980), comprising the identification of common *components* that might underlie different imagery change *techniques or strategies*.

Key components of imagery change techniques

In this chapter we explore some of these common components. We suggest that there are three components that are fundamental to tackling intrusive imagery. These are:

1. The establishment of a reflective *metacognitive stance,* in which the client is able and willing to reflect on aspects of their imagery (or lack of it), and to hold these aspects in awareness, providing an opportunity for the establishment of a wider perspective.
2. Evocation of disturbing imagery, and accompanying meanings and affect, and/or acknowledgement of the lack of healthy imagery. This provides opportunities for reflection, and cognitive and metacognitive change.
3. Deliberate introduction of old or new incompatible information to change negative imagery and/or its meanings, or to create positive images and carry out imaginal rehearsal of new possibilities.

Maintaining a reflective stance while working with imagery

Clinical observations and research studies suggest that two elements required when targeting imagery directly are the evocation of disturbing imagery (or reflection on the lack of positive imagery), and the provision of incompatible information, to make a new mental image. We will now consider how to provide the proper context for this work.

Teasdale (1999) addresses emotional processing within the context of the model of interacting cognitive sub-systems (ICS). He notes that simply dwelling on emotional material may produce mixed results, at least in depression. He suggests that mental representations that can directly produce emotion should be activated. However, this should be done in a special way: information coming into awareness should not be reacted to immediately, as this could give rise to 'mindless emoting'. Instead, information should be held in awareness while a wider array of information is accumulated and considered. This is best accomplished in a state in which the client has been encouraged to allow emotional material into awareness and reflect upon it, without adding any additional self-criticism or rumination around the content. In this reflective frame of mind a 'workspace' is available for the assembly of new patterns of meaning, including the instantiation of new metacognitive appraisals of the imagery, i.e. 'I am safe now, this is only imagery, etc'.

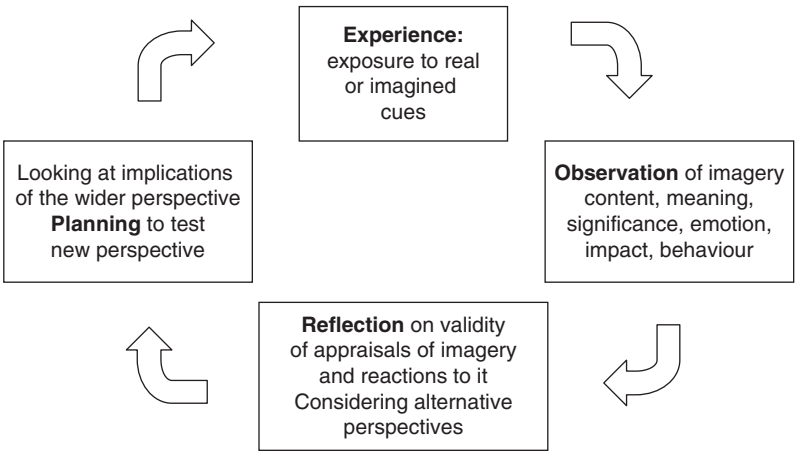


Fig. 4.1 The Learning Circle applied to imagery.

The element of objective reflection on one's experience is also apparent in Kolb's (1984) learning circle (Figure 4.1). Kolb presented a model of learning, suggesting that there are a number of elements in the process, namely experience, observation, reflection and planning. This template has been usefully applied to behavioural experiments in cognitive therapy (Bennett-Levy et al. 2004).

Applied to imagery, the stages of the learning circle are:

- Experience: i.e. exposure to real or imagined cues to evoke imagery
- Observation: i.e. objective awareness of aspects of imagery, including what triggered it, sensory components, emotions, meanings of the content, appraisals made of the significance of having the image, behavioural reactions etc.
- Reflecting: i.e. analysing, making sense, relating the experience of the image to the formulation, to current and past experience, knowledge, and ideas, formulating new perspectives
- Planning: considering the practical implications of this wider perspective. How might aspects of the new perspective be tested out?

While we would suggest that a reflective stance is a key component in effective imagery processing, sometimes clients' affect may be too high for reflection to be possible; or clients may have strong schizotypal (magical or superstitious) beliefs which make it hard for them to be objective, or even to approach the imagery. Emotion may overwhelm them, as in a dissociative flashback, where the client is not in touch with current reality or with other aspects of past knowledge or experience. In this case the therapist needs to be mindful to keep affect at a reasonable level, so that the client is able to process relevant information to help them update their ideas. Too much affect can lead to clients dropping out of therapy, or to ruptures in the therapeutic alliance. Details of how to encourage an appropriate metacognitive stance will be provided in the chapters in parts 2, 3, and 4

of this book. In particular, chapter 5 gives detailed information about how to prepare the client for imagery work.

Evoking disturbing imagery

During the development of CBT, various treatments have involved deliberate evocation of intrusive imagery. Techniques include the 'reliving' of traumatic memories in PTSD (e.g. Foa and Rothbaum 1998), imaginal desensitization (Wolpe 1958), imaginal flooding (Stampfl and Levis 1967), covert sensitization (Cautela 1966), and EMDR (eye movement desensitization and reprocessing; Shapiro 2001). Within these different protocols, therapists have provided varying degrees of structure and different levels of exposure to the imagery. There have been two principal purposes of exposure to imagery: to gather information for the formulation, and to use it as a core treatment strategy.

This section on evoking disturbing imagery discusses these two principal purposes for evoking imagery in the first two subsections: *Evoking disturbing imagery to gather information for the formulation*; and *Repeated or prolonged evocation as a core component of treatment*. To these we have added a third section, *Mechanisms of change during the evocation of imagery,* to provide a framework for understanding how spontaneous or autonomous change may sometimes occur when imagery is deliberately evoked.

Evoking disturbing imagery to gather information for the formulation

Clinically, it has become apparent that evoking imagery is an excellent way of gathering information about an emotion-laden situation, the person's response, and the meaning given to it. Usually, much more information will be revealed when imagery is evoked than has been apparent during verbal discussion. Details of the emotive stimulus situation, its meaning, and the person's response to it may be apparent from the client's description of the imagery. Sometimes clients themselves are surprised by what is evoked (e.g. the strength of feelings, details they had forgotten or been unaware of, the meanings they attach to the imagery, etc).

During treatment for PTSD, clients are often asked to 'relive' a traumatic event, recalling as many aspects as possible, and describing them in the first person, present tense (e.g. Ehlers and Clark 2000; Foa and Rothbaum 1998; Marks et al. 1998; Tarrier et al. 1999). Reliving can evoke extremely vivid, distressing imagery, or even dissociative flashbacks (see chapter 2 on phenomenology). Should this prove too taxing, some of the material can be accessed with less affect by asking the client to start by writing or typing out the details of the event (Brewin and Lennard 1999; Pennebaker 1997).

In cognitive therapy a distinction is made between 'hot' and 'cold' appraisals, and attempts are made to catch the 'hot' ones, i.e. those triggered automatically and accompanied by strong affect, which are considered to be likely to drive behaviour (Greenberger and Padesky 1995). 'Hot' material is accessed as follows: the person is asked to describe a recent, *specific* episode, including detailed sensory aspects, and appraisals made at the time. This process, akin to reliving, often elicits imagery reflecting key

appraisals of the situation, and greater specific detail in the description appears to evoke more imagery.

Similarly, deliberately (or inadvertently) facing a real emotive situation, either during a therapy session or between sessions, can trigger intrusive imagery. This imagery can then be examined, providing potential clues as to how the individual is appraising the present or the future, what they plan to do in response, and whether imagery has its roots in memories of disturbing past experiences. Again, exposure to real situations appears to trigger more imagery and emotion than simply speaking about something upsetting in more general terms.

As described above, evoking imagery can clarify the formulation of a problematic area in a client's life. In addition, evoking imagery can bring about an autonomous reassessment by the client. For example:

> A client with PTSD was wary about revisiting the scene of the car crash, and tense on arrival. Suddenly she burst into tears of relief. The scene she was imagining did not match reality. Her image suggested that she could have avoided the crash. Seeing the actual bend in the road, and recalling that the other driver had been on the wrong side of the road, helped her reappraise the accident as unavoidable.

Repeated or prolonged evocation of imagery as a core component of treatment

Repeated or prolonged evocation of imagery is a common aspect of effective CBT interventions. Historically, imagery has often been accessed either through imaginal exposure, or exposure to situational cues. Exposures may be lengthy, as in reliving, flooding, or *in vivo* exposure sessions, or much briefer, but repeated, as in desensitization, or with changing features, as in EMDR. The usual response to repeated or prolonged evocation of intrusive imagery is a decrease in the distress associated with the imagery, accompanied by decreased signs of incomplete emotional processing.

The impact of repeated or prolonged evocation of imagery has been well documented in the literature on behaviour therapy (Foa and Kozak 1986; Rachman 2001) and in more recent CBT approaches (e.g. Ehlers and Clark 2000). Foa and Kozak (1986) and Rachman (2001) provide comprehensive reviews of evidence concerning the efficacy of various methods of delivering exposure treatments (e.g. length and medium of exposure, effects of repetition, components accessed in exposure, etc.). Studies based on Ehlers and Clark's approach to PTSD, in which reliving traumatic memories and exposure to cues play a prominent part alongside other more cognitive treatment strategies, have repeatedly shown a progressive decline in the frequency, distress, vividness, and 'nowness' of the intrusive imagery over the course of cognitive therapy (Hackmann et al. 2004; Speckens et al. 2006).

Currently, there is considerable interest in *cognitive* aspects of treatment, their relationship to theoretical models concerning imagery, and possible mechanisms of change. Before moving on to the third key component of change—the therapist introducing incompatible information to create new meanings—we will examine some of the mechanisms that may bring about the autonomous changes sometimes seen during deliberate evocation of imagery.

Mechanisms of change during the evocation of imagery

Researchers have identified a variety of possible mechanisms of change to account for the impact of evoking intrusive imagery. These include: autonomous restructuring of meaning; habituation; introduction of safety information from the therapy environment; opportunities for discrimination between the trauma and other non-traumatic events; discovering that facing memories does not lead to losing control; opportunities to focus on and modify the elements of the trauma which have driven negative evaluations; and providing a fuller context for fragmented images by elaborating them and reflecting on their meaning.

As noted above, verbal discussion does not appear to be as effective as imaginal or *in vivo* exposure at accessing distressing material and its meanings. Once accessed through imagery, these contents of consciousness are available for reflection and possible reappraisal, and indeed some *autonomous restructuring of meaning* on the part of the client can quite often be observed during repeated exposure. For example:

> A client felt very angry in his first reliving of a traumatic memory, recalling that friends had held him back when he wanted to get to the crashed car in which a girl was trapped. He was desperate to rescue her. In a later session he remembered that he had already been to the car several times, observed how damaged it was, and had been unable to get a response from the girl. He also recalled that the policewoman had said she could not feel a pulse, and that she was sure the girl was dead.

These parts of the memory had not previously been connected. Before the reliving he had believed that he had let the girl down, and that his friends had been cruel to hold him back. Once the fragments of memory had been reassembled in a broader context, he felt sad that no-one would have been able to help the girl, but was far less guilty and angry about what had happened.

Autonomous changes in imagery and its associated meaning and significance were occasionally mentioned in the behaviour therapy literature, in studies of desensitization and imaginal flooding (e.g. Levis 1980; Weitzman 1967). Levis noted that during imaginal flooding using 'worst case scenarios,' memories of past traumatic events were sometimes evoked, which could have a therapeutic impact. For example, a client might shift to seeing his distressing images as merely reflecting aspects of past memories, rather than accurately indicating what might happen in the immediate future.

In EMDR, when an image is held in mind, other images and memories often arise, and ultimately the images often move in a positive direction indicating cognitive change (Shapiro 2001). If this does not spontaneously occur, other techniques may be employed to prompt for cognitive change.

A common impression amongst clinicians is that the effective mechanism in any technique involving exposure and the evocation of imagery is *habituation*. However, Foa has consistently offered a more complex, cognitive account. Foa and Kozak (1986) suggested that as well as evoking as much of the 'fear structure' as possible, *information incompatible with pathological elements needs to be provided.* Habituation is one source of corrective information: the client learns that anxiety fades, and does not go on forever, lessening the desire to avoid it. However, habituation is only one of the possible mechanisms of change, even when the procedure involves only the repeated evocation of imagery.

Jaycox and Foa (1998) list other mechanisms in addition to habituation that members of Foa's research group have considered may be responsible for improvement with exposure to intrusive imagery in PTSD. These include:

a) the introduction of safety information from the therapy environment (i.e. the client is simultaneously aware that they are in a safe place with a therapist, and deliberately evoking imagery)

b) opportunities for discrimination between the trauma and other non-traumatic events

c) the discovery that facing memories does not lead to losing control (i.e. going crazy, collapsing, dying etc.) and

d) the opportunity to focus on the elements of the trauma which have driven negative evaluations, and modify these.

Also, with repetition, a less fragmented, more coherent narrative of the trauma starts to emerge (Foa et al. 1995). This in itself may be helpful, in some cases, partly because the client connects the fears they had about what might happen with the later experience of the worst not happening (Ehlers and Clark 2000). In principle, imaginal exposure itself provides activation of the material, opportunities for reflection and the incorporation of corrective information, and hence the opportunity for cognitive-emotional processing. Some clients are able to take advantage of imaginal exposure in this way; some may require further facilitation and support from the therapist (see next section).

A sophisticated analysis of mechanisms of change in imagery has been provided by Ehlers and Clark (2000), who have identified a variety of functions of reliving and *in vivo* exposure in PTSD. They suggested that distressing fragments of intrusive imagery may be elaborated, and seen within a wider context of other knowledge and memories. Holding images in awareness and putting meanings into words provides an opportunity for seeing that previous appraisals were distorted. In this context, other autobiographical knowledge can be used to constrain the implications of previous traumatic events, and a coherent narrative can develop. For example, someone who thought their child would die during a car crash can make a connection between this terrifying idea, and the fact that the child was not actually hurt. Further, a 'time-code' is attached to the input from memory, so that, instead of feeling like something happening now, intrusive imagery is recognized as only a mental event, without implications for the present.

In so far as intrusive imagery in disorders other than PTSD also reflects elements of past experience, evoking the imagery deliberately provides similar opportunities for spontaneous updating and reappraisal. An example is provided by a study of images in agoraphobia (Day et al. 2004). The authors noted that all the clients interviewed reported recurrent intrusive imagery, and the majority made a link between the imagery and earlier traumatic experiences. However, several clients remarked that this was a striking connection they had not made before. A week after the interview there was a significant drop in avoidance scores for the group as a whole, suggesting that some spontaneous updating and reappraisal may have occurred as a result of evoking the imagery. Clients may have realized

that the frightening images owed more to the past than to present day reality, thereby increasing motivation to make finer discriminations between the past and the present.

In summary, researchers have identified a number of possible mechanisms of change through which effective emotional processing of intrusive images can take place, when these images are deliberately evoked. However, spontaneous change does not always occur. As we will see in the next section, the client may get 'stuck' and require more active intervention on the part of the therapist.

Deliberate introduction of incompatible information to develop new meanings

In the section above, we have described ways in which autonomous cognitive change can take place simply through exposure and the deliberate evocation of disturbing images. In the present section, we describe a number of important ways for the therapist to enhance their facilitative role by *deliberately prompting* for cognitive change. The therapist may introduce these techniques when evocation on its own fails to produce the desired change. The three key methods—(1) verbal (2) imaginal and (3) behavioural strategies—are described below.

Verbal strategies to introduce new perspectives

Ehlers and Clark (2000) have noted that reliving and *in vivo* exposure procedures do not always lead to spontaneous restructuring of meanings in PTSD. Where there are obvious cognitive distortions in the meanings given to the trauma and its consequences, the usual more 'cognitive' techniques of guided discovery and challenging automatic thoughts can be employed. There are a number of randomized controlled treatment trials whose results suggest that cognitive therapy (without any exposure) is as effective as an exposure program, but that when these two approaches are combined there is no additional benefit (e.g. Marks et al. 1998; Tarrier et al. 1999). However, in these trials the two approaches were kept in separate segments of treatment: no attempts were made to interweave them.

In contrast, Ehlers and Clark (2000) suggested that there may be additional benefit to be obtained if verbal and experiential elements are more closely interwoven. In two randomized controlled trials of treatment for PTSD, Ehlers and colleagues obtained very large effect sizes (Ehlers et al. 2003, 2005). Fewer reliving sessions were conducted than in purely exposure based treatments, but greater efforts were made to access and challenge distorted 'hot' appraisals, using a mixture of verbal and imaginal strategies like those described above, and described more fully in later chapters. Similarly, Arntz et al. (2007) found that treatment for PTSD involving imaginal exposure plus imagery rescripting of the memories was more effective than imaginal exposure alone, in some signficant ways. There were fewer drop-outs and the therapists felt less helpless. This treatment was also more effective at reducing some aspects of anger, hostility and guilt. For further discussion on this topic see chapter 9.

Clinical experience suggests that the material needs to be 'hot', i.e. capable of evoking strong emotion. Verbal discussion does not necessarily tap into mental representations

that directly produce emotion, and such material may need to be accessed by exposure to situational or imaginal cues. Once accessed the meanings can be closely examined, and new perspectives explored. Verbal methods are useful here, but may have the effect of convincing 'the head' but not 'the heart'. Logic alone may not change the way one feels. Something experiential (arising from a new real or imagined experience) may be needed to reinforce the new perspective.

There are several methods of potentially enhancing cognitive–emotional processing in PTSD. The client may be asked to relive the trauma once again, incorporating updated meanings of the events that have been generated by the CBT technique of guided discovery (Ehlers and Clark 2000; Grey et al. 2002). This has been described as 'cognitive restructuring within reliving' by Grey et al. In this technique the client relives the trauma while the therapist gently prompts at particularly distressing moments, e.g. 'And what do you know about that now?' so that the client can update the meaning of such moments. In this way, an alternative (more benign) interpretation of events can be constructed, in the light of the wider perspective. For example:

> A client who thought on impact in a car crash that they might lose their legs (although they did not do so) was asked in the reliving: "What do you know now about what really happened to your legs?"

Incorporating new information in this way appears to reduce the toxicity of the appraisals with which the memory fragments were originally encoded.

Another useful tactic used by the Ehlers and Clark group is to draw out aspects of the traumatic event on a whiteboard, so that the correct temporal order and all significant details can be kept in view. Some clients derive benefit from writing out a trauma narrative, with all the distressing appraisals made at the time, and then inserting what they know now at the relevant points (see chapter 9). Clinically it appears that this provides an opportunity to update and contextualize the trauma memories with information acquired subsequently.

Imaginal strategies to introduce new perspectives

Sometimes it is helpful to change not only the narrative, but also the sensory aspects of the memory representation using imagery techniques. This applies particularly when the client accepts that in principle that there is another way to construe what happened, but their affect or belief ratings remain unaltered.

> Simon crashed his car in the grounds of a hospital. He felt sure at first that help would be at hand. However, almost at once two nurses walked straight by without looking. As he had very neglectful parents and a sad and lonely childhood, his instant conclusion was that, as on so many previous occasions, no-one would care enough to help him. He had flashbacks to this moment, despite knowing that in fact only seconds later several people had run forward to help. To insert this information into the memory representation it was suggested that he should relive the episode, viewing it from the sky, so that at the same time he could see the nurses walking past, but also people running to help him. This reliving session (viewed from a different perspective) decreased his distress.

Various other methods of rescripting imagery will be described in full in chapter 9. These methods all involve using imagery to deliberately introduce new perspectives to 'hot' memories or images. For instance, Hunt and Fenton (2007) compared exposure with rescripting of the distorted images of snake phobics. The treatments were equally beneficial, and combining them increased their effectiveness. Another effective rescripting strategy was devised by Grunert et al. (2007). In a treatment study of clients with PTSD who had previously failed to respond to prolonged exposure therapy, they asked their clients to imagine their 'survivor self' today visiting their traumatized self in the past, enabling them to cope with and process the traumatic events more effectively.

Methods of rescripting early memories have often been used in cognitive therapy for personality disorder and childhood abuse (e.g. Arntz and Weertman 1999; Edwards 1990; Layden et al. 1993; Smucker et al. 1995; Weertman and Arntz 2007; Young et al. 2003). Although less emphasis has been placed on rescripting or updating memories in other disorders, recent research on clients with depression (Wheatley et al. 2007, 2009) and other disorders including social phobia (Wild et al. 2007, 2008) and bulimia nervosa (Cooper et al. 2007) suggest the potential of extending this approach to other diagnostic groups.

A recent strategy devised by CBT therapists to introduce information incompatible with old meanings has been the development of positive imagery. Here, the therapist assists the client to create fresh, positive imagery, rather than dismantling the old negative imagery (Gilbert 2009; Padesky 2005). Where there is a lack of positive images of self, the world and the future, the therapist can assist the client to deliberately construct new images to enhance confidence and motivation, and create a wider behavioural repertoire. These techniques will be examined in detail in chapter 13.

Behavioural strategies to introduce new perspectives

It was suggested above that behavioural exposure *in vivo* also provides opportunities for the evocation of imagery, and for spontaneous cognitive change of various kinds. If change does not happen spontaneously, the client can be encouraged to note all the *differences* they can find between the current *in vivo* situation and the original traumatic event, rather than only processing the similarities (Ehlers and Clark 2000). For example:

> A female client who had been raped avoided intercourse with her husband because he had a few physical characteristics that triggered memories of the rapist. Her therapist asked her to deliberately identify and focus on all the aspects of him that were different (e.g. his voice, the colour of his hair, his respect for her, etc.).

This process of stimulus discrimination can be extended into a behavioural experiment:

> A client involved in an accident with an ambulance predicted that there was a 50% chance of another ambulance crashing into her if she was out of doors. She was asked to watch ambulances arriving at a hospital, and note that none of them crashed into her.

Similar procedures are used in the other anxiety disorders. *In vivo* exposure is often used in CBT, and several studies indicate that for greatest therapeutic effect it is important

to instruct individuals to pay close attention to stimulus properties of feared situations, rather than not giving them instructions, or suggesting that they distract themselves (e.g. Kamphuis and Telch 2000; Mohlman and Zinbarg 2000).

The behavioural experiment paradigm (Bennett-Levy et al. 2004) can strengthen the cognitive reappraisal of imagery that sometimes occurs spontaneously with *in vivo* exposure. Behavioural experiments add to *in vivo* exposure the additional cognitive element of prediction: the client is asked to carefully operationalize and test their predictions about what will happen while they are in the feared situation (e.g. Salkovskis et al. 2007). This provides enhanced opportunities for the person to compare their catastrophic images and predictions with what is actually happening now.

Thus, a wasp phobic with an intrusive image of a wasp flying into his ear could be encouraged to observe that the wasp present now is behaving differently. A client with agoraphobia who has images of people abandoning him if he collapses in public could be encouraged to pretend to faint to find out what really happens (Hackmann 1998). Similarly, people with social phobia can benefit from viewing and rating video recordings of themselves, having made detailed predictions of what they will see and hear in the video (Harvey et al. 2000). More examples are provided in chapter 8.

Conclusion

Intrusive imagery can provide what Freud might have called a 'royal road to the unconscious.' Intrusions of material, which has not previously been adequately consciously processed, provide us with an opportunity to reflect upon their content, and update, elaborate or contextualize them in such a manner that they no longer hijack attention and drive maladaptive behaviour.

Our ideas in this chapter arise from the observations of astute clinicians over many years, and from empirical studies which have tested their effectiveness. This analysis gives rise to a novel proposal for which there appears to be a considerable amount of consensus. It suggests that the following therapeutic elements are key components in effective imagery-based treatments:

1. Maintaining a reflective metacognitive stance while considering intrusions within a broader context: being prepared to face difficult material, reflect on meaning, and think about thinking.
2. Evoking affect-laden intrusive imagery and holding it in awareness, or reflecting on the lack of appropriate imagery, and thus providing opportunities for autonomous cognitive change.
3. Deliberately prompting for change by using verbal, imaginal, or behavioural methods.

Once processed effectively, previously intrusive images will no longer be 'out of context, or out of proportion, or simply out of time' (Rachman 1980, p. 51).

In this chapter, we have illustrated a number of ways that autonomous or therapist-assisted changes in imagery, emotions, cognition and behaviour may take place. They include: comparing imagery and actual reality (discrimination); considering how

accurately the imagery reflects past, present or future reality, and deliberately making links with other autobiographical memories/knowledge (manipulation, elaboration and contextualization); giving traumatic memories a time-code, and placing them in a wider context amongst other autobiographical memories; and actively transforming or constructing imagery that reflects a new perspective, is less toxic, more positive, and can compete with old memory representations (transformation and creation of new images).

In parts 3 and 4 of this book, we describe in greater detail many of the strategies used in treatment to bring about cognitive change. The key components of change described in this chapter form their core.

CASE VIGNETTE

Transforming an image to reflect a more positive future

Clare Philips, *Vancouver B.C, Canada*

A 50 year-old experienced cashier had fallen at work 5 months previously, and had hurt her knee and been unable to return to work. She reported being frequently disturbed by an image that was crystal clear and always the same. It lasted for only seconds, but returned a number of times a week when her pain was bad.

'I see myself being confronted by my co-workers in their frustration at having to do my work load. I don't know what to say to protect myself.'

When asked to let herself see this image, she was able to do so immediately with a clarity of 9/10 (where 10 = crystal clear). The potency of the imagery was evidenced by large increases in emotion (anxiety +40%; sadness +60%), with the pain in her knee increasing by 50%.

She believed the likelihood of the image event occurring in the future was 85%. Her sense of control dropped by 30% and her belief in her physical fragility increased 30%.

She spoke of the meaning of this image as:

'My life will be difficult. Because of their attitude, my work won't be easy. I should be respected . . . but I am disrespected.'

During a single session of imagery rescripting, she was asked how she would like to change the image to make it better. She developed the following image description:

'I am going into work and the co-workers are smiling. The two trickiest ones come up to me. They are saying they are glad I am better! . . . They are pleased I can help them again!'

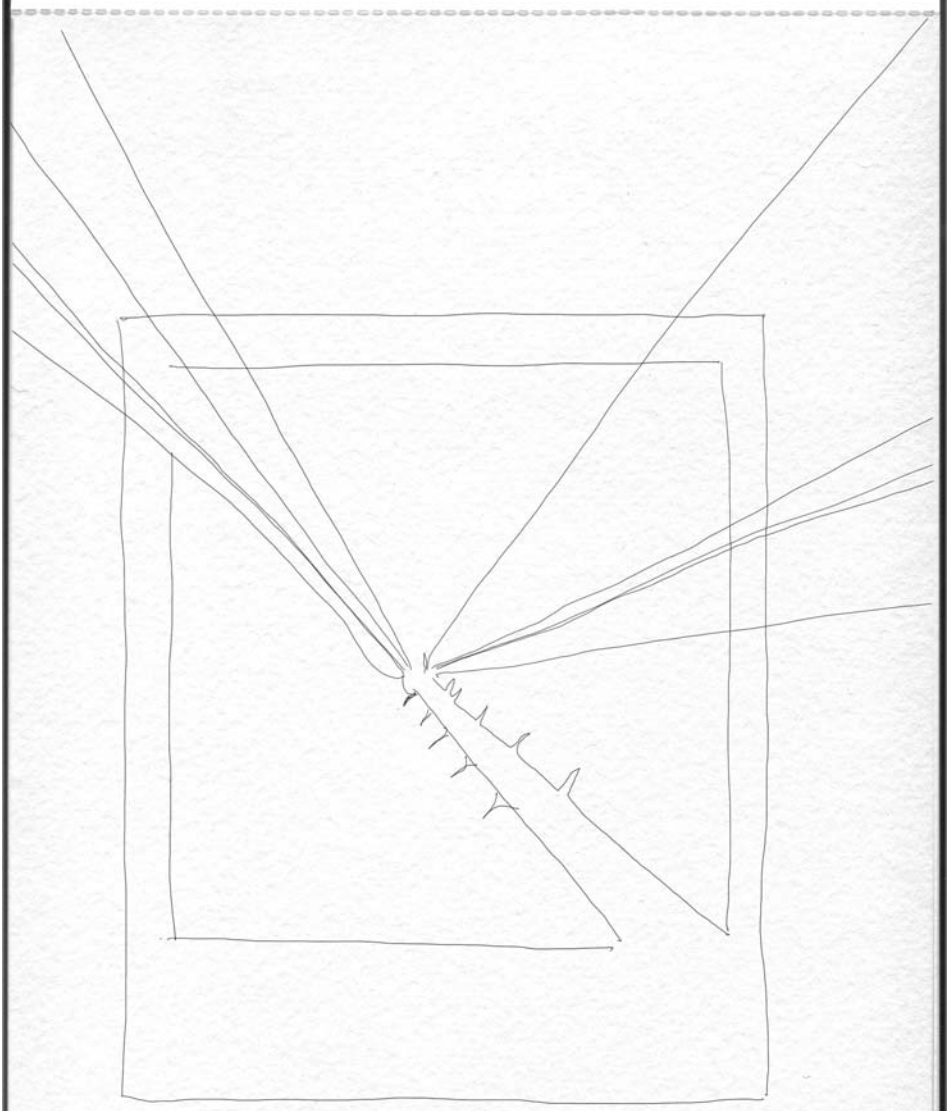
She was happy to let herself see the rescripted image, and reported it to be clear (7/10). Her anxiety and sadness fell below the level she had reported at the onset (pre-discussion of images). Her pain level fell to the onset point. Her rated physical fragility fell 20% below the onset level and her feeling of being threatened dropped to 1/10. At the onset point she had rated it 7/10.

When asked the meaning of this new image she replied:

'I am wanted . . . I am accepted as a person'.

Part 2

Preparation for imagery interventions



establishing the platform for imagery interventions

Chapter 5

Establishing the platform for imagery interventions: general principles and practices

'If one doesn't know to which port one is sailing, no wind is favourable'.
Seneca the 'Younger' (c. 4 BC–65 AD).

Introduction

In this chapter, we outline some general principles and practices for imagery work with clients across a wide range of situations. In the following chapters, we provide more detailed discussions of specific procedures applicable to the assessment of imagery (chapter 6), its formulation (chapter 7) and imagery-based interventions (chapters 8–13).

This chapter is divided into four sections. The first three sections follow the four phases of the experiential learning model—plan, experience, observe, reflect (Bennett-Levy et al., 2004; Kolb 1984; Lewin 1946)—that we have found to be a very useful heuristic for describing experiential interventions in cognitive therapy (see Figure 4.1). The fourth section addresses difficulties that may emerge in the course of imagery interventions. The sections are:

- Planning/preparation for imagery interventions
- Experiencing/enacting imagery interventions
- Observing, reflecting and following up imagery interventions
- Troubleshooting: other difficulties with imagery interventions that may emerge.

Planning/preparation for imagery interventions

Establishing what imagery is and is not

Clients do not always understand what is meant by imagery. Some may consider mental images to be unsafe, fanciful, unrealistic, weird, or a sign that they are going mad. It is important for therapists to establish what ideas clients may have about imagery, then to normalize imagery to help clients understand what it is and what it is not, and to provide a sound rationale for any given imagery process.

Statements such as the following can normalize the experience of having images:

'Most people, when they are upset, have upsetting things going through their minds. Sometimes they are in the form of thoughts or words, and sometimes in the form of pictures or feelings in the body. Does this happen for you? Do you sometimes get pictures, images, or words?'

Another strategy for those who are sceptical whether they have images is to ask questions such as:

'Imagine eating a lemon—how does it feel in your mouth?' or 'Think of the front of your house—how many windows does it have?'

These almost automatically induce kinaesthetic/gustatory and visual imagery, and help clients to recognize that mental imagery is part of everyday experience.

If therapists do not ask about images, they tend not to get reports of them. Clients may be unaware of them, embarrassed, or worried about the therapist's reaction. Clinicians' awareness of just how pervasive imagery is across various domains of experience has grown in recent years (Arbuthnott and Arbuthnott 2001; Butler and Holmes 2009; Hackmann 1998; Kosslyn et al. 2001; Murphy et al. 2008; Taylor et al. 1998). This recognition has brought the further realization that if the therapist asks appropriate questions, imagery is found to play a significant part in many disorders (Day et al. 2004; Ehlers and Clark 2000; Hackmann and Holmes 2004; Osman et al. 2004), including depression (Holmes et al. 2007b; Wheatley et al. 2007), which has usually been considered a more 'verbal–ruminative' than imagery-based disorder. For descriptions of the varied phenomenology of imagery across different disorders, see chapter 2.

Providing a convincing rationale for imagery interventions

Clients (and sometimes therapists) unaccustomed to using imagery may have reservations about therapeutic interventions based on imagery, and may consider them unlikely to be helpful. Such concerns need to be elicited and discussed before clients will fully engage with the process. Unlike verbal forms of psychotherapy, where the form of linguistic communication is readily recognizable as 'normal', formal imagery procedures are not a usual part of social transactions in everyday life. We rarely ask people to close their eyes and then 'imagine you are there right now, what are you feeling in your body?' It is quite natural for clients to require further explanation and a convincing rationale.

Rationales may vary according to the type of intervention and what is likely to 'fit best' for the client. Compassionate mind training often uses a 'neurophysiotherapy' analogy for practising compassionate imagery (Gilbert 2005). Gilbert (pers. comm., February 2007) advises that 'practising compassionate imagery will help you build and strengthen a new way of relating to yourself, just like building your body strength.' Further explanation of compassionate mind training is found in chapter 13, and Gilbert (2005, 2010). For clients building new skills, functional equivalence theory, which suggests that the same neural processes are involved in imagining enacting a skill as actually doing it (Kosslyn et al. 2001), may also provide a helpful rationale. Other clients may benefit from a psychological enhancement explanation, e.g. 'using our imaginations can help access

memories and new perspectives which are otherwise inaccessible when we just talk about them.' Others may find an explanation of process helpful: 'imagery will help you to make sense of confusing aspects of your life–for instance, the links between your current problems and your childhood experiences–and help you change your emotional reaction to similar situations in the future'.

The rationale needs to be checked out with the client, for instance by asking 'Does this make sense?' 'Is it helpful to know this?' 'Is there anything that doesn't make sense?' 'Shall we discuss this?'

Putting the client at ease

As with many other types of intervention, clients need to feel at ease with the process in order for imagery interventions to be most effective. Some clients may feel uncomfortable closing their eyes or having therapists look at them (Young et al. 2003), or engaging in relaxation procedures which might lead them to feel out of control (Gilbert and Procter 2006; Layden et al. 1993). If so, use the collaborative relationship to accommodate to whatever feels most comfortable for them (e.g. keeping their eyes open or the therapist averting their gaze).

Clients need to be forewarned, where appropriate, that intense affect may be aroused by certain procedures (e.g. imaginal reliving, discussed further in chapter 9). Therapists should reiterate why the experience of such feelings is unavoidable if therapy is to be most effective, and express empathy for the anticipated discomfort, which is usually short-lived. Individual formulation can help clients to understand the role of avoidance in maintaining the problem, including the avoidance of strong emotions and aversive images (see chapter 7). If clients feel that they may not be able to cope with intense affect, it is helpful to identify and practise ways to minimize their anxiety. Signalling to the therapist if the affect is too intense, or helping the client to develop 'safe place imagery' (see next section) may be effective (Gilbert and Irons 2005; Young et al. 2003). Clients may also try out coping skills in small-scale imagery experiments (e.g. by describing a recent upsetting experience, and then returning to the 'safe place') before significant interventions take place.

Creating 'safe place' imagery

When clients become deeply distressed by their negative images (e.g. during imaginal reliving for PTSD), it is helpful to create anchors for them (e.g. smell a bottle of perfume, notice the colour of a room, or feel the texture of a chair), so that they may return to the here-and-now of the therapist's office (Gilbert and Irons 2005; Kennerley 2000; Young et al. 2003). Anchors help clients to start and leave sessions in a relatively calm state.

An alternative strategy for some clients (e.g. those with a history of abuse) who are frightened by distressing images or debilitating mood fluctuations is to create 'safe place imagery' (Gilbert and Irons 2005; Kennerley 2000; Young et al. 2003). Unlike many other imagery interventions, where the goal is to augment the level of emotion (positive or

negative), the goal of 'safe place' imagery is to provide a place of comfort, support and relaxation from which the client may start and/or return to if they feel unduly stressed.

The safe place should be a place of refuge with warm, pleasant associations. Often it is helpful to use real places or people that have served this function in a client's life (e.g. playing in sand dunes on a delightful holiday, or being cuddled by granny). Sometimes the safe place may be an imagined one (e.g. the image of a guardian angel, or a scene from a film).

The therapist may assist the client: 'Imagine that you are in a place where you feel safe, secure and comfortable, where you feel relaxed, can be yourself, and feel calm and at peace. Let this safe place float into your mind, coming into focus more and more. Can you see it? Where is it? Is there anyone else present? Describe what you see, and what you feel . . .'

If the client has difficulty imagining a safe place, the therapist may suggest some beautiful places (deserts, forests, mountains, rivers, or sea), or offer nurturing images (Lee 2005) or the safety of the therapy room (Young et al. 2003).

Experiencing/enacting imagery interventions

Structuring the imagery intervention within a session

The actual imagery intervention should ideally be completed within the first 30 minutes of a 50 minute session. If necessary, the session may be lengthened to ensure that at least 20 minutes is available for debriefing and following up the intervention. For some interventions (e.g. imaginal reliving for PTSD, or imagery rescripting of upsetting childhood memories), the therapist and the client might arrange an extended session, perhaps as long as one and a half hours. In general, where an imagery session can be anticipated, it is preferable to do preparatory work in the previous session by discussing the rationale and potential content, and seeking the client's permission to proceed. This allows more time for the intervention in the session itself.

In particular, it is important to leave at least 20 minutes after an imagery intervention for three purposes:

1. To debrief the experience
2. To ensure that the client is grounded back in normal reality, and/or does not leave in a distraught state
3. To discuss any follow-up homework. This might include replaying the therapy session recording several times, reflecting on the content, or imaginally practising new skills.

Structuring imagery interventions across sessions

Imagery interventions usually take place across a number of sessions. As demonstrated throughout the book, imagery is used for a number of different purposes. For example, in one session the therapist may be evoking and exploring a trauma memory with the client; in another, they may plan an intervention to transform the memory; in another, they may carry out the intervention and reflect on its meaning.

At times, imagery work can take more time than anticipated, whereas at other times significant changes can be achieved rapidly and strikingly. Reliving and rescripting sessions where there are a number of 'trauma hotspots' (Grey et al. 2002) may need either an extended session, or may be carried over several sessions. Imagery work cannot be rushed. The devil is in the detail.

Physical aspects of imagery interventions

Imagery sessions are best undertaken where there is minimal external noise interference. The sound of a lawnmower is not usually helpful either at the time or when replaying recordings later. A comfortable chair (ideally an armchair) should be used. Clients should be advised to find a comfortable, relaxed position; usually with their legs uncrossed and stretched out in front, with their glasses removed, and their eyes closed. Some clients may like to loosen tight clothing, such as ties or shoes.

The interpersonal skills of the therapist

Imagery work can be deeply evocative and upsetting, so as with other aspects of skilful CBT, good interpersonal skills—including therapeutic warmth, curiosity, empathy and genuineness—are of prime importance (Grey et al. 2002). However, when working with imagery, there are times to express empathy, and there are times when its expression is quite inappropriate and even anti-therapeutic.

Key times to express empathy are *prior to* and *following* imagery interventions. Therapists can and should empathize with the level of distress experienced, and link this with the personal meaning for the client and the (traumatic) nature of the actual event. However, *during* imagery interventions, when the purpose of the intervention is to bring a traumatic or upsetting experience 'on-line', expressions of empathy tend to be disruptive, interrupting the flow of experience. The therapist needs to adopt an essentially neutral stance in order to facilitate and uncover the personal meanings with the client.

As with other therapeutic interventions, advance preparation for potential distress is important. Where appropriate, the therapist should forewarn the client that a session may be upsetting in the short term, though worthwhile in the long run. As it is important not to interrupt the process unless absolutely necessary, the therapist explains to the client that they will try to remain in the background, simply asking prompting questions and will not offer comfort unless the client's distress becomes extreme. In the latter case, it can be helpful to arrange an 'interrupt signal' if extreme distress is anticipated, such as raising a hand to terminate distressing experiences, if they become unendurable. It is always useful to have a box of tissues to hand.

Generally, in imagery work, the therapist should maintain a neutral stance and tone. However, there may be specific times, usually when doing transformational or constructive work, when the therapist may become more animated. If the client is standing up to an abuser or bully (Young et al. 2003), the therapist may facilitate the process by adopting an assertive or angry tone of voice. If the client is celebrating the development of new skills and attitudes, such as feeling competent at work, the therapist may choose to reflect some of that delight in their own voice and facial expression (Padesky 2005b).

Therapist roles and technical skills: differences in emphasis between exploring spontaneous imagery and creating new transformational imagery

As we shall see in later chapters (chapters 8–13), there are some differences in the therapist's role and skills when facilitating the evocation and exploration of spontaneously occurring imagery (e.g. traumatic imagery), and when assisting the client to create new transformational imagery. This chapter foreshadows these differences, and the following chapters expand on them and map in detail specific procedures for each stage of the process. The principal difference in the two roles is that while in the evocation/exploration role, the therapist is largely a facilitator helping the client to uncover their own experience, in the transformational role, the therapist may play a more active part in exploring ways to script and design new ways of being.

The key therapist technical skill in imagery work is probably the process of guided discovery (Padesky 1993), facilitating the evocation, exploration, contextualization, and transformation of negative images (Grey et al. 2002). When starting to evoke, explore, and formulate spontaneous imagery (see chapters 6–11), the therapist's role is to create cues that trigger the contents of relevant images and experiences. The therapist may create these cues in actuality, e.g. by bringing a birdcage into a room when working with a client who has a bird phobia. Alternatively, the cues may lie in the imagination: 'Cast your mind back to last week, when you were in the supermarket and felt terrified . . . what is going through your mind? How are you picturing that? What's the first indication that something's wrong?' It is particularly important to ensure that the images are those of the client, and that the therapist does not suggest or inadvertently lead the client towards images or 'recovered memories' that are not authentically the client's own (Brandon et al. 1998).

When evoking and exploring events from childhood, Young et al. (2003) recommend that the therapist instruct the client: 'Now close your eyes and let an image float to the top of your mind. Don't force the image; just let the image come into your mind, and tell me what you see.' Thereafter, the therapist continues to act as a non-intrusive facilitator of the image, asking Socratic questions to enhance the vividness and experience, and explore meaning, e.g. 'What's happening? What do you see? What's the atmosphere? Who is there? What are they saying? What do you say? What are you feeling? Where in your body do you feel this? Are there any sounds, tastes or smells that you are noticing? What does this mean about you, the world and other people? What are you learning about yourself?'

For imagery transformation work, the therapist typically needs to provide rather more scaffolding to facilitate the development of new skills or new ways of being. Cognitive and emotional avoidance often means that clients have not linked up crucial pieces of information which could change their understanding of events (see chapter 4). Well-structured Socratic questions which enable clients to reflect on past experiences from a new perspective such as 'How would you like it to (have) be(en)?' and 'What do you know about that

now that you didn't know then?' are particularly useful. Therapists can help the client to 'paint imaginal pictures' of the desired new way of being by eliciting clients' new, often unaccustomed feelings, and new beliefs and assumptions (Padesky 2005a, 2005b). For instance, with a client with social anxiety, the therapist might ask:

'As you experience yourself getting to feel more and more confident, what are you telling the audience? How does that feel? How are they reacting? What kind of new rules or operating principles do you have in place? What kind of basic beliefs do you have about yourself and others?'

This may lead into further detailed Socratic questioning, e.g. 'How is that different from before?'

In some forms of transformational work (e.g. in schema-focused therapy, Young 1999), the therapist may need to adopt a still more proactive role when the client feels powerless and stuck. For instance, fighting back against abuse is central to schema therapy, and the therapist may need to facilitate and suggest different means by which this takes place (Arntz and Weertman 1999). For example, questions such as: 'Imagine that you can have any person you want now to be on your side against him. Who do you select?' Or, based on prior conversations with the client, the therapist might introduce a known protector: 'Bring your father into the scene. What is he doing and saying to your uncle now?' The therapist may need to coach the client in new skills, perhaps suggesting that the 'young self' recruits the 'adult self' to say 'Enough is enough, get out of my sight and never come back.' to the abuser.

Other strategies to enhance imagery vividness and immediacy

As previously discussed in chapter 2, research indicates that vivid imagery is frequently associated with strong emotions. These emotions are usually negative in clients with psychological disorders. An interesting corollary of this observation is that if the therapist can help clients to create *vivid positive* images, this may significantly enhance clients' *positive* emotions, their motivation, and their confidence in their future actions. To facilitate vivid positive imagery, therapists can first of all help clients to practise with easily evoked neutral images, such as sucking on a lemon. Various other strategies which are also beneficial are listed below:

1. Get a detailed description of the environment in which the event takes place: 'Where are you? What colour is the room? What's in the room? How does it smell? What's the temperature?'
2. Focus in particular on bodily feelings. When asking about other elements of the image (e.g. emotions, thoughts, and behaviours), it is often helpful to lead with imagery of physical feelings and sensations (e.g. heart rate, tingling, the pit of the stomach, or body temperature). 'What are you feeling in your body? Where do you feel it? What's that like? How extensive is it?' The therapist picks up any metaphors that clients might use, and reflects these back: 'So it feels as if you have a big black hole in the pit of your stomach?'

3. Emphasize that images can be multi-sensory: ask about visual, auditory, kinaesthetic, tactile, and olfactory elements; or explore felt senses and atmospheres.
4. Get rich detail, such as: 'Imagine you are a film director. I can't see the film. Explain exactly what's happening, and what you can see to me.'
5. Have the client adopt a 'field perspective' (see chapter 2) where they live the experience 'from the inside'. This should be: 'As you are looking at the wall, what are you noticing?' rather than an observer perspective, where the client is looking on at the experience as if an 'outsider': 'As you see yourself looking at the wall, what do you notice?'
6. Ask the client to use the first-person present tense, recounting the experience as if it is happening to them now ('I am running down the road, being chased . . .'). If, at first, this is experienced as too threatening, the client might start from the observer perspective using the past tense: 'See yourself back then, six months ago, running down the road, being chased . . .' The therapist can then move the client to the first-person, present tense, as they gain confidence in their ability to cope with high emotion.
7. Explicitly name different parts or aspects of self which may be present in the same image, so that the client is clear which 'self' is centre stage at any given time: (e.g. 'Adult John', '8 year old John').
8. Keep checking with client to make sure they are staying with the process, and that the image is clear (e.g 'Tell me what you are seeing. What's happening in your body? Where are you now?')
9. Ask specific questions at certain points: 'What are you learning from this experience; about yourself, about other people, about life in general?'

Audio recording the imagery session

Giving clients an audio recording of each therapy session to listen to at home is part of good practice in cognitive therapy. Clients can also refer back to recordings of previous sessions if they wish to refresh their memory. Repeated exposure to the content is not seen as necessary with most imagery interventions. This is even the case in sessions in which there has been reliving of distressing memories, although listening to the audio recording once or twice may evoke more detail in the memory, or consolidate new perspectives.

However, where new skills or 'new ways of being' are being imagined, the element of practise may be beneficial. Many top-class athletes and sports coaches create imagery audio recordings (MP3s, tapes) to enhance their skills (Porter 2003). They may listen to these several times a week. Similarly, audio recordings of imagery sessions can be vital when clients are developing new skills or 'new ways of being'. An audio recording, made available for homework practise, (see the section below on imagery homework) is likely to significantly potentiate the effect of developing the new skill in the session.

Observing, reflecting, and following up imagery interventions

Debriefing

Imagery sessions are often out-of-the-ordinary experiences for clients; they may be rich in sometimes quite unexpected detail and meaning. Attention needs to be given to making the most of the experience by giving adequate time for observation and reflection. In the first instance, it is helpful for the therapist and the client to recapitulate the experience, getting a detailed description of the content: 'What was it like? What happened?'

Secondly, the therapist and the client should reflect on the meaning and the implications of the experience: 'What did the images mean to you?' 'Does this image represent reality?' 'What if it were literally true?' 'What if it were not?' 'Are there other interpretations?' 'How does this experience fit with the formulation?' 'Let's compare your belief ratings now with those before we started doing the imagery work—what differences are there? How do you account for that?'

With clients who are engaging in positive imagery, such as new assertiveness skills, questions such as the following can be helpful: 'What did you notice, when you were rehearsing these behaviours in your imagination?' 'How has imagining these scenarios affected your confidence?' 'Has it made it more likely or less likely that you'll try this out in the next week?' 'What will enable you to do so?'

The therapist and the client also need to plan for future sessions. 'What would be the next step?' 'Should we broaden the imagery intervention to other similar experiences?' 'What behavioural experiments can now be done to follow up this work?' 'What ways can we think of to moderate the amount of distress you are experiencing when we do imagery sessions?'

Leaving the session grounded and not unduly distressed

It is particularly important that therapists give time to discussing relevant issues and to settling the client before the session ends. If necessary, returning the client to their 'safe place' (see above) is one way in which to help clients to leave sessions in a settled state. If the client is still quite dissociated, then the therapist can help to ground them by asking for detailed descriptions of objects in the room, or discussing current events, such as the latest news. A particularly useful strategy for returning clients to the here-and-now is to suggest that clients smell and apply perfumes with strong positive associations (Kennerley 1996).

If necessary, the client should be advised to take some extra time, perhaps by going for a walk, before driving home or returning to work. If a difficult session is anticipated (e.g. a first reliving session), the therapist might advise that the client to bring a partner or friend to drive them home, or to take the afternoon off from their work or other duties.

Imagery homework

Imagery homework can take various forms depending on the particulars of the intervention. It is not easy for most clients to re-create scenarios on their own, so audio recordings

of therapy sessions can be particularly important to reinforce new skills and perspectives. Listening to a recording over the following week(s) can help clients incorporate the new way of being at a bodily, as well as emotional and cognitive level (Grey et al. 2002). Skills-building tapes are typically replayed more regularly than other types of imagery session (see chapter 12). However, they may lose their impact after a while as the client gets used to them. It can be particularly useful to renew them by making new recordings that incorporate recent success experiences, thus maintaining interest and reinforcing the sense of change. For instance,

> a socially anxious client made a new recording with his therapist, incorporating the unexpected feelings of confidence, calm and self-belief which he had experienced at a recent social gathering.

Clients will need to find a time and space to listen to recordings where they will not be disturbed. If others are at home, clients should negotiate quiet time in a room on their own, and will probably prefer equipment with earphones, to avoid being overheard. Clients should be advised not to use imagery recordings while driving. Although this is a tempting idea for busy people, it is a potentially dangerous thing to do.

Other kinds of recommended imagery homework include:

- drawing images (Butler and Holmes 2009)
- collecting evidence to do a micro-formulation of the image (see chapter 7)
- considering alternative meanings, where appropriate, in preparation for the next session
- noticing reactions to images in everyday life
- keeping an intrusive images diary, tailored to the client's concerns to monitor the frequency of the client's distress
- comparing images against reality.

Troubleshooting: difficulties which might emerge

When to encourage persistence, and when not to

When should therapists encourage clients to persist with imagery, and when should they yield to clients' avoidances? Young et al. (2003) recommend that a key distinction be made between imagery work focused on extremely traumatic situations, and less traumatic imagery work. It is appropriate for the therapist to be quite persistent and coaxing with non-traumatic imagery work, but caution needs to be exercised where there is very significant trauma.

For instance, if the client becomes distressed by images of childhood abuse, the therapist should let the client work at a pace that is comfortable for them. On the other hand, if the aim of the session is to rehearse the client's responding more assertively to a critical family member, persistence and coaching may well bear more fruit than yielding to the thought, 'I can't do this.'

If clients find the emotional impact of a memory overwhelming, they can be encouraged to use writing, drawing or metaphorical imagery to provide a 'cooler' space. Having a written narrative of a traumatic memory can be particularly helpful in organizing memories (Neuner et al. 2004), and can help build confidence to engage experientially with the memory.

What to do when clients are having difficulty accessing images

Some clients say that they cannot access images; others appear reluctant to engage with imagery, perhaps because of fears about what the image represents. When clients report difficulties with access or engagement difficulties, it is important to conceptualize why. Is it because they don't understand how imagery is going to be of benefit? Is it because they see imagery work as unsafe or threatening? Is it because they are only thinking of imagery as visual? Is it because they do not have good visual imagery ability? Is it because the memory is not available? Or does the scenario seem too far-fetched (e.g. imagining being rescued by a protector when this did not happen in reality)?

Depending on the formulation, a variety of strategies may help. If the client seems unable to access imagery, helpful interventions include:

- defining what is meant by imagery
- allowing time for the image to emerge
- giving permission for 'fuzzy' images, or images that are experienced with one sense (e.g. kinaesthetic) but not another
- providing the experience of imagining neutral images to show that they have access to visual imagery, e.g. 'See your house from the outside. How many windows are there? Which rooms are on the left side? And the right? Tell me what furniture you have in your bedroom? Where is it?'
- providing powerful cues for imagery by introducing physical elements of the imagined situation, e.g. hyperventilating to accelerate heart rate
- bringing photos e.g. of self as a child, or of parents, or of relevant environmental landmarks such as the site of trauma or of a previous home.

If on the other hand the client seems unwilling to approach disturbing imagery, possible strategies could include:

- ensuring the rationale is understood
- cultivating an atmosphere of trust in the therapeutic relationship
- engaging the client in relaxation procedures prior to imagery induction
- identifying ways to cope with any intense affect which may arise during imagery
- starting with 'safe place imagery', and introducing threatening images only gradually
- using image manipulation techniques to give the client experiences of taking control of imagery—this might be putting negative images on to an imaginal TV screen, then

shrinking or enlarging them, turning the volume up and down, replacing one person by another, introducing cartoon characters, and so on

- negotiating with the 'detached protector' in schema therapy (Young et al. 2003); that part of self which keeps the client cut off from their emotions, in order to access other more vulnerable parts of self
- practising mindfulness so that passing images become part of normal nonthreatening reality, a form of mental phenomena.

Conclusion

In conclusion, this chapter provides general rationales and procedures for engaging in imagery work. The first task for therapists who are planning imagery interventions is to help allay the clients' fears, and to provide a rationale that is consistent with the formulation, and that 'fits' for them. Welcoming doubts and answering any questions facilitates the process. As with other cognitive therapy strategies, therapists' own confidence with using imagery interventions tends to increase with self-practise (Bennett-Levy et al. 2001), as well as through clinical practice. The following chapters provide more specific rationales and procedures for different stages of imagery interventions.

CASE VIGNETTE

Transforming an image of the 'hereafter'

Arnoud Arntz, *Maastricht University, Maastricht, The Netherlands*

The client was in treatment for borderline personality disorder, when one of her pets died. She was very attached to her pets, and had experienced severe mourning with earlier losses. She wanted to leave therapy, as she felt it was senseless as I could do nothing about the death of her beloved pet. When I convinced her to come and see me, I was alarmed by her condition. She was not eating, felt life was meaningless, and said she would be better off dead. She resisted exploring early abandonment experiences that might be related to her sense of loss. In fact, she resisted any attempt to address the death of her pet. After that session I felt powerless, but rethinking it, I realized that she had talked about feeling guilty if she continued normal life, as if she was obliged to her deceased pet to suffer continually. So I decided to try to explore that issue further.

In the next session I expressed serious concerns about her reaction, and persuaded her to address the loss. After some exploration, the patient described having an image of her deceased pets and family members in the hereafter, although she was not religious. In this image, the deceased ones were looking at her, and it felt disloyal not to think of them every moment, and express her love by showing her grief. I asked to close her eyes and get the image of the deceased pets in the hereafter (amongst green fields and hills). I asked her to picture herself there, meeting her former pets. She said that she also saw her deceased uncle and aunt.

I convinced her to ask the pets, and her aunt and uncle, permission to not show her loyalty by mourning, but to resume normal life and commemorate them once a year. She requested this in imagery, and they all spontaneously consented, even with pleasure. She now had an impressive image of how happy they were in the hereafter, and felt relieved. Returning to the present she could imagine resuming normal life and commemorating the deceased once a year. After the imagery rescripting, she told me she felt enormously relieved, and amazed that I was able to deal with something she initially felt could not be covered in treatment. The week after she reported that she had resumed her normal life, ate again, and did not feel guilty any more. This experience greatly contributed to her trust in therapy and me as a therapist. One year later we successfully finished therapy. She no longer suffered from BPD, and although still a bit overly worried about the health of her pets, felt better able to deal with future deaths.

Observing the presence of imagery and encouraging exploration

Chapter 6

Assessment of imagery

'And the end of all our exploring
Will be to arrive where we started
And know the place for the first time.'
T.S. Eliot, 'Little Gidding' (1942).

Introduction

In previous chapters, we have noted that imagery plays an important role in the genesis and maintenance of psychological disorders. However, as we observed in chapter 5, if therapists do not ask about imagery it may not be reported by clients. Therefore assessment of imagery needs to be part of any comprehensive CBT assessment.

Once we have determined that imagery may be playing a significant role in the client's presentation, we need a range of questions to open up further exploration of this area. As with other aspects of CBT assessment, the imagery assessment needs to home in on the specificity and detail, rather than addressing the client's concerns in a general way.

Relevant questions to help people understand what we mean by imagery, and prepare for imagery interventions, were discussed in the previous chapter. In this chapter, we discuss techniques to investigate the content of the imagery, and its associated meanings; and to determine the client's metacognitive beliefs about having imagery (see chapter 2); for instance, whether the imagery is thought of as a mental event (which may have distorted content), or whether it is given extra significance by being seen as something real, or unquestionably valid. As clinicians, we are also interested to establish the links between imagery and past experience: for instance, to determine the extent to which images may have input from actual memories (see chapter 9), and whether the client has previously made this association.

In this chapter, we examine in detail how to assess these different elements of imagery. We describe how to:

- Observe the presence of imagery and encourage exploration
- Examine the imagery closely
- Identify encapsulated meanings
- Assess metacognitive beliefs about having the imagery
- Assess the overall impact of the imagery

- Assess the client's response to the imagery
- Trace the historical roots of the imagery
- Bring the information together and move towards the formulation.

Observing the presence of imagery and encouraging exploration

As we saw in the previous chapter, clients may require help to tune into the presence of imagery. The therapist can explain: 'Some people have little "pictures" or images mixed in with their flow of thoughts in difficult situations. Other people hear imaginary sounds or people's voices; experience the body in various ways, like feeling small and fragile, or feeling stuck in a box; or experience imaginary tastes or smells. These images may initially be vague or fuzzy, and may not seem to make sense, but they may still turn out to be worth tuning in to.'

Although such imagery can carry important meanings, people may not want to approach or explore it if it seems likely to be distressing. Nevertheless, it is well worth exploring images and memories in a safe and containing environment such as therapy, precisely because they are often accompanied by strong emotions, and these are usually a marker for important meanings that people give to situations. The client needs to be encouraged to bring imagery into awareness and examine it, as a first step to addressing some of the associated problems.

If the client expresses reluctance to deliberately bring the imagery into full awareness the therapist can help them explore their fears and weigh up the pros and cons of examining the material. Sometimes metacognitive beliefs stand in the way (see below). For example, the client may feel that the imagery will be accompanied by unremitting high emotion, or that holding the imagery in awareness might make the feared event actually happen. As we have seen in chapter 5, psycho-education and reassurance can help here, and the client can be gently encouraged to test out some of their beliefs whilst in the safety of the therapist's office (see the section in chapter 8 on manipulation of imagery).

Where there has been substantial prolonged avoidance, the client's own understanding of what they might feel or believe in a problematic situation may be quite vague. Situational cues can trigger informative imagery, so real life exposure is a good way to check that none of the relevant material has been inadvertently overlooked by the therapist and/or the client. The notion of dual-belief systems (the experience of 'hot' or 'cold' cognitions/emotions depending upon whether the person is in the presence of the threatening situation or simply talking about it; see chapters 1 and 2) can be explained to the client, with reference to examples from the client's own life. For example, someone with a spider phobia may recognize that they might think they could cope pretty well with spiders until they find a large hairy one in the bath, when disturbing imagery and high levels of distress might suddenly be triggered.

The therapist can explain that avoidance of imagery means that important information may have been out of the field of awareness, so as part of the assessment it will be helpful for the client to begin to expose themselves to problematic situations. Exposure may

Date	Situation	Emotion	Thought, image or memory	Meaning

Fig. 6.1 Adapted thought record.

trigger associated imagery, emotions and meanings so that treatment can be tailored appropriately. For homework, the client can experiment with exposure, taking note of what they observe. Alternatively, during therapy sessions, the therapist can either provide objects or create imaginal situations which are liable to trigger emotion and imagery, or accompany the client into a real situation. The client is encouraged to notice and comment upon their affect, body sensations, images, thoughts, memories, posture, gestures, and behaviour. Afterwards, the therapist and client reflect on what happened, and how this fits together.

It may also be a good idea to furnish the client with a simple diary or amended automatic thought record, with space for recording images and memories (as well as thoughts and feelings) that are triggered between sessions (see Figure 6.1).

Questions to help people to tune in to the existence of imagery (i.e. a literal or metaphorical image, a memory, or a dream) might include:-

- What went through your mind then?
- How do you picture that?
- Do you have a mental image of that?
- Was that a memory?
- Do you see it in your mind's eye/hear it in your mind's ear?
- How does it feel in your body?
- What is that like?

Examining the imagery closely

Having observed some imagery (for instance, an image of experiencing humiliation), the next step is to examine it more closely in order to fully comprehend its content and significance. A metaphor one can use for bringing imagery fully into awareness is that this is rather like clicking on an icon on a computer screen, in order to properly open and examine the contents of a file. The therapist can explain that bringing imagery fully into focus can reveal a wealth of detail, not apparent before, as noted by Jung (1935, reprinted

1990, p. 193), who observed that 'when you concentrate on a mental image picture, it begins to stir, and the image becomes enriched with details.'

To examine the imagery more closely, the client is asked to evoke it by closing their eyes and describing it in as much detail as possible, in the first person, present tense. Their account may include the events in the image, what led up to this situation, what might happen next, the emotions evoked, the meaning of the image, appraisals of its significance, all the sensory details, and so on. When the imagery is actually evoked and examined, it usually becomes more vivid, detailed and distressing as it is allowed more fully into awareness. Even the client may be surprised by some of the contents. For instance, in the humiliation example above, careful questioning may lead to a full elaboration of the content and context (how the person imagines they will look, the response of other people, the place, and the situation) in which these feelings take place.

Examples of typical imagery phenomenology were given chapter 2. The imagery may be an image of what happened in the past, what is happening now, or what might happen in the future. It might portray fears of external danger, images of the self, or images of what might be happening in the body. It could be a memory of some past event heavily laden with emotions such as fear, helplessness or horror (especially in PTSD), or loss, family disputes, or failure (particularly in depression). It could also be a metaphorical or fantasy image, the content of which reflects a current predicament or preoccupation, or a nightmare reflecting current concerns. Any of the senses could be involved, but the most common sensory content is visual and/or somatic.

Useful questions to elicit greater detail include:

- What is happening in the imagery?
- Can you describe it as if it was all happening now?
- What can you see, hear, taste, smell or feel in your body?
- What has led up to this?
- What do you think will happen next?
- How does that make you feel?

Identifying the encapsulated meanings

As we saw in chapter 2 on phenomenology, for the client with intrusive imagery, images often appear to convey important messages. These messages may arise from distorted appraisals of past or present experience. For the cognitive therapist, unpacking the beliefs encapsulated by the imagery is an important step. Appraisals can be very idiosyncratic, and what sounds like similar imagery may turn out to have quite different meanings. For example, after a car crash many clients have an intrusive image of a car about to crash into their vehicle. Different clients may attribute a range of meanings, such as:

'I am about to die'

'I am about to kill someone'

'This is my fault'

'I am jinxed; bad things always happen to me'

'This crash is a punishment because I am a bad person'

'The other driver is a total idiot'

'I have martyred myself to my job so I can retire early, and now I will never enjoy it!'

Hence even in what appears to be a straightforward case we need to spend time reflecting on what the imagery seems to mean about the person, other people, the world and the future.

Useful questions to elicit meanings include:

- When you have that image/memory/dream in mind what does it seem to mean about
  - Yourself?
  - Other people?
  - The world?
  - The future?

Once the meanings are identified, **ratings for each belief** should be taken, by asking:-

On a 0–100% scale how much do you believe that now?

Assessing metacognitive beliefs about having imagery

Clinical experience suggests that in addition to the content of imagery clients may have a range of negative and/or positive metacognitive beliefs (Wells 2000) about the experience of having imagery. These beliefs will influence what the client does in response to the images, and hence may affect the maintenance of the imagery and disturbing affect. After exploring the content, the therapist can ask more open-ended questions about what significance the client gives to the intrusive imagery that they are experiencing. Some hunches can be developed in this way, and may need to be checked out by asking a few of the following more specific questions:

- When you have that experience does it feel real, like something actually happening in the outside world?
- Does it feel like something happening now?
- Does it seem to reflect the past, the present or the future?
- How do you interpret it?
- Does it seem like a premonition?
- Does it seem like a warning?
- Are you afraid of what might happen to you if you hold that imagery in mind?
- Are you afraid you might go mad, die, collapse, or be overwhelmed if you allow this into your mind?

- Does it seem as if just having that imagery can change reality?
- Do you think it could affect other people?
- Do you think that having positive imagery about something could make it more (or less) likely to happen?
- Do you think that holding negative imagery in mind could make it more (or less) likely to happen?
- Do you think that holding that imagery in mind could suck you back into the past/into another reality?
- Do you think that having imagery like that makes you a bad person?
- Do you think that holding negative imagery in mind helps you make better decisions about what to do?

As we have seen in chapter 2 on phenomenology, such metacognitive beliefs are important in a range of disorders, such as PTSD, obsessive-compulsive disorder, health anxiety, social phobia and many other disorders. In addition to examining the content of the encapsulated meanings, reflecting on the metacognitive beliefs that the person has about the imagery helps considerably with formulation.

Clients may have a range of metacognitive beliefs (see chapter 2). Because imagery can be vivid, distressing, multi-sensory (and often without a proper 'time-code'), some clients may appraise it as something real in the external world. For instance, someone who was abused as a child might have a flashback to their abuser, and think he is really there in the room. Imagery that has been derived from a past experience may seem to signal current threat, and may not be recognized as a 'ghost from the past' (see chapter 2).

Other clients may have rather magical beliefs about imagery: they may believe that the image is a premonition, or that it could have an effect on the real world. Or the client may believe that the image is strongly connected with action, as in thought–action fusion, where the client may fear that because they have a thought or an image this will lead to them taking actions they do not want to take. A case example of an image associated with a metacognitive belief (i.e. 'this is a premonition') is given below:

> Jill was suffering from health anxiety. The therapist asked her to describe an occasion in the past week when she had felt very afraid. Jill said that she had been shopping with her friend, and had suddenly had an image of herself collapsing on the pavement. She began to cry as she spoke, and said she did not want to think about it. The therapist gently encouraged her to carry on with her description. She said that she could see a crowd gathering, and someone had called for an ambulance. The therapist asked her what the image meant to her. Jill said that what really frightened her was the idea that this image was a premonition, and meant that she was about to die, leaving her baby without a mother. Discussing this made her even more tearful. When she had images like this she would typically stay at home, worrying and crying, and asking others to reassure her that the images were not premonitions. She tried repeatedly to reassure herself that that she was about to faint rather than die. Therapy involved helping her to see that the images did not necessarily 'mean' anything about the present.

For a description of the intervention that changed Jill's metacognitive belief that this was a premonition, see chapter 8.

Assessing the overall impact of the imagery

Having carefully assessed the content, meaning, and metacognitive significance of the imagery, the therapist asks the client to summarize the impact the imagery has on them, in the present. Typical questions might be:

- When that image/memory/dream (i.e. imagery) comes to mind what impact does it have on you?
- What is the main message it conveys?
- What is the overall sense of threat (or promise)?

The imagery could impart a sense of current physical, interpersonal, or even supernatural threat. It could reflect ways in which the client is inaccurately predicting the future, or remembering the past. Whether the imagery is literal or metaphorical it could reflect ideas about the self, the world or other people. For example, someone with health anxiety might have an image of her own funeral, with very few people to mourn her death. This could convey a terrible sense of loneliness. A client described in chapter 11 visualized her anxiety as a large shaggy dog that grew and loomed over her when she wanted to go out. This reflected her sense of powerlessness and vulnerability. Many other examples are given in chapter 7 on micro-formulation, and throughout the book.

Assessing the client's response to the imagery

The therapist should also assess how the client reacts in response to the imagery and their appraisals of it. The therapist might ask:

- When you feel the impact of the imagery what do you feel like doing?
- What actions do you take?
- Do you try to suppress the imagery?
- Do you take any special precautions against danger?
- Do you feel like avoiding anything?
- Do you start to dwell on the content of the imagery?
- Do you ask anyone for reassurance about it?

Behavioural responses are usually meaningfully linked to appraisals and to their overall impact in the present. They can vary widely, and may involve distraction, avoidance of triggers, suppression of imagery, magical rituals, rumination or worry in the verbal mode, substitution of one type of image for another, reassurance seeking, checking, and a whole gamut of other safety behaviours. Some examples are given below:

- A client who saw 'something' in her bedroom every night believed it was demonic, and was about to have her house exorcised. In fact it was a fragment of memory of an aspect of a car crash, not recognised as such.
- A client had imagery of becoming ill and dying. She interpreted this as a premonition, and wrote her will.

- A woman who had images of a recent car crash saw them as a warning that God wanted to punish her, and would do so by sending her another car crash. She avoided driving.
- A client thought that if he had images of stabbing people he would act on them. He hid his knives.
- A client thought that if she had images of herself as a physically well person she would be struck down with illness. She tried to suppress positive images of a healthy self.
- A client who had an image of himself shaking uncontrollably would always turn his head and body away from people when he was drinking to hide the shaking.

Tracing the historical roots of the imagery

In many cases, imagery interventions are focused in the here and now, as we shall see in later chapters. However, sometimes one cannot make progress without uncovering the likely historical source of the imagery. Once clients start examining the imagery closely, they may spontaneously remark that they realize where all this comes from.

If a client has a recurrent image in particular situations, it may be that subtle triggers are activating memories of real experiences, which are not recognized as such by the client. As we saw in chapter 2 on phenomenology, images based on real experiences are fairly ubiquitous in psychopathology. The therapist can explore with the client connections between current imagery and past events using the 'emotional bridge' technique. In essence the client is asked to evoke the imagery and the whole felt sense, and then dwell on when they remember having this type of experience in the past. For an example, see the case of Rosa, her imagery and the origin of her phobia of birds, described below.

Often this helps the client target one or more memories that are feeding into the current imagery. New insights about the historical source of images may result in a change of focus in therapy, where the old material from memory can be worked upon to change any pathological appraisals that are feeding into the present problem (see chapter 9).

Once the imagery has been carefully assessed questions which can be helpful in tracing its historical source might include:

- When you hold that imagery in mind how does it make you feel?
- When in your life do you first remember having the sorts of thoughts and feelings and sensory experiences that are present in your imagery?
- Can you tell me a little more about that experience?
- Was there any other experience that seems more strongly associated with your current imagery?

Bringing the information together and moving towards the formulation

Once intrusive imagery has been assessed, the therapist and client can embark on making a micro-formulation showing the links between the particular imagery, its possible source, its encapsulated meanings, appraisals of its significance, the impact of the imagery, and

the resulting behaviour, as well as the likely consequences. This can be drawn out in the session with the client. How to take this next step is discussed in the following chapter on the micro-formulation.

Below is a description of a case in which the therapist helped the client to uncover imagery, encapsulated meanings, and safety behaviours, as well as information about the source of the imagery. This material was evoked at assessment through *in vivo* exposure, which enabled the therapist and client to design appropriate behavioural experiments.

> Rosa had a bird phobia. The therapist put two little pet birds in a small cage in an adjacent room, under a cloth. She suggested that Rosa try to enter the room with her, and watch whilst she removed the cloth. Reluctantly the client agreed. On opening the door Rosa shrank back, requesting that the therapist did not lift the cloth. She explained that she imagined that the birds would see the fear in her eyes, and that they would then try to scare her, which might make her heart jump out of her chest. Eventually she entered the room, and let the therapist remove the cloth. The fear subsided as she noticed that the birds were not trying to scare her, but seemed rather sleepy.
>
> At the next session Rosa and her therapist went to a park. Here another belief was activated. Rosa had images of birds seeing the fear in her eyes and flying off to tell their friends, and of them all gathering and coming to attack her, as in Hitchcock's film 'The Birds'. She had seen this film as a very small child, and assumed that what she saw was realistic. This film had provided the material for her frightening images. She was tempted to scream and run for safety, and found it difficult to stay where she was and make eye contact with some of the ducks that were wandering around the park.

For a description of how these beliefs were challenged during her treatment see the section on discrimination in chapter 8.

Conclusion

In this chapter, we have focused on the importance of conducting a thorough assessment of clients' imagery. Clients may need to be encouraged to explore their imagery, and to become aware of its presence. Having done so, the assessment needs to focus on the content of the imagery, and the client's appraisal of its meaning, and on the client's metacognitive understanding of what it means to have imagery. As we have already seen in previous chapters, both the content of imagery and the metacognitive beliefs about its significance can have a considerable impact on the client's experience, and can shape their responses. Both impact and response need to be carefully assessed. In some cases, it is also important to assess the historical roots of the imagery, as these may play an important part in the therapeutic intervention.

Once this information is brought together, the therapist and client are in a position to develop an imagery-based micro-formulation of the client's problems. This is the subject of the next chapter.

CASE VIGNETTE

Using an image to explore the meanings of death and life

Diana Sanders, *Oxfordshire Mental Health Trust, Oxford, UK*

Richard was feeling extremely low and anxious following a heart attack six months previously. The heart attack had come out of the blue and was a huge shock to him. He was finding it difficult to get back to work or to get involved in his life again, thinking 'What is the point: I may be dead soon.' The thought of death also terrified him: he could not bear the thought of leaving his children, his own mother having died when he was young. He felt 'paralysed', as though he was at the brink of a great precipice, representing his death, and unable to move.

In therapy, he was encouraged to look at the precipice: where was he, what did it represent, what was at the bottom of it, and on either side? As he viewed the precipice, he realized that he had, in fact, stopped well short of the edge: he saw himself being hauled back by the medical treatment he'd received, which also acted as a 'fence' around the edge to prevent him getting too near again. He then looked on either side of the precipice, and saw where he had come from to get there: a life where he took his health for granted, did not do much to look after himself, worked too hard. On the other side, he saw himself exploring his 'new' life: focusing much more around his family, with less work and more exercise, seeing a fitter side of himself running around with his children.

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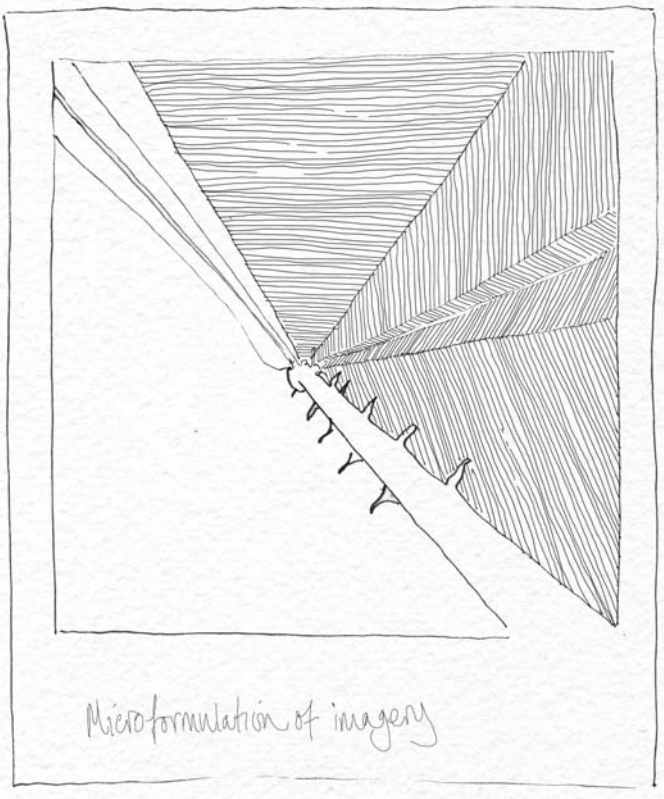
Microformulation of imagery

Chapter 7

Micro-formulation of imagery

'Topography displays no favourites
North's as near as West.
More delicate than the historian's
Are the map maker's colours'.
Elizabeth Bishop, 'The Map' (1946).

Introduction

In the previous chapter, we discussed the assessment and elicitation of problematic imagery. What next? We need to determine how a specific type of image or imagery problem is affecting the client, how this impacts on the maintenance of their symptoms or well-being, how to map it out, and how to intervene (for the latter, see chapters in parts 3 and 4). In this chapter, we will:

- Discuss the notion of formulation in cognitive therapy
- Move to the suggestion that we can 'micro-formulate' specific images, drawing on all the information gleaned in assessment (see chapter 6)
- Go through each of the steps involved in imagery micro-formulation
- Provide illustrations of a micro-formulation for a PTSD flashback image, an agoraphobic image, and for a more complex case with two linked images in a complicated grief reaction
- End with a skeleton micro-formulation that can be developed as a template for a wide range of images with different clients.

Formulation in cognitive therapy

Cognitive therapy uses individually tailored formulations, i.e. a guiding framework from which to understand an individual client's difficulties, and to derive the optimal treatment method (e.g. Kuyken et al. 2009; Westbrook et al. 2007). Formulation is developed collaboratively between therapist and client throughout assessment, and revised over the course of treatment as necessary, as new information is gathered. Typically a formulation is drawn out during the session, like a map or chart, on paper or using a white board. It can provide a roadmap both of how to understand the current situation as well as where

to go next. The use of formulation is a standard part of cognitive therapy and a fuller description of how to develop a wider case formulation can be found in most textbooks on cognitive therapy. In this chapter we suggest that it can be useful to 'micro-formulate' the role of the problematic image(s) within the wider case formulation.

Micro-formulation of imagery

We have found in both our own clinical practice and teaching that, when using a full case formulation, it can be easy to neglect the role of specific, problematic images, unless we are already expecting them to be part of the standard formulation for that disorder, e.g. in PTSD or social phobia. In the elegant cognitive models of these two disorders by Ehlers and Clark (2000) and Clark and Wells (1995), problematic imagery provides the hub. In PSTD, it is the image-based flashbacks to the trauma (e.g. visual and auditory images of a car crash) that fuel a sense of current threat, and the avoidance of such flashbacks that perpetuates a vicious cycle that maintains the disorder. In social phobia, intrusive negative images of the self (e.g. seeing oneself red as a tomato, sweating, and looking like a fool) lead to current distress and related safety behaviours (e.g. wearing heavy powder to hide the imagined redness) that in turn perpetuate a vicious cycle maintaining the disorder. How can we formulate the role of problematic imagery that can be revealed during assessment of other or comorbid psychological disorders?

We suggest that imagery uncovered at assessment (see chapter 6 for a full discussion of assessment) can be better scrutinized and understood by mapping it out within a 'micro-formulation'. In essence, we engage in a process similar to drawing out a typical case formulation (collaboratively derived, as a map to understanding the current situation and how it is maintained, as well as how to intervene). However, rather than starting by placing the image in the case formulation in its entirety (which may be more appropriate at a later stage), to begin with the image is instead placed as the hub of an image-centric enquiry. Starting with the image allows its content and effects to be explored and mapped out in detail. Thus, the formulation is 'micro' in that it is a small part of the entire case formulation, centred round the image itself.

Steps in imagery micro-formulation

Figure 7.1 illustrates a micro-formulation for a simple PTSD image. It identifies six steps (though the number could vary) that were useful in drawing out and better understanding the role of this particular image. In so doing we draw on information gathered in assessment so this will echo some of the themes raised in chapter 6, but illustrate how to pull these together to create an imagery micro-formulation:

1. **The image itself: what is it of?** The client in Figure 7.1 experienced a vivid flashback image of a red car approaching. Of course images vary widely, can be multimodal, and require careful and sensitive description. Useful questions to explore the image include: What can you see/hear/smell etc? And then what happens? Is there anything else in the image? (For further detail on enabling clients to provide rich descriptions

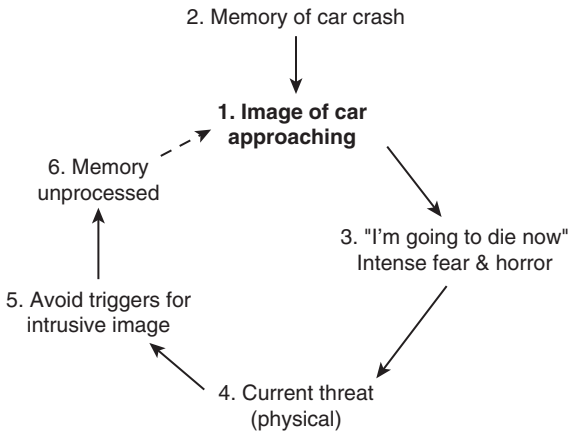

Fig. 7.1 Micro-formulation for a PTSD flashback image (in bold).

of their imagery, see chapters 5 and 6). As a rule of thumb for the level of detail required for a rich content description, you should be able to draw out/reproduce their image yourself, or see it in your own mind's eye. Though frequently this is straightforward, it should be noted that some people may understandably find it difficult to describe everything in one go.

2. **The source of the image: where did the image come from?** While this may not be known in disorders other than PTSD, possible sources of images include a recent or old traumatic or stressful incident, an early memory, or possibly an imagined fantasy (see chapters 8 and 9 for a description of the emotional bridge technique, where the aim is to establish links between current images and past experiences or memories). In the case in Figure 7.1, the image came from a memory of a car crash that occurred six months previously.
3. **Appraisals and emotions: what are the hot cognitions associated with the image?** One can ask 'what does this image mean to you? What other thoughts are in your mind when you are experiencing this image? What do you feel right now (when the image is in mind)?' In this case, the client reported having the verbal thought/appraisal 'I'm going to die now', accompanied by the emotions of intense fear and horror (see also chapter 2 for discussion of PTSD hotspots). It is important to prompt for appraisal*s* and emotion*s plural*, as there may be additional appraisals and/or emotions attached which will be important in best understanding the micro-formulation.
4. **Current impact: what is the overall effect of the above?** In this case, the image of the approaching car and its associated meaning and feeling led the client in that moment to have an acute sense of current threat, that is, that they were in immediate physical danger. The client became jumpy and also avoided cars where possible and refused to drive. Clearly, the current impact will vary according to both the perceived content of the image, as well the various idiosyncratic appraisals or emotions that could be attached to any given image. This is why it is important for the client to determine the meaning, rather than the therapist just trying to infer this from what the image

'looks like'. While the therapist should certainly not interpret for, or foist a meaning on a client, the usual cognitive techniques of guided discovery may be useful.

5. **Maintenance factors: what is making this image persist in being problematic?** There are many possible maintenance factors, and exploring these can be useful in designing an intervention to break a vicious maintenance cycle. Possible candidate maintenance factors include thought suppression, e.g. trying to push the image from mind (Wegner 1994); neutralizing the image, e.g. trying to replace an aversive image with a more benign or positive one, as in imagery in obsessive compulsive disorder (de Silva 1986); and safety behaviours, e.g. avoiding eye contact with another person one is trying to talk to (Clark and Wells 1995; Salkovskis et al. 1999). In Figure 7.1, one factor maintaining the image was avoidance of triggers for intrusive images: the client had stopped driving their car and avoided busy roads where possible. Over time a fuller range of factors emerged, including trying to strongly push the flashback from mind as soon as it occurred.
6. **Cognitive consequence.** In Figure 7.1, the upshot of the vicious cycle mapped out for the image is that through avoidance, the memory remained unprocessed, and the image remained vivid, strong, and readily triggered (see Ehlers and Clark 2000 for a fuller description of this process in PTSD).

Extending micro-formulation to other types of imagery

People with agoraphobia can experience a variety of distressing images which fuel their agoraphobic behaviour, and seem often linked to thematically similar earlier memories, e.g. of moments of humiliation during adolescence (Day et al. 2004; Hackmann et al. 2009). Our research and clinical experience indicates that, in contrast to images in PTSD, agoraphobic images are rarely spontaneously reported by clients. As we have already seen (chapters 5 and 6), it is usually necessary to ask specific questions about imagery at assessment. Such images may have persisted for years, even decades, and perhaps be all too familiar to clients as their view of 'what would really happen'. Rather than being recognized as an image, the client may experience this as reality or a prediction of what would happen if they try to leave the house. Figure 7.2 illustrates a micro-formulation for an image in agoraphobia, with the client being surrounded by a sea of faces with their eyes staring at her. The associated appraisals about entrapment and ridicule led to a sense of current threat to self—in this case, the threat of imminent humiliation. Such a threat is labelled as 'psychological threat' to contrast it with the physical threat illustrated in Figure 7.1.

In the case illustrated in Figure 7.3, the first image presented as problematic was less straightforward. The client, Jason, a teenager, had stopped college and socializing, and was spending long periods of time inactive, sitting still, isolated, and withdrawn in his bedroom. When asked what was going through his mind during these times, he replied that that he was pre-occupied in an imaginal fantasy of being in a night club, imaging the sights of coloured lights and the sounds of rhythmic beats (1). When asked about the associated meaning and feelings, he replied that this imagery was not aversive and he

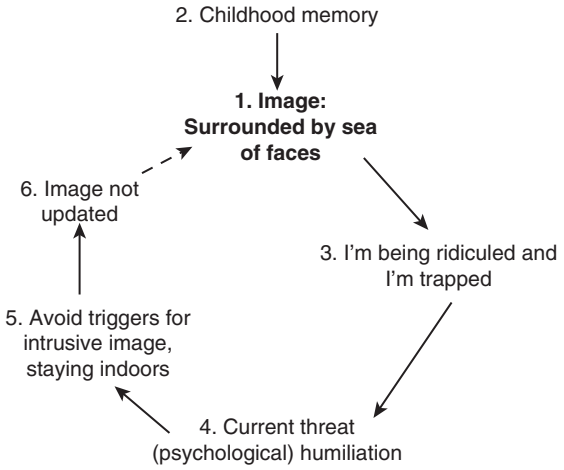

Fig. 7.2 Micro-formulation for an image (in bold) in agoraphobia.

found being engaged in it quite absorbing (2). Puzzled, the therapist explored further. Jason replied: 'Although I don't enjoy the dance club images, it's not unpleasant, and it's better than what'd be there otherwise.' Further exploration revealed that Jason was also experiencing intrusive imagery of a real incident when he had been questioned by the police about the accidental death of a friend (3). The night club image was used to distract him (4) from dwelling on the upsetting memories of the police interview, and moreover from adequately emotional processing of the death of his friend (5). The cycle therefore perpetuated a complicated grief reaction, in which Jason had not attended the funeral and had not yet begun to acknowledge the loss of his friend.

Figure 7.4 provides a generic skeleton for micro-formulating images that readers can use in developing their own micro-formulations. Micro-formulations may vary hugely from image to image, and from client to client, so this is a framework to begin exploring

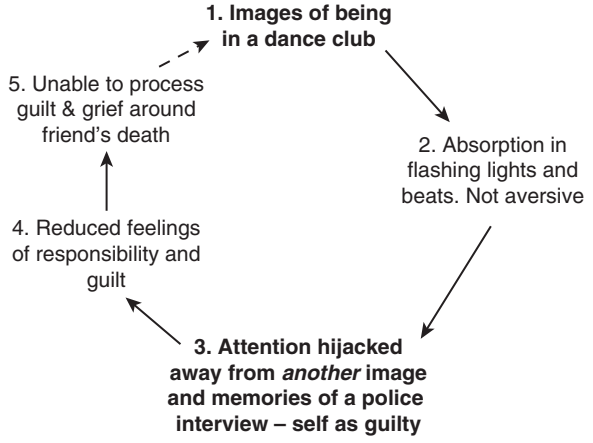

Fig. 7.3 Micro-formulation for two linked images (in bold) in a complicated grief reaction.

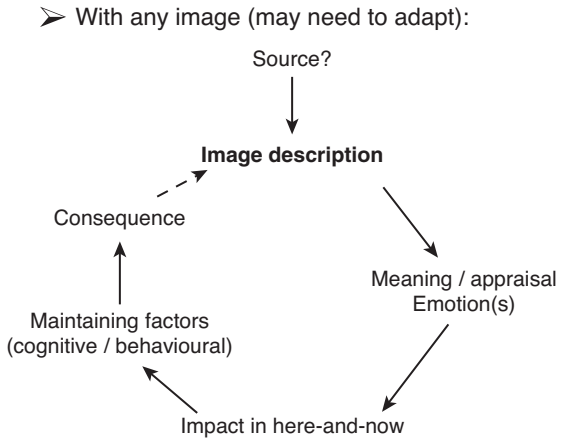

Fig. 7.4 Skeleton micro-formulation.

with, which can be adapted as is most useful. A collaboratively developed micro-formulation that is drawn out and shared with the client can be taken away by the client for homework to be test driven and amended where necessary. It can also be updated as therapy progresses and more information comes to light. Drawing out the micro-formulation, and seeing it unfold on a piece of paper, whiteboard, computer, etc. (see for example Butler and Holmes 2009), can help to inspire curiosity about imagery and what is happening, and also start to treat the image as it is, just 'an image' rather than reality. The imagery micro-formulation will help in guiding the next step in therapy, e.g. whether to choose imagery rescripting (Holmes et al. 2007a) or some other method. Methods of intervention and techniques that can be used are described in parts 3 and 4 of this book.

Conclusion

This chapter provides a framework to understand and map out how a specific type of image or imagery problem affects a client; how the symptoms are maintained, and what the implications might be for treatment. We have proposed the notion of 'imagery micro-formulation', akin to the cognitive therapy tool of 'formulation'. The key in imagery micro-formulation is to begin by placing the image as the hub of an image-centric enquiry. Starting with the image allows its content and effects to be explored and mapped out in detail. The formulation is 'micro' in that it is a small part of the entire case formulation, centred round the image itself. We have illustrated micro-formulation with several case examples. Towards the end of the chapter, we provide a skeleton micro-formulation, which can be developed as a template for a wide range of images in different clients.

CASE VIGNETTE

Imagery rescripting to change the significance of an image in OCD

Nicholas Page, *Institute of Psychiatry, KCL and Anxiety Disorders Residential Unit, Bethlem Royal Hospital, London, UK*

Mr A. was a 63 year old mixed-race heterosexual man with a very successful career, who had suffered from Obsessive Compulsive Disorder (OCD) for 48 years. The primary symptom of his OCD was an intrusive image of a black flaccid penis which he interpreted as meaning there was something 'different about him', that he was a homosexual or a potential sexual predator, who would be found out and ostracized from society. When the image occurred (many times a day) he would become extremely anxious and retreat into mentally weighing up the likelihood of this, thus reinforcing the significance of the image. He had had several courses of CBT but was unable to resist the mental ritual for long, thus maintaining the OCD.

Mr A was brought up in a white female dominated working class environment. His father returned to Africa shortly after his birth. He remembers growing up as an exotic curiosity as there were no other mixed raced people around. He took on his mother's message that he would have to work twice as hard as anyone else to succeed. The intrusive image started around the age of thirteen. Mr A had frequently looked at anthropology books out of curiosity about his African heritage and had seen numerous images of black people 'living in the wild'. From these books and also from society Mr A concluded that black people were wild and savage, (particularly sexually) and feared that he might become like this.

Mr A's fear of ostracism seemed to date from much earlier than the image of the black penis. A particularly poignant memory was being on holiday aged five, and sitting on the beach in summer in his full school uniform whilst the other children were wearing swimming trunks. Mr A produced a photograph of this, and distinctly remembers asking to wear his uniform as he felt this would seem more civilized. During imagery rescripting Mr A relived being the five year old (with the central feeling of being alone and different) before entering the scene as a 63 year old to help his younger self. As the adult, Mr A spoke skilfully and patiently with the child, explaining that life was difficult not because there was something wrong with him, but due to how others treated him. He reassured him he would survive and successfully find his place in the world. When he revisited the scene from the five year old's point of view, he seemed surprised but comforted by this 'arm around his shoulder'.

Within a week of the rescripting Mr A's OCD symptoms reduced, and quickly became sub-clinical. He was now able to resist responding to the image which had subsequently reduced in vividness and frequency. As a result of the imagery intervention Mr A had been able to accept at an emotional level an alternative narrative of his difficult experience and was therefore more able to dismiss the catastrophic belief that he would be ostracized. The image had lost its significance and catastrophic meaning and therefore its ability to provoke anxiety. He now accepted any intrusive images as normal, rather than meaning something negative about him.

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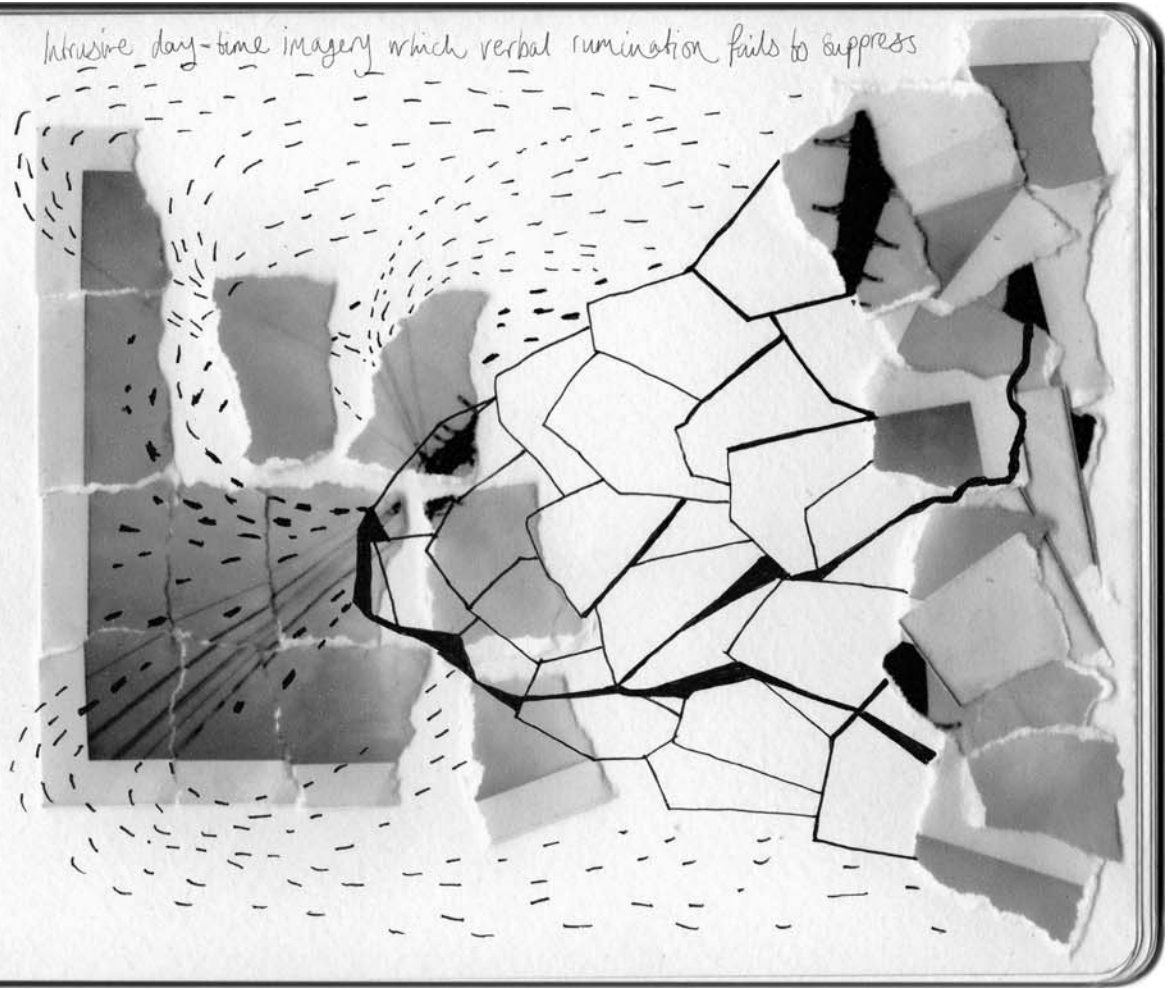
Part 3

Imagery interventions: removing and transforming negative imagery


Intrusive day-time imagery which verbal rumination fails to suppress

Chapter 8

Working with intrusive day-time images

'Webster was much possessed of death
And saw the skull beneath the skin
And breastless creatures under ground
Leaned backward with a lipless grin.'
T.S. Eliot, 'Whispers of immortality' (1920).

Introduction

In the discussion of phenomenology in chapter 2 we made four distinctions between different types of imagery:

- Images and memories
- Day-time and night-time imagery
- Literal and metaphorical imagery
- Negative intrusive imagery and deliberately constructed positive imagery.

The topics for these next six chapters on imagery-based interventions (chapters 8–13) have been derived from these distinctions. The present chapter focuses on negative intrusive day-time images. Clients often do not (at least initially) recognize negative images as being coloured by the memory of past events. Instead, clients frequently experience images as representing something negative about the present or the future (e.g. the image will drive them mad, or is a premonition of what will happen). The fact that the image can often be directly related to a past experience/memory may be out of conscious awareness (as we have already seen in chapter 2). Sometimes, as we shall see, clients come to realize during the course of an intervention that the sensory or thematic content of an image does owe more to a past experience—a past memory—than to present reality. In this case, some of the techniques described in chapter 9, 'Using imagery to work with upsetting memories', may be utilized to target the disturbing memories that have shaped current imagery.

As we noted in chapter 2 on phenomenology, images often seem to clients to reflect reality, yet these reflections can be quite distorted, in a variety of ways. In this chapter we examine methods of working with negative day-time images that the client experiences as relating to the present or the future, and which are not recognized as memories. These

include methods to engage the client (socialization), methods to reflect upon the content and significance of the image (assessment, evocation and micro-formulation), and methods to prompt for change using a variety of techniques (discrimination, transformation, and making a bridge to the past).

In the following chapter (chapter 9), we discuss images which the client knows to be memories. In other chapters in this part of the book, nightmares, dreams, and other night-time imagery are addressed, in chapter 10, and metaphorical imagery in chapter 11; while positive imagery is addressed in chapters 12 and 13 (part 4 of the book).

Socialization

General principles for socializing the client to imagery interventions are addressed in chapters 5 and 6. The reader should turn to these chapters for more detail. In brief, as far as socializing the client to day-time imagery is concerned, the therapist can explain to the client that:

- People often have little pictures or other sensory experiences mixed in with their flow of thoughts in difficult situations.
- Such images can carry important meanings and can have a significant influence on how people feel and what they do.
- Even if people notice these images, they may not want to explore or engage with them more closely if they seem likely to be upsetting.
- Nevertheless it is worth deliberately evoking and exploring images in therapy, precisely because they are often accompanied by strong emotions.
- These emotions usually indicate that the meanings carry a lot of importance for the people concerned.

If the client expresses reluctance to engage with the image, the therapist can help them explore their fears and weigh up the pros and cons of examining the material. Sometimes metacognitive beliefs stand in the way. For example, the client may feel that the image will be accompanied by unremitting high emotion, or that holding the image in awareness might make the feared event actually happen. Psycho-education and reassurance can help here, and the client can be gently encouraged to test out some of their beliefs while in the safety of the therapist's office (see the section below on manipulation).

Where there has been substantial, prolonged avoidance, the client's own understanding of what they might feel or believe in a problematic situation may be quite vague. Situational cues can trigger informative images; real life exposure is a good way to check that none of the relevant material has been inadvertently overlooked by the therapist and/or the client. The evoked images can then be discussed in detail.

As we have seen in chapter 6, a useful *metaphor* one can use for bringing an image fully into awareness is that this is rather like '***clicking on an icon on a computer screen, in order to properly examine the contents of a file***'. The therapist can also explain that bringing an image fully into focus can reveal a wealth of detail, not apparent before.

Evocation and assessment

In some cases, clients may report images that have been spontaneously triggered in problematic situations. These can be deliberately evoked in the therapy session, and described by the client (with their eyes closed) in the present tense, in as much detail as possible (as described in the section on evocation in chapter 6 on assessment).

Alternatively, since the client's avoidance means that important information may have been out of awareness, the therapist can explain that it will be helpful for clients to begin to expose themselves to problematic situations, in order to trigger any associated images and emotions, so that treatment can be tailored appropriately. The therapist can offer to do this with the client, to make sure that nothing important is missed, and to offer moral support. The therapist can explain the notion of dual belief systems (see chapters 1 and 2) illustrating this by using examples from the client's own life. For example, someone with agoraphobia may suddenly become more nervous in a public place, and have an image of collapsing in the street, despite thinking at home that they would be able to cope with the shopping trip. Once an image has been triggered it can be carefully examined, as described below in the section on formulation.

It is interesting that, as we saw in chapter 4 on effective components of therapy, cognitive change sometimes occurs simply as a result of bringing the image to mind and reflecting upon it without any other active therapist intervention, as in the following example:

> Gemma had a worm phobia, and had images of worms when reminded of the topic. She saw these at the top of her field of vision, and tried to ignore or suppress them. Asked by the therapist to bring them to mind more fully she refused at first, but was encouraged to test out her fears. As she focused properly on the images she became very tearful, and revealed that in the full image she saw herself in a coffin, with worms dropping onto her eyes and mouth. She then spontaneously linked this to a childhood nightmare she had had after she had been teased with worms at school. Relief followed the fuller examination of the image, as she reflected 'But it is not me now, that was me when I was a girl!' Thus, although initially distressed, she also experienced sudden relief, as she appreciated the origins of her image, and the fact that it was only a fragment of memory of a nightmare.

As we have seen in chapters 6 and 7 on assessment and micro-formulation, before we can plan an intervention we need to consider the meaning of the image, its significance to the person, and the processes that may be maintaining the intrusive images and associated distress. Useful questions may include:

- ***What is in the image?***
  - Elaborate on the actual content (multi-sensory)
- ***What does it mean to you?***
  - About you, other people, the world?
- ***What do you see as the significance of having the image?***
  - Is it a warning, a premonition, dangerous to hold in mind, or capable of affecting the future?
- ***What is the impact of this image in the present?***
  - How does it make you feel? What is the most threatening aspect?

- ***When you get this image what do you do?***
  - Do you try to suppress it, distract yourself, substitute a nicer image, worry about what it means about you, or take action to make sure nothing bad happens?
- ***What is the likely source of this image?***
  - When in your life do you first remember having this sort of experience?

For further detail see chapter 6 on assessment.

Micro-formulation

Once the information from the assessment is available, we can construct a micro-formulation. An example is shown in Figure 8.1. This client with health anxiety was distressed by her negative images, which she appraised as being premonitions of her death.

For more detail, some examples and a template for creating micro-formulations see chapter 7.

Manipulation

Once the formulation is in place elements of it can be tested out. Manipulation of the image is a useful way of testing distorted appraisals of the significance of having the image, i.e. testing metacognitive beliefs such as:

- The image is something real, in the external world
- Suppressing the image will keep it at bay
- Allowing the image into my mind could kill me, make me mad or ill, overwhelm me, or mean that my distress will go on for ever
- If I have this image in mind I will act on it, OR it will affect reality (for better or worse).

Discussion of such appraisals of the significance of having the image can lead to one or more carefully tailored behavioural experiments. For instance:

1) Manipulating the image to demonstrate that it is only a mental event
2) Examining the paradoxical effects of suppression

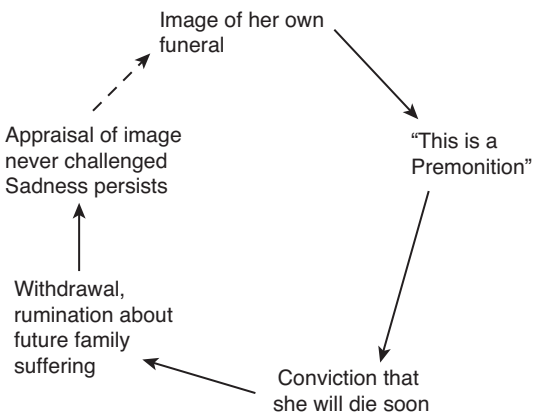


Fig. 8.1 Distorted appraisal of image.

3) Testing whether an image can make one ill or go mad, etc.
4) Testing the reality of thought–event fusion and thought–action fusion, i.e. testing whether images can cause events to happen; or whether images lead to involuntary actions.

Manipulating the image to demonstrate that it is only a mental event

If the client is finding it difficult to appreciate that the image is simply a mental event, they may feel more convinced that it is if they have some practice in manipulating the image. One strategy is to ask the patient to put their troublesome image on a television screen, and then suggest: 'OK, now turn it off . . . or turn the volume down . . . or change the channel.'

> Morrison (2004) describes a psychotic man in whom such an intervention proved therapeutic in itself, by changing the significance the client gave to his intrusive imagery. He was troubled by images of white vans, which he feared might reflect current reality, meaning that people were coming to get him. By putting his images on a television screen and then inserting advertisement breaks he shifted to seeing the images as merely products of his own mind, with subsequent relief.

Some other possible experiments to help establish accurate metacognitive appraisals of imagery in psychosis are described by Close and Schuller (2004), for example:

> A client felt he had absolutely no control over an auditory image of his abuser's voice, which appeared to come and go at will to torment him. He practised bringing on the image of the abuser's voice, and then fading it out by concentrating on other things, which gave him a greater sense of control, and made him feel safer.

Testing the effects of suppressing images: The thought suppression experiment

If the client thinks that suppressing the image will make it *less* likely to recur, a thought suppression experiment can be carried out to demonstrate that in fact the opposite is likely to be true. In this experiment the therapist asks the client to imagine something bizarre, for example, the therapist says:

'Imagine a pink rabbit sitting on my head . . . Can you do that? Now I would like you to look at my head for a few minutes, and try very hard not to think about the pink rabbit. You can think about anything you like, except that particular rabbit'.

Invariably (almost!) the client soon realizes that this is almost impossible to achieve. Once the mind gives itself such an instruction it seems to remind itself quite frequently of what it was that it determined not to imagine. Realizing this may motivate the client to abandon some of their efforts to keep the imagery at bay.

Testing whether holding an image in mind can make one suffer overwhelming or unending distress, or even make one go mad

If the client is afraid that they might become insane, or suffer from overwhelming emotion, then grounding strategies and a cautious approach might be advisable, with graded

exposure to the image, and reflection on the results (see chapter 5 on establishing the platform). This provides the client with the opportunity to gather information about imagery and emotion. With repeated exposure imagery tends to become less distressing and the client will usually find it more manageable (see chapter 4).

Testing the reality of thought–event fusion and thought–action fusion

Thought–event fusion: if the client fears that holding the image in mind will somehow make a feared event occur (or make a desired outcome less likely) this can be tested out. As an example, a series of experiments were carried out by a client with obsessive-compulsive disorder, who believed that her negative images could cause actual harm to other people.

> Chloe was persuaded to test the effects of imagining bad things happening to her therapist within the therapy session. First she imagined that the therapist collapsed across the desk, and emboldened by the lack of effectiveness of this image she tried imagining that the secretary in the department would break her arm before she left the session. Since this also did not occur, Chloe became more confident, and for homework imagined first of all fairly minor mishaps that might happen to her husband (e.g. that he would lose his diary, or fall over when they were out together). She then moved on to imagine worse events happening, even accidents to her children. Her confidence gradually increased, and her belief that images could harm other people fell as the weeks went by.

This experiment is an example of working with images where there is thought–event fusion (Obsessive-Compulsive Cognitions Working Group 1997).

Similar beliefs can be encountered in the treatment of health anxiety and panic disorder with or without agoraphobia. In these disorders it is not uncommon for clients to have superstitious beliefs that if they allow themselves to have images of themselves as ill or dead then this will make these events more likely to happen (Wells and Hackmann 1993). Fear of visualizing oneself in good health can also present a block to progress: as the fear of becoming ill recedes the chance of imagining that one is going to be well increases, and may engender a fear that this could have the effect of somehow 'tempting providence' and thereby being struck down by illness.

Clearly one can test these beliefs in the way described above, although sometimes the client thinks that the catastrophe will only occur in the distant future, so that the belief is hard to challenge definitively using a behavioural experiment. In this case other approaches (such as transformation, emotional bridge technique and working on traumatic memories; see remainder of this chapter, and chapter 9) may work better.

Thought–action fusion: an example of thought–action fusion would be testing the beliefs of someone who feared that their images might lead them to carry out an action that they were fearful they might take.

> John was fearful of handling any knives, particularly when there were children around. He had images of people with knife wounds that he had inflicted. The therapist encouraged him to handle knives in the session, and to try to let go of any attempts to control himself. He was asked to compare what actually happened with his images of what he thought would occur. Subsequently he

experimented at home, starting with handling small knives when the children were in bed, and building up to carving the Sunday joint with all the family at the table.

This approach can be further refined by asking the patient to deliberately form an image of the feared consequence when taking this sort of risk. A good example is described by Morrison and Westbrook (2004). A client with OCD was afraid of harming her baby. Every evening she was asked to spend time alone with him, in a darkened room, telling herself that she was going to strangle him, and imagining herself doing this. Her anxiety subsided along with her belief ratings. As the authors point out, this type of experiment should only be attempted with clients for whom the images are ego-dystonic (i.e. with clients who really do not want to harm anyone), and not with people who might actually want to harm themselves or other people.

Discrimination

Where images are considered by the client to accurately portray present reality, or events that will happen in the immediate future if exposed to certain situations, a range of behavioural experiments can be devised to help the client discriminate between the image and reality.

These could include experiments to discriminate between:

1) Imagery of perceived danger (e.g. from the physical world or animals) and actual danger
2) Imagery of one's reactions to perceived danger, and actual reactions
3) Imagery of 'how others see me', and how I am actually seen
4) Imagery of how other people will react, and how they actually react.

Imagery of perceived danger, and actual danger

Since *in vivo* exposure is a very effective treatment for specific phobias (Öst 1989), cognitive interventions are not always necessary. However, when the therapist asks about beliefs, this can enhance the degree of therapeutic focus, adding information about where the client's attention needs to be directed. Since images can be compact 'meaning capsules' they give splendid clues as to those beliefs.

Rosa (described in chapter 6 on assessment), whose bird phobia imagery was heavily influenced by Hitchcock's film 'The Birds', used behavioural experiments to test out her predictions. Her images were of birds looking straight into her eyes and seeing the fear, then going to get their friends who would return to attack her and scare her to death, by making her heart jump out of her chest. Each of these images was compared to reality in a series of behavioural experiments.

Similar experiments might be done by someone with a spider phobia, who believed that the spider had 'malicious intent' (Thorpe and Salkovskis 1995). Perceived external danger from the physical world can also be tested with behavioural experiments:

Janine had images of the cliff crumbling and collapsing. She was encouraged to jump up and down, and not hang on to anything, to test the stability of the cliff.

Imagery of one's reactions to perceived danger, and actual reactions

Sometimes in a feared situation the images reflect how one fears one might react, rather than how one will actually react.

For example, people with height phobias often have images of losing control. Such images can be tested against reality using targeted behavioural experiments.

> One client had a fear of jumping from a great height. He was encouraged to relax his muscles, and sway around a little to find out whether he would then jump off.

Similarly, in the earlier example of John, the man with OCD who was afraid of handling knives lest he stabbed his children (see thought–action fusion section), the series of experiments enabled him to discriminate between his imagined reaction and his actual behaviour when given a knife.

Imagery of 'how others see me', and how I am actually seen

In social phobia, clients have negative, distorted images of themselves, seen as if through the eyes of others (i.e. from the observer perspective (Hackmann et al. 1998, 2000)). These images appear to play a causal role in social anxiety (Hirsch et al. 2003). Formulation with clients suggests that negative self-images are triggered in stressful social situations, leading to safety behaviours designed to hide the feared anxiety symptoms etc., which has the unfortunate effect of heightening self-consciousness, and impairing performance.

A useful set of behavioural experiments has been described by Butler and Hackmann (2004):

- First the client is videoed having a social interaction with a 'stooge'. During this interaction they are encouraged to utilize all their favourite safety behaviours (e.g. tensing their hand muscles, and turning away when trying to drink from a cup).
- Next the client is asked to describe how they feared they came across. Their predictions about what they will see when they watch the video are carefully operationalized, based on their image of the self in that situation. If, for example, they believe that they blushed, the actual shade of the imagined blush is chosen from a paint shade card. If on the other hand they are worried that they have been visibly shaking they are asked to mime how bad they thought this was, and a second video is made to compare with the video of the actual interaction.
- Next the therapist invites them to have a second interaction with the same person. This time they are asked to drop their safety behaviours and the self-focused attention, and focus instead on the person to whom they are speaking. Similar ratings are taken.
- Ratings of blushing, shaking etc. are also made by the stooge after each of the interactions.
- The client's ratings of beliefs about how they come across in these two situations are then carefully compared with what is visible when they view the video, and with ratings made by the stooge.

Finally the client gets to reflect on the results of these experiments. They typically discover that in both interactions they come across better than they thought; that they feel better and come across better if they are not carrying out their safety behaviours or focusing on themselves; and that the stooge generally rates them as coming across better than they have rated themselves, and has often noticed nothing unusual apart from any obvious safety behaviours.

In a range of other problems including eating disorders, body dysmorphic disorder, and physical disability and/or disfigurement, techniques similar to those used in the treatment of social phobia can be utilized. Clients may have images of their appearance or performance that are negative and distorted. Having operationalized the client's predictions first, as described above, video or audio feedback and feedback from others, can be used.

Photographs can also be useful. Ree and Harvey (2004, p. 297) describe a client with insomnia.

> The client believed that if she slept badly she looked ghastly the next day. Her partner agreed to take a photograph of her every morning, for a week. There was no relationship between the amount and quality of her sleep at night and her physical appearance the following day, when the photographs were evaluated by a number of other people.

Imagery of how other people will react and how they actually react

Several studies have indicated that agoraphobic clients are afraid not only of mental or physical catastrophes during panic attacks, but also of the likely interpersonal consequences (Hoffart et al. 2006). These feared consequences are often vividly depicted in images triggered in feared situations. Clients may picture themselves becoming ill in a public place, and being ignored, trapped, or ridiculed by others (Day et al. 2004).

The validity of such predictions can be tested using behavioural experiments. If the client is afraid of what might happen if they collapse in a public place, the therapist can first test this out for them, by taking them to a public place and then pretending to collapse so that the client can observe the reaction of others. Luckily, the usual response is expression of concern by a few people, who usually offer help such as a chair, some water or a phone call. What never happens is that a big crowd gathers, or more help is offered than the client would wish (e.g. no ambulance is summoned). This is usually reassuring for the client, who might be prepared to visit a second venue and test this further, by repeating the 'collapse' that the therapist modelled for them, to compare their images against reality.

> James had many catastrophic thoughts about what might happen if he had a panic attack in a public place. He feared having a stroke, a heart attack, fainting, having a brain tumour, going crazy or becoming paralysed. Yet he always had the same image of what would happen as a result of these catastrophes. He saw himself collapsing, being surrounded by people, and an ambulance arriving. When asked to run the image on he described being put in a straitjacket, taken to a mental hospital, and kept there forever. The therapist modelled collapsing for him in a local shopping centre, and the client was happy to observe that only a few people came forward to help, and were soon reassured by the therapist's insistence that he needed no help. Subsequently the patient was prepared to act out feeling a little unwell by sitting on a bench and mopping his forehead. Again he did not receive any unwelcome attention.

Similar experiments can be conducted to help a person with social phobia test how people would react if their anxiety symptoms got out of hand. This type of experiment has been described as 'broadening the bandwidth'. The patient describes how they imagine they might look if their symptoms were really exaggerated. The therapist offers to mimic these symptoms in a public place, while the client observes other people's reactions. For example, the therapist might apply makeup to simulate an extremely vivid blush, or might put water on their face and under their arms to simulate sweating. The client is generally astonished to note that other people appear oblivious to these symptoms, or at least show no harsh or even discernible reactions. If the client discounts these positive reactions, suggesting that people would respond differently if they were confronted by the client's own extreme symptoms, the therapist can encourage the client to repeat the experiment themselves.

Transformation

There are a number of ways to transform negative imagery to make it less threatening and/or more realistic. These include:

1) Providing a wider context by running the image on past the worst point
2) Recovering a sense of agency and grounding the self in the present by re-entering the body and observing events from the field rather than the observer perspective
3) Deliberately generating positive images of the future
4) Updating aspects of the image to make them more realistic.

Providing a wider context by running the image on past the worst point

Another way to detoxify the impact of a negative image is to elaborate the context in which it appears. For example, images typically stop at the very worst point: someone imagines the moment they vomit or faint in a busy department store, or discovers they are lost far from home. It is possible to encourage the client to run the image on past the worst point, and visualize what might happen next. In some cases this works really well; the client imagines coping with the situation, or finding people to help them sort out what to do next. Lazarus (1968) describes this technique as 'time projection'. Here are two examples cited by Beck et al. (1985):

> A man became anxious when he learned that his newborn son would require a minor operation for a hernia. He was preoccupied with possible complications and psychological damage. He was asked to visualize how the child would be in six months time, and also three years later. In the first image he saw him with a bandage, but seemingly unconcerned; in the three years time image, he saw him as perfectly healthy, and playing with other children.
>
> A second patient was obsessed with the fear that her husband might be unfaithful. She was asked to imagine what her reaction would be immediately she found out, one week later, and after six months. Her immediate imagined response was that she was feeling furious. One week later she imagined herself still very angry, but making plans. She imagined herself six months later aware that other men found her attractive, and that she had the chance to consider marrying again, or remaining married to her husband who had come crawling back.

Eliminating distressing images of the future by re-grounding the self in the present and observing events from a field perspective

For clients with more profound interpersonal concerns, the imagined scenario can deteriorate further if one tries to run it on. In such cases the formulation might be revisited, and a different way of transforming the imagery may work better. In the following case, the image is manipulated by putting it on a screen, and in addition the client vividly imagines being there as a spectator firmly grounded in the present and looking at the troublesome image of her future self which she can then manipulate.

> June was being treated for depression and health anxiety. While the therapist was on holiday she had a severe setback, and was admitted to hospital. The therapist went to see her, and found her completely distraught, with many frightening images of herself becoming really ill. The therapist wondered if merely getting her to run the image on would be a helpful strategy, and hoped that the client might see herself recovering and being well again. This naïve idea backfired: the patient visualized herself becoming emaciated, and being so ill that nurses were pushing her into the coffin. As if that was not bad enough, the client then reported an image of her grave, with her husband standing there with their child, and another woman.
>
> The therapist decided that she and the client needed a rest. The next day she returned to find the client still very upset. Formulating the problem with the client revealed that her appraisal of the imagery was that it was a real premonition. The therapist recalled that several months previously the client had had an image of her own grave, with a specific date on it. Once again this had been seen as a premonition, until the appointed date actually passed without incident, and the image disappeared. Armed with this understanding, the therapist reminded the client about this, and gently suggested that something similar might be happening again. Although she remained upset the client agreed that this was a possible alternative perspective.
>
> The client and therapist devised a new scenario, which the client then imagined in great detail: in this scenario the client experienced herself sitting on the sofa, with her husband and child beside her. She could look down at her clothes, and see what she was wearing and that she was not emaciated. She imagined that the horrible scenes of her future illness and death were part of a programme they were watching on television. She visualized eliminating the images by changing the channel, switching the television off, and ultimately smashing it up and throwing it out of the window. She then imagined that she and her family got into their car and went for a drive. This intervention was very successful: the incessant images and repetitive dreams of illness and death disappeared.

Depressed patients sometimes report images of the self seen from outside. Like the image reported above, these images are only constructions, but can carry disturbing meanings. Re-entering the body and looking out through their own eyes can re-establish a sense of being able to take action, replacing a sense of passivity and helplessness, as in the following example:

> Jack had been through several rather traumatic experiences, and ended up feeling depressed and traumatized. Following an earthquake when he was abroad the previous year he had lost the power of speech for several days. In social situations he could suddenly re-experience losing his ability to talk fluently, and would excuse himself and go home. He would go to bed, full of hopelessness about the future. This would be accompanied by an observer perspective image of himself, lying in bed looking helpless. The meaning of this image was that he was incurably depressed, would never recover, and could never again take an active part in life. The therapist encouraged him to try gently bringing his attention back to his current direct experience, viewing the room though his own eyes rather than imagining himself seen from the outside. This manoeuvre resulted in a profound

shift: he discovered that his sense of hopelessness disappeared and he was able to decide to get up and get on with his life.

Deliberately generating positive images of the future

Borkovec and colleagues' (2004, 2008) seminal work with clients with generalized anxiety disorder (GAD) suggests the potential value of generating positive imagery. Clients with this disorder are typically beset with anxieties relating to future potential problems, and abortive efforts to plan ways to solve them. The anxious thoughts in GAD have a largely verbal ruminative quality. Borkovec suggests that such thinking has short-term reinforcement value, as verbal thought tends to block more disturbing imagery. However, the downside is inadequate processing of distressing images. One of many suggested strategies to relieve the condition is that of helping the client deliberately evoke images of positive future events (Borkovec 2008). This informal version of positive interpretation training (see chapter 3) is reminiscent of the childhood story featuring Pooh's approach to Piglet's anxieties. For example, when Pooh and Piglet are walking in the forest and Piglet is worrying about the storm, Piglet says 'What if the storm blows the tree down?' to which Pooh replies 'What if it doesn't?'

Forming images of a future in which the worst does not happen is one way of establishing a less anxious perspective (for more examples see also Beck et al. 1985).

Updating aspects of the image

In some cases, an image that seems to be about the present is really an echo of a past memory, and needs to be updated. This can sometimes be done simply by altering the distorted aspect of the image to fit reality. Beck et al. (1985) describe such a case:

> A client had to return some faulty windows he had ordered. He was dreading complaining to the manager. His therapist asked him to describe the image he had of the anticipated meeting. As the client described this image he realized that he was seeing himself getting smaller and smaller, whilst the manager was becoming bigger, more threatening, shouting at him, and very red in the face. The client spontaneously remarked that this was all reminiscent of scenes with his father when he was a boy. Having made this connection he was asked to run though the imagined meeting again. This time he saw himself as being his real adult size, and able to assert himself appropriately. This more realistic image restored his confidence, and he was able to deal effectively with the situation.

The 'emotional bridge' technique: making a bridge to the past

As we saw in chapter 2, recurrent, distressing images are reported across a range of disorders. Another way to work with a recurrent image is to explore its possible origins using the 'emotional bridge' technique described in chapter 6. This involves asking the client to deliberately evoke the image with their eyes closed, describing everything about the image in the first person, present tense. Having evoked it and described the events depicted, the multi-sensory components, and the personal meaning and significance of the image, the client is asked to consider when in their life they can (first) remember having the same feeling. This can provide an elegant route to uncovering significant moments in the past that seemed to the client to signal unpleasant meanings about their self, other people,

and/or the world. Such insights can strengthen the formulation, and help with the engagement of the client, who may become curious about the extent to which the past is 'haunting' them, and may be more willing to reverse any avoidance that is currently maintaining the problem. A finding supportive of this suggestion was presented by Day et al. (2004). The authors note that following a semi-structured interview investigating the prevalence of recurrent images in agoraphobia and their links to traumatic memories, the participants often remarked that they had not made the connection between the images that signalled current threat and the salient past experiences they had reported. Nevertheless, they were intrigued by the connections that had come up. One week later, there was a significant drop in scores on a measure of agoraphobic avoidance among the clients who returned the questionnaires.

An interesting parallel in OCD has been uncovered in the area of 'mental contamination' (Rachman, 2006). There is a subgroup of clients who describe feeling contaminated, in whom the fear of contaminating others is not pronounced, and in whom exposure and response prevention may have limited therapeutic impact. Rachman has shown that by evoking the 'felt sense' of contamination, and exploring when the client first felt that way, a bridge is often made to an interpersonal trauma, in which the client felt seriously betrayed. The feeling of contamination can be easily triggered by reminders of the betrayal. Clinical observations suggest that while not very much relieved by washing, this felt sense can be addressed and transformed by imagery rescripting of the memories of betrayal, making it easier to proceed with effective exposure and response prevention. Imagery rescripting techniques are described in chapter 9.

Sometimes, the early memory that has been accessed reveals the source of information from the past that is fuelling the distress in the present, and accounts for the significance given to imagery in the present:

> Catherine was suffering from panic disorder. Her panic attacks were triggered by any reference to serious illness or death, or by physical sensations in her body that she catastrophically misinterpreted as meaning that she was about to die. Detailed examination of the phenomenology revealed that when something triggered a panic attack she would feel as if her soul was leaving her body, and that she was spiralling down to Hell. She would touch her face and arms, or cling to the chair where she sat, to reassure herself that she was still inside her body. She believed that it would be possible for her to arrive in Hell before her body was cold, and before anyone realized that she was dying.
>
> The therapist enquired when in her life she had first experienced similar bodily sensations and ideas. Catherine recounted an incident when she was seven years old. She was playing in the garden with a friend, and against her mother's wishes they had left the garden by the back gate and crossed a busy road. She had been knocked down by a car and broke her arm. At the hospital she was given a general anesthetic, and as it took effect she was convinced that she was dying, and spiralling down to Hell. This interpretation was explicable in that her parents took her to a church where there were sermons about needing to be saved if you were not to go to Hell when you died. Catherine had been worried that she wasn't saved, because the vicar had said that if you had any doubts this indicated that you were not saved. He also preached about how it would be possible to die and be on your way to Hell before your body was cold.

The discovery of a link between present day imagery and past memories can be an eye-opener for clients. For Catherine, uncovering this early memory and the way it coloured

her experience in the present led to a further extension of the formulation, and work on the early memory, using methods described in chapter 9.

Creation

As indicated above in the discussion of Borkovec's (2004, 2008) work, positive imagery may provide another strategy to counter negative intrusive day-time imagery. Strategies to create and generate positive imagery are discussed in detail in chapters 12 and 13.

Conclusion

In this chapter we have considered many ways of working with the types of images that clients experience as representing aspects of 'now' or the future (rather than an experience derived from memory, the subject of the next chapter). We briefly reviewed aspects of socialization, assessment and micro-formulation (see also chapters 5–7) as a precursor to more detailed coverage on how to help clients with interventions including:

- Manipulating images to reinforce a metacognitive shift, towards seeing the image as a mental event rather than a reflection of current or future reality
- Discriminating between their experienced images and reality
- Transforming images by providing content that reflects a more realistic, wider context
- Making an 'emotional bridge' to examine the possible historical source of the image, underlining the idea that the image may owe more to past than to present or future reality.

These basic strategies run through the other chapters in part 3, with variations on the content. The creation of completely new positive images (as opposed to working with the original troublesome imagery) is covered in part 4.

CASE VIGNETTE

Using imagery transformation to reduce anxiety: 'sticks to roses'

Kathleen A. Mooney, *Center for Cognitive Therapy, Huntington Beach, California, USA*

Emma experienced spikes of high anxiety at work during periods of increased responsibilities. Whenever her boss came into her office, she had a difficult time listening and could not remember what he had just told her. Emma feared he would be enraged if she did not do everything perfectly.

A review of Emma's work experiences revealed that her boss did not have negative feelings, behaviours, or attitudes toward her. Even so, she felt like he was about to hit her and reported an image of him holding a large stick in his hands looking angry and hostile.

I proposed to Emma that we could help her use that image to her advantage. How could she transform it to match the positive experiences she had with her boss? The following week, Emma returned with a new image: her boss approaching her with his arms full of long stemmed red roses. This image made her smile and relax. If she could see her boss this way, she believed she would be able to listen and remember what he said. After Emma practiced in session bringing up the traumatic image and transforming the stick to long stemmed red roses, she was ready to try it at work. When her boss approached her that next week, she transformed the stick to roses. She was no longer under attack. Emma discovered she was able to smile, stay curious, and attend to their discussion. As a result, she became more relaxed and efficient at work.

Images from upsetting memories

Chapter 9

Using imagery to work with upsetting memories

'Art thou a dagger of the mind, a false creation, proceeding from the heat oppressed brain?'
Shakespeare, Macbeth (pub. 1623).

Introduction

As we have seen in part 1, memories of significant events usually involve imagery, which may be multi-sensory. This imagery is accompanied by appraisals of its meaning and significance. Sometimes the imagery is not recognized as reflecting the past, and may be thought to signal something about the present or the future, in which case it may be dealt with as described in chapter 8.

In this chapter, we examine imagery that the client clearly recognizes to be a memory representation. We address memories, which either intrude or are considered significant because they have thematic and emotional similarity with the current distressing felt sense. Such memories may be identified spontaneously by the client, or by starting with the felt sense and using the emotional bridge technique (see chapter 8). As we saw in chapter 2, depression and PTSD researchers often ask direct questions about intrusive *memories*, while researchers of other disorders have tended to enquire initially about *images*. Later, they may ask about any closely associated memories. This chapter focuses on *imagery which is recognized as a memory, either spontaneously, or on reflection.*

As with other chapters in part 3 (chapters 8, 10 and 11), we have organized this chapter in the following sequence:

- Socialization to 'memory' interventions,
- Assessment and micro-formulation, using similar methods to examine intrusive and other emotionally salient 'hot' memories.

We then describe a broad range of imagery strategies for working with upsetting memories. These include:

- Reflection on any cognitive change arising from evoking the memories
- Manipulation of memory images to challenge metacognitive appraisals
- Discrimination between memory images and reality

- Transformation methods including verbal updating of 'hotspots'; imaginal techniques for elaborating and contextualizing memories; imagery rescripting; and interweaving verbal and imagery techniques
- Making an emotional bridge to even earlier memories that coloured memories of more recent events
- Creation of new memories (briefly discussed here, and more extensively in chapters 12 and 13).

Socialization

Like Macbeth, clients may wish that they could '*pluck out from the memory a rooted sorrow, raze out the written troubles of the brain.*' Yet no matter how they attempt to suppress the memories, or distract themselves, they find themselves like Lady Macbeth, still '*troubled with thick-coming fancies*' that distress them. We need to explain that the very opposite may be what is required: they may need to face the memories and their meanings if they are (paradoxically) ever to be rid of them.

To illustrate the point, the 'pink rabbit' thought suppression experiment detailed in chapter 8 can be useful. From this, one can develop a *metaphor* to help the client to adopt an appropriate metacognitive stance. For example, an intrusive memory comes at us sometimes with the force of '***an express train***'. The best place to be when a train approaches is on the platform, watching the train come and then go. Through guided discovery the client is led to appreciate that '***jumping onto the tracks in front of the train and attempting to stop it, or boarding the train to grapple with the driver can lead to further problems***'. Here the allusion is to the unhelpful strategies of avoidance and suppression on the one hand, and rumination on the other (see chapters 6 and 7).

However, before the therapist encourages the client to try letting memories simply come and go, he or she needs to explain that in the short term this strategy may lead to an increase in intrusions and distress. In the long term, it will probably work out better not to suppress memories, particularly if each memory is carefully examined and attempts are made to reflect on its meanings, and on their validity or lack of it.

Some other useful *metaphors* to explain how bringing the memories to mind can be useful include:

- ***The cupboard metaphor:*** after an upsetting experience it is tempting to push painful memories out of one's mind. This is reminiscent of clearing up a mess in the aftermath of a burglary, when one might try to stuff everything back into a cupboard. If this is done too hastily the cupboard tends to burst open. Socratic questioning is used to arrive at the conclusion that in this situation what frequently is needed is to get things out of the cupboard again, and sort through them before neatly putting them away.
- Memories of new events normally behave like ***pieces of luggage on a conveyor belt*** at an airport: they circle round for a while before being recognized, removed, and carried away. However, during an extremely distressing event our thoughts can be so

upsetting that one does not want to revisit the memory and dwell on its meaning. Therefore, like unclaimed luggage, the memory can cycle round, reappearing again and again. The solution is to remove it from the 'conveyor belt', take it away, unpack it, and put its contents away. In the case of a memory, this means placing it in its proper context amongst other memories and knowledge. Ultimately, this process leads to the memory being less likely to intrude, as it loses its over-generalized (and often distorted) upsetting meanings.

Psycho-education

If appropriate, the therapist can explain to the client that:

- Usually, the pieces of memory that intrude are of moments when meanings abruptly changed, mostly for the worse (Conway et al, 2004; Ehlers et al. 2002; Grey et al. 2002)
- Upsetting 'hotspots' in memory seem to be stored with the meanings they were given at the time of the incident (Ehlers and Clark 2000)
- Bringing the whole memory to awareness often reveals information that one has not been attending to, which can help soften the meanings given to the worst moments
- Reflecting on aspects of the memory also allows them to be placed in a broader context, including knowledge that the person may have currently but which they did not have then. This may be new information, or old information explored in therapy.

Evocation and assessment

The first step in assessing a memory is simply to ask the client for a brief description. Once the therapist and client decide to explore it further, the next step is usually to invite the client to 'relive' the memory. The term 'reliving' has been used to describe imaginal exposure to disturbing memories (Foa et al. 1991). The purpose of reliving at the assessment stage is to gain information that can assist the therapist and client in understanding and formulating the problem, which can provide strong pointers for treatment.

The technique of reliving has been widely used in the treatment of upsetting memories in PTSD, and is a component of some treatment strategies used in anxiety disorders, mood disorders, eating disorders, body dysmorphic disorder, psychosis, personality disorders, and childhood sexual abuse (for reviews of therapeutic strategies incorporating a degree of reliving, see chapter 4 and Holmes et al. 2007a). Reliving is used to explore intrusive memories, and other memories which appear linked to current distress. Exceptions where one might choose not to use reliving (at least initially) would be where there is overwhelming affect, or very severe, early, or repeated trauma (see below).

During reliving the client is asked to close their eyes, and evoke the memory as vividly as possible, describing the events in the first person and present tense, and attempting to relive the experience imaginally. This procedure usually accesses much more sensory detail and affect than merely talking about what happened.

In the next part of the assessment section, we describe the various precautions we need to take when evoking memories. Following this, we describe the basic reliving procedure used during the assessment, and various modifications for specific circumstances including:

- Selective reliving of parts of the memory
- Simply describing what happened with little detail, if the affect seems overwhelming
- Writing about the incident, especially if shame or humiliation is involved
- Constructing a narrative where there are numerous traumatic memories (as in Narrative Exposure Therapy, e.g. Neuner et al. 2004)
- 'Real life' exposure strategies to evoke memories. This may take the form of exposure to cues that were present at the time of the original incident (e.g. sounds, objects, animals), or exposure to the site of the trauma.

The choice of strategy is determined by the amount of affect that the client is capable of tolerating, and also the sheer volume of traumatic memories with which they have to cope.

Precautions when evoking and exploring memories

Usually the process of evoking and exploring memories is deeply informative, both for the client and for the therapist. Often the client is amazed by the strength of the emotion aroused, and the extra details of the memory that are accessed. However, precisely because of the strength of the feelings aroused, the precautions outlined in chapter 5 need to be in place. These include:

- A trusting relationship
- Adequate time and opportunities for reflection after exploring memories
- The chance for clients to re-ground themselves in current reality, so that they are safe when leaving the session. This is particularly important in the case of childhood sexual abuse and in other cases with overwhelming affect, vivid flashbacks, and/or dissociation (Kennerley 2009). If necessary the therapist and client should plan activities and sensory experiences which could help ground the client back in the present (see chapter 5).
- Caution with respect to ensuring, as far as possible, that the client has adequate support outside the sessions, and a relatively stable living situation without ongoing threat.

'Reliving' the memory

The therapist explains that reliving the memory is likely to reveal more information than simply talking about the upsetting incident, but may also be distressing.

During reliving the following points are important:

- The client is asked to close their eyes (if they are comfortable with this), and to speak in the first person, present tense.

- They are asked to describe the event including all the sensory features, their emotions, and the meanings given to the situation as it unfolds.
- The therapist carefully observes affect, posture, and gesture, and prompts for more detail if the client's account is sketchy or lacking in emotion.
- The therapist can prompt by asking 'What is happening now? How are you feeling?' etc.
- It is wise to allocate a longer session to such work (typically 90 minutes), and to do the reliving near the start of the session, with ample time to reflect.
- During reflection, 'hotspots' in memory can be identified, along with their meanings
- It is wise for the client to plan some quiet time after the session.

The process of reliving can help the therapist and the client to understand many things about a traumatic event and the client's reaction to it, as in the following case:

> Jacqui was on the waiting list for treatment. She rang to say that she was very depressed, and suffering from back pain. However, she was no longer troubled by intrusive memories of her car crash. Because of the severity of her depression she was asked to come in early for treatment. The therapist asked her to relive the crash once diagnostically, i.e. to check on the current state of her memory of the accident. Jacqui spoke calmly at first, describing approaching the scene of the accident. However, as soon as she mentioned being hit by the other car she wailed loudly, gave a very confused account, and rocked backwards and forwards, weeping copiously. She was astonished by her own reactions, and agreed that the therapist could include further reliving, elaboration and updating of the memory as part of her treatment package.

Reliving can be used to evoke memories and explore their content in disorders other than PTSD, e.g. in cases where childhood memories are being targeted.

> Harry was suffering from depression following a car crash. He believed that the accident had occurred because he was bad, and that it was a punishment from God. This belief proved difficult to challenge. The therapist enquired about Harry's evidence that he was bad. The strongest piece of evidence seemed to be that when Harry was a child he had done something that his mother had told him was proof that he was bad and would be punished terribly in this life and the next. Harry could not recall his 'crime' and so felt unable to repent. Since childhood he had interpreted many difficult experiences as punishments.
>
> The therapist suggested that Harry should relive this memory, which he agreed to do, with some reluctance. He described playing under the table with his brother. His mother came in carrying a tray, and fell over a toy train and dropped something. She hauled Harry out from under the table, and screamed that he was bad, and God would never forgive him. He would be punished by God forever.
>
> Harry was astonished that by reliving the memory he had been able to remember what his mother was angry about, and could see that he had done nothing worthy of eternal punishment. Instead the events described fitted better with the possibility that his mother was mentally ill and cruel to the children, a view recently expressed by his aunt. This shift in perspective still left Harry feeling terrified, but prepared the ground for a transformation (see section on transformation).

Reliving sets the scene for interventions aimed at processing upsetting memories. It is interesting to note that the relived memories may show evidence of content from even earlier traumatic events, as in Harry's case (see Figure 9.1). Also some clients have intrusive memories of a number of distressing events, with similar thematic content. During a

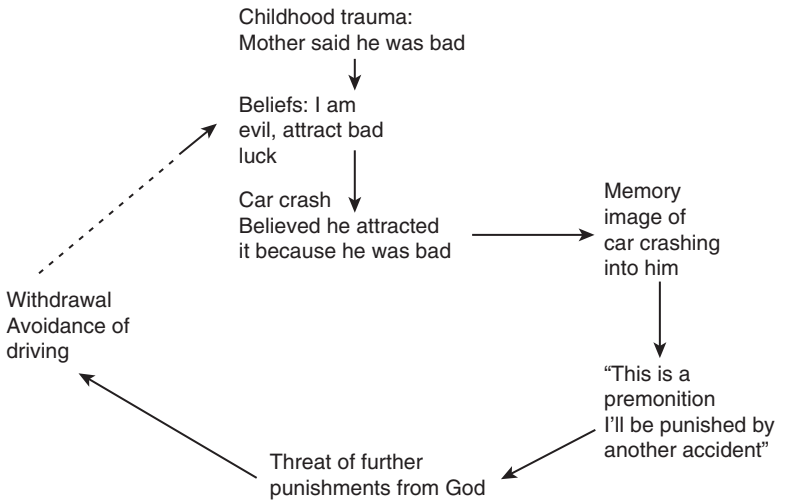


Fig. 9.1 Meaning of memory coloured by core beliefs.

course of treatment several different memories may need to be explored and processed. For example, in an article on working with intrusive memories in depression Wheatley et al. (2007) describe two cases:

> In the first case, a woman reported intrusive memories of having a termination of pregnancy, being bullied at school, and being humiliated by her father. These memories carried similar themes of being at the mercy of others, unable to stand on her own feet, and being worthless and powerless.
>
> In the second case the client's memories were of sexual and physical abuse at the hands of her brother, her uncle and her ex-husband. These memories shared themes of seeing herself as bad, weak, and powerless.

Once the 'hotspots' have been identified during reliving or discussion, sections of the memory, each containing a 'hotspot', can be relived and then updated (see later sections of the chapter). Belief ratings are taken for meanings associated with each of the 'hotspots', before and after attempts to work on changing these appraisals.

Selective reliving

In some cases, where traumatic events occurred early in a client's life, and/or were very overwhelming, the therapist may place more emphasis on developing new and more positive imagery than on reliving much of the original traumatic memory. Here the original memory is revisited in imagery only in order for the client to experience the possibility of perceiving events or acting in a different way, e.g. expressing their true feelings, and/or incorporating help from other people. The whole memory may not be relived, but only run on to the point where the person realizes what is about to happen to them. At this point the new imagery is developed (e.g. Arntz and Weertman 1999; Weertman and Arntz 2007).

Alternatives to reliving: talking or writing about the memory

Sometimes a memory is so overwhelming that the client cannot face evoking it, for fear of getting 'lost' in the memory and associated affect. There may be unbearable shame

attached to the memory, or metacognitive beliefs about the outcome of talking about what happened. For example, the client may be scared that even talking about the event could make it all happen again, or that they would never recover if they brought it fully to mind. Here it may be possible to make a start by encouraging the client to talk more generally about the event without attempting to relive it, or even to write about it if they can. Pennebaker's studies suggest that when people write about emotional experiences, significant physical and mental health improvements follow (e.g. Pennebaker 1997). Brewin and Lennard (1999) suggest that writing may provide a 'cooler' space in which the client can approach the material, and begin to share it with the therapist. In their study, less emotion was generated when writing about an emotional experience on a computer than when writing in longhand.

In the case of repeated and prolonged traumatic events, including torture, it is difficult to target one particular memory. Neuner and colleagues have used a method of developing a narrative with clients that spans their whole autobiography. Clients are encouraged to talk about all aspects of their lives, experiencing the associated emotions as they do so, and gradually placing the most traumatic events in the wider context of the rest of their lives. The therapist witnesses the narrative and translates it into written form. This technique of Narrative Exposure Therapy (NET) involves some evocation of memories (though not reliving as such), and has been shown to be significantly more effective than supportive counselling or psycho-education (Neuner et al. 2004).

Exposure to cues to evoke memories

In any disorder, exposure to cues is liable to trigger imagery, including memories of events that preceded the onset. Using exposure to salient cues as an assessment procedure will provide material for behavioural experiments, which can help the client distinguish between past and present reality.

> Paul was afraid of wasps. The therapist introduced a wasp in a (closed) jam jar into the therapy room. The client immediately covered his right ear, predicting that the insect would escape from the jar, and fly into his ear. His phobia had begun when a wasp stung him in the ear. As in the case of Rosa (the client with bird phobia, described in chapter 6), he was aware that his current imagery and predictions were directly derived from memory.

Site visits to evoke memories

Some clients dread the thought of returning to the place where the trauma occurred. They believe that they will feel horribly distressed, and often have the uncanny feeling that something terrible will happen if they return to the site. As we saw in chapter 4, researchers (e.g. Ehlers and Clark 2000) have suggested that traumatic memories are often evoked out of context, and without a time code, and so appear to signal current threat, leading the client to imagine that the traumatic event will happen all over again. Other clients cannot explain why they avoid the trauma site, or make sense of their anticipatory dread.

In order to further explore their experiences, the site of the trauma can be visited with the therapist, after adequate preparation and reassurance, in order to see what memories are accessed. As in reliving, clients are often surprised by the results.

Hugh was hoping to start work at the hospital where his wife had died, but was very fearful of how he might react when he went there with the therapist. On arrival he became anxious. He had images of his wife's sister, and interpreted them as meaning his sister-in-law might appear again, and blame him for his wife's death. This was despite the fact that he knew that she lived abroad, and did not know that he was visiting the hospital. As he approached the ward he became afraid again, and had images of his dying wife, whom he feared he would see in her hospital bed, despite the fact that he had attended her funeral. When he finally entered the ward, he was very relieved that his image did not fit reality, and emerged exclaiming, 'She is not there now! It is only a memory'. In this case visiting the real situation had two beneficial effects: Hugh appreciated what was troubling him about going to work at the hospital, and was also able to begin to update the old memories, triggered in a situation that no longer presented a current threat.

Marie had recently been traumatized by an accident at work, which had activated flashbacks to a much earlier accident, when she had been hit by a car. Since most of her flashbacks and nightmares involved material from the first accident, the therapist decided that she and the client should visit the original trauma site. On arriving at the site Marie became frightened that she would find her own dead body at the scene of the accident that had occurred 25 years previously. The visit dispelled the fear, and photographs were taken of her standing at the exact spot on the road where she had lain unconscious.

Next the therapist and Marie visited the site of the second accident, where some shelving and a pile of cardboard boxes had fallen on top of the client, damaging her arm. Reconstructing the event proved illuminating. Faced with the sight of the shelving that had fallen on top of her, the client had a sudden flashback to coming round under the car at the time of the earlier accident. She realized that she must also have had such a flashback during the second accident, which made sense of her catastrophic response to it, when she had become confused and believed that she was about to die.

Micro-formulation

Sometimes there is a spontaneous shift in perspective when the memory is evoked, as described above, but more often exploration paves the way for the therapist and client to reflect further on the significance given to the memories at the time and subsequently.

As we saw in chapter 2, the fragments of memory that appear as intrusions in PTSD are typically the moments when meanings of the event changed, usually for the worse (Ehlers et al. 2002). Most intrusions are classified by clients as mapping on to the worst moments of the trauma, described as 'hotspots' (Grey et al. 2002). Such 'hotspots' in PTSD have been shown to be accompanied by a wide range of emotions, including sadness, anger, shame and guilt, as well as fear, helplessness, and horror (Holmes et al. 2005).

In disorders other than PTSD, intrusive images and memories also often appear to reflect what Conway has called 'negative, self-defining moments' (Conway and Pleydell-Pearce 2000) that can recur again and again in imagery, accompanied by a variety of possible emotions. Despite differences in content and associated affect, moments encapsulated in fragments of memory can be examined in a similar way across a range of disorders.

Paul was very nervous of socializing, especially when it involved standing and talking to people at a party. He would become afraid that he might suddenly start lurching around and making strange

noises. He ascribed this fear to an event at primary school. He was new to the class, and trying to make friends. He decided to pretend to be a horse in a game with a few other boys. But the boys jeered at his attempts to gallop and neigh, and called him stupid. This had been a negative, self-defining moment in his early life, and it continued to haunt him.

When evoking a memory, clients may spontaneously articulate some encapsulated meanings. If this does not happen, the therapist can enquire what each 'hotspot' in memory means to the client, and get them to elaborate further on the meanings, by asking typical questions used in cognitive therapy, such as:

- 'When you contemplate that memory what does it mean about you? About other people? About the world and/or about the future?'
- In addition the 'downward arrow' questions can also be pursued: 'If that is how you see it, what is the worst thing about that for you? And what is the worst thing about that?'

Often salient information can be gathered quickly in this way, to flesh out aspects of the 'anxiety equation', i.e. appraisals of probability, cost, coping, and rescue factors.

It can be important not only to explore meanings given to events at the time, but also the meanings currently associated with disturbing imagery. Metacognitive beliefs may be involved, such as believing that what is really a fragment of memory is a premonition, a warning or something supernatural.

As described above, Harry was inundated with images of car crashes after a recent accident. For him, the meaning of these images was that although he had emerged unscathed, he would be sure to have another accident, and probably kill someone. This accident would be a punishment from God, as he was (in his own eyes) a bad person. The longstanding belief that he was bad originated in childhood, and in particular reflected an earlier trauma in which his mother terrified him by insisting that he was bad, and would be endlessly punished by God. This message was also delivered on many other occasions. The micro-formulation diagram for Harry is presented in Figure 9.1. Therapy targets included challenging the belief that he was bad, using imagery rescripting to change the meaning of the most vivid early memory.

Here is a second example:

Claire was working in an abattoir when she was attacked by a bull that escaped from the killing pen. At one point during the trauma, she became convinced that the bull had become a monster, and that reality had changed. Whenever she encountered any reminder of bulls or cows she had images of the 'monster', and was terrified that she could be transported to another, horrifying reality, from which she would never return. She avoided any situation that might trigger the images. She was terrified of doing anything twice, particularly in the presence of bull reminders. This was because she had tried twice to escape from the bull, but on her second attempt had been badly injured, and nearly died. She feared that if she did anything twice she would relive the whole experience and this time she would die.

A micro-formulation of Claire's memory image and maintaining factors is presented in Figure 9.2.

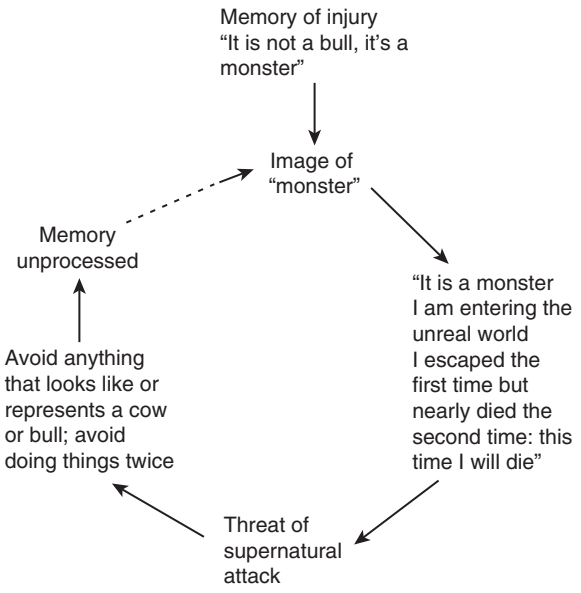


Fig. 9.2 Beliefs not tested and updated.

Other examples of micro-formulation are given in chapter 7. Sometimes, one memory turns out to have been highly influenced by an earlier distressing memory (or memories) as in the cases of Harry and Marie, described above. Such connections may be reported spontaneously by the client, or revealed by using the emotional bridge technique (see later in this chapter).

Manipulation

In earlier chapters, we have seen that distressing memories are often spontaneously triggered, but deliberately suppressed, because they are accompanied by great emotion, overgeneralized meanings, and a sense of current threat. Reversing avoidance and allowing the memories to stay in awareness can in itself bring about cognitive change, as this offers opportunities for reflection.

Repeated reliving

In the classic exposure treatment for PTSD, the intervention consists of repeated and prolonged imaginal and *in vivo* exposure (Foa et al. 1991). Reliving of the traumatic memory is accomplished (perhaps several times) in each session, and repeatedly for homework. Some newer treatment protocols have reduced the reliving component, substituting increased cognitive restructuring (e.g. Ehlers and Clark 2000; Resick and Calhoun 2001; Resick and Schnicke 1993). Typically, therapists who follow the Ehlers and Clark (2000) approach to PTSD incorporate an average of three sessions where the whole memory is relived, and within the same sessions also spend time identifying the 'hotspots' and examining their meanings. With this more 'cognitive' focus, the reliving procedure is seen mostly as a method of identifying meanings that are targeted later in treatment.

However, there is often spontaneous cognitive change during and after reliving sessions, suggesting that the strategy should not be abandoned too soon (see chapter 4).

As Jaycox (1997) has pointed out (see chapter 4), repeated reliving may bring about cognitive change in several ways. It allows for the discovery that the anxiety begins to fade, and does not have catastrophic results; the safe context of therapy is introduced; the client has the opportunity to reflect on the validity of the negative meanings previously attributed to events; and a more coherent narrative begins to emerge.

> During Jacqui's first reliving session, her account was highly emotional and confused. During the second session she relived the memory of the car crash again. This time she was much calmer and more coherent, using phrases such as 'I think', 'I realize' etc. There was evidence of cognitive change as she explained that at the time she had been distraught because she thought no-one was helping her. Now she realized that the man she was yelling at had not caused the accident himself, but was a bystander who was really trying to help her free her child from the wreckage. In her intrusive memory of the 'hotspot' she was screaming at him because she thought he had caused the crash, and had not processed what he was actually saying, or how he had gone on to help her.

Playing with the memory image, and changing its significance

To reinforce the idea that intrusive memory images are only fragments of memory, and there is no longer any current threat, the images can be manipulated in various other ways. Here are some examples:

> A man had been working at the scene of a terrible crime. He was left with an image of a room in which the walls were spattered with blood, although he knew that subsequently it had been thoroughly cleaned up. He manipulated the image by imagining that the room was filled with concrete, left until it set solid. The block of concrete was then lifted out by a crane, which removed all the bloodstains along with the concrete.

> As a child, Kate had been repeatedly abused by a male family friend. She was suffering severely from depression, and was hospitalized. She had recurrent memories of her abuser's face, which she believed meant that he was coming to abuse her again, although she knew he was dead. Instead of suppressing her memory images of him, she was advised to imagine him arriving, but being confronted by her, with support from two of the nurses. She imagined that they told him to go away, that he could not hurt her any more because he was dead, and that she now had plenty of support. In her imagination she saw him getting smaller and smaller, until he vanished completely. He had been sent back into the past.

> Wheatley et al. (2007) reported that a client who had dealt with memories of childhood sexual abuse began to experience intrusive memories of being violently beaten by her abusive ex-husband, despite the fact that she had escaped the abuse many years before. Instead of trying to suppress the memories she imagined herself standing up to him, surrounded by her adult children, who backed her up. She went on to imagine that she watched him safely from the window as he tried ineffectually to get into her flat. Ultimately she watched him walking away, getting smaller and smaller.

Discrimination

Discriminating between what is real, and what is imagined or remembered

Visiting the place where a traumatic event occurred can have several important functions. As described above, it can help in the retrieval of parts of the memory that were

previously not accessible. In addition, it helps the client appreciate that the event really lies in the past, and is not a current source of threat.

As we have noted in chapters 1 and 2, imagery is triggered by sensory or meaning cues reminiscent of past events. This process is particularly striking in PTSD, where an intrusive memory can be so vivid that the client may have a full dissociative flashback, and lose all awareness of their current situation.

> Claire (described above) who had been attacked by a bull in an abattoir, saw a picture of a bull in an office at work. Immediately her perception began to change. The wallpaper lost its pattern, fading to white. Simultaneously the temperature in the room appeared to drop, and she began to shiver. When a friend spoke to her she could not hear her for several minutes. During that time she believed she was back in the abattoir.

Treatment of PTSD usually involves some *in vivo* exposure to cues that trigger imagery. Initially, therapeutic effects can be enhanced by the therapist helping the client carefully discriminate between what they think they perceive, and what is actually present. This is beneficial, as many clients are hypervigilant for signs that what they fear is about to happen. Having spotted a cue, they then avoid the feared situation, attempting to get away quickly, before being able to process what is really happening. For instance:

> Polly had been threatened by a drug addict. When she was in the street she often spotted youths in the distance, and gave them a wide berth. Her image was that they were drunk or drugged, and probably aggressive. Walking out with the therapist she was encouraged to approach young people. She was enabled to see that the boys were usually harmless enough, and just chatting among themselves.

Sometimes even very unobtrusive sensory cues trigger flashbacks:

> Susie was in a dress shop. She felt panicky and had to leave abruptly. The next day she returned to the shop with her therapist, to see if she could spot the trigger. She realized that there were pairs of spotlights in the shop, resembling the headlights of the car that had crashed into her own. These lights had triggered an intrusive memory and a rush of terror. Once she recognized the sensory cue her anxiety subsided, and she was able to stay in the shop.

Environmental cues for practicing discrimination need to be carefully graded, so that the client can gradually learn to stay grounded in current reality, as in the case of Claire:

> Claire (described above) had flashbacks that were triggered by anything even slightly resembling a bull. For example, she was afraid of toys, books or household objects with images of bulls or cows on them. The more fantastic the representation the more terrified she felt.
>
> Her appraisals made during the trauma were driving the fear. During the trauma, she had almost been killed by the bull when she made a second attempt to escape. As a result, she was more frightened of twice encountering anything reminiscent of the bull, than of seeing it once. She believed that if she saw a bull-like object and did something twice she would be transported back to another reality, be attacked by a monster, and die.
>
> A series of behavioural experiments were carried out, to help her discriminate between past experience and present reality. For example, she was asked to open a children's book twice, at a page that depicted cows. She also left the room, re-entering it twice to see if the illustrated bull could become real and kill the therapist. Although she was diagnosed as having PTSD the presentation had features of OCD, with fears of being responsible for harm coming to others, and some magical thinking.

Intrusive memories are often triggered where there has been major childhood trauma. Here, even more than in PTSD, the client may be unaware that what they are experiencing are fragments of real memories. As we saw in chapter 2, Layden et al. (1993) describe a developmental sequence in which they suggest that early memories are laid down nonverbally in varying sensory forms. They describe the content of earliest memories as arising from 'the cloud'. The infant is aware of physical sensations such as touch and temperature, as well as sounds such as the tone and volume of voices. Later, visual impressions are formed, and later still, children start to encode and remember words and meanings. The implication of Layden et al.'s theory is that in adult life, sensory (and meaning) cues in the real world can unconsciously trigger childhood experiences with similar sensory properties—sometimes very early ones (e.g. of abandonment)—that get confused with reality. Clients may then be prone to experiences which are 'out of context, out of time'.

> Layden et al. (1993) described a client who broke into inconsolable weeping on a warm spring day. Probing her memory revealed that, as a child, she had gone boating on just such a day, only hours before her father suddenly died. The authors also described a client whose mother had been severely depressed when she was a small girl. If she felt anyone important was rejecting her, she would get flashes of her mother's cold, unresponsive face, which made her feel sad and lonely. Another client who had been sexually abused by her stepbrother would feel numb, cold and stone-faced if she felt that any man had positive feelings for her. To help her discriminate between what happened with her stepbrother and what was currently happening, the therapist suggested that she could bring a warm blanket to the session. Wrapping herself in the blanket when she felt the bad feelings coming on helped her stay focused on the present.

A template to help discriminate between the 'Then' and the 'Now'

Ehlers et al. (2005) have developed a template to help clients discriminate more clearly between the past and the present when intrusive imagery is activated. The therapist draws two columns on the white board, and begins by making notes in the two columns of the similarities between the current situation and those present during the trauma. Next, in two differently coloured pens, lists are made of the ways in which the two situations differ. This technique was invented as a therapy strategy for PTSD: however, it could be utilized in any other disorder where intrusive memory imagery is triggered. For examples see Tables 9.1 and 9.2. It can be seen that usually the similarities are sensory features that are in fact harmless and coincidental. The differences, however, are between intrinsically dangerous and safe aspects. By focusing on the differences the client is usually able to feel calmer, and to feel better equipped to make discriminations if the old traumatic feelings and memories are triggered.

Having demonstrated this technique in the session, the therapist can suggest that, for homework, the client deliberately seeks triggers for intrusive imagery associated with past memories; and then carefully attends to the similarities and differences between the current trigger situation and the past traumatic situation. This typically results in the intrusive imagery being triggered less and less frequently.

Table 9.1 PTSD following a car crash: similarities and differences (differences in italics)

Now (Having an MRI scan)	Then (After car crash)
Lying back	Lying back
Enclosed space	Enclosed space
Surrounded by metal	Surrounded by metal
Panic button	*No way to get help*
Someone who could get me out	*No-one around to help me*
Not trapped	*Trapped*
No danger of death	*Car might catch fire*
Not injured	*Badly injured*

These techniques for addressing upsetting *memories* in Type 1 and Type 2 trauma are closely related to the behavioural experiments to discriminate between *intrusive imagery* and reality which we described in chapter 8. Whether comparing memories and reality, or intrusive imagery (which may or may not be understood by the client to be a memory) with reality, the technique is essentially the same: the primary purpose is to learn to discriminate between the 'Then' and the 'Now'.

Transformation

There are two main approaches to the transformation of memories, namely:

1. Strategies to update and contextualize distressing fragments of memory

The purpose of these strategies is to identify often erroneous or unhelpful interpretations; to develop new understandings of the traumatic situation; and to integrate these new understandings into the wider context of the person's autobiographical experience. This approach has been favoured by Ehlers and Clark (e.g. Ehlers and Clark 2000; Ehlers et al. 2005).

2. Imagery rescripting strategies

The purpose of these strategies is to allow the client to experience and express emotions that were suppressed at the time, and imagine actions taken by the self and others that would have evoked a sense of mastery or compassion for the self.

Table 9.2 Childhood trauma: similarities and differences (differences in italics)

Now (alone in her flat on a cold night)	Then (parents left her alone when they did night-shifts at work)
Feeling cold	Feeling cold
Alone	Alone
Grown up	*Three years old*
Can leave the flat	*Unable to leave*
Can turn on the heating	*Unable to get warm*
Could telephone for help	*Unable to get help*

Strategies to update and contextualize distressing memories

As described in chapter 2, fragments of upsetting memories can carry distorted meanings that have not been updated. Verbal challenging using guided discovery and Socratic questioning may reveal more realistic perspectives. Cognitive and affective change may ensue. However, in many cases, clients may remark that logically, they can see that their appraisals were distorted, but this does not necessarily change the associated beliefs about the significance of events, or the affect. As we have seen above, reliving may help fill out the wider context of the 'hotspots' and thus change the appraisals made at the time, resulting in spontaneous cognitive change. However, sometimes other more active strategies are required from the therapist to enable the client to bring emotions into line with logic. Below we describe five of these techniques. What they all have in common is the capability to change the client's perspective:

- Verbal updating of meanings, with new information being brought into reliving to update the 'hotspots'
- Running the memory on in imagery past the worst point
- Imagining the scene from another perspective
- Moving on past the point of death
- Imagining taking actions not taken at the time.

Verbal updating of meanings

One method of verbally updating meanings is to ask the client to relive the memory (or the part of it that includes a 'hotspot') in the first person, present tense, and follow the description of each 'hotspot' and its distorted meaning by asking, 'And what do you know about that now?' The answers may come spontaneously, or may have previously been arrived at during guided discovery, while drawing out what happened, or via behavioural experiments (Ehlers and Clark, 2000; Grey et al. 2002).

> Polly was injured at work, when a plate glass window fell and cut her face. A year later she had a lingering memory image of her face covered with scars. Behavioural experiments involving video feedback and feedback from others had provided reassuring information about how she looked now. She was reminded of this during reliving, at the point in the memory when she had believed she would be scarred for life. She was asked at that point what she knew now about her scars, and replied that a year later they would be almost invisible. She also pinned up recent photographs of herself and her children to update the memory. This reminded her that not only had her scars healed, but also that she was alive and well. At the time of the accident she had also feared for her life, and wondered if she would see her children again.

An example of a written record of verbal updating of another client's traumatic memory is given in Box 9.1.

As a more realistic narrative begins to develop the therapist asks the client to write out the new version of events, highlighting any updating in a different colour or font. This process can be utilized in PTSD, but also in other disorders where intrusive memories carry distorted meanings.

Box 9.1 Verbal updating of a hotspot during reliving

I left the petrol station and set off up the hill. Suddenly, I saw a car on the wrong side of the road, driving straight towards me. I thought I was going to die. ***Now I know that I survived.*** As the other car hit me I managed to swing the car round to avoid a head on crash, but the bonnet still crumpled, and I felt pain in my legs. I had an image of myself in a wheel chair, having lost my legs. ***Now I know than one of my legs was hurt, but has healed well. I did not lose my legs.*** As the car came to rest I saw the other driver slumped across his wheel. I thought he was dead. ***Now I know that he was unconscious, but not for long. Miraculously, neither of us was badly hurt.***

Running the memory on past the worst point

A simple but potentially powerful intervention is to run the memory on past the worst point. This may happen naturally during reliving and sometimes facilitates spontaneous cognitive change. Alternatively, when this does not happen, it can be helpful to run the memory on past the worst point a few times to consolidate the shift in beliefs about what happened. This provides the opportunity for the person to realize at an emotional level that although they feared the worst during an event it did not actually happen.

> During a serious accident Bill had an image of his legs being shattered and the bones sticking out. However, only a moment later he looked down and realised he was not nearly as badly hurt as he had feared. Running on past the worst point of this hotspot helped diminish the associated emotion.

Imagining the scene from another perspective

If the above procedures do not shift belief ratings or decrease upsetting affect, imagery can be used to help a client place an upsetting fragment of memory into a broader, less toxic context, and thus change the meaning. Sometimes all that is needed is to imagine the scene from another perspective:

> Simon was involved in a car crash. When his car came to rest, two nurses passed by, and Simon felt sure they would help him. However, they just walked straight on. This plunged Simon into a familiar sense of abandonment and neglect. As a child his needs had often been ignored. His lingering appraisal was that no-one cared about him, even though he knew that only a moment later, several other people had come to his assistance. To shift the felt sense, the therapist suggested that he viewed the accident from another perspective: Simon imagined himself viewing it from above, and realized that as the nurses walked past, other people were running to help him. He concluded that the nurses might have felt that they could safely leave his care to them. This transformation of the image brought emotion into line with logic, and Simon felt less bleak about the incident.

Moving on past the point of death

Sometimes, when people have seen someone who is dead, they are left with very disturbing images. As usual, the first step is to evoke the image and explore its meanings. Very often this reveals a sense that the dead person is still stuck in their body, and suffering.

It can be helpful to enquire about the client's spiritual beliefs, and in particular what they think happens when people die. If the client wants to try this, it is then possible to imagine that they are the dead person, and move on past the point of death, until they leave their body, or have some kind of near death experience (NDE), consistent with the client's own beliefs. The following example provides an illustration:

> Julie's children died in a fire. Julie wept when she described her image of her son suffering and dying whilst she was out of the house. Her therapist encouraged her to imagine what his life that day was really like for him. She imagined being him, playing with his sister, going upstairs just before the boiler exploded, and being almost immediately overcome by the fumes (but not hurt by the fire). Julie took her son past the point of death. She imagined being him, travelling down a tunnel and out into the light. There he met his sister (who had died before him) and his grandmother, who had also recently died. This was a much more comforting image.

After the Omagh bombings in Northern Ireland some people were left with traumatic images of shattered bodies. In some cases it helped if the client imagined that the victim's broken body had been reassembled, and buried intact (pers. comm. from Gillespie and Duffy, describing the work reported in Gillespie et al., 2002).

Imagining taking actions not taken at the time

Sometimes, a client is almost convinced that if they had done something different a better outcome would have occurred, although logic tells them that this would not have happened. This may be true of adult or childhood memories. In this case, a useful strategy can be to ask the client to imagine that they did in fact do what they wish they had done. Needless to say this strategy is best employed where the therapist can see that the outcome is unlikely to be as good as the client might have hoped. Often this is already clear to the client from a logical perspective, but emotionally they return to torment themselves with this idea time after time.

> Sheila was on a ferry that sank. She was rescued from drowning, yet tried to rescue an old man who was still struggling in the icy water. Eventually she gave up, and he drowned. Sheila thought constantly about whether she might have been able to save him if she had gone back into the water, although her partner tried to convince her that this would have been impossible. Eventually the therapist suggested that she should imagine getting into the water and trying to rescue him. She was able to imagine this vividly, and pictured herself with him in the icy water, with the boat rapidly sinking and listing to one side. She became rather quiet and the therapist tried to rouse her. The client said that at first the imagined water was very cold, but after a while she started to feel warm and sleepy. She recalled that that is what had happened earlier, when she nearly drowned. She realized then that if she had gone back into the water, she would probably have drowned herself. She acknowledged at last that she would not have been able to save the old man. After the session she planted a small tree in his memory.

Imagery rescripting techniques

Imagery rescripting has been utilized by a number of cognitive therapists working with Axis II disorders (Arntz and Weertman 1999; Edwards 1990; Smucker et al. 1995; Weertman and Arntz 2007; Young et al. 2003). In this technique, part or all of a negative memory—often of abuse—is evoked, and the client is assisted to 'rescript' and imagine the

event so that a desirable outcome is achieved (e.g. the abuser is caught before they can do anything, and removed forever). Typically emotions that were suppressed are brought to the surface and expressed, and the client imagines taking actions (or seeing others taking action) that would have beneficially changed the course of events. This has been described as an 'experiential technique' (Young et al. 2003); the aim is to bring about lasting cognitive as well as emotional change. Rather similar procedures have recently been used to target distressing memories in Axis I disorders such as social phobia, eating disorders, and depression (Cooper et al. 2007; Wheatley et al. 2007; Wild et al. 2007, 2008). Therapists differ in the extent to which verbal discussion is incorporated in the procedure.

Smucker et al. (1995) developed a protocol for treating adults with PTSD following childhood sexual abuse, called Imagery Rescripting and Reprocessing Therapy (IRRT). Following an assessment, the client relives the original abusive situation, immediately followed by the start of the imagery rescripting phase. During rescripting, the client visualizes and describes the beginning of the abuse, but as soon as the molestation begins, they imagine their adult self arriving and attempting to master the situation by stopping the abuse, protecting the child and driving out the perpetrator. If, after several attempts, the client is unable to imagine successfully doing this they may choose to bring in support people, such as police, friends or the therapist. The imagery is not directed by the therapist, who remains warm, empathic, and encouraging.

After the client has imagined rescuing their child self, the emphasis moves towards offering the child nurturance. In the absence of very pathogenic self-schemas, clients can generally imagine hugging and comforting the child. However, some clients continue to feel hatred and contempt for their child self. Here it can be helpful to encourage the adult self to imagine moving closer and looking into the child's eyes. This frequently leads to more compassion for the traumatized child, and a chance to identify and work on badness, unlovability, and other schemas. For homework the client listens to the taped sessions twice a day, writes a letter to the perpetrator, and fills in a diary. The aim is to alleviate symptomatology and alter trauma-related beliefs. Some detailed case examples are provided by Smucker and Niederee (1995).

IRRT has been adapted for use with adult victims of accidents with PTSD (Grunert et al. 2003, 2007). In the most recent study, IRRT was offered to clients who had failed to improve with prolonged exposure treatment. The first phase involved reliving the traumatic event. Next came mastery/adaptive imagery: during the moments of highest affect, the client was asked to visualize their 'survivor self' (today) entering the scene to assist their 'traumatized self' (then) to cope with the trauma more adaptively. The therapist remained non-directive, using guided discovery to help the client to develop their own imagery. Once the 'traumatized self' had received sufficient support, assistance and nurturance from the 'survivor self', there was further therapeutic focus on these more positive representations. In this study, the clients who had not responded to prolonged exposure had predominant emotions that were not fear-based (e.g. guilt, shame, and anger). With the added treatment component of IRRT most clients made a full recovery, after only a few sessions. This is of clinical interest, because it suggests that interventions other than simple prolonged exposure may be necessary where clients have prominent emotions other than fear.

Another variant of Imagery Rescripting (IR) was developed by Arntz and his colleagues, based on the principles outlined by Smucker and colleagues. In the Arntz and Weertman (1999) protocol, the therapist first identifies a childhood memory laden with negative schematic meaning. The client is asked to relive the memory first from the child's perspective, then from the perspective of their adult self, who sees what is happening and may intervene. Where the events are extremely traumatic, the client may only be asked to relive a small part of the traumatic experience before proceeding to rescripting. Arntz and colleagues then added a third phase, in which the client relives the event again from the child's perspective (experiencing the interventions of the adult self or others) and is asked what else they would like to happen. The client again returns to the memory, this time imagining from the child's perspective that the event took place as they would like it to have happened (e.g. the perpetrator is thrown out of the house forever and the child is embraced with love by the adult self). This step has been added to Smucker et al.'s original protocol, so that the client imagines actually experiencing the help and nurturing received, and not just witnessing it from the adult perspective. Several empirical studies have demonstrated that this version also has powerful effects (Arntz and Weertman 1999; Weertman and Arntz 2007).

Arntz et al. (2007) have also adapted imagery rescripting for adults suffering from PTSD. They suggest that this can not only alleviate PTSD symptoms, but also change the sense of powerlessness, victimization, or badness. The method involves changing the traumatic imagery, but without denying the reality of the original trauma. For example, the client is encouraged to experiment in imagery with gaining control, by expressing their needs and feelings, and imagining behaving differently. In their study they contrasted imaginal exposure with imaginal exposure plus imagery rescripting, and found that although overall the treatments were equally effective there were fewer dropouts in the group who had some imagery rescripting, and they showed greater changes in aspects of anger, shame and guilt. Therapists also preferred this version of treatment, and felt less helpless.

Brewin et al. (2009) extended the use of imagery rescripting to working with clients with a sole diagnosis of depression and intrusive memories. Sessions focused on accessing and rescripting both adult and childhood memories, incorporating elements of mastery and compassion for the self. In this study belief ratings fell, and rapid and long-lasting symptom relief took place, without any of the usual verbal or behavioural interventions for depression. Greater detail and case material from this study is given in two other papers by Wheatley et al. (2007, 2009). It was observed that spontaneous behavioural change took place, without any therapist encouragement to try behavioural experiments or activity scheduling. The authors noted that memory is not just a way of recording the past; it also enables us to model and experiment with alternative versions of reality (see also chapters 12 and 13).

Interweaving imagery rescripting and other cognitive therapy techniques

Therapists vary in the extent to which imagery rescripting techniques are given a cognitive rationale. It also remains an empirical question as to whether the effects of experiential

techniques would be enhanced (or diminished) by more thoroughly interweaving them with other cognitive therapy techniques, such as by embedding imagery work among guided discovery and behavioural experiments. Preliminary results suggest that significant effects of this technique can be produced in social phobia, after a single session in which Socratic dialogue and memory restructuring are interwoven (Wild et al. 2007, 2008). In this approach, Socratic dialogue plays a part in deciding how to modify the imagery. For example, Wild et al. (2007) describe the following case:

> John was suffering from social phobia, and believed that he was seen as ugly, not likeable, and immature. He anticipated confrontation, and felt that no-one would back him up. These beliefs and his image of himself appeared linked to memories of being bullied as a teenager, because he would not bow to pressure from 'friends' who wanted him to take drugs. Socratic questioning revealed that in fact the boys who had bullied him had grown up to be 'losers' themselves, and were criticized by all. However, John had a secure job, a partner, and lots of support from his family. He brought this updated perspective into an image in which he met the bullies again as an adult. They were surrounded by their families and friends, and everyone present had to decide whose side they would choose to be on. As the client explored this in imagery, he realized that he was now the one with all the support. Even the families of the bullies had lost patience with them.

On occasions, imagery transformation simply arises in response to the imagery rescripting intervention. As mentioned above, Socratic dialogue may not always be required. For instance, the therapist might guide the client to consider possible changes with questions such as 'What would you need to happen to make you feel better about this?' 'What do you know about that now?' 'Can you imagine that actually happening?' As we have seen with other imagery interventions, spontaneous change can sometimes occur with more experiential techniques in the absence of detailed cognitive work.

Making an 'emotional bridge' to the past, to even earlier memories

In chapter 8 we provided examples of making an emotional bridge between current recurring images, and memories which may well have been the source of the image. When working with distressing memories, we may sometimes observe that these representations of events have themselves been heavily coloured by input from earlier memories.

> Petra was traumatized during a tsunami. When she had heard the roar of the approaching water she experienced this as aeroplanes about to drop bombs, a memory from an earlier trauma. This faulty appraisal of the noise accompanied her intrusive memory of the tsunami.

The influence of earlier memories can sometimes become apparent during the usual process of exploring the content and meaning of a more recent distressing memory. However, sometimes, their influence may not be obvious from initial exploration. A clue for therapists to probe further is when the appraisals seem out of proportion to the event being described. At such times, the therapist may ask the client: 'Has there been any time in the past when you have experienced similar feelings? When was the first time? Or is there a time which stands out in your mind?' There is no need for the therapist to explain

why they are asking this, and indeed it is probably better approached in the spirit of guided discovery. The client should not feel under pressure to come up with what might be spurious associations. However, if the client does make a link between the memory being examined and other past traumatic events, guided discovery can be used to examine what the client makes of this. If appropriate this can lead to some psychoeducation, along the lines that some images are like 'ghosts from the past', appearing to tell us things about one event, but having their roots further back in time. This material can then be fed into a new micro-formulation.

For therapists, the implication is that past events that are colouring a more recent experience can become an important target in therapy, as in the following examples:

> Will suffered a fairly trivial car crash. He realized that it upset him so much because his immediate appraisal was that his son (who was in the car) had been killed. This brought back a memory of a time when (as a tiny baby) his son was found to have stopped breathing in the back of the car. The recent car crash shocked him so much that he had to ask his wife to drive, even though no-one was hurt. He felt that this showed that he was a weak, inadequate person, an appraisal he found hard to shift. The therapist asked when in his life he had had similar feelings about himself, and he replied that certain childhood experiences had left him feeling helpless and guilty in the face of stress. This feeling was strongly associated with a childhood memory of his father beating his mother, while his disabled aunt begged Will to intervene. He was nine years old. He could not decide what to do, and ended up doing nothing. This memory was activated by the car crash, and he found himself ruminating about being weak, and thinking about how he should have stood up to his father. The therapist suggested that he imagine doing this. Will imagined lunging at his father and shouting at him, which angered his father. He was able to see that this would not have ended well: in the imagined scene his father picked up a stick and hit his mother with it. He also recalled that on the day of the fight his father had soon stopped hurting his mother and had left the house. Doing nothing had proved to be the more sensible strategy. Will was then able to reframe his reactions after the car crash as understandable in view of his traumatic childhood experiences, and the previous experience of his baby son nearly dying. His sense of guilt and weakness was reduced.

> As described on page 117, Harry's appraisals after his car crash included the idea that he had attracted the accident. His distressing childhood had led him to believe he was bad, and attracted disaster. Treatment involved work with an intrusive memory of a childhood incident when his mother managed to convince him that he was bad and would always be punished. After several unsuccessful attempts to change his perspective the therapist tried imagery rescripting. The client imagined his mother yelling at him, and his aunt arriving unexpectedly. She explained to the children that their mother was not well, and said she would try to find another way to care for them until their mother recovered. Imagery rescripting led to a change in the appraisal of this significant childhood memory. Importantly, changing the client's understanding of this earlier incident also changed his appraisal of the car crash, and led to a significant reduction in his current depressive symptoms. He no longer believed that he had attracted the accident, or was being punished by God.

Creation

In cases where distress is more profound or widespread, positive imagery to create whole new 'ways of being' can be constructed afresh to counteract the negative schematic beliefs (see chapter 13). New positive imagery can also be helpful as an aspect of schema change, even when there are no intrusive memories repeatedly troubling the client (Holmes et al. 2007a).

Sometimes positive imagery arises spontaneously, while other work is being done on intrusive memories. For example, both of the clients described by Wheatley et al. decided to introduce some spiritual imagery. In one case a compassionate angel was imagined, in the other, a cleansing light. Lee (2005) describes developing a compassionate image, and bringing this in to the reliving of a distressing memory, to soften the emotional impact. For further details about compassionate mind imagery and other interventions to change clients' 'ways of being', see chapter 13.

Conclusion

In this chapter we have considered a range of strategies for working with memory images. These include ways of helping the client to:

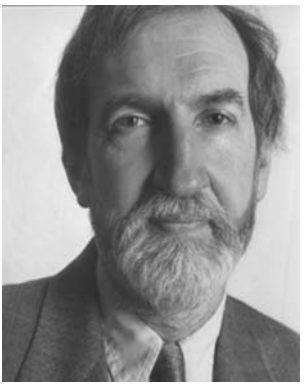
- Understand the importance of accessing and reflecting upon the upsetting memory images (socialization)
- Access and relive the memory using methods to ensure that the affect is activated
- Micro-formulate hotspots in memory, considering associated meanings, avoidance and safety behaviours
- Engage with the triggers for disturbing memory images
- Learn to discriminate between memory and present reality
- Update memory images using verbal and imagery techniques
- Rescript traumatic early memories that have continued to have a negative effect on current functioning
- Create an emotional bridge to early memories that are colouring current appraisals, and rescript if appropriate
- Create new positive and self-compassionate imagery (see chapter 13 for fuller description).

Many of the techniques described here have been developed in the fields of childhood trauma and PTSD. However, there is a growing body of evidence that they may have much wider usefulness across disorders (e.g. Brewin et al. 2009; Cooper et al. 2007; Wild et al. 2007, 2008).

Our clinical experience suggests that often the result of working with memory images is that beliefs change to more realistic, measured appraisals than those made at the time, and negative affect is decreased. When upsetting memories are accessed, reflected upon and put in a broader context, the associated imagery no longer has toxic implications for the present. The rationale is based not on exposure or habituation, but focuses instead on changing appraisals and affect. If the intervention works, the event is seen as an isolated event (or string of events) in the past—an exception rather than the basis for a rule about how the self, others, or the world are perceived (Arntz and Weertman 1999). In short, successful cognitive–emotional processing has occurred (Rachman 2001).

CASE VIGNETTE

Imagery and imagery rescripting as spontaneous processes



Chris R. Brewin, *University College London, London, UK*

Charlotte had very strong flashbacks to abusive events in childhood and adulthood, and tended to dissociate when they became overwhelming. One day a man jostled and slapped her while she was downstairs standing in a queue to pay at a self-service restaurant. The staff were busy taking orders and did not help her. She then began to have frequent intrusions of him taking her upstairs in the restaurant where there were no people and backing her into a corner where she could not escape, at which point she started to have very bad feelings she associated with her past.

The therapist suggested she imagine carrying a large Victorian hatpin in her bag and using it to keep him at a distance. She responded positively to this idea and could easily imagine using the hatpin. This strategy helped her to reduce her anxiety and exercise more control over the images, but they continued nevertheless. A short time later Charlotte was in bed when she had the intrusion again. She spontaneously imagined hitting him very hard over the head with a cosh. At the point that his head splintered and he died, she realized she was seeing one of her childhood abusers. From that point on the intrusions did not recur.

Night-time imagery

Chapter 10

Working with night-time imagery

'To sleep, perchance to dream, ay there's the rub.'
Shakespeare, Hamlet (1601).

Introduction

Night-time imagery can be frightening. Often clients have troubling images and memories, and poor sleep accompanied by bad dreams or nightmares (Freeman 1981; Freeman and White 2002; Rosner et al. 2004). Disturbing affect can be pervasive. Some clients stay up for hours, hoping that they will fall straight into a dreamless sleep if they are tired enough. They may be trying to avoid imagery that arises while they are awake at night or disturbing dreams once they finally fall asleep. Cognitive avoidance may be the order of the night, as well as the day.

A robust finding is that people with insomnia suffer from excessive cognitive activity during the pre-sleep period (e.g. Espie et al. 1989, Lichstein and Rosenthal 1980). Nelson (2001) found that, while poor sleepers had fewer unpleasant images than good sleepers, these images were significantly more unpleasant. Poor sleepers also experienced more verbal thought than the good sleepers. These observations led Nelson to speculate that since unpleasant imagery is associated with somatic arousal (Vrana et al. 1986), this may motivate people to block their imagery and engage in verbal thought. Interestingly, when participants were instructed to adopt a reflective stance and dwell on a current stressor in imagery (rather than engage in verbal thought about it), they fell asleep more quickly and were subsequently more relaxed when they woke than subjects who engaged in verbal thought. Yet they were more aroused both subjectively and objectively whilst attending to the imagery (Nelson 2001). This supports Borkovec's view that, whilst more upsetting in the short-term, thinking in images may be associated in the longer-term with more successful emotional processing (Borkovec et al. 1998).

Such observations lead one to conclude that distraction may not be the best medicine for night-time imagery. Instead, as we will argue in this chapter, it may be better to encourage clients to try engaging with disturbing imagery, evoking it fully, reflecting on it, and perhaps manipulating or transforming it. This runs counter to suggesting distraction as the way to manage poor sleep. However, we acknowledge that further research is needed to determine more clearly whether staying with the imagery works better than distraction.

Beck argued that dreams were 'ideational cousins' of automatic thoughts and followed a unique pattern, specific to each disorder. He studied the dreams of clients with depression, reported in several early papers (Beck and Hurvich 1959; Beck and Ward 1961). Beck concluded that in depression 'dreams were analogous to the kind of suffering the depressed patient experienced in his waking life' with cognitive themes similar to those reported in day-time negative automatic thoughts. Ward et al. (1961) looked at a wider range of psychiatric problems, and again found dream themes characteristic of the cognitive themes found in waking life in each disorder.

Beck (1976) suggested that focusing on the more obvious and easily described aspects of the dream is more satisfactory than speculating about hidden underlying processes. He observed that dreams might provide a useful 'biopsy of the patient's psychological processes', as during sleep, when 'external input is withdrawn the cognitive pattern exerts a maximum influence on the content of dreams' (Beck 1971). Thus it is possible to hypothesize that the material in dreams or nightmares may be at the same 'address' in the mind as day-time automatic thoughts and imagery, and therefore may be amenable to similar techniques.

Beck (1967) noted that when treating clients with 'neurotic–depressed' reactions there was a high incidence of dreams with unpleasant content. As treatment progressed, the dream frequency and content changed, reflecting the waking cognitive changes. A similar observation was made by Hackmann (2004), who presented data indicating that with successful treatment, clients with PTSD showed a progressive decline in nightmare frequency and distress, plus improvements in sleep quality, in synchrony with the decrease in intrusive memories.

In Hackmann's 2004 study, the emphasis of PTSD treatment was on targeting intrusive day-time imagery; no direct attention was given to sleep or dreams in the treatment group. In contrast, a number of studies have specifically identified bad dreams and nightmares as a treatment target. For example, Krakow et al. (2001b) reported a significant drop in frequency of nightmares as the result of an 'imagery rehearsal' technique to modify the nightmares of PTSD sufferers. This was accompanied by a drop in overall PTSD scores including scores on the intrusion cluster of symptoms.

Imagery techniques have been shown to be beneficial in the treatment of bad dreams and nightmares in a number of studies. Techniques used in cognitive behavioural approaches have included systematic desensitization to dream material (Celluci and Lawrence 1978), imaginal exposure (Bishay 1985), rehearsal relief of nightmares (Marks 1978), imagery rehearsal (e.g. Krakow et al. 1995), and approaches targeting cognitive themes using a mixture of guided discovery and imagery techniques (Edwards 1989; Freeman and White 2002). Each approach has suggested methods that we may utilize to work with dreams.

As we saw in chapter 1, Beth Rosner (2002) has provided a fascinating analysis of the historical development of Beck's cognitive therapy. She points out that Beck privileged method over theory, and espoused the value of experimental science. He presented his data to psychoanalysts and to behaviour therapists, hoping for a movement towards an

Box 10.1 Working with dreams in cognitive therapy

- The patient records and reports a dream in the therapy session
- The dream is described, and cognitive themes are explored
- There is reflection on how these themes are also manifest during waking life
- The client considers how they would like to feel about the situation depicted in the dream, and how they would like to behave
- In imagery the client experiments with changing the dream in various ways
- This continues until the client feels that there has been a shift in perspective on the target situation in the dream, with attendant affect and belief change
- The client then reflects on what this means in terms of their waking life, and how they might respond differently to similar situations in the future
- The client may wish to experiment with changing their behaviour in similar situations between the sessions.

integrative approach to psychopathology. Beck was interested in seeing therapists, researchers and clients all working in a spirit of collaborative empiricism. He warned that we need to 'try to avoid getting hung up on theoretical disputation' and instead take the pragmatic approach: 'if a technique works (and there is no contraindication for its use), then use it' (see Rosner, 2002, p. 14). Hence, in the remainder of this chapter, we look at what works for our clients at night, using the same section headings as in previous chapters: Socialization, Assessment and Evocation, Micro-formulation, Manipulation, Discrimination, Transformation, Making an emotional bridge to the past, and Creation.

In each section below we present ideas for working with people who experience night-time images while lying awake, or who experience disturbing dreams and nightmares. In particular, this chapter is influenced by the work of Freeman and colleagues (Freeman 1981; Freeman and White 2002), see Box 10.1 for a summary of their approach, and Krakow and colleagues (Krakow et al. 2001a, 2001b, 2006). We define a nightmare as a dream that wakes the person in a state of high arousal.

Socialization

Because problems often seem worse at night, clients often try extremely hard to suppress imagery of any kind, using various distraction techniques. Therapists can inadvertently aid and abet these efforts, if they suggest remedies such as getting out of bed if not asleep within a short amount of time, or distraction by reading a book before returning to bed.

Alternatively the therapist can help the client to see that actually some of their avoidant strategies may be keeping poor sleep, bad dreams, and intrusive imagery going. In fact the opposite strategy may be more efficacious: as in the case of day-time intrusive imagery, what may be needed is to actually approach, explore, manipulate, or transform disturbing

imagery, rather than try to avoid or suppress it. A variety of possible strategies are available, and the choice of technique can be guided by the formulation.

Like day-time disturbing imagery, night-time imagery of every sort is often suppressed, without any opportunity for reflection. In addition, having got rid of the imagery the client may start to ruminate verbally around the content of the imagery, delaying a return to sleep. The therapist can suggest to the client that there may be other more effective ways to deal with night-time imagery: a useful *metaphor* to explain these ideas is 'attempting to be like a person watching ***an express train*** passing through a station, whilst remaining on the platform, rather than jumping onto the tracks to try and stop the train, or boarding the train and grappling with the driver'. 'Jumping on the tracks to try and stop the train' is presented as analogous to suppression, while 'boarding the train and grappling with the driver' is presented as analogous to rumination (see also chapter 9).

This leads to the suggestion that, when the imagery arises, the client should try attending to it, and moving towards rather than away from it. In the short term this may result in greater physiological arousal, but sleep may soon improve. There may also be some spontaneous restructuring of the material, or of the client's metacognitive understanding of the imagery. In other words, the tactics that work in the day may also be helpful at night. Even if no changes take place, reflection may provide valuable material for a micro-formulation.

The therapist can explain to the client that dreams and nightmares often have the same meaning themes as day-time thoughts and images, accompanying emotions. There are ways of changing the content and meanings of dreams that will reduce distress in the day as well as at night. The idea that a nightmare is like a dream that one has not had the opportunity to end helps some people to understand why it might be helpful to work on the content of their dreams, running them on past the point at which they would normally wake up, or even taking charge and changing the content of the imagery before that point. We can also reassure clients that working on their dreams can help with life in the day-time (Freeman and White 2002; Krakow et al. 2001b), and also that working on their day-time imagery may also have a beneficial effect on their sleep and their bad dreams (Hackmann 2004).

Evocation and Assessment

Evocation and assessment of waking night-time images and dreams follows a similar pattern to examination of day-time imagery (see chapters 8 and 9). Attention is directed to the content (literal and metaphorical), the meaning, the metacognitive beliefs about the significance of the imagery, the emotional impact, and the client's responses to the imagery, as well as its likely source.

As we know from everyday life, describing a dream to someone else is often the beginning of a process of reflecting on the content, identifying a problem that is on our mind, and ushering in problem solving, or heightened awareness of cognitive distortions and exaggerations in the dream material. This process of reflection can lead to autonomous cognitive change, even during assessment.

Date	Dream recall	Emotion (Degree: 0-100)	Dream restructuring	Re-rate emotion

Fig. 10.1 Dream analysis record.

Clients often spontaneously mention disturbing dreams, which can then be evoked using reliving (i.e. with the client describing the dream with the eyes closed, in the first person, present tense–see chapter 9). Alternatively, if the client is reporting frequent dreams or nightmares, they can be asked to record details in a dream diary, which they bring to treatment sessions. Freeman and White (2002) advocate the use of what they call a dream log. The dream log is a small notebook near the client's bed in which to record dreams, dream fragments, and images soon after waking. The client also records affect and physiological arousal on 10 point scales (e.g. 'woke up scared, 8'). Such notes are very helpful because if dreams are not discussed or recorded (or at least reflected upon) they quickly fade and are no longer possible to retrieve. If any dream is particularly salient and/or recurrent, the client can be asked to close their eyes and recount the nightmare in all its graphic detail. The therapist and client can subsequently reflect on the thematic content, and its possible links to current problems, and/or past traumatic experience.

> Bill was waiting for an underground train when there was an explosion followed by a fire. Bill fell backwards onto the ground, and was trampled on by people trying to leave the platform, who did not see him lying on the ground. He presented with PTSD, and had recurrent nightmares. He dreamed of not being able to communicate with anyone, get anyone to help him, or find his way out of labyrinthine structures. This nightmare appeared to reflect both his recent traumatic experience and his childhood, which was characterised by neglect and lack of protection.

Together with the dream log, a second technique used by Freeman and White (2002) with these clients is the dream analysis record (DAR), an adapted version of the automatic thought record (see Figure 10.1). The DAR is used (at home or during a therapy session) to explore the content of the dream. In column 1, the dream is recorded. In column 2, the 'highlights' of the dream (comparable to hotspots in memory) are recorded. In column 3, the emotion associated with the dream and its highlights is rated on a 0-100 scale. There are two other columns used to record the restructuring of the dream and its effects on emotions (see transformation section below).

If the client likes painting or drawing they can be encouraged to produce an illustration of the worst moments of the dream.

Fig. 10.2 Drawing and reflecting on the meaning of a nightmare.

Clara painted an image of a dream she had had when she was five years old (see Figure 10.2). In it a huge figure that looks like the crucified Christ dominates the scene. Clara and her brothers are drawn on the stairs waving pieces of the banisters, which her older brother told them to break and use as weapons, saying 'it doesn't matter now'. They look very vulnerable. In the next part of the dream the children go under the bunk beds, and Clara finds a little satin handbag, containing a sparkly necklace. The feeling in the dream was one of terror and a total lack of protection. Clara's mother had died when she was only four, and her father was not able to acknowledge the loss to the children, or help them modulate their feelings. In the dream Clara eventually finds the handbag and the necklace under the bed, and this instils a sense of comfort, as it is her mother's bag: tangible evidence that there was security in the house in the past, and her mother might still be there somewhere.

In a seminal paper, Edwards (1989) discussed the use of Gestalt techniques and imagery in cognitive therapy. He presented a case described by Perls (1971) exploring metaphorical imagery in a dream, with a client (Linda). Edwards described this as a masterful example of guided discovery. In this example, simply inviting the client to dwell on the meaning of each aspect of the dream provided the opportunity for the kind of autonomous shift in perspective that we have discussed in previous chapters (see in particular chapter 4).

Linda dreamed of a lake drying up, and a group of porpoises dancing around, no longer able to breed in the lake. The water gradually dried up, and all that was revealed was an out-dated license plate on the lake bed. Perls asked the client to explore the image, imagining herself first to be the license plate, and then the lake, describing her emotions and the meanings she gave to these symbolic aspects. By using this process she was able to access various assumptions, including the belief that as she was no longer able to have children her creativity was at an end, and she had no recognized position in society. As she dwelled on the imagery, and the associated sadness, the meaning of the imagery changed. She described how, as the water from the lake dried up and sank into the ground, she became aware that this might provide the water needed if more flowers were to grow there. This suggested to the client that she could find new ways in which to be creative.

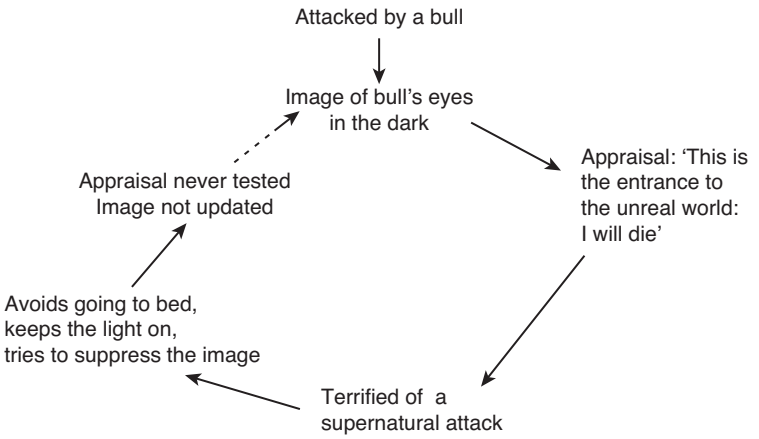


Fig. 10.3 Suppression of night-time imagery.

Micro-formulation

Following the assessment and evocation of imagery, the therapist discusses a specific example with the client, and draws out a micro-formulation including the responses that maintain the problem (see chapter 8). This determines the therapeutic strategy chosen. For example:

> The woman attacked in an abattoir by a bull (see chapter 9) had images of the bull's eyes revolving in her head every time she got into her bed. To her this meant that she was about to enter the 'unreal world', where the 'monster' was waiting to kill her. She would be transported back there if she focused on his eyes, and then she would suffer a horrible death and an agonizing entry into the afterlife. Understandably she was making heroic efforts to suppress the images, which meant that her beliefs were never challenged, and the imagery was maintained. For a micro-formulation diagram centred round this image see Figure 10.3. She used manipulation of the image to strengthen the idea that the image was actually only a mental image, with no significant meaning in the present (see section below on manipulation).

As we have discussed, dreams and nightmares can seem so real and be so distressing that frequently sufferers try their hardest to suppress the imagery and affect by distracting themselves. This does not leave any opportunity for reflection on its content or appraisal of the imagery, thus perpetuating the problem.

> Dorothy had a recurrent nightmare, replicating her experience of being knocked off her bike by a car. In the nightmare she flew into the air, and smashed through the windscreen of the car, believing she would be killed. She woke in a panic after this nightmare, feeling she was about to die. She immediately got out of bed, and tried to suppress the imagery and affect by using distraction, and reading a book or watching TV. In their formulation, Dorothy and her therapist hypothesized that the distraction strategy was fuelling the recurrence of the nightmare (See Figure 10.4).

Manipulation

In a seminal paper on working with dreams in cognitive therapy, Freeman and White (2002) suggested that, as well as using imagery techniques to transform the thematic meanings of dreams, one can also deliberately manipulate the dream imagery to make it feel less threatening. For example, they discussed a client who dreamed of a snake attacking

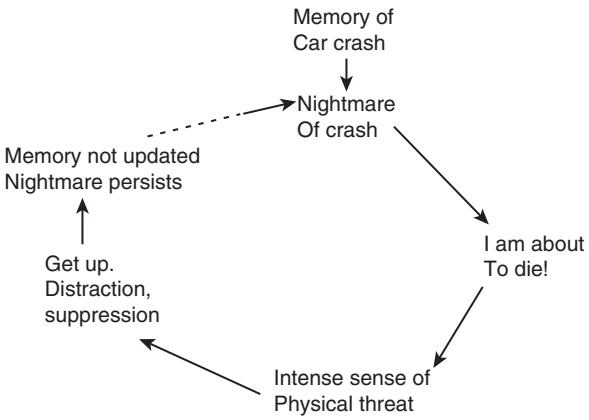


Fig. 10.4. Micro-formulation of a nightmare.

her, and her own inability to respond to such attacks. They suggested that she might have been helped by making visual changes to the snake image in the dream, e.g. by turning the snake into a Sesame Street cartoon figure, or making it smaller to reduce the sense of threat. As we have discussed in chapters 8 and 9, such manipulations can make the client feel more empowered, and more convinced that the dream image is only a mental event, over which they have some control, as in the following example:

> The woman described above, who was attacked by a bull, obtained relief in the following way: when she got the horrifying image of the bull's eyes, she used her imagination to swivel the imaginary eyes in the opposite direction, and make them smaller and less violently red. This weakened her belief that the eyes were a signal that she would be swept into another reality, from which she could not return. Instead she began to appreciate that this was simply mental imagery, over which she could assert some control.

Many of the dreams of sufferers of PTSD are replicative nightmares: the client wakes in turmoil at the worst moment of an exact nightmare replay of the actual trauma. Here a useful strategy can be to try to stay with the traumatic material, running the memory on deliberately to incorporate the understanding that the nightmarish outcome (e.g. death) did not actually happen (see also chapter 9).

> Dorothy (described above) was encouraged not to get out of bed and distract herself, but to continue reliving the memory. Instead of being killed as she had feared at the time, she had ended up under the car, and was eventually taken to hospital, and survived. After a few nights of staying with the memory, she woke having had the nightmare, but with the assurance that it was really just a dream, of no significance in the present. Subsequently the frequency of the nightmare decreased, and she was also able to return to sleep more easily if it occurred.

Discrimination

Sometimes at night (as in the day-time) imagery can be both vivid and devoid of context. It appears to the client that the image is something real and happening now, rather than a memory from the past. This is particularly likely to occur in cases following trauma (PTSD, acute stress disorder, or childhood sexual abuse) and in cases of personality disorder. This confusion of past and present realities is also more likely to occur at night if

that is when the trauma took place. It is important to help the client discriminate between what is real, and what is only imagery. Understanding what triggers the imagery, and what it represents, is helpful, as in the following example:

> Paul was very concerned because every night when he was in bed he saw a black rectangular shape with glowing eyes. He realized that the shape was not really there in the room, yet it seemed more real than a mere product of imagination, and it appeared again and again. A friend suggested that it could be some kind of demonic apparition: a rather alarming idea. However, Paul's daughter hazarded a guess that the 'apparition' might be somehow connected with a serious car crash the family had been involved in some months previously. Paul suddenly realised that what he was 'seeing' at night was the memory image of the car approaching from behind with its headlights blazing, a warning signal that there was about to be a crash. Armed with this knowledge, Paul adopted a different stance towards the image: he greeted it with more equanimity, and played with shrinking and expanding it. Soon it faded away.

> Susie had horrible intrusive memories at night of her husband standing by her bed, strangely dressed and about to shoot her. This event had occurred when he was suffering from a psychotic episode, which led to him being admitted to hospital. Susie realized that these images were only triggered if she lay on her left side, as she had done on the night of the trauma. Changing her position to lie on her right side helped her to feel more in control, and more able to remind herself that these images were only memories, and that her husband was now receiving medical care.

Drawing or painting a dream may help the client to be more objective, and may assist in the process of spotting cognitive distortions, following which the client may be better able to discriminate between the dream and reality. Subsequently, the content of the imagery can be altered accordingly, by vividly imagining the transformation, or even painting the transformed scene.

> Jennifer painted a dream in which her alcoholic ex-husband was breaking into her house to take everything away from her. In the painting she was there with her new partner and grown up children, but while her ex-husband was huge and menacing she and her family looked tiny and ineffectual. In reality, Jennifer appreciated that her ex-husband did not know where she lived. She had taken out an injunction against him, and she had lots of support from her family, her friends, and the police. With this in mind she painted the scene again, making her family larger and more powerful looking, and her ex-husband smaller, less menacing, and on the outside of a locked door. While the feeling of vulnerability in the dream was initially coloured by previous experience, in current reality she came to realize that (with the support of the police, relatives and friends) she would be able to deal with any threat posed by her ex-husband.

Transformation

Any of the methods suggested for day-time imagery and intrusive memories can be used at night, e.g. letting the imagery run on past the worst point, introducing coping or rescue factors, seeing the imagery from another perspective, or rescripting a dream. In the following example, Julie and her therapist transformed her night-time imagery by reflecting on Julie's own belief systems, and adopting a different perspective from which to view the troublesome experience:

> Julie's mother had died suddenly of a brain haemorrhage. Many months later Julie was still troubled every night by a disturbing image of her mother's face, when she saw the body shortly after her death. Julie and her therapist decided that rather than continually trying to suppress the imagery, it might be better to explore the image and its meaning. When she allowed herself to reflect on the

image she began to cry, realizing that the meaning for her was that her mother looked defeated, and might still be somehow trapped in her body and suffering. Julie then reflected on what she believed actually happened to people when they died. She did not believe that a person's soul could really be trapped in their body. In fact she had recently been impressed by a TV program about near-death experiences. This suggested to her that her mother might have been able to escape from her body, and end her own suffering. To make this more real to herself, she then imagined being her mother, and actually dying. She experienced in imagery what it might be like to move out of her body, look down on herself from above, and experience relief from the fear and pain. Her own feelings shifted dramatically, and she was no longer troubled by the images at night.

The most detailed accounts of working with dreams in cognitive therapy have been provided by Freeman (Freeman 1981; Freeman and White 2002; Rosner et al. 2004). The steps described by Freeman and White are listed in Box 10.1.

It will be seen that here as in other aspects of imagery work elements of the experiential learning circle (Bennett-Levy et al. 2004; Kolb 1984) are apparent (see also chapter 4):

- The dream material is closely examined
- Reflection on the content takes place
- Plans are made to change the content
- Action ensues: the client restructures the dream
- They observe what this feels like, and how the dream unfolds
- They reflect again on the implications for real life, and make fresh plans to test the new perspective.

Freeman and White (2002) give several case examples. In the 'snake attack' case example reported above, the client linked the snake's aggression to her passivity in work situations, where she was unable to defend herself if attacked. The therapist encouraged her to visualize the snake again, and to try responding more effectively in imagery. Initially the client's responses were ineffectual, but after several attempts she managed to imagine chopping off the head of the snake. This felt empowering, and she was able to follow it through by being more assertive at work.

Another therapist had a client who was suffering with depression and described this recurrent nightmare:

Something is going to destroy me. I'm in bed, it's very dark, and I become aware of something. I can see a presence, which turns out to be my mother. It is totally evil, and destructive, and is going to murder me. I try to get it to go away. I see a hideous, threatening face, and wake up. The whole dream is black.

The client described a feeling of complete helplessness, and a fear of being totally destroyed. She woke with her heart thumping, sweating, and in a panic. In fact her mother had died some time previously, and wasn't able to contact her or hurt her again in any way. Using the technique described first by Marks (1978) and more recently by Freeman and White (2002), the therapist suggested that she should rescript the dream so that it would no longer frighten her, and write it out. She then practiced reading the rescripted dream before going to bed:

I am in bed with a large silver sword beside me. When the evil thing comes I wake up, get out of bed and stand up to it. I hold the sword up and its light shines out into the corners of the room, so

> the evil blackness dissolves, and the room becomes light with sunshine and colours. I put the sword back, go back to bed and sleep peacefully.

The outcome of this transformation strategy was that the client reported that the nightmares ceased to occur.

Making an emotional bridge to the past

Making an emotional bridge to the past can be done formally after a disturbing dream has been brought to mind. It can form part of the process of assessment and formulation, and can reinforce the client's ability to achieve a degree of objectivity about the content.

This technique has already been described in detail in chapters 8 and 9, and is only briefly discussed here. Suffice it to say, it is equally applicable to night-time imagery. For instance, through her painting, Clara (see above) was able to see the link between her frightening dream, the death of her mother when she was small, and her feeling of terror and lack of protection. Similarly, once Paul (see above) had realized that the black rectangular shape with glowing eyes was a representation of the car approaching from behind with its headlights blazing, the image lost its potency, and soon faded.

Creation

'Creation' imagery techniques involve not so much transforming old imagery as creating new imagery (see chapters 12 and 13 for fuller discussion). Often the question 'how would I like it to be?' or 'how would I like it to have ended?' is part of creation imagery.

As early as 1978, Marks described a 'creation' technique which he called 'rehearsal relief of a nightmare'. Marks (1978) encouraged clients to practice using imagery to give their nightmares a different ending. Building on Marks' work, Krakow and colleagues have produced a substantial evidence base for 'imagery rehearsal' as a treatment for chronic nightmares (e.g. Kellner et al. 1992; Krakow et al. 1995, 1996, 2001b; Neidhardt et al. 1992).

In their earlier papers the technique used by Krakow's group followed a similar procedure to Marks'. It involved the clients repeatedly bringing the dream to mind, and running through it in imagination, but giving it a different ending. In more recent papers, the authors have de-emphasized deliberately bringing the start of the nightmare to mind. Instead they embark on transforming the nightmare, with the client sculpting it in any way in which they would like it to be different. The client uses this technique by first writing out the new dream with the preferred content, and then rehearsing it regularly at home. Thus, there is little in the way of actual direct exposure to the original material, although since the client is rescripting it, the content must be there at some implicit level.

Other therapists have obtained good results using similar techniques (e.g. Forbes et al. 2001, 2003). The characteristics of imagery rehearsal therapy for dreams and nightmares are displayed in Box 10.2.

Even in the absence of nightmares, fantasy images which are imbued with compassion can be generated to imbue a sense of warmth and compassion when troubled at night (see chapter 13).

Box 10.2 Characteristics of imagery rehearsal therapy

- There is an initial period of psycho-education about dreams and nightmares (see Krakow and Zadra 2006 for a good description). This appears to enhance treatment compliance during the self-help phase.
- Rescripting: clients are asked to produce a written narrative of their nightmare, in a rescripted form. In some protocols clients are asked to change the content at any point they wish, while others advise changing the ending.
- Some protocols advise giving a positive-feeling tone to the rescripted image; others leave all changes in the clients' hands. Indeed one patient rescripted her nightmare to include her own death, and the nightmares ceased.
- Germain et al. (2004) concluded from their study that increased mastery in the rescripted nightmares appeared to be an important ingredient.
- Some protocols tackle only one nightmare (with some generalization effects noted) whilst others target a greater number, though not working usually on more than two per week.
- Rehearsal: Clients are asked to rehearse the rescripted nightmare at home on a daily (or nightly) basis.
- The treatment may be delivered effectively in a group or individual format.
- Time and number of sessions vary widely, from as little as a single one hour session, to as much as nine hours of therapy delivered over six sessions. More recently, the time allowed in trials has been longer.

Conclusion

Working with night-time imagery involves many of the same ingredients covered when working with images, memories, and metaphorical images that arise in the day-time. Approaching the disturbing imagery in an open, reflective manner helps clients to begin to achieve the appropriate metacognitive stance of realizing once again that this imagery is a construction of the mind, and signals threat where none may exist.

Exploring the intrusive imagery typically reveals distortions in the content, and in metacognitive appraisals. Manipulating the imagery reinforces this perspective. Transformation techniques such as seeing the imagery from another perspective or rescripting dreams can be utilized to enhance the sense of mastery, control and safety. Reflecting on the content may provide an indication of the origin of the imagery, enabling the client to reframe it as fragments of past memories, without implications for the present or future. Finally, the work of Krakow and colleagues suggests that creation techniques may be particularly helpful in working with nightmares. Compassionate imagery may be an additional source of self-soothing at night.

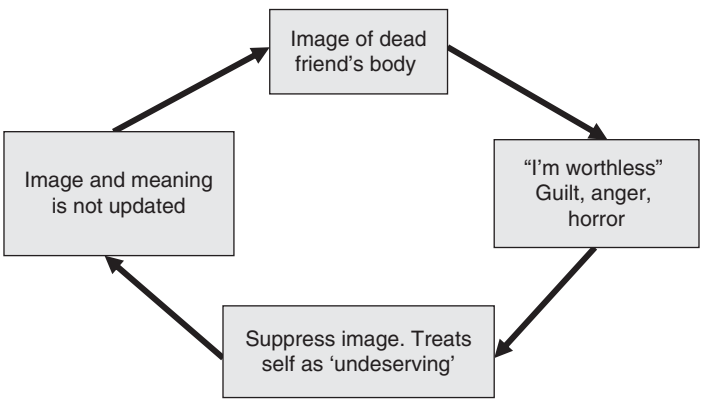
CASE VIGNETTE

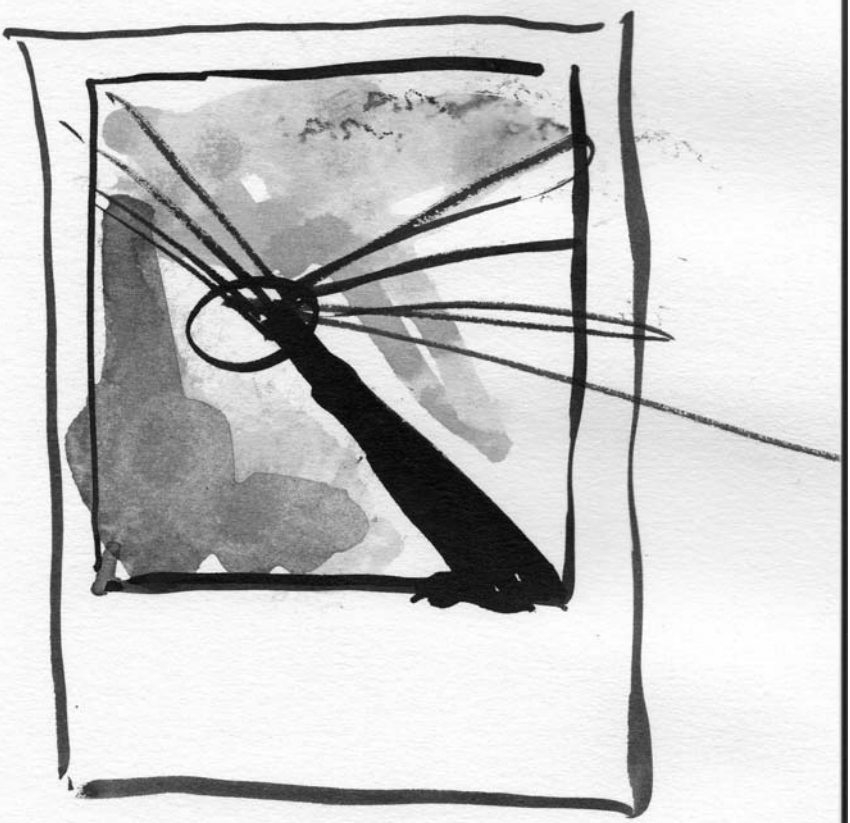
Imagery rescripting in the treatment of horror-based flashbacks

Martina Mueller, *Oxford Cognitive Therapy Centre, Oxford, UK*

After completing several tours of duty in the Middle East with the British military, Bill sought help for severe Post-traumatic Stress Disorder. He had regular vivid and intrusive images to several horrific events, including witnessing the death of his friend, Jamie, by an improvised explosive device. At the time, Bill had no choice but to leave the scene despite his overwhelming urge to stay with Jamie's remains. The formulation of his intrusion is shown below:

After reliving this event the therapist asked Bill how he would have wanted to respond if he had been able. His reaction was unequivocal 'I wanted to stay with Jamie's body so I could put him back together again, and take him to safety'. This fitted with his overwhelming feelings of grief and horror, allowing him to imagine behaving in line with his beliefs and values rather than in contravention to them as the traumatic event had forced him to do. Bill described what he would have liked to have done in concrete detail '. . . After I have put his remains in the body bag and gently removed debris from his torso, I straighten his arms and close his eyes. Then I wrap him tightly in a cloth so nothing can hurt him again. When I'm done four of us carefully pick him up and we talk to him as we carry his body to the waiting ambulance . . .' During the rescripting Bill was able to feel grief for the tragic loss of a friend rather than focusing on self blame for leaving Jamie behind. He went on to refine the details of his imagined response before the next session when he inserted the new image into the traumatic hotspot. He repeated this process whenever he had an intrusive recollection, leading to a gradual reduction in intensity, vividness, and frequency, moving from full blown flashback to more manageable and less frequent intrusions.





Metaphorical Imagery

Chapter 11

Working with metaphorical imagery

'When I wake in the morning my breakfast is not solitary, the black dog waits to share it, from breakfast to dinner he continues barking . . .'
Samuel Johnson, writing about depression, letter to Mrs Thrale, 1783.

Introduction

The term 'metaphor' has been defined as 'the figure of speech in which a name or descriptive term is transferred to some object to which it is not properly applicable' (The Shorter Oxford English Dictionary, 1973). Yet this transference is not arbitrary: metaphorical images are mirrors, reflecting our images of our experience of self, others and the world, and encapsulating the idiosyncratic felt sense that we are targeting in therapy.

The use of metaphorical imagery has been described by many therapeutic schools. Examples include Jung's active imagination (Watkins 2003); guided fantasy in psychosynthesis (Assagioli 1965); and imagery psychodrama in Gestalt therapy (Perls 1971). It has been argued by Adler that even early memories can be regarded as metaphorical images, in that they can convey 'the story of my life' from a subjective point of view (Shulman and Mosak 1988). As we have dealt with more literal images and memories in previous chapters, we focus on those with more symbolic meaning here.

Metaphors in therapy are either therapist generated, or client generated (Kopp 1995). We have seen in other chapters of this book how cognitive therapists utilize various therapist-generated metaphors to socialize patients to working with imagery, and also to describe the processes that maintain or relieve psychological distress. Many more rich examples are provided by Stott et al. (2010) in their excellent book the *Oxford Guide to Metaphors in Cognitive Therapy*. However, client-generated metaphors have not been used extensively in cognitive therapy. Some exceptions involve the use of drawing in cognitive therapy (Johles 2005), including its application in individuals groping towards a sense of identity (Butler and Holmes 2009).

Gestalt techniques using metaphorical imagery have been described in the cognitive therapy literature (e.g. Edwards 1989; Hackmann 1998). Edwards pointed out that, although on the surface dissimilar, the process of cognitive restructuring even using metaphorical imagery has a close affinity to the restructuring that takes place through Socratic questioning and guided discovery, using verbal representations of experience.

Meanings and assumptions can be identified and challenged using metaphorical imagery. The client can experiment in imagination with alternative perspectives, which can be tested out later, in reality.

The poet Ted Hughes described the potential power of metaphor to capture the emotionally charged felt sense when describing the difference between writing in prose or in verse. He noted that once he began to write his notes in verse rather than prose, he observed many more of his own physiological and emotional responses, despite the fact that in one sense he was writing about the same thing (Hughes 2007). In this respect, it is interesting that clinical experience suggests that metaphorical imagery can most easily arise after one tunes into the bodily felt sense (or embodied experience) of a problem area (Butler et al. 2008, p.101). This chimes with observations by Lakoff and Johnson (1980) who describe metaphors as complex experiential gestalts, arising from past lived experience. Teasdale (1993) has described metaphor as reflecting holistic, implicational level meanings, tied to proprioceptive and other sensory systems in the body.

We discuss a range of ways of working with metaphorical imagery in this chapter, covering the topic under the headings used in chapters 8, 9, and 10: Socialization, Evocation and Assessment, Micro-formulation, Manipulation, Discrimination, Transformation, Making an Emotional Bridge and Creation. In addition, we have included a section, *Extending the Work with Metaphorical Images* to describe the value of using stories, pictures, films, and drawings in working with metaphor.

Socialization

Most of us use metaphors quite spontaneously when describing our feelings. For example, when faced with a difficulty someone might talk about 'Feeling wrung out', 'Looking into the abyss', 'Having my back to the wall', 'Being at the end of my tether' or 'Losing the will to live'. None of these expressions are to be taken literally, yet they carry implicit meanings that are conveyed to others when used in conversation. It is advisable for therapists to notice the metaphors that clients are using, and ask them to reflect on their significance, as an aid to assessment and formulation.

We can discuss our everyday use of metaphor in conversation when preparing clients to explore metaphorical images for how they experience the felt sense in a problematic area of life. The use of metaphor may be indicated if the client (or the therapist) finds it difficult to understand why they feel the way they do about something. It can also be beneficial in situations where there appears to be overwhelming affect about complex or long-standing problems.

Where the therapist thinks it would be useful to encourage the client to explore the felt sense of a situation, and generate a new, idiosyncratic metaphorical image for how they feel, some of the following points may be made:

- There are two aspects to the working of the mind: the conceptual, rational way of thinking about things; and the more experiential, holistic, poetic way of thinking, which encapsulates our feelings, and not just the facts
- Sometimes feelings are hard to put into words, and we may find it difficult to understand why we feel the way we do about something

- The experiential part of the mind is more sensory, imaginative and symbolic
- To explore difficult and perplexing feelings it can help to tap into this more experiential type of thinking
- For this reason we sometimes invite clients to explore the felt sense, and let a metaphorical image arise, and then reflect on its meaning.

If the client is prepared to go ahead, we can then move on to evoking and assessing metaphorical imagery.

Evocation and assessment

An important step (as with other types of imagery) is to evoke and carefully examine metaphorical images, whether they arise spontaneously, or when exploring an area where the use of metaphor might be informative for understanding the idiosyncratic meanings given to a symptom, a situation or a relationship. The client needs to explore the metaphorical image experientially, rather than just talk about it.

The therapist explains that it is possible for the client to enquire more closely into the meanings being given to something disturbing them by looking at the metaphors they might use to describe it. To get beyond a superficial examination of meaning the therapist advises the client to close their eyes and reflect on the situation or symptom in all its aspects, and allow a metaphorical image to emerge. Having reflected on the sensory, emotional, and meaning aspects of the image, the therapist and client can explore its historical associations by making an emotional bridge. Steps in the exploration of a metaphorical image are provided in Box 11.1.

Metaphorical imagery can be particularly useful when a person cannot quite understand the strength and nature of the feelings they are having about something.

> Penny was struggling with the task of looking after her elderly father. Her therapist asked her to reflect on how she felt about the situation, and notice how she felt in her body as she did so. Next the therapist directed her to let a metaphorical image for her current difficulties arise, taking her feelings into account. Penny exclaimed that it was as if she had an old-fashioned washboard embedded in her back, over which her skin was starting to grow. This reminded her of her childhood in Africa many years before, where a servant had done the laundry using a washboard and wringer. To the client this meant that she had allowed herself to get trapped in a relationship with her father, based on old-fashioned ways of thinking about a woman's role. Later she was able to transform this image into a more adaptive symbolic representation of how things could work better between them (see transformation section below).

Evoking metaphorical imagery and reflecting upon it allows for the elaboration of new perspectives and new ways of dealing with potential obstacles. For example, evoking and exploring metaphors for a given situation can help people understand their different perceptions of it, and help them begin to explore their differences, and arrive at mutually acceptable perspectives of what is wrong, and what needs to happen to deal with it.

> Joy and her husband Bill were involved in a dispute with Joy's brother, Gary, over which extended family members should attend their daughter's wedding. When feelings ran high between Joy and Gary, she noticed that there was also tension with Bill, and they found it hard to agree on the

Box 11.1 Exploration of a metaphorical image

- The client is asked to close their eyes if they feel comfortable doing this.
- To capture the idiosyncratic meanings given to a particular distressing situation or symptom, the client is asked to explore the emotions and bodily sensations evoked when they call the situation to mind.
- Next they are asked to allow a metaphorical image to arise, symbolizing the situation and their own reaction to it. They are advised to stay with any image that arises, however banal or unrelated it might seem at first. If a number of images arise they are asked to choose the one that seems to carry the most emotional weight.
- Once an image has been selected and fully evoked, the therapist prompts the client to tune in to the accompanying bodily sensations, and then the other sensory aspects of the image, including colour, texture, sounds, smells, tastes, weight, size etc. They then reflect on how it might look from different angles (above, below, from the side, etc), or from various distances.
- Finally they are asked to reflect on what this image may mean. It could signify meanings about the self, other people, the situation, a troublesome symptom, and/or the world in general.

Metacognitive beliefs are also explored: for example, does the client think that the metaphorical image is a premonition? A warning? A realistic interpretation of what they are upset about?

approach she should take. Joy's therapist suggested that she and Bill should each reflect, and describe a metaphorical image for the way they viewed the situation. This proved to be useful intervention, as it helped the couple understand what was happening. Bill saw Gary as having created a situation in which the wedding plans had been spoiled. He visualized this as excrement plastered over everything. Any attempts to sort things out felt as if they would result in the creation of an even bigger mess. The only solution Bill could see was to leave Joy, and only return once the emotional tone had reduced. He felt angry and impotent. Joy, however, saw Gary as having hidden himself behind a huge steel barricade. He had left only a tiny aperture covered with paper, through which he would randomly stick a bayonet. Joy felt that there were two options: either to find a way round the barricade so that they could try to communicate more effectively, or at least to remove herself from potential harm, perhaps by communicating via a third party. She felt very anxious, but not really angry. The couple reflected on the possible origins of their images. Joy's husband Bill had had an abusive childhood, in which his alcoholic father had spoiled everything, and his only strategy had been to withdraw from conflict, and then re-enter once the latest drama had subsided. Bill had also left home at an early age. Joy, on the other hand, reflected that her brother had always had fragile self-esteem. Her parents had tried to support him, but had ended up spoiling him, and making it difficult for him to appreciate other people's perspectives. These insights helped the couple find some common ground, and make sensible plans for handling the situation.

Working with metaphorical imagery can also be helpful when the affect involved in facing issues directly seems overwhelming.

> Kathy came to therapy following a violent attack from her partner, and was given treatment for PTSD. However, towards the end of treatment she revealed huge amounts of distress about another previous abusive relationship, but feared that she would never be able to confront those distressing memories directly. Nevertheless, she felt that she could not get fully better without attempting to do so. After a few weeks of this impasse the therapist noticed that she was describing a 'ball of memories' that was trapped in the back of her neck. They decided to explore this felt sense by using metaphor. Kathy was asked to focus on the sensations in her neck, and let a metaphorical image arise. She described the 'ball of memories' as shaped like a rounded crescent, black in colour and very heavy. She could think of no way of removing it without cutting her head off. When asked what was inside the 'ball' she said it was packed with bees, and some of them were dead. There was no food in there, except clumps of tumbleweed. It was dark and windy inside what she now described as 'the beehive'. There was no way for the bees to get out.

Kathy said that these 'bees' represented suppressed memories, and the fear that if they were expressed her sorrow would be never-ending. After this session Kathy went home and wrote the following poem about the image, which was very helpful as a vivid description of how she felt.

> **Song of the bitter bees**
> *In my head there is a hive of bitter bees, built with salts of unshed tears.*
> *Sharp crystals of anguish guard the honeycomb of memories,*
> *And secret emotion is the only nectar my bees suck.*
> *Afraid to claim them as my right, to bathe and cleanse them in the light,*
> *I turned away and sealed each cell with shame.*
> *Hidden deep within the hive are the living ghosts of all my pain,*
> *Each secret thought a bitter bee, moving silently,*
> *Compressed within my memory.*
> *Dark and cold they bide their time, a cancer growing.*
> *Each sob unheard, each tear unformed,*
> *Each secret wound ignored feeds the silent swarm.*
> *Inside the eyes of every bee*
> *Are mirrored lots of little 'me's, trapped for all eternity.*
> *The hive was built when I was small, and memories were built with words—*
> *Sharp weapons with which to kill*
> *The real me, the gentle bee, the sweetest bee within.*

This poem reflects all her suppressed memories of traumatic events, and an allusion to the idea that the tendency to suppress painful memories and emotions was engendered during childhood.

Micro-formulation

Metaphorical imagery can be used during the process of formulation in a number of contexts. Below we feature uses of metaphorical imagery for micro-formulation with individual clients, with couples, and with therapists for supervision purposes.

Kathy (see above) went on to write another poem the following week, which helped her consider her assumptions, their origins, and ways in which these assumptions might need to be modified.

Naming of the bees: Old bees loitering at the entrance to the beehive
There was 'Stiff upper lip' who was joined at the hip
With his Siamese twin 'Don't cry'
There was 'Stand up straight' and his twin 'Don't be late'
Who were loitering nearby
'Don't be afraid of the dark' was having a lark with the 'Monster from under the bed'
And 'Spilt milk' and 'Smile' were resting a while,
Taking a break from scratching their heads.
'Being bored is a sin' was kicking his twin 'Elbows off the table'
And 'Don't answer back' was having the crack with 'Tell the truth when you are able'
'Fear God' and 'Don't sin' (who were very old twins)
Stood apart from 'Head up - stomach in'
And right at the back, shrouded in black, were 'I can't' and 'I will give in'

Kathy's second poem begins to formulate a set of assumptions that set the scene for suppressing emotions. In addition to insisting upon a stiff upper lip, not crying, standing up straight and not answering back, it transpired that her parents had urged her to be sympathetic and understanding. Reflection on this material led to the realization that while her old assumptions had some value, they were not ideal in the context of an abusive relationship. In addition, her partner had heavily reinforced the idea that she was not to cry, or she would be hurt again, or even annihilated. For a micro-formulation centred on the original image of the beehive, see Figure 11.1.

Following this second poem, and having reminded herself that her abusive partner was no longer alive, she wrote a third poem, which signalled a sense of hope about the possibility of her re-emerging into life, having shed some of the old assumptions. It also acknowledged and expressed the horror of having lived with her abusive partner: 'the beast with rage in his eye'.

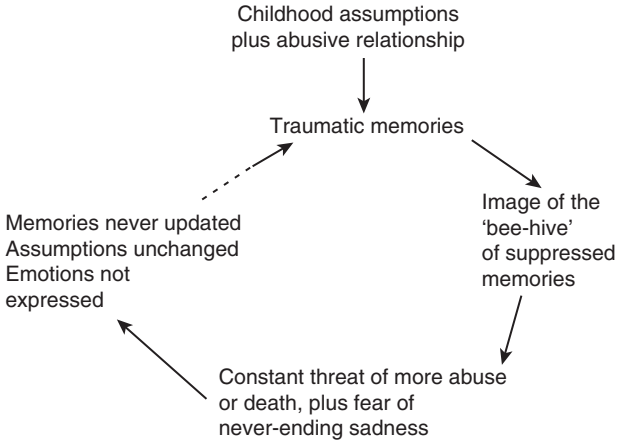


Fig. 11.1 Metaphorical image of the beehive.

The glimmer of light
Something happened in the dead of night
The tiniest bee saw a glimmer of light
While she sucked the dark nectar of tears.
Syrupy sweet it had clung to her feet
Infused with the perfume of dread.
Spilt from each eye in secret they'd lie,
The tear drops she had not shed.
She was blinded with pain,
From the fists, from the shame,
When she learned it was not safe to cry.
As the tears they had spilled
Like petrol they filled
The beast with the rage in his eye
Don't cry!
Don't cry!
Whatever you do don't cry!
There is a rainbow in every tear drop
You just have to look at it right
In the light, not at night!

As Kathy recognized where most of the fear of expressing emotion had come from, and that her abuser could not hurt her any more, there was just a glimmer of hope that she could escape from the 'hive' of trapped memories, and begin to rebuild her life. This work strengthened her resolve to re-engage with people, having modified some of her assumptions to express her new beliefs that 'it is all right to cry when there is something to cry about' and 'there is a difference between giving up and giving in', which meant that she was more able to be gentle with herself as she picked up the pieces of her life.

Metaphorical imagery can be used during the process of formulation, for individuals, or where there is conflict between individuals, or in supervision. Collaboration can be improved by enhanced attention to the metaphors used by clients, and by making summaries using their own words.

> Ray was beginning to recover after the breakup of his marriage, and was making some tentative plans for the future. The therapist used the metaphor of things beginning to sprout in a garden. However, the client spoke of building foundations and making steps, metaphors he returned to the following week. The therapist reflected on his use of language, leading the client to explain that in a sense he was building his own castle, carefully but well. As he climbed the steps he was aware of strong rubber bands that could pull him back. These were the assumptions of his family, which had proved to be counter-productive in Ray's experiences of close relationships. For example, his family believed that if one was upset or angry it was best to hide it, and that it was important to always put others first, which had often meant that he had neglected his own needs.

Therapists can utilize metaphorical imagery to examine their own problematic emotional reactions to clients. This can be done in a period of self-reflection (Bennett-Levy et al. 2009), or undertaken during supervision. Padesky and Mooney (2000) have described using metaphorical imagery in this context. The therapist can bring to mind a client with whom they have ongoing difficulties, and use metaphorical imagery to

Box 11.2 Exploration of a therapeutic impasse

- The therapist brings to mind a client with whom there is some kind of recurrent impasse.
- Having brought a typical example to mind the therapist reflects on how this makes them feel in their body, and what associated emotions are present.
- Then they are asked to allow a metaphorical image arise for the way they feel in this situation.
- The metaphor can then be explored for its meaning, including any assumptions.
- The therapist can be asked to reflect on its possible history in the therapist's own life: why this particular client situation evokes such a strong emotional reaction and inflexible, 'stuck' behaviour in the therapist.

The therapist is then able to make a micro-formulation of their own reactions. This insight can be helpful in itself, or the image can be transformed (for an example, see the transformation section, below).

represent the difficulty (for some suggested steps see Box 11.2). For examples of working with therapist imagery see sections below on discrimination and transformation.

Manipulation

Once an image has been identified, the client can be encouraged to continue to hold it in awareness, and notice what happens. As we have seen in previous chapters, there may be some autonomous cognitive change. In the example below, there is both spontaneous change, and direct therapist involvement in reinforcing the changes the client has already initiated:

> Wendy had health anxiety and fears of contaminating others. These had developed after a surgical procedure that had caused a temporary infection. Her fears led her to refrain from any close contact with family members or food preparation. The therapist asked her to investigate her felt sense when she was concerned about contamination and illness by focusing on her bodily sensations and letting an image arise for how she felt. The client visualized a red bloody mass in her abdomen. The therapist asked her to focus on the image, and notice any changes to it. As she did so, it started to change. A halo of white light began to engulf the image and this developed into an angel-like motif, the wings of which subsequently encircled and obscured the red ball. These modifications to the image were not guided by the therapist, but appeared to occur spontaneously. The therapist then suggested that Wendy should stay with the sense that the angel was encircling then floating off with the red ball. The impact of this session was immediate and almost 'miraculous'. The image of the ball faded over subsequent weeks and the client resumed intimate contact with her close family and was able to prepare food again.

Metaphorical imagery can be used to symbolize a range of symptoms and difficulties. The imagery can then be actively manipulated, bringing some relief.

> Karin described dealing with her insomnia when she was stressed by using the following procedure. She got out of bed, and sat comfortably, inviting an image to represent how she felt. The image that arose was of a busy radio station, with bright lights and a loud broadcast from every room. As it was

the middle of the night, the staff were off duty, and no-one was listening to all of these excellent broadcasts. The noise was quite overwhelming. Karin decided that what was needed was to visit each room in imagery, dim the lights and turn down the volume, or switch off the program completely. She visualized this happening, until all that was left was one quiet program. She went to bed and slept soundly. On other occasions, different imagery arose, but in each case, once she had attended to what needed to happen in the image, she fell asleep.

Hilda had suffered from lifelong anxiety and low mood, and had tried many forms of therapy. During a course of cognitive therapy, Hilda could not uncover verbal cognitions, and the therapist hypothesized that this was because her anxiety had developed at such an early age that the associated memories were laid down non-verbally. This formulation made sense to Hilda, as her mother was hospitalized for depression when Hilda was only a few weeks old, and her father walked out when she was still a toddler. Hilda described her anxiety as like a big shadow, a 'shaggy dog', dark in colour. As her anxiety grew, the dog grew too, until it was as big as a house, looming over and smothering her. The therapist suggested trying to change the dog into something less scary, perhaps a poodle with bows. Hilda rejected this idea, and chose instead the image of a friendly cat, like the beautiful pet that belonged to a neighbour of hers. Hilda imagined the looming shaggy dog morphing into a friendly cat, playful and non-threatening, with a collar and lead so that she could lead it away from the place where she saw the image of the dog. Despite years of unsuccessful treatment, this imagery intervention had a big impact. The original image seemed far less threatening, and there was a significant decrease in Hilda's anxiety about leaving home.

Discrimination

Bringing a metaphorical image to mind and dwelling on its meaning can lead to a useful metacognitive shift, as the client (and/or the therapist) begins to realize that their appraisal of the current situation owes more to past than to present reality, or is distorted in some other way. As we have seen in previous chapters, reflecting on imagery can aid discrimination between 'then' and 'now', and put events in their rightful place.

Penny (discussed earlier, see page 153) still felt quite panicky at times when thinking about her relationship with her father. The therapist asked her to close her eyes, focus on the current situation, notice what was happening in her body, and let another metaphorical image arise. This time the image was of her father as an eagle, who had her in his claws, and was about to take her to his eyrie on a distant hillside, cutting her off from everything else in her life. Reflecting on this image, Penny was immediately aware that it was wildly out of proportion. It suggested that her father had all the power, and was strong and blindly determined. In reality he was so frail now that she had all the power herself. This led to much greater compassion for her father, lessening of her feeling of panic, and the start of her being able to make constructive plans about his care, and her other relationships. For a micro-formulation of Penny's image see Figure 11.2.

Where there is a therapeutic impasse, it may be helpful for the therapist to reflect on their own imagery, and share something about the metaphor and its meaning with the client, who could also be invited to explore and share their own metaphor, as in the following example.

Terry found working with Maria very difficult. He could not really engage her in collaboration, and however he tailored homework she never managed to complete agreed assignments. Terry's metaphorical image was of himself rowing the wrong way up a river, with Maria sitting back amongst the baggage. Terry realized that this felt very reminiscent of his relationship with his difficult

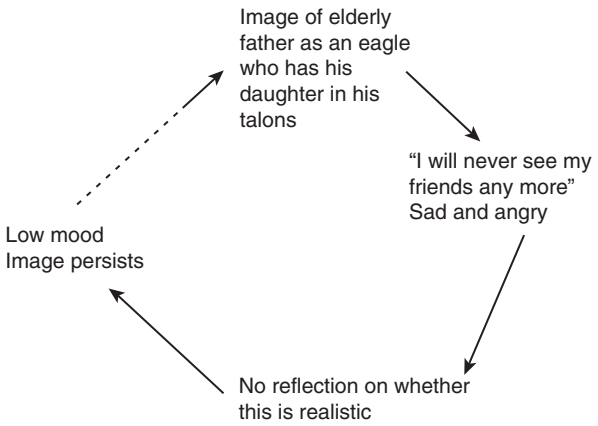


Fig. 11.2 Affect arising from metaphorical image.

mother. His only solution had been to try harder and harder. Reflecting on this metaphor helped him to understand his current difficulty with Maria. He addressed it by explaining to Maria how he felt in terms of the metaphor (although not its history), and then asking her how it felt to her. Her metaphorical image of herself was as a decorative but passive doll. She had had a very critical father, who had always criticized her for showing any initiative, and constantly told her that anything she did was wrong. With these metaphors on the table, therapist and client were able to move forward with their collaboration, with Terry working less hard, while Maria did some homework, testing the reactions of her therapist and others in a series of behavioural experiments, comparing the results with the reactions of her father.

Transformation

Sometimes the metaphorical images that people report when distressed seem like distorted representations of their plight. It is possible to work directly with such an image by evoking it, reflecting on its meanings, and asking what the person feels they might need to change in the image in order to get a wider or more realistic perspective, which can then be put to the test in real life.

This may seem a far cry from cognitive therapy. However, it does still involve evoking and reflecting on meanings, and using the processes of Socratic questioning and guided discovery to help the client arrive at a new perspective. This new perspective can be examined in imagery to check on how they feel once the image has changed, and how things might work out if a new course of action is taken. In other words, a type of 'thought experiment' is carried out. A detailed description of this technique is provided in Box 11.3.

The next section discusses examples of transformation in the context of clients' and therapists' metaphorical imagery.

Transforming a client's metaphorical imagery

Penny, who had a difficult relationship with her elderly father (see pages 153 and 159), worked on the image of the in-growing washboard on her back to develop a new perspective, which could lead to constructive action. The therapist enquired as to what would need to happen for Penny to feel better, and she began to experiment with making changes in her imagery. At first it felt as if surgery would be required, but it came to feel as if she could just let the washboard float slightly away from

Box 11.3 Transformation of a metaphorical image

- Having elicited and explored a metaphorical image in all its aspects, the client is asked to reflect on what would need to be different about the image to make them feel better
- They are then asked to imagine these changes taking place
- Just as the contents of the metaphorical image may have been surprising to the client (but informative), it may also transpire that the image appears to be difficult to change in the way anticipated initially by the client
- Several attempts may need to be made to change the image in a satisfactory way
- It is also possible that a new metaphorical image may arise and need to be dealt with
- When the image is finally transformed, there will be a shift in the associated affect and the meanings ascribed to the image
- These meanings should be identified and reflected upon.

The new perspective can then be tested out in real life.

her back. However, it was still attached to a rope round her neck, and she realized she would need help. In her imagination she asked her husband, and he moved the washboard from her back to her front. As he was an antiques lover, he still hesitated to cut the rope. Penny then imagined herself telling her husband quite firmly that she needed him to remove it. Once the rope was cut, Penny, her husband and her father were ready to look objectively at the washboard in front of them, and consider what needed to happen next. Penny felt happier after this transformation of the metaphorical imagery. For homework, she decided to embark on sensible planning for her father's future care. She realised that she would need to be assertive, and get her husband's support before conferring with her father.

Roberta, who suffered from social phobia, also used metaphorical imagery to express how she felt, and to arrive at a new perspective.

Roberta was convinced that others did not like her. She described how she felt in social situations, by saying that she felt as if there was a banner over her head with the word 'spoilt' emblazoned on it. This was the way that her mother had described her in public when she was small, on a number of humiliating occasions. It emerged that her mother had favoured her sister, who suffered from ill health, and that other people did not share her mother's harsh view of Roberta. Roberta was asked what kind of changes she would need to make in the imagery in order to have a more accurate appraisal of herself in relationship to others. She suggested that perhaps she could take an imaginary journey, and meet someone who might be able to tell her what she was really like. This seemed promising, so the therapist suggested she could close her eyes and imagine embarking on this journey. Roberta imagined being on a vast plain and meeting a wizard with a crystal ball, who said he would help her examine the truth about herself. Many pleasant images of herself appeared in the crystal ball. Roberta watched the pictures change until finally she saw herself filling a hot-water bottle for her mother, something she used to do every night. Over this final picture another banner appeared, bearing the word 'kind'. Roberta cried as she realized that her mother's criticism had given her too harsh a view of herself. This led to a deep and lasting shift in her view of herself.

Transforming the therapist's metaphorical imagery

Having explored a therapist's metaphorical image of a recurrent impasse in therapy, new perspectives and possible responses can be experimented with within the metaphorical mode, as in the following example.

> Margaret felt very stuck in her work with Harry, a client with chronic depression. If Harry failed to respond to an intervention, she was overcome by a sense of helplessness and could not think of what to do next. Her metaphorical image for this was of herself as a toy car that constantly ran into obstacles. When it hit something the wheels continued to turn, and the car dug itself into the ground. The emotion accompanying this was a sinking sense of hopelessness and impotence. The emotional bridge technique (see chapters 8–10, and later this chapter) revealed that the feelings were identical to those Margaret had had as a child, when living with her father who was often ill and depressed. No matter how much she tried, she could not lift his spirits. For a micro-formulation of this therapeutic impasse see Figure 11.3. In supervision, Margaret was asked to reflect on what changes she might need to make in the imagery to shift her perspective. She decided to change the image to one in which she (as the toy car) would back off and change direction if she hit an obstacle, rather than running herself into the ground. She was able to change the image easily, visualizing the car backing off and trying again. This shifted her mood in a positive direction, and gave a useful hint as to what needed to happen in therapy with Harry.

Extending the work with metaphorical images

Stories, pictures, and films

When working with clients with entrenched views of themselves, other people and the world, it may be difficult to help clients shift perspective. In such cases, the use of pictures, stories, and films can help the client express how they see their situation in life, and

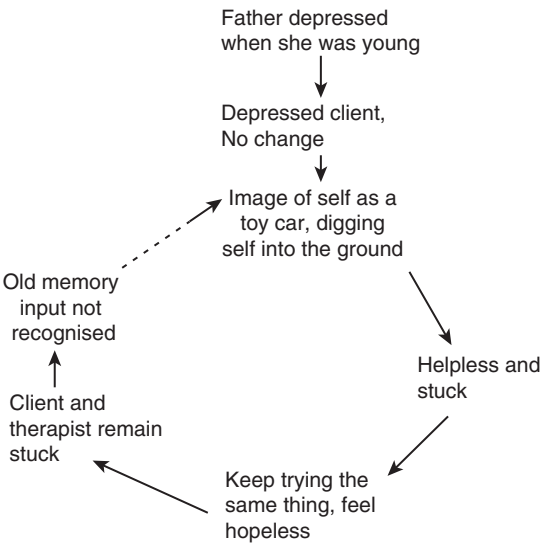


Fig. 11.3 Micro-formulation of a therapeutic impasse.

begin to configure how they would like to be. The therapist may sometimes play a role in these metaphorical scenarios.

> Elizabeth had had a difficult life, and had many negative, unconditional beliefs, reflecting her sense that she was emotionally deprived, and had to fend for herself in a harsh world where she could trust no-one. In therapy, she was moving towards being able to tackle negative feedback from others without a catastrophic emotional reaction. The therapist had also started to introduce the idea of ending therapy. The client reacted vigorously to this, complaining that she felt like Gretel in the story of Hansel and Gretel, sent into the forest, and abandoned, and having great difficulty finding the way back to safety. She compared the therapist to the old witch in the forest, who offers sweets and other treats for a while, but harbours plans to eat the children. The therapist consulted various books of fairy tales and chose another tale to offer Elizabeth. This was the story of Vasalisa, whose mother died when she was small, like Elizabeth's own mother. However, before she died she gave Vasalisa a little doll to keep in her pocket, and said that she should consult it if ever she was in trouble. Vasalisa grew up, and (like Cinderella) had to endure a wicked stepmother and step-sisters. They sent her out into the forest alone to fetch fire. There she met the terrifying Baba Yaga. However, the doll in her pocket helped her time and again, giving her intuitive responses to each new challenge. Finally she returned home with the fire, which turned the wicked stepmother and step-sisters to cinders. Initially, Elizabeth could not see any value in the story, but returned a week later saying that it seemed a good summary of her new sense of herself. She felt supported by others, but also able to be independent and make her own judgements about when to act and when to refrain. Thus the story of Vasalisa formed the backbone of her blueprint of what she had learned in therapy, represented in the story as the doll her mother gave her to help her later in her life.

Some excellent fairy stories for use in therapy with women (including the story of Vasalisa) are provided by Pinkola Estés (1998). Bettleheim (1976) described the usefulness of fairy stories for children from a Freudian perspective. Although some of the predicaments children (and adults) have to face in these stories are quite terrifying, there are also useful lessons to be learned about being awake and aware in relationships, and testing oneself and the world to find out how it really works. These lessons are often exemplified in fairy stories. Padesky and Mooney (2000) frequently refer to the usefulness of stories and films to help clients express what certain aspects of childhood were like for them, and also to suggest heroes and role-models on which to base a more adaptive set of assumptions for carving a path through life.

Drawing

Instead of merely evoking a metaphorical image of something in one's imagination, useful images may also be drawn or painted by the client. For instance, Johles (2005) has presented a technique utilizing drawings to symbolize problems and their potential solutions. In this technique, the client is asked to consider their current situation, and make four drawings, in response to the questions in Box 11.4.

The therapist provides some drawing materials, and allows enough time for the client to finish each sketch. If it is considered helpful, a short period of relaxation may precede the questions and the drawings. Subsequently the therapist helps the patient to reflect on the appraisals apparent in their metaphorical imagery. In this way material may be gathered for a formulation. Further drawings can be made to represent potential transformation of assumptions, behaviour and emotions: 'how I would like things to be'.

Box 11.4 Questions for the drawing exercise

- How is your life at the moment?
- What is your next step: what is emerging for you?
- What barriers or obstacles are there?
- What qualities do you need to help you deal with these?

Simple drawings can also be helpful to the client, in order to symbolize the way in which they experience their relationship to others.

> Elizabeth (see page 163) drew a boil to symbolize the way in which she experienced her relationship with the therapist, and with other significant people. She felt that either she was on the outside trying to control others (who were like the pus in the boil), or she was in the centre of the boil feeling terribly controlled and about to burst out. She also used the metaphor of a 'badness meter' to explain how she felt about how others saw her. The badness meter was half white and half black. It had a pointer on it. Her feeling was that others were always trying to push her 'into the black' while she tried to force the pointer back into the white. These colours represented bad and good; there were no shades of grey.

Taken together, these two metaphors shed a helpful light on Elizabeth's assumptions and core beliefs.

Drawing can be a helpful way for clients to express what can seem like the inexpressible or unacceptable. Butler and Holmes (2009) have described pictures drawn at the start of therapy by clients who had been physically, emotionally, or sexually abused as children. One client drew herself as stuck in a bramble bush so dense that to open her eyes would be to have her eyes pierced by thorns; another client drew a flood in which a stick figure was struggling. Some of the functions of drawing images in therapy are described by Butler and Holmes, and include enabling the client to talk about something traumatic, summarizing and condensing experience, and making connections between different aspects of experience, or periods of time.

Making an emotional bridge to the past

We have seen in a number of these examples that once the felt sense and the associated metaphorical image have been identified, clients often become aware of the historical origins of the material evoked. If this is not autonomously identified by the client, the therapist can enquire when in their life they first had the sort of felt sense accompanying their metaphorical image. Sometimes the sensory qualities of the image reflect actual sensory experience from the past.

> As described in chapter 2, Elizabeth also used the metaphor of being pushed 'into the black' when made to talk about emotional topics. When asked to evoke and stay with that feeling she described it as a sense of being about to lose consciousness, possibly to die. Asked when she had had that kind of felt sense in the past she described breath-holding attacks in childhood. At times she lost

consciousness and had to be taken to hospital. These attacks were triggered by her stepmother, who made her feel terrified and angry, and left her alone in her cot screaming for prolonged periods.

Creation

We have already seen in this chapter the value of creating new metaphorical images to create new perspectives. Further examples of the use of metaphorical imagery for creating new *ways of being* are covered in chapter 13.

Conclusion

Working with metaphorical imagery may seem a considerable distance from the territory of cognitive therapy. However, it can be useful to evoke and use metaphors in various circumstances where traditional methods of accessing and transforming meanings may be difficult to apply. For example, metaphorical imagery can be particularly effective when affect is overwhelming, or when feelings are difficult to put into words. It can also be helpful to explore metaphorical imagery when an impasse is reached in a relationship, or when examining feelings that are not entirely understandable to the person experiencing them. For therapists, also, metaphorical imagery can be of particular assistance when a therapist is feeling 'stuck'. We have seen in previous chapters that the processes of evocation, manipulation, transformation, making an emotional bridge, and creation all play an important role in changing negative imagery. The same processes are equally helpful for transforming metaphorical images.

In this chapter we have also seen how adventurous therapists can make use of stories, pictures, films, fairy tales, and drawing to create further depth, and potentially to derive new perspectives. Further examples of the value of metaphorical images for creating a different sense of self are presented in the following chapters.

CASE VIGNETTE

Using metaphorical imagery to deal with a process issue in therapy

Margret Hovanec, *The Lupina Foundation, Toronto, Canada*

Barbie presented for treatment of depression. She had once again been passed over for a work promotion. She was frequently late with projects and often failed to complete them. She had recently missed two work related flights, felt overwhelmed and described her life and apartment as disorganized and cluttered with half-finished projects.

Barbie's greatest pleasure in life was baking. She never missed contributing elaborate, complicated confections to her two gourmet cooking clubs.

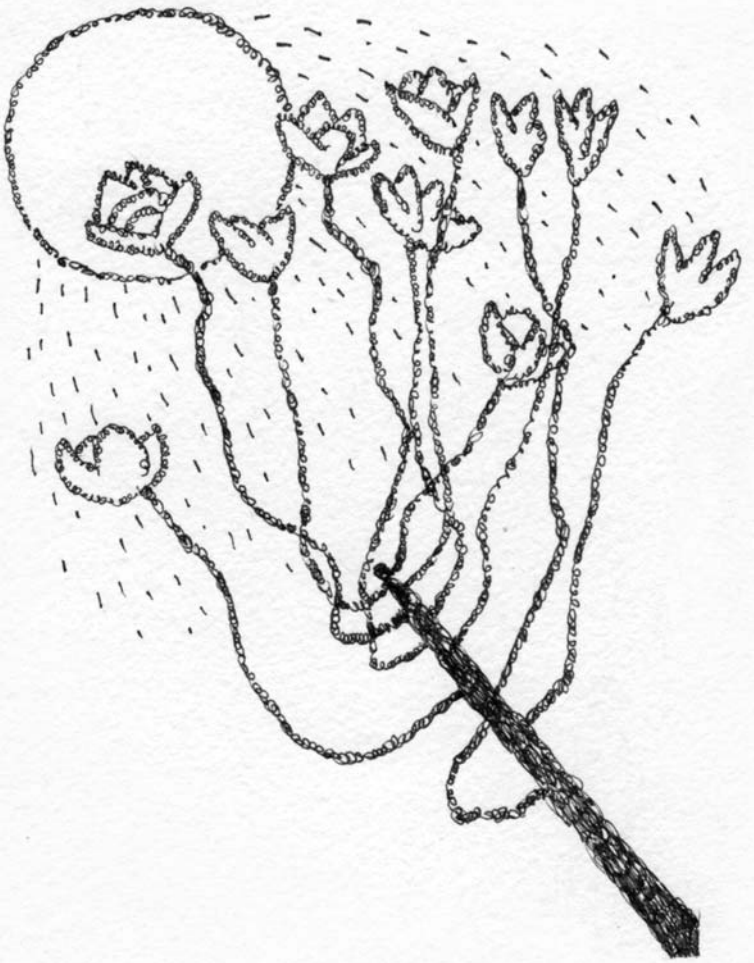
From the outset, she did not complete homework assignments. Building on this non-completion trend, she was asked to deliberately not complete her next cake contribution to her gourmet group, but to just take a bowl of batter. She was to record her thoughts and feelings about this. Amused by this, she agreed to do it. Again, she did not complete the task, but was able to describe her thoughts and feelings at the time. She said it was only logical to bake the cake, as it took a lot of preparation, the ingredients were expensive and it would be wasteful not to bake it. She said she could not face the disappointment of members, losing their respect and her status as a baker. She would also lose out on the validation, satisfaction and praise associated with the end result. She also saw not finishing it as breaking the rules and not living up to a promise.

When confronted with the contradictions between the gourmet clubs and her work situation, she was able to see that at work she did all the preparation but 'did not bake the cake'. She generated the image of a wasted bowl of rich batter as an unfinished project. A fully decorated delicious concoction was the ideal result. These personally generated, imagery laden, metaphors became sprinkled throughout the following sessions and treatment. 'so you didn't bake the cake', 'it didn't get into the oven', 'just rich goop, no cake', 'putting the icing on the cake', 'iced it' and 'needed the cherry on the top'.

At work and gradually with her clothing and apartment, Barbie used the same metaphorical imagery. As she valued her culinary skills, she began to appreciate and enhance her skills at work. She started 'really cooking' at work and feeling the same satisfaction on completing her tasks as preparing fabulous cakes. She started to internalize positive rewards, and increased self-esteem. She described her depression decreasing, and saw praise as possible but secondary. Barbie expressed herself as 'not being stupid anymore'.

Part 4

Imagery interventions: creating positive imagery



Positive transformation from a negative underlying image

Chapter 12

Positive imagery: creating goals, developing new skills, and problem solving

'I skate to where the puck is going, not where it's been.'
Wayne Gretsky, Canadian Ice-hockey player (attributed 1985).

Introduction

Chapters 12 and 13, which comprise Part 4 of this book, *Imagery Interventions: Creating Positive Imagery*, focus on the use of positive imagery in clinical practice. In this context, the phrase 'positive imagery' is used to denote imagery procedures that start from the generation of positive imagery, rather than evoking negative images and trying to transform them. The distinction between this chapter and chapter 13, *Positive Imagery: Creating New Ways of Being*, is that the focus of chapter 13 is on using positive imagery interventions with people with long-standing emotional and behavioural difficulties, whereas the focus of the present chapter is on techniques that are useful in cognitive therapy regardless of the level of psychopathology. What the present chapter suggests is that goal setting, skill development, and problem solving can each be enhanced through use of imagery processes.

Part 4 is necessarily speculative as there is currently little CBT evidence on which to base the impact of generating positive imagery. It is included in the book because:

- The potential value of positive imagery interventions is suggested by a sound body of theory and a growing empirical base derived from neuroscience, cognitive science, and sports psychology (Decety and Grezes 2006; Holmes et al. 2006; Holmes and Collins 2001; Lang 1994). For example, generating positive images has a powerful and positive impact on emotion (Holmes et al. 2006; Holmes et al. 2008d), and enhances goal setting and skill development (Cumming and Ramsey 2008; Jones and Stuth 1997; Taylor et al. 1998).
- Some CBT clinicians (Beck 2005; Sanders and Wills 2005) advocate the use of imagery to enhance the effectiveness of standard CBT techniques such as goal setting.

- In clinical populations, pilot studies have provided support for positive imagery approaches, e.g. compassionate mind training (Gilbert 2010; Gilbert and Irons 2004); competitive memory training (COMET) (Korrelboom et al. 2008; Korrelboom et al. 2009b); and positive imagery generation for depression (Blackwell and Holmes 2010).
- With the recent experimental evidence on positive imagery training (Holmes et al. 2006, 2008a, 2009c), and a growing evidence base for positive psychology interventions (Lyubomirsky 2007), positive imagery work in CBT is likely to be a future growth area.

The relationship between positive imagery interventions and CBT interventions to transform negative imagery

There are certainly overlaps between the strategies that are identified for creating positive imagery in Part 4 (chapters 12–13), and those that modify negative imagery, as set out in chapters 8–11. For instance, both positive imagery and transformative imagery focus on the elicitation of new cognitions to create changes in mood and behaviour, and both require a reflective stance. However, there are also differences in emphasis as illustrated in Table 12.1.

In particular, whereas transformative strategies often emphasize the derivation of meaning from negative images before transforming them, positive imagery strategies focus, from the start, on creating positive images afresh. There are other differences: ongoing rehearsal and practice appear to be particularly important strategies in positive imagery interventions, just as they are for the development and refinement of new sports skills.

Table 12.1 Comparing Transformative Imagery with Positive Imagery

	Transforming negative images	**Creating positive images**
Nature of imagery	◆ Negative ◆ Spontaneous ◆ Involuntary ◆ Avoidance	◆ Positive ◆ Constructed ◆ Voluntary ◆ Engagement
Emotion	High levels of negative emotion experienced during negative imagery	Positive emotions (excitement, happiness, warmth, care etc.) while constructing and practising new imagery
Focus of Imagery	Modify a limited number of negative scenarios (e.g. hotspots)	Simulate a range of positive scenarios, then check, appraise and adjust
Process of Change	◆ Evoke and unpack meaning ◆ Reflective stance ◆ Introduce and integrate incompatible information	◆ Construct positive image ◆ Rehearse/practise ◆ Review and adjust
Desired outcome	Purpose is put an end to involuntary recall of negative images and alleviate negative affect	Purpose is to integrate positive images and memories which enhance new skills or new ways of being

Positive imagery and sports psychology

Positive imagery is one of the main psychological interventions in sports psychology, with an evidence base over several decades of research (Cumming and Ramsey 2008). Currently, there is little overlap between the sports psychology and CBT imagery literature. In contrast to the CBT literature, imagery research in sports psychology has focused on positive imagery and paid little attention to negative imagery. The impression within the sports psychology literature is that negative imagery is an irritant to be circumvented; in contrast, until recently CBT has paid little attention to the deliberate construction of positive images.

In the absence of much research on positive imagery in CBT, this chapter draws on sports psychology literature, examining the possible implications for CBT interventions. Future interpenetration of these two literatures may be to their mutual advantage.

The concept of 'mental simulation'

Central to positive imagery is the concept of mental simulation (Greitemeyer and Wurz 2006; Taylor and Pham 1999; Taylor et al. 1998). Mental simulation enables clients to create the imaginal representation of an event or series of events in the past or in the future, and to simulate their unfolding. Human beings are probably unique in the animal world in being able to project themselves backwards and forwards in time over many months or years (Wheeler et al. 1997). Mental simulation may involve replaying past events (e.g. behaving like a mouse when unfairly criticized by the boss) to problem solve what one could have done differently; imagining hypothetical future scenarios and seeing what one would do under various circumstances (e.g. imagining being in the role of the boss); or mixing real and imagined events, for instance by inserting into the imagined scenario 'what I should have said instead when the boss criticized me'. Imaginal simulation allows clients to identify future goals and processes in order to achieve them. It enables them to develop problem solving and emotional self-regulation skills and to simulate these under a variety of different circumstances (Taylor et al. 1998). In short, through self-generated, positive imagery (MacLeod et al. 2008) or through elicitation by computer (Holmes et al. 2009c; Lang et al. 2009), it is possible, imaginally, to simulate positive scenarios with positive outcomes.

As discussed below, imaginal mental simulation can enrich standard cognitive therapy strategies such as goal setting, skill development, and problem solving. In the process, clients' self-confidence and motivation are often enhanced. As Bandura has written: 'having people visualize themselves executing activities skilfully raises their perceived efficacy that they will be able to perform better' (Bandura 1986, p. 62). Furthermore, positive imagery can increase the perceived likelihood that future positive events will occur (see chapter 3). While there is little literature within CBT specifically addressing the impact of imaginal practices in enhancing standard CBT techniques, there is evidence from other domains, e.g. sports psychology, health psychology, and cognitive science, to suggest the value of imaginal simulation.

After a brief discussion of socialization and formulation, the remainder of this chapter is divided into three sections: goal setting, developing new skills, and problem solving using positive imagery. The focus of each is slightly different. The principle focus of goal setting is on *image construction and mental simulation*; the focus of developing new skills is particularly on *imagery rehearsal* (as well as imagery construction); while the principal focus of problem solving is on *checking, appraising, and adjusting* previously constructed images. The same processes of imagery construction, imagery rehearsal and checking-appraising-adjusting are also central to the next chapter, *Creating New Ways of Being*.

Socialization

Goal setting, skill development and problem solving are standard procedures in cognitive therapy. Clients will usually be introduced to these ideas in the initial treatment sessions (Sanders and Wills 2005; Westbrook et al. 2007). What clients may not necessarily be expecting are closed eye procedures, in which they imagine themselves multi-sensorily in future scenarios. If therapists introduce imagery strategies to enhance goal setting or skill development, clients may require a rationale.

Some of the rationales for imagery interventions have already been discussed in chapter 5. For goal setting, skill development and problem solving, it is often helpful first to ask clients what they see themselves doing (imaginally) in problematic situations; for instance when responding to criticism or talking with the boss. Having elicited a detailed description, including the felt sense, the therapist asks the client whether they think these images might affect the way they act in these circumstances, and proceeds to inquire: 'What if this image were to change, and you saw yourself in your mind's eye responding assertively and confidently? Do you think that might have an effect on what you do in reality?' (see also the Formulation section below). Socratic questioning along these lines usually helps clients to see the relationship between their images and their behaviour.

For many clients, it can also be useful to draw the analogy with building skills in sports, and let them know about sports psychology research. It is helpful for clients to know that imaginal practice of sports skills has been consistently shown to enhance performance and skill development, and top sportspeople use imagery more than lower level performers (Cumming and Ramsay 2008). For instance, the former world footballer of the year, Ronaldinho, reported that he spent large amounts of time in imaginal practice (Carlin, 2006, p.21):

> 'When I train, one of the things I concentrate on is creating a mental picture of how best to deliver that ball to a team mate, preferably leaving him alone in front of the rival goalkeeper. So what I do, always before a game, always, every night and every day, is try and think up things, imagine plays, which no one else will have thought of, and to do so always bearing in mind the particular strengths of each team-mate to whom I am passing the ball . . . I imagine the game.'

As noted in chapter 5, functional equivalence theory provides another important rationale for imagery interventions. Researchers have reported that the same neural structures are used in imagining a skill, as in actually carrying it out (Kosslyn et al. 2001).

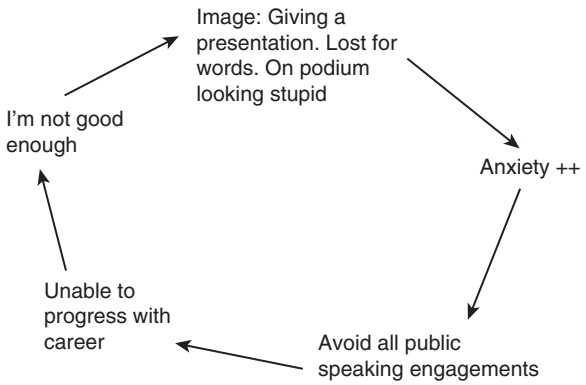


Fig. 12.1 Micro-formulation of the impact of negative imagery.

For some clients this is a particularly useful piece of information, enhancing the credibility of what can feel like an odd procedure.

Micro-formulation

Simple micro-formulation diagrams can be developed with clients to explain the role of positive imagery. By starting with a negative image, and engaging in a process of Socratic questioning, a first diagram can illustrate the effects of negative imagery (see Figure 12.1). Following this, the therapist can take the client through the same process, starting with a positive image, and asking further questions about its likely impact (see Figure 12.2). The example here is of Jack, who suffered from social anxiety. He is featured later in the chapter.

Goal setting using positive imagery: image construction and mental simulation of strategies

Goal setting is one of the key techniques in CBT (Beck 1995, 2005). To illustrate the impact of goal setting, try writing your answer to the following question: 'What are your

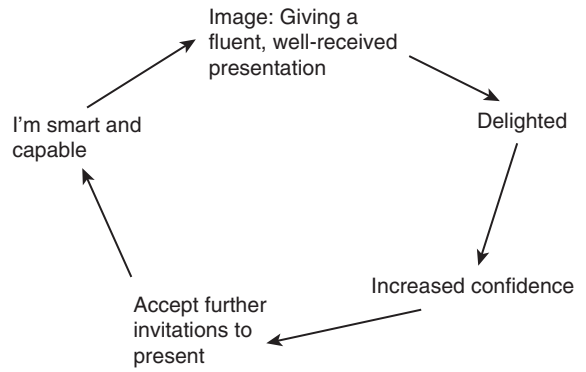


Fig. 12.2 Micro-formulation of the impact of positive imagery.

goals in reading this chapter?' Note these down now and we shall return to this question shortly.

Conventional wisdom suggests that goals should be SMART: specific, measurable, achievable, realistic, and within a time frame (Westbrook et al. 2007). If you answered the goals question above cursorily, your answer is unlikely to have contained all of these SMART components. Beck (2005) has suggested that imaginal techniques can be particularly helpful for clients who have difficulty in setting goals. When imaginative questions are used, clients can create specific examples, specific feelings, and identify specific behaviours. A therapist might invoke imagery with a depressed client, and ask: 'Can you see yourself a year from now sitting right here? Notice your arms and legs as they sink into the chair. Imagine that the year has gone really well, and you are doing the things that you used to do that gave you such pleasure. Imagine that you are feeling relaxed and happy and are telling me about the great day you had yesterday with your children. What might you have been doing with them? What will I notice that is different about you? How will you be thinking differently about yourself?' Creating a positive future picture is a highway to designing effective goals.

Conway et al. (2004, p.525) have suggested that mental imagery is 'a type of mental representation specialized for representing information about goals . . . a sort of "language" of goals.' The analysis of Conway et al. was largely focused on negative imagery, which the authors construed to be a manifestation of dysfunctional goals. However, research also suggests that imagery may also be a particularly valuable strategy for amplifying the impact of positive goal setting (Taylor et al. 1998). Purely 'verbal' goals often feel as if they have a two-dimensional quality: goal setting supplemented by imagery provides a third dimension, in which emotion (Holmes and Mathews 2005), greater specificity, and quite often new creative ideas may catch the participant by surprise.

Holmes et al. (2008c) have reviewed how imagery increases the likelihood of acting on and achieving a specific goal. Although this function of imagery may not be particularly helpful for people in impulsive states (e.g. in the manic phase of bipolar disorder), for those who need additional strategies to help them achieve certain goals, imagery can be very useful. For instance, imagery may assist depressed clients who lack positive goals for the future and any sense of optimism (Holmes et al. 2008c).

To return to the goal setting question above ('what are your goals in reading this chapter?'), try carrying out the following exercise. If you are able to give it several minutes, see whether it makes a difference in your approach to this chapter:

- Imagine that it is 30 minutes' time. You have reached the end of the chapter.
- You have used your best 'absorption' strategies to take in the content and are excited by its implications.
- You have taken a little time to reflect on the implications for your CBT practice, and asked yourself: 'What will I try out that might be different from what I'm doing now?'

- How have you gone about absorbing the contents of the chapter to get the very most from it?
- Imagine further that when you next see a client, you have some new ideas to try out—your questions have led to new learning. What difference will this make to your practice?
- How do you feel right now? Where do you notice that in your body? How does that affect your motivation to continue with this chapter—and to see your next client? What difference might this potentially make to your self-confidence as a CBT therapist using imagery?

If you took the time to do this exercise, you may have found that your goals became rather richer than the answers that you gave to the simple question, 'what are your goals in reading this chapter?' at the start of this section. Furthermore, the 'strategies' question, 'How have you gone about absorbing the contents of the chapter to get the very most from it?' might affect the way you continue to read the rest of the chapter. It is possible that you may be experiencing more motivation to read on and absorb, with more anticipation that this chapter has the potential to make a difference to your practice.

Empirical evidence suggests that imagery is at its most effective in goal setting when focused on both the *outcomes* and the *strategies* required to achieve them (Greitemeyer and Wurz 2006; Taylor and Pham 1999; Taylor et al. 1998). If anything, it appears as if focusing on the strategies has the greater effect (Taylor et al. 1998); knowing what steps are needed to achieve an outcome is as necessary and effective as knowing what the desired outcome might be. For instance, Taylor et al. (1998) reported that envisioning the successful completion of a goal such as achieving success in exams did not enhance the outcome for undergraduate psychology students. However, when students were asked to visualize themselves studying for the exam in a way that would lead them to obtain an A grade, they not only spent more time studying but achieved better grades. Apparently, the mental simulation of the *process for reaching the goal* led to better anticipation and management of emotions, and better problem solving skills (Taylor et al. 1998). Other researchers have also reported that the mental simulation of both *outcomes* and *strategies* has a positive impact on the attainment of goals (Greitemeyer and Wurz 2006; MacLeod et al. 2008; Taylor and Pham 1999). Furthermore, it appears that it is better to simulate the actions necessary to achieve goals rather than think about the reasons for achieving them (Eyck et al. 2006).

Outcome questions which make explicit use of visual and other sensory qualities tend to promote specificity: 'If I were following you and your partner around with a video-camera in a year's time, what would we capture you doing and saying on film? How would this be different from now?' 'If you were feeling really relaxed and full of energy, what would I see you doing differently?' There is also some evidence from sports psychology that enriching the sensory modalities in the image, including the kinaesthetic as well as the visual, enhances outcomes (Hardy and Callow 1999).

Process questions address how the client would get there. 'Imagine that it's two months from now, and I'm listening to you talking to your partner and noticing how you are

carrying yourself, what would I see and hear?' 'Imagine we are having a conversation afterwards, and you are proudly telling me how you've gone about making these changes, what will you be saying?'

For some clients, it can be very helpful to ask them to close their eyes, so that they enhance the imagery and contact with their hypothetical world. For other clients, sensory-based questions which naturally tend to evoke imagery ('what would I observe you doing?') may be sufficient.

Skills training using positive imagery: the importance of imagery rehearsal

Skills training plays an important part in CBT, helping clients to regulate their emotions better, get active again, or respond assertively to criticism. As already noted, sports psychology has a rich tradition in using imagery for skills training. Positive mental imagery improves athletic performance on its own or in combination with physical practice, and is rated effective, valuable and enjoyable by coaches and athletes (Cumming and Ramsey 2008; Jones and Stuth 1997). Furthermore, imagining events actually appears to make them more real (Taylor et al. 1998) and to increase their perceived probability of occurrence.

One of the most common ways that CBT therapists provide skills training for clients is through role-plays (Beck 1995). This can be helpful during sessions, but what about afterwards? Imagery homework between one session and the next may be beneficial, especially where there may not be predictable opportunities to use the skill, or where such opportunities are low-frequency, e.g. to respond assertively to a colleague's criticism. Structured mental simulations where problematic situations are successfully addressed may be one of the best ways to build on and enhance new skills (Korrelboom et al. 2009b).

Audio recordings of sessions may be very useful. The client can take a recording of an imagery session home and listen to it on a few occasions before the next session. COMET (Korrelboom et al. 2008; Korrelboom et al. 2009b) makes extensive use of imaginal rehearsal between sessions (see chapter 13). Korrelboom and colleagues suggest five minutes practice, six times a day. In the sports psychology literature, there is uncertainty about the optimal amount of mental practice required per day for optimal performance. Cumming and Ramsey (2008) suggest that the quality of the image may be more important than frequency of practice. An important area for future research in both sports psychology and CBT is to determine how imagery quality can be reliably enhanced (Cumming and Ramsey 2008).

The advantage of recordings is that the client does not have to use attention to be the creator of different scenarios, as well as to be the lead participant. Audio recordings that paint a rich picture can be particularly effective in enabling the client to experience situations more deeply. Suggestions for creating 'rich' multi-sensory recordings are contained in chapter 5. The disadvantage of recordings is that they become predictable, and

may involve just one or two static situations. Ideally, clients should use some knowledge of different possible scenarios to extend their skills across a range of possible situations. To take an example:

> Jack, who had had a distressing experience where he had found himself lost for words during an important presentation, was now very anxious at office meetings. He routinely took anti-anxiolytic medication before each meeting. The therapist and Jack listed potentially difficult situations, role-played them during several sessions, and then made an imagery recording for Jack to take home. After several weeks, Jack reported enhanced confidence in meetings. On some days where he felt less anxious, he resisted taking any medication. Over the next eight weeks new recordings were made every fortnight and the difficulty level of the scenarios was increased. On alternate days, Jack put the recordings to one side and imaginally simulated new scenarios. Through this mix of imagery recordings, imaginal self-practice, and behavioural experiments in the real world, he was able to gradually reduce his medication, until he had no use for it at all.

Problem solving: checking, appraising, and adjusting through mental simulation

Mental simulation enables clients to check, appraise, problem solve, fine-tune, or adjust when things go wrong. To continue with the example of Jack:

> Jack had one meeting where he experienced acute anxiety when he had to wait his turn to give his report at a large roundtable meeting. He made his excuses and left the room, saying that he had been feeling unwell. After discussing various options, Jack and his therapist recorded a new imagery session, in which Jack was able to regulate his anxiety through external attentional focus, imaginal rehearsal, and helpful self-talk. Jack played the recording twice a day for the next two weeks until he felt 90% confident that he would handle a similar situation in a different way. As it happened, he soon had an opportunity to try out his new strategies at another meeting, and did so successfully.

The available evidence from sports psychology suggests that simulations tend to work best if the conditions match the 'real' conditions as closely as possible, with similar neural mechanisms involved. For example physical location, body posture and movements, behaviours, thoughts and emotions should as far as possible approximate the desired outcomes (Cumming and Ramsey 2008; Holmes and Collins 2001). Such ideas provide a further rationale for the value of imaginal rehearsal between sessions. If new behaviours and self-regulated emotions are simulated in the environment where they are likely to be triggered, the chances of effective implementation are probably greater.

Conclusion

Positive imagery work, through mental simulation, provides an internal laboratory for the creation of enriched SMART goals, and for trying out different strategies and skills so that the most effective are identified. Clients can note their impact and experience different physiological sensations in the safe knowledge that it is indeed simply a 'laboratory' situation.

Summarizing this chapter, there are three key imagery processes when clients are using mental simulation to imagine positive futures:

1. *Positive Image Construction* used in particular in goal setting
2. *Positive Image Rehearsal* used in particular in skills training
3. *Checking, Appraising and Adjusting* used to solve problems and fine-tune skills.

All three elements are central to creating *new ways of being*, the subject of the following chapter.

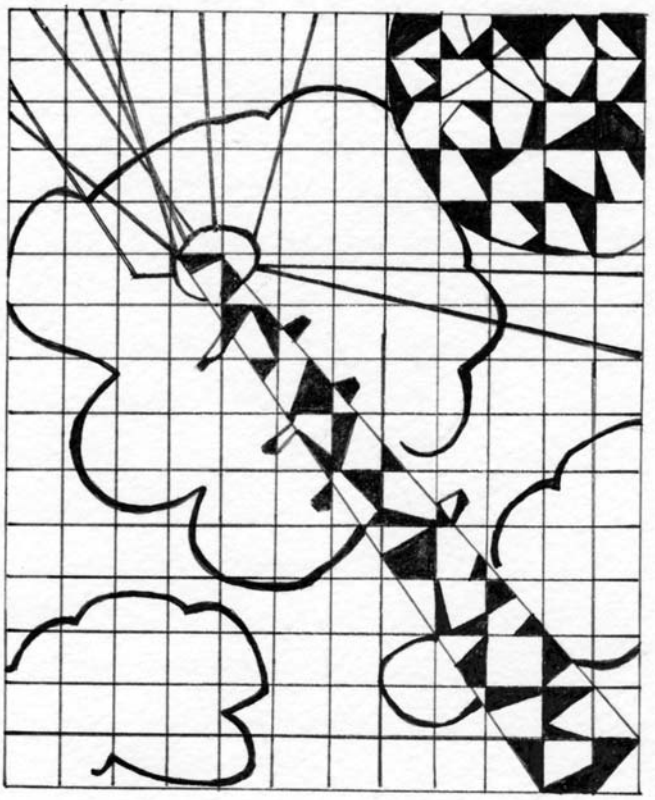
CASE VIGNETTE

Use of strengths-based imagery

Christine A. Padesky, *Center for Cognitive Therapy, Huntington Beach, California, USA*

Carmen avoided social situations because she feared she was not as smart and competent as others. She believed her deficits would be revealed especially in the intimacy of dinner conversations. Thus, she felt extreme anxiety when her employer required her attendance at monthly business banquets. Her anticipatory anxiety scored as high as 28 on the Beck Anxiety Inventory days before each dinner event.

Exploration of her strengths and areas of life contentment revealed that Carmen felt totally at ease when she was bird watching. She avidly enjoyed long periods of observation and experienced great excitement when she occasionally discovered 'new birds' for her list. When asked to consider how her bird watching strengths could be used to help her carry out behavioural experiments at dinner parties, Carmen proposed that she imagine each person at the table was a bird in the field. With this imagery in mind, she transformed her own role at the banquet to that of an active observer rather than someone being examined by others, a stance desirable during behavioural experiments designed to overcome social anxiety. She imagined various ways she could search to identify the unique characteristics in each person she met. Strengths-based imagery transformed Carmen's perception of business dinners from a time of painful scrutiny to enjoyable opportunities for discovery.



CREATING NEW WAYS OF BEING

Chapter 13

Positive imagery: creating 'new ways of being'

'The visions we offer . . . shape the future. It matters what these visions are. Often they become self-fulfilling prophesies. Dreams are maps'.
Carl Sagan, Pale Blue Dot (1995).

Introduction

The present chapter focuses on the use of imagery to bring into existence *new ways of being*. We use the term *new ways of being* to refer to a new positive orientation that clients, who have previously had strong persistent negative beliefs, are encouraged to develop towards themselves through the approaches featured in this chapter. New ways of being encompass a variety of new cognitions, behaviours, emotions, physiological reactions, and felt senses. For instance, treating oneself with kindness rather than disgust can mean changes at a fundamental level—termed 'implicational' by Teasdale (1997), see chapters 2 and 3—which impact at every other level of the system (behaviour, emotion, physiology, cognition). Other authors have used other terms to refer to what we describe as new ways of being; these include new 'minds-in-place' (Teasdale 1997), new 'social mentalities' (Gilbert 2005), 'new systems' (Padesky and Mooney 2005), or new 'cognitive emotional networks' (Korrelboom et al. 2009b).

In earlier chapters (e.g. chapters 8–11), considerable attention was focused on the importance of first of all evoking negative images, and then analysing their associated beliefs and assumptions. Once the negative images and meanings are understood, contradictory information is introduced in order to achieve transformative change. In contrast, in the previous chapter on positive imagery (chapter 12, on goal setting, skill development, and problem solving), the starting point was the creation of new positive images; no attempt was made to start with negative images and transform them.

In the present chapter, *new ways of being* methods lie somewhere between the two approaches. It is usually essential to validate current dysfunctional ways of being as understandable and adaptive responses to past circumstances, before moving on to the construction of alternatives. However, the principal focus of new ways of being therapeutic work is on envisioning new ways of being or desired states. The goal is a completely different way of relating to oneself, others, and the world. Since imagery has a more

powerful effect on positive emotion than verbal thoughts about the same information (e.g. Holmes et al. 2006; see also chapters 3 and 12), imaginal strategies appear to be particularly useful tools for generating positive new ways of being.

This chapter explores three approaches to engendering new ways of being, in which imagery interventions play a central role:

1. Compassionate mind training (CMT), which teaches people who frequently experience intense shame and self-criticism to adopt compassionate ways to think and behave towards themselves (Gilbert 2005b, 2009; Lee 2005).
2. Padesky and Mooney's (2005) *new system* approach to constructing a new sense of self in clients whose *old systems* are poorly adapted to current circumstances.
3. Korrelboom and colleagues' competitive memory training (COMET; Korrelboom et al. 2008, 2009a, 2009b, 2011) which aims to help clients *believe* at an emotional level what they may only know about themselves at an *intellectual level* (e.g. I'm OK, competent, lovable).

The clients for whom Gilbert's approach (CMT) is particularly relevant are those with strongly negative images of self (and sometimes of others). They have often had abusive or difficult childhoods (see chapter 2). Consequently, they may have a dearth of pleasant autobiographical memories and therefore may lack an alternative, positive set of images, cognitions, attitudes and feelings about the self. Hence it is necessary to develop positive ways of being *de novo*. Padesky and Mooney's old system/new system model allows that clients might have little or no belief in an alternative 'new system' and addresses ways to build such beliefs, particularly through behavioural experiments. Korrelboom's COMET training assumes that clients have at least some sense that their invalidating emotional beliefs may not be accurate, even if the alternative beliefs are usually inaccessible or only held at an intellectual level. These three approaches appear to be oriented to slightly different clients: Gilbert's to those with high levels of self-disgust or self-hatred, Padesky and Mooney's to those with little sense of an alternative self, but not necessarily as self-antagonistic as Gilbert's clients; and Korrelboom's to those who have at least some sense of an 'alternative self'.

Compassionate mind training, new system/old system work and COMET are featured in this chapter because positive imagery work plays a significant role in all three. In compassionate mind and COMET training, imagery is used on a consistent basis, often over many months, not only to construct but also to build and reinforce new ways of being. Indeed, Gilbert (2005b) specifically terms his approach compassionate mind *training*, and suggests it should be treated like a 'neurophysiotherapy' (i.e. repeatedly practised to build the compassionate 'musculature'). Padesky and Mooney place their principal emphasis on positive imagery in *constructing* the 'new system'. They place rather less emphasis on imagery (and rather more on behavioural experiments) than Gilbert and Korrelboom in the *consolidation* phase of new ways of being work. COMET has a similar 'imagery training' perspective to CMT, with consistent imagery practice being recommended on a daily basis in both the construction and consolidation phases.

At the outset, it should be made clear that all three approaches have been well elaborated by their authors, and are only briefly summarized here. A thorough understanding of compassionate mind training, old system/new system work and COMET is a prerequisite for their effective use. All three approaches use many therapeutic strategies other than imagery, and the reader is strongly advised to go to the source material to gain a full understanding of the approach (Gilbert 2005b, 2009; Gilbert et al. 2006; Gilbert and Irons 2004, 2005; Korrelboom et al. 2008, 2009a, 2009b; Kuyken et al. 2009; Lee 2005; Mooney and Padesky 2000; Padesky 1990, 1994). For the purposes of this chapter, the imagery aspects of these models are highlighted, and two clinical examples are featured. In the context of this book, these approaches are featured to illustrate the key role that imagery may play in creating new ways of being.

Socialization

Previous chapters (5–11) have emphasized the importance of socialization and formulation in preparing for imagery interventions. These are also two essential prerequisites for engaging in new ways of being work. First, the client needs to understand the rationale for using imagery to build compassionate mind, a new system, or to increase access to a positive cognitive emotional network. Some of the rationales for imagery work are discussed in chapters 5 and 6. More specific rationales for compassionate mind, new system work and COMET may be found in various sources (Gilbert 2005b, 2009; Gilbert et al. 2006; Gilbert and Irons 2004, 2005; Korrelboom et al. 2008, 2009a, 2009b, 2011; Kuyken et al. 2009; Lee 2005; Mooney and Padesky 2000; Padesky 1990, 1994). They include Gilbert's neurophysiotherapy analogy as noted above (Gilbert 2005b, and see chapter 5); Padesky's valuable metaphor of negative core beliefs as a *prejudice against the self* (Padesky 1990); and Korrelboom's rationale (based on Brewin's (2006) retrieval competition theory) for 'restoring a fairer balance between accessing positive and negative self-opinions, by making the accessibility of positive opinions more competitive' (Korrelboom et al., 2011, p. 5).

Formulation

The therapist and the client also need to agree on the formulation for these interventions to proceed effectively. For instance, in CMT, the therapist may work with the client to create a formulation in which shame and self-criticisms are seen to develop in response to threats (e.g. parental abuse, bullying) and are maintained as forms of safety strategies (Gilbert 2010). Without a sound functional analysis and understanding of the pernicious way in which self-criticism and/or the old system operates, and its deleterious impact on psychological wellbeing, there can be resistance and fear of change. For clients doing old system/new system work, even the idea of being able to develop a 'new system' may seem very foreign. Specific information about formulation in CMT, old system/new system work, and COMET training, is beyond the scope of the present chapter; it may be found in the primary reference sources noted under *Socialization* above.

The remainder of the chapter focuses on imagery techniques used in compassionate mind training, new system work and COMET. Following a short introduction to each model, each section features the three elements of imagery work which were introduced in the previous chapter on positive imagery:

1. Image construction
2. Imaginal rehearsal
3. Checking–appraising–adjusting (termed 'road testing' by Padesky and Mooney 2005).

Compassionate mind training

CMT has been developed and articulated in a series of publications by Paul Gilbert (Gilbert 2005a, 2009, 2010; Gilbert and Irons 2004; Gilbert and Procter 2006). It draws on evolutionary psychology, cognitive neuroscience, experimental psychology, Buddhist psychology, and clinical psychopathology to propose a sophisticated model for working with clients who have a particularly negative self-to-self relationship (e.g. self-hatred, self-disgust, self-loathing, and shame). A full discussion of the theoretical underpinnings is beyond the scope of the present chapter. It is recommended that therapists study Gilbert's own writings if seeking to use CMT.

Gilbert (2005a) noted that in some clients there can be heightened internal conflicts, especially between one part of the self that is critical and attacking, and another part that feels crushed by such criticism. For instance, when things go wrong for people or they make mistakes they are apt to react with aggressive thoughts such 'You're/I'm pathetic, idiotic, pitiful', while for another part, this 'attack' triggers the submissive defence of feeling inferior and vulnerable, with thoughts of 'I'm no good', 'I'd better lie low, and keep out of the way'. Not only is the content of the thoughts crucial; the emotions are often felt to be hostile, aggressive and/or contemptuous. What these clients find hard to do is to be understanding, supportive, and kind to themselves in situations of threat or difficulties.

Gilbert (Gilbert 2005b, 2009; Gilbert and Procter 2006) has posited that these clients have an underdeveloped self-compassion/affiliative system, due to harsh parenting, and histories of lack of affection, abuse, or bullying. Instead, they have internalized hostile voices which call them bad, worthless, or useless. Not having received much in the way of compassion from others, they have not learnt how to generate self-reassuring, compassionate images (Gilbert et al. 2006). Gilbert suggests that there is evidence that 'compassionate signals' can trigger soothing systems in the brain; it is these systems that CMT looks to stimulate and 'bring online' when clients are in difficulties.

Where there is an absence of self-compassion, it is often necessary to help people experience what self-compassion, self-support, and kindness actually is like, and then to train them to switch on and develop self-compassion *de novo*. Self-compassion is a whole 'way of being' experience; its induction is as much about experiencing feelings of warmth and comfort in the body as about self-to-self attitudes and behaviours with components of kindness, care, wisdom, and acceptance. CMT aims for change on a number of levels

(cognition, behaviour, emotion, physiology) and uses a range of strategies (behavioural experiments, imagery, dialogue, gestalt work etc.). Amongst these, imagery plays a key role in the strategies for eliciting a compassionate mind (Lee 2005).

Image construction

One of the main CMT interventions is to try to construct an image of the ideal qualities of compassion. A useful approach is to ask: 'if one could design one's own ideal compassionate companion or nurturer what would he, she or it be like' (Lee 2005)? The therapist might ask the client to close their eyes, and enquire: 'when you think of compassion, what images and feelings arise in you?' (Gilbert 2009). In this way, the client is encouraged to fantasize a personalized image that symbolizes compassion and can act as an ever-present reminder/coach/guide to be compassionate towards oneself. The image may be of a real or imagined person, or a mythic figure (Gilbert does not encourage religious figures because there may be ambivalent pre-existing associations). Even some aspect of the natural world (e.g. a beautiful place or mountain) may work; Gilbert and Irons (2004) give an example of a 'bush in bloom'. The form is relatively unimportant; what is important is that the image imparts a sense of a 'sentient mind' that can perfectly understand the feelings and suffering of the person. Its construction could be as a 'perfect nurturer' (Lee 2005) or it might be imbued with other compassionate elements that fit best for the client (Gilbert and Irons 2004, 2005). The image is then available to be summoned and used under a variety of circumstances. Gradually, it becomes internalized, so that compassion for oneself becomes an intrinsic quality.

The image will usually have the following qualities:

- It will be created by the client rather than prescribed by the therapist, ensuring that it 'fits' and is owned.
- It will symbolize the client's personal *ideal* of complete compassion—what they would ideally like from feeling cared for or about. It may be an image of a person or non-human being or element that is compassionate towards the self; or an image of oneself having all the desired qualities (e.g. as older, wiser, and kinder).
- It will have a range of compassionate qualities. Neff (2003) identifies self-kindness, perception of common humanity with others, and mindfulness as qualities of self-compassion. Gilbert (2009) further suggests that the image should be sentient—not merely soothing as with a transitional object such as a blanket. It will have qualities of: (i) wisdom (from experience), (ii) strength (as in fortitude and 'ability to bear'), (iii) warmth and kindness, and (iv) non-judgmental acceptance of the self. The therapist may spend time exploring each of these qualities with the client and evolving how they might be manifested in imagery.
- It will be multisensory. In particular, the image needs to cue 'warm' feelings in the body; a felt sense that has the same quality as compassion that might be felt for others (e.g. compassion for a small child who has been hurt); and compassionate emotions (e.g. sympathy, empathy). The therapist should also elicit a description of how it

looks visually, how it sounds (e.g. voice tone) and other sensory qualities (e.g. touch, or feel). Other helpful questions for building the image can be found in Gilbert and Procter (2006), e.g. 'Would you want your caring/nurturing image to feel/look/seem old or young?' 'Male or female or non-human, e.g. an animal, the sea or light?'

Clear pictures in the mind are rare (Singer 2006) and people will usually only have a fleeting essence of any image (just as sexual imagery can be patchy and fleeting, but still physiologically activating). Compassionate imagery is also worked on 'mindfully'. If the image fades or is difficult to form or sense, or if the mind wanders then the mind is gently brought back to focus in an observing, non-judgmental way.

A further interesting issue is whether or at what point in CMT it is preferable to *experience* compassion from the compassionate being, or *be* compassionate in an internal experience of self-directed compassion. In addition, there is the question of how to ensure that the compassionate image, when viewed from the observer perspective, is felt (e.g. 'visualize the compassionate being talking to you') and experienced internally (e.g. 'allow that sense of compassion to course through your body, *being* compassion'). Possibly, at first, it is easier to create an observer perspective, and later in therapy, it becomes easier and perhaps preferable to imagine *being* the compassionate being. However, this is a question for empirical research.

It may be helpful to have a visual representation of the image to serve as a cue for eliciting compassionate mind. If clients are comfortable with drawing, this can help to personalize the image (Butler and Holmes 2009). Other clients may cut pictures out of magazines, use icons or statues, or use photographs that encapsulate the compassionate being. Drawings and photos may be photocopied and put in different rooms as reminders. Lee (2005) also suggests that, having formed an ideal compassionate image, clients should fully articulate its qualities in written form (see the 'inner helper' example below).

Heather, a 35-year old sales manager with highly perfectionist beliefs, constantly berated herself for not being good enough—at work, in relationships, and in her choice of hobbies. She quickly understood the rationale for CMT, and as homework drew her compassionate being (which she termed her 'inner helper'). At her next session, she presented her drawing and said it was 'crap' (see Fig 13.1). This provided the opportunity for a spontaneous behavioural experiment to predict whether her therapist shared this belief (which he did not). The following week, Heather and her therapist designed a further behavioural experiment to draw her inner helper 'imperfectly' (Fig 13.2). Heather delighted in the fact that 'the eyes are wrong and that's fine.'
The qualities she attributed to her inner helper were:

- I picture her by the sea, a place I've always loved and where I've felt alive
- She is the kind of person I aspire to be, a sort of older and wiser me
- She is kind, loving and forgiving
- She is totally at peace with herself and has a kind of wildness and freedom borne from an innate self-belief
- She allows for human frailty and doesn't judge
- She is sensible and logical, but never condescending

Fig. 13.1 A 'crap' inner helper.

- She finds it easy to express emotions and to tell you she is proud of you
- She is always ready with a genuine smile and a huge hug
- Because of her sense of stability, she makes you feel warm, secure, and above all, accepted.

Imaginal rehearsal

Gilbert (2005b) states that the purpose of CMT is to develop access to the neurophysiological systems that underpin the affect of soothing. Self-soothing brings a new compassionate 'social mentality' to bear on a self which has been prone to severe self-criticism. Facilitation of the new pathways in the face of many years of self-criticism is likely to require considerable practice and perseverance.

Accordingly, compassionate imagery needs to be practised regularly, under a variety of circumstances using different strategies. Although there is little research on what 'regularly' means in this context, Gilbert (pers. comm., Feb 2007) has indicated that members of his CMT groups practise at every group session and are also encouraged to do so at home, e.g. by writing compassionate letters from the perspective of the imaginary compassionate being.

Fig. 13.2 An acceptable imperfect inner helper.

Examples of situations in which compassionate imagery may be practised include:

- When self-attacking, ask the question: what would my compassionate being say to me?
- When working with sensory memories (e.g. of abuse): what would my compassionate image/perfect nurturer feel, say or do towards me?
- Using the compassionate being to write a letter to the self. With the therapist acting as guide, generate compassionate warmth in the writing.
- Compare and contrast doing automatic thought records from the usual perspective, and from the perspective of the compassionate being.
- Listen to a self-compassion audio recording that has been prepared with the therapist using compassionate imagery, or try a loving-kindness meditation CD.

Cues in the environment which are cultivated in order to trigger a compassionate mentality can be particularly useful (e.g. putting on a little perfume or making a meal). Clients need to be reminded not only to bring the compassionate qualities to mind, but to get the feeling in the body when they practise CMT. Below we provide some examples:

- Jon bought himself a new watch (in itself an act of compassion), and linked compassionate feelings to the watch, so that when he checked the time, he was reminded to be compassionate.

Situation	Mood	Automatic Thoughts	Compassionate Perspective	Re-rate
About to phone son who is depressed	Sad 80%	I'm always saying the wrong thing. I always do the wrong thing. (Core Belief: I'm a failure) Evidence for: Sometimes my negative attitudes lead to self-fulfilling prophecy. Often I may affect or annoy others by this negativity	This isn't true all the time. If a friend had these feelings, I would say quite truly that there was exaggeration here (and if other people are sad it's not generally my fault). Though I fail sometimes, and do say the wrong thing, as my confidence grows, this may happen less often.	Sad 30%

Fig. 13.3 Jane's automatic thought record completed using a compassionate image.

- Jane used her compassionate being to generate a new compassionate perspective towards her negative automatic thoughts. See Figure 13.3.
- Sally used her compassionate being as a tool whenever she noticed she was feeling negative about herself. 'I ask myself: If I were talking to a friend, what would I say to them? So what might my compassionate being say to me?'
- Heather photocopied her compassionate drawing, reducing it in size in order to stick it on the back of her cigarette packet, so that each time she smoked (about 20 times a day) she triggered self-compassionate feelings (whether this led her to give up smoking is unknown).

Checking–appraising–adjusting

Once the image has been developed, it needs to be checked in a variety of circumstances: for instance, when the client is stressed, or when they are spending time with difficult colleagues or family members. If necessary the image can be adjusted. Some useful questions to ask clients are

- How easy was it to get the imagery?
- How easy was it to be kind and supportive to yourself?
- What went well? What didn't go so well?
- What needs to happen next time to remind yourself of your compassionate being?
- How can you sustain the image under these difficult circumstances?
- Is there anything that needs to change in the image, for it to be more effective for you?

It may be helpful to review what is working well and to draw conclusions about the impact of CMT.

Jon found that the self-attacker was particularly powerful when he was with his brothers. When comparing himself with them and focusing on what he perceived as his lack of career success, he castigated himself with comments such as 'you're a pathetic failure'. Neither using his watch as a 'compassion cue' (as in the example above) nor imaging his compassionate being made much impact on how he felt. With a family gathering approaching, Jon and his therapist first imagined

his dear sister Holly feeling the same as himself, and he re-engaged with feelings of compassion, both for her (rating 9/10), and by extension for himself (6/10). He and his therapist worked to remind him of all his positive qualities that had been identified by his compassionate being in previous sessions.

After identifying a number of potential trigger situations with his brothers (e.g. the brothers boasting about their recent successful business dealings and the money they had made), Jon and his therapist worked through each one in turn, with the therapist engaging Jon's strong sense of belief and pride in his own positive qualities, together with feelings of warmth and self-compassion. At the same time, Jon imaged his brothers in their most self-aggrandizing states. After rehearsing these scenarios, Jon felt calm. He could see himself acting in a centred way, and could see how he would respond. Their pointed questions about how he was 'getting on' would not hurt. He no longer felt afraid. In the event, the family gathering passed more happily than it had for many years.

Reviewing his progress after a few months, Jon noted, 'I'm not nearly as hard on myself. And I'm much better at acknowledging what I do well. I'm also much more tolerant of my mistakes. I can handle emotional upset better, and can look at situations more objectively than I used to without getting wound up in spools of negative thinking.'

A cautious approach is necessary when working with CMT, as it is still in its infancy. At present there is little available outcome data. Reports to date suggest that clients have quite varied experiences of the imagery component of CMT (Gilbert and Procter 2006). Some clients take weeks to develop their compassionate beings; for others, trying to develop compassion can be frightening. Sometimes, a seemingly compassionate image can reverse back into a distressing image (Gilbert and Irons 2004). On other occasions, a compassionate being may trigger a strong emotional or cathartic response and the therapist may need to work with grief about the past. CMT can be richly rewarding, but it is also complex because of the power of the emotions involved. Therapists should proceed with care and compassion for self and others—and preferably have good supervision.

The old system/new system approach

Christine Padesky and Kathleen Mooney have developed the 'old system/new system' approach for transforming persistent problems (Greenberger and Padesky 1995; Kuyken et al. 2009; Mooney and Padesky 2000; Padesky 1994, 2005a, 2005b; Padesky and Mooney 2005). This approach is aimed principally at working with people who have chronic difficulties that have not responded to standard CBT protocols: often those with a diagnosis of personality disorder. What we understand Padesky and Mooney to mean by the *new system* is: new core beliefs, new underlying assumptions, new behavioural strategies, and a new set of emotions and felt senses that are far more adaptive than the 'old system'. In their workshops, Padesky and Mooney (2005) suggest that imagery plays a key role in generating new beliefs, assumptions, and strategies.

For work with personality disorders, Padesky and Mooney recommend starting work with Axis I problems first, and then moving on to compassionately conceptualizing the old personality system, and validating its reasons for being ('we all do things for good reasons'). However, in contrast to more traditional CBT approaches that maintain the focus on negative beliefs, the conceptualized old system is merely the jump-off point for collaboratively creating a new system. In recent years, Padesky has consistently

emphasized the value of developing a new system, rather than de-constructing and transforming the old one (Kuyken et al. 2009; Padesky 2005a, 2005b). In this approach, the therapist engages the client in creating, building, and strengthening a whole 'new system' comprising how they would like things to be and how they would like to be themselves.

Image construction

Imagery plays an important role in creating the new system. By its very nature, the new system requires a leap of imagination. Mooney and Padesky (2000) suggest that clients can use other people (real or imagined), movies, fairytales, stories, and icons to engage their own creativity and to be inspired in their development of new beliefs and rules. Clients are encouraged to use imagery, kinaesthetic awareness, and other non-verbal processes to imagine the best outcomes they can possibly envisage. The authors argue that this approach increases motivation and produces greater potential for change.

In constructing the new system, the therapist first asks clients to identify how they would like others and themselves to be in their general area of persistent difficulty (e.g. in interpersonal relationships for clients seeking to change a personality disorder pattern). Once an ideal is identified, the therapist may suggest that the client close their eyes, and imagine how he or she would like it to be: 'How would you like to be? What are you doing? What does that look/smell/sound/feel like? How do you feel?' In particular, the therapist focuses on the client's kinaesthetic experience: 'How does that feel? Where do you feel it? What's that like?' A further link can be made with the client's therapy goals, and how they will feel when the new system is in place.

Checking–appraising–adjusting: 'road-testing' the new system

At the start of the process, clients may have little belief or confidence in their capacity to develop a 'new system'. However, once a new system of core beliefs, assumptions, and behavioural strategies has been created imaginally, the therapist and the client can collaborate to design behavioural experiments to test them out (Bennett-Levy et al. 2004); and use schema change strategies such as continua and positive data logs (Padesky 1994) to strengthen the new system.

Padesky and Mooney emphasize the importance of behavioural and experiential methods for what they term 'road-testing the new system' (checking–appraising–adjusting), and place less emphasis on frequent imagery rehearsal than the other two approaches featured in this chapter. However, if problems emerge with the new system, the therapist and the client may again return to imagery techniques to 'road-test' imaginally other ways of addressing the problems. Strengthening the new system may take time, often many months or sometimes several years. Belief and confidence ratings in the new system should be monitored over this period.

Although clinical research trial data to support the model is currently lacking, the ideas have strong face validity. Additionally, they appear to enhance clinician and client enthusiasm when working on persistent problems.

COMET interventions

COMET is a brief CBT intervention to promote new ways of being in which imagery plays a central role (Korrelboom et al. 2008, 2009a, 2009b, 2011). It is not designed as a stand-alone intervention, but rather as an adjunct to other interventions. It has a developing evidence-base through pilot studies that have demonstrated its impact on clients with low self-esteem (including a significant number with a diagnosis of personality disorder), eating disorders, and obsessive-compulsive disorder (Korrelboom et al. 2008, 2009a, 2009b, 2011).

Brewin's retrieval competition theory provides a theoretical framework for COMET interventions (Brewin 2006). Brewin has posited that CBT does not directly modify negative information in particular memories. Rather, in any given situation, retrieval competition exists between a number of possible representations, both positively and negatively valenced. The purpose of COMET interventions is to affect the relative saliency of positive and negative cognitive representations so that there is a bias towards retrieval of more positively valenced responses.

A second theoretical framework underpinning COMET is Lang's concept of cognitive emotional networks (Lang 1985, 1994). Lang (1979, 1985) suggests that emotional networks in long term memory have *stimulus representations* (e.g. triggers), *response representations* (e.g. avoidance), and *meaning representations* (e.g. danger). The rationale for COMET interventions is for clients to *feel* what they already know. With a group of friends (stimulus representation), a client may feel completely unlovable (meaning representation) and say little (response representation) even if they *know* at least some of the time that some friends do love them. A client with OCD may feel an overwhelming sense of necessity to protect others from harm by checking and re-checking the locks (response representation), even though they know at some level that this repeated checking is unnecessary. COMET aims to bring feeling and knowing into line.

COMET is usually a 7–10 session intervention, sometimes in groups, sometimes working individually. Having identified a negative belief or emotional theme that is impairing effective functioning (e.g. I am unlovable), the client is directed to find an incompatible positive belief or theme, i.e. what they might plausibly believe about themselves even if they do not currently feel it. The purpose of therapy is to make these positive representations more perceptible and retrievable so that they 'win out' against the negative representations. Clients are directed to start describing, imagining and writing about examples of positive situations from the past, at a time when there was evidence for the alternative. These examples are used together with new examples to build evidence for the positive belief. Based on experimental research indicating the positive impact of imagery, self-verbalization, posture and facial expression and music on mood, four key strategies are used to enhance and reinforce positive response representations:

1. Positive imagery
2. Positive self-talk

3. Use of empowering music

4. Adopting positive bodily postures and facial expressions.

Once the new way of being is established, it is checked for functionality. The client imagines problematic situations (negative stimulus representations), and counter-conditions by implementing the new positive strategies (response representations) that carry new implications (meaning representations).

For the imagery intervention, COMET suggests 30 minutes of positive imagery per day; five minutes each on about six occasions. Clients visualize examples of positive actions and beliefs; and reinforce the positive actions by adopting positive physical states (e.g. looking assertive, shoulders back). They then pair their images with music, which they have selected to be symbolic and empowering of the new way of being, and use positive self-statements alongside these other interventions. As the imagery becomes established, clients are encouraged to envisage progressively challenging situations which would previously have elicited the negative response, and to practise the new positive imagery, self-statements, physical reactions, and music in these situations. Through this 'counter-conditioning', the new beliefs become more salient and more firmly associated with these challenging situations. Thus, they are more likely to 'win out' in the retrieval competition.

The COMET model places imagery at the heart of its interventions, and assigns extensive homework time to its practice. Particularly compelling is its link to Brewin's retrieval competition theory (a theoretical framework which could apply equally well to the Padesky and Mooney model).

Image construction

As exemplified in both COMET and old system/new system approaches, image construction is a key strategy in the development of new ways of being. Engaging the imagination allows clients to 'unstick' themselves from current reality, which may often feel very fixed, and to move to a vista of possibility. It opens up the potential for change, creating a dynamic that moves them forwards,

The COMET approach (Korrelboom, et al. 2008, 2009a, 2009b) to image construction is to have the client identify an opposite to the negative self-image, which may not be currently believed, but which is at least in principle believable. Next, the client is asked to systematically collect some examples, which exemplify the positive self-image in specific terms. They may also turn these into short stories. COMET makes a distinction between correcting errors in the self-image, and compensatory qualities, which minimize the impact of the negative self-image (e.g. 'Even if I am extremely overweight, there are other qualities I have like curiosity and friendliness which are attractive to people'). Systematic, regular, daily homework is central to the process of image construction.

The following case example incorporates some of the imagery principles of the COMET and old system/new system approaches. However, it should not be seen as representative

of either. Although a number of cognitive behavioural interventions were used, apart from imagery (e.g. behavioural experiments, positive data logs, goal setting etc.), this case study focuses predominantly on the imagery elements of the intervention.

Jill was a 35-year old librarian who had suffered recurrent depression and low self-esteem since early adolescence. She had a history of self-harming and regarded herself as worthless, stupid, useless, and a failure. She went to great lengths to avoid interaction with others which might lead to criticism. She thought her opinion counted for nothing. In her first sessions, she and her therapist focused on her goals for therapy, developing short-term goals and strategies, mapping her old way of being to conceptualize her problems. This led to developing a rationale for the creation of a new way of being. Imagery construction was a four-stage process:

1. At session 8, the therapist and Jill undertook an imagery session to develop her new way of being. The therapist asked Jill to relax and imagine how she would like to be in general, and then more specifically, in a variety of situations that she was currently finding difficult. The session was audio recorded.
2. Jill took the recording home. Her homework was to listen to the recording and do further written work to elaborate on her new way of being, including identifying what new beliefs, assumptions, and behavioural strategies would enable her to act in new ways. She also collected any examples she could find exemplifying the new way of being, at least to some small extent. The therapist suggested that this would be as if she was 'painting a new canvas, which could then be tested out. Any bits that were not working well could be painted over with new paint'.
3. At the next session, the therapist and Jill discussed the new beliefs and rules, and fine-tuned them. Her new beliefs included: 'I am worthy of respect and of value; I am an organized person; I am intelligent. People are forgiving and reasonable.' New assumptions included: 'If my opinion is not correct, it does not affect my intrinsic worth'; and 'I am only human–people are only human.' These new elements in her self-image suggested new ways of behaving, such as facing up to problems, rather than running away; challenging any dismissal of her opinions; learning from mistakes and moving on quickly.
4. Another imagery session followed, focused on some of the difficult situations. Jill enacted her new strategies and linked them to her new rules and beliefs about herself and others. An audio recording was made of this session and Jill took it home.

Imaginal rehearsal

Jill was advised to listen to the 'new way of being' audiotape at a quiet time of the day when she was at home by herself, and to follow the relaxation and closed-eye instructions at the beginning of the tape. She was then encouraged to 'see' herself and notice her bodily feelings and emotions, while enacting her new ways of doing things. Space was left within the tape for her to generate scenarios in which she would use her 'new way of being' strategies. It was suggested to Jill that she listen to the tape five times over the next two weeks. She also undertook behavioural experiments to try out her new strategies in reality. After two weeks, she was already reporting greater confidence and some changes in belief.

Checking–appraising–adjusting

After four weeks, a difficult situation arose. Jill had a disagreement with her partner. She had found herself quickly being hijacked into her old belief: 'I'm an idiot'. She felt frustrated and worthless. Old rules soon resurfaced, such as, 'If I'm not right that shows how idiotic I am and worthy of contempt', or 'If I get really frustrated it's all right to scream at other people'. These had led her to verbally abuse her partner and to end up feeling wretched.

Checking, appraising and adjusting consisted of:

1. *Reviewing the new way of being*

   In the session, therapist and Jill looked first of all at what beliefs and assumptions in the new way of being would be helpful in this context: 'I am intelligent'; 'My opinions are valid'; 'If I don't get everything right, it doesn't affect my intrinsic worth.' Then they looked at what she would have said if the new way of being had been in place. Jill didn't feel happy about role-playing the situation so the therapist suggested that Jill run it through in imagination, using her ideas about new ways of being.

2. *Imagery Intervention*

   The therapist 'painted the scene': Jill feeling upset and angry, while her partner responded that the issue wasn't such a big deal. Then the therapist and Jill together ran through the scene with the new way of being in place. In the new scenario, Jill gave her reasons why she was upset, listened to her partner's ideas. Although in the imagined scene she still did not agree with him, Jill felt able to disagree while retaining the idea that her own opinions were valid, and that her partner's were worthy of respect as well. At each stage the therapist checked how Jill felt in her body and in her emotions.

   Jill ended up saying that this all felt much better. As a result of this experience, she added some additional new rules: 'I am only human; people are only human'; and 'It's okay to be as forgiving of myself as towards others.' She replayed the tape at home several times until she was able to engage the new ways of being regularly, and then in progressively more challenging circumstances.

Issues and difficulties in 'new ways of being' work

There are several issues that therapists need to bear in mind when helping to create new ways of being. First, therapists and clients often have to build the new ways of being from the ground up. The preliminary work of creating a formulation and rationale then building a relationship of sufficient trust may take considerable time, before any development can take place for a compassionate mind, new systems, or new cognitive emotional networks.

Second, by their very nature, the old ways of being are deeply ingrained, take considerable time to change, and are prone to raising their heads again when there is a significant change in mood. Developing new ways of being requires perseverance, persistence, and compassion when things go wrong.

Third, because this work takes time, the therapist and the client need to have the necessary time at their disposal to do what is required. It is not a way of working that fits easily into ten sessions of CBT. Although COMET is a relatively brief training, it is regarded as an adjunct rather than a whole intervention in itself. It is perhaps best conceived as an intensive catalytic programme which is 'built to last'. Although there is a dearth of good data on the kind of time commitments necessary to make these 'ways of being' changes, Christine Padesky (pers. comm.) suggests that concerted work on any given core belief may produce significant shifts in about six months. For multiple negative core beliefs, the time will be correspondingly longer. Accordingly, both the client and the therapist need to make a long-term commitment if this kind of work is to be effective.

Fourth, a drop in mood or a challenging life event is highly likely to trigger a re-emergence of the old way of being in full force, and a corresponding loss of the new way of being. Clients may become dispirited under these conditions, and lose motivation for the therapy work. It is important for therapists to anticipate these fluctuations, and make strategic plans for them with clients. 'What if the old system does re-emerge? What should we do? What if you feel that you have done something completely wrong, and start castigating yourself again? What should we do then? How can we reinstate a compassionate mind when you are feeling deeply un-self-compassionate?'

Fifth, it is unknown how much, and what kind of imagery practice is optimal. At present, we can only hazard a guess. Audio recordings made by the therapist in session appear valuable, but once they have been played a few times they become predictable. Making further recordings and updating them in the light of new experiences, including successes, is one way to ensure freshness and continued commitment to practice. It is a moot point how many times a week clients should listen to imagery recordings and at which points in time (e.g. more at the start of new system development?) It is likely that imagery practice will be needed until the positive cognitive emotional networks are reliably accessed, even in stressful situations. The aim is for such networks to become more accessible than the old negative ones.

Conclusion

In summary, imagery plays a vital role in sparking creativity and new ways of being in compassionate mind training, new system work and COMET training. It can be wonderfully rewarding and enlivening, and it can be painstaking work: it is often both. Imagery work is central to producing the kinds of deep changes that have been discussed in this chapter (Holmes et al. 2006; Teasdale 1997; Torey 1999). The therapist who works with clients with strong enduring negative self-schema without using imagery is at a great disadvantage—and may be missing the opportunity for creativity and surprise.

CASE VIGNETTE

Using Perfect Nurturer imagery to work with shame-based memories

Deborah Lee, *University College London and Berkshire Traumatic Stress Service, UK*

Peter was suffering from PTSD and depression. He was plagued by many painful memories from childhood. These memories made him feel really ashamed and triggered thoughts of self-loathing. To cope with these torturous images, Peter had developed a habit of extreme cutting. Peter would become very agitated and distressed if the therapist asked about his thoughts and images. He could not tolerate the shame he felt, and the desire to cut himself would become overwhelming. It became quite apparent that Peter had no way of ending these painful emotional experiences other than by using self-harm.

The therapist decided Peter needed to develop a compassionate mind and access feeling of care and warmth before they could work more directly with the childhood memories. Peter developed a Perfect Nurturer image which proved very helpful in reducing his level of distress and agitation. Once Peter was accessing his image regularly as a way to self-soothe the therapist suggested that they brought the image into a childhood memory. Peter was able to tolerate the memory and focus on the feelings of warmth and care for himself. Over time the memory became less powerful and threatening.

Using Perfect Nurturer imagery allowed Peter to access the state of psychological safeness, as an emotional felt sense. This technique can be used to reduce the sense of current psychological threat (shame) by increasing access to feelings of warmth, care, and kindness and thus help individuals with shame-based memories work through their experiences.

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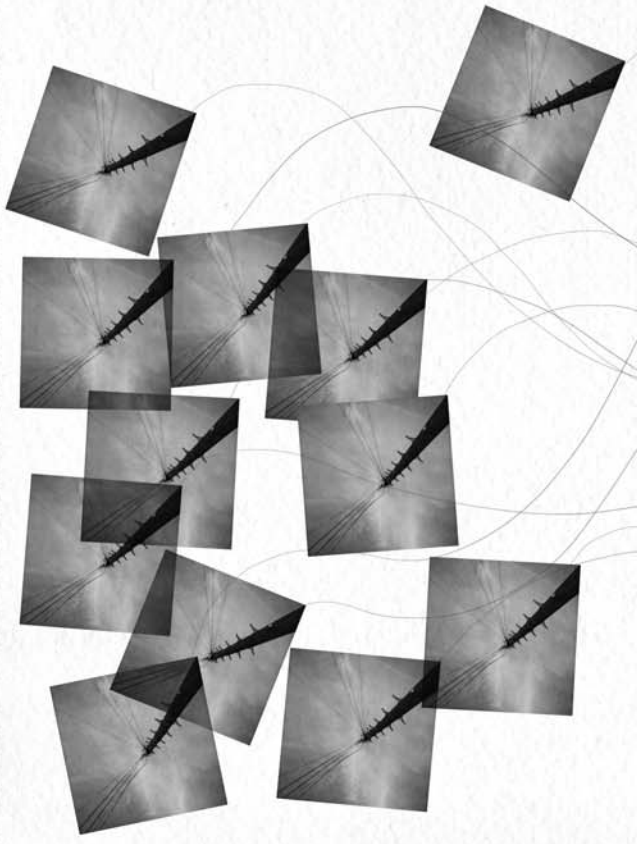
Part 5

Concluding comments

Balloons : Future Directions



Chapter 14

Future directions in working with imagery in cognitive therapy

'Imagination isn't merely a surplus mental department meant for entertainment, but the most essential piece of machinery we have if we are going to live the life of human beings'.
Ted Hughes, Children's Literature in Education (1970).

To consider the future it is useful to think about the past. In fact, the brain mechanisms underlying our future thinking are the same as those involved in the production of our memories (Schacter et al. 2007). In this last chapter we therefore review future implications from each section of this book in turn.

The Foreword of this book brings a statement from Aaron T. Beck, the founder of cognitive therapy. He speaks of imagery aiding a shared communication between patient and therapist about the content of their inner cognitions. In fact, one of Beck's earliest academic papers was on the subject of imagery and dreams (Beck and Ward 1961). One fascinating area for us in the future is to ensure that we fully communicate about inner cognitions by assessing imagery. To not ask about imagery may be to ignore a key feature of someone's mental life that holds relevance for psychotherapy. One clear example is flash-forward imagery to suicide (Holmes et al. 2007b): if one doesn't ask, the patient simply may not tell.

Again, using the past to go forwards, the Invited Essay by David Edwards contains a historical background to working with imagery in psychotherapy. Edwards elegantly provides a historical context going back to the ancient Greeks and prior to psychotherapy as we know it today. A striking feature of imagery-based case illustrations as psychotherapy emerged over a century ago (e.g. the work of Janet) is their similarity to techniques used in the present day (Hackmann 1998; Hackmann and Holmes 2004; Holmes et al. 2007a). However, imagery has had a variety of labels and meanings over the last century (e.g. visualization, fantasy, active imagination, dreams, illusion, hallucinations). A future goal will be to define our terms clearly, and to identify what constitutes an imagery technique (despite the, at times, confusing myriad of names). We have described a preliminary taxonomy of imagery in chapter 4, but further development will be needed as new techniques emerge that draw on imagery yet may not use this term.

Chapter 1 places imagery in the tradition of Beckian cognitive therapy. Beck espoused method over theory, and was an astute clinician. His observations laid the foundation for working with imagery in cognitive therapy. Continuing in his tradition means being prepared to work at refining our understanding of which interventions that involve either directly or indirectly working with imagery have good results, and when, and for whom. Such investigations may also illuminate the nature of the underlying cognitive processing.

In chapter 2 we voyaged into the study of imagery across different psychological disorders. A growing body of research now considers the phenomenology of imagery in clinical practice. This involves details of the content in different disorders and their likely metacognitive significance, as well as their general features. It appears that examining the content of imagery can help with formulation (see chapter 7), often providing extra information about the client's assumptions and core beliefs. Future directions should continue to delineate the different types of images found in various disorders.

In chapter 3, we explored experimental research on imagery and implications for clinical practice. Research on imagery is critical, and essential to an endeavour to ground therapeutic innovation in scientifically–informed evidence. One key aspect covered was that imagery has a special relationship with emotion (Holmes and Mathews 2010). Emotion is central to psychotherapy. We have only touched the surface in terms of research on imagery, and this is an exciting area where a huge amount remains to be investigated and more imagery researchers are needed! Critical questions for future research will include understanding more of the basic mechanisms behind imagery in terms of cognitive processing. A second area will be research on imagery across different disorders, as most work has focused only on PTSD and social phobia. For example, new frontiers include overly 'positive' (rather than just negative) imagery in mania or in suicidality. Two strong basic recommendations emerged from this chapter for working in imagery in cognitive therapy. If imagery has a more powerful impact on emotion than does verbal thought then: (1) assess for the presence of negative imagery (2) use positive imagery when trying to bring about positive change.

What is it about imagery that might be effective clinically? In chapter 4, our understanding of the effective components of imagery interventions suggests that there are three important components: Achieving and maintaining an appropriate metacognitive stance; reflecting on affect laden imagery (or its absence); and deliberately prompting for change using imaginal, verbal or behavioural methods. Further research and clinical observations may help us clarify how much of each of these elements may be required in different situations. The relative effectiveness of different imagery techniques is as yet unknown: how do they compare? For example, one burgeoning area of interest is the more 'indirect' imagery techniques, such as mindfulness-based cognitive therapy, other metacognitive strategies, image-competing tasks and positive interpretation training.

Chapter 5 established the platform for imagery interventions, providing general principles for incorporating imagery within clinical practice. The issues covered included planning for imagery interventions, experiencing imagery interventions, following up from

imagery interventions and, finally, troubleshooting. This is a chapter that can be re-visited many times, as it provides a foundation for whichever form the particular imagery intervention may take. One aspect that practitioners should bear in mind is that, while the therapist may become more certain and fluent in working with imagery, there are huge individual differences between clients, and clients may surprise and challenge our skills—an explanation/technique that works with one person may need adaptation for another. Basic issues such as finding a common language, and defining what is meant by imagery, will be something to approach with care and curiosity with each new client.

Chapter 6 addresses how to carry out an assessment of a client's imagery, and leads into chapter 7 on the 'micro-formulation' of imagery. This is a fresh term used for this book, as we are more used in cognitive therapy to consider the whole case formulation. By 'micro-formulation' we mean examining imagery and mapping at the level of cognitive process—in this case, putting the image in the centre of the formulation. A future direction using micro-formulation is to use the skeleton template provided in Figure 7.4, and collaboratively develop the skeleton with the client. Another exciting future direction will be for each therapist to extend and develop this skeleton itself to maximize its utility: it is not cast in stone and we hope it evolves. At present it includes the target image, its source, appraisals and emotions, impact, maintaining factors and cognitive consequences. We may find new aspects to add. We may also find new ways of drawing it out collaboratively (e.g. working on computer/white board/sketching/other) with clients to best externalize and create an image-based overview of their own micro-formulation.

After assessment and formulation, the focus of the book moves to intervention. The transformation of negative imagery was discussed in chapters 8, 9, 10 and 11. Chapters 8 and 9 make a pragmatic distinction between an image which the client experiences as representing something about the present or the future, but does not recognize as a memory (chapter 8); and imagery which the client clearly recognizes as a memory (chapter 9). Methods of working with images seen as representing the present or future were described in chapter 8. These involve holding the image in awareness and reflecting on it; manipulating the image; discriminating between the image and reality; transforming the image to reflect a more realistic perspective; and making an emotional bridge to the past to explore the possible source of the image. The relative efficacy of such strategies in different instances is a matter for further exploration.

Imagery which has been clearly recognized as a memory can also be dealt with in similar ways, and under the same headings (chapter 9). A number of potential treatment protocols are available for transforming the meanings of memories, and softening their emotional impact. Empirical questions awaiting further research include topics such as: how much verbal discussion and Socratic questioning, and how much exposure to negative memories is optimal, and for whom?

Working with night-time imagery including dreams and nightmares (chapter 10) can be done using similar strategies to those used with day-time images and memories. Imagery rescripting of nightmares now has a good evidence base in certain disorders, and can result in changes in behaviour and affect in everyday life. Metaphorical imagery can

also be addressed using the procedures of cognitive therapy (chapter 11). Clients and therapists alike may be surprised by the way in which a metaphorical image can crystallize the meaning of a difficult emotional experience, and its transformation can indicate a fresh perspective. As yet, there is little research on the efficacy of using metaphor within a cognitive therapy framework, and this will be an exciting future direction (see also Stott et al. 2010).

With a continued focus on intervention, chapter 12 moved from negative to positive imagery: creating goals, developing new skills, and problem solving. That is, rather than evoking and transforming negative imagery, clients are encouraged to start directly with generating positive imagery. The suggestion to use positive imagery when trying to bring about positive change has its basis both in the experimental clinical research described in chapter 3, and in sister literature (e.g. sports psychology). A term sometimes used in this regard is 'mental simulation' and a clinical example is its use for goal setting. Future directions will involve harnessing positive imagery more routinely in therapy, and also learning from other literature as this area develops.

Chapter 13 continued to focus on positive imagery, this time expanding the horizons and scope of an intervention into creating 'new ways of being'. This is an exciting area. A variety of emerging therapeutic interventions, which use imagery techniques to change 'way of being' at a core level, were discussed. Imagery may fuel just the type of creativity needed to develop and improve our interventions, especially in complex, chronic, and comorbid disorders.

An intriguing question for the future is not only to consider clients' imagery but the therapist's too. Will a curiosity and enthusiasm for imagery more generally (from engagement with art to noticing one's own internal imagery) help in the therapist's continued evolving work in using imagery in clinical practice? Can imagery be used creatively in supervision, as suggested by Bennett-Levy and Thwaites (2007) in their supervision model for addressing therapeutic relationship difficulties?

Whether we look from the researcher's perspective or the clinician's, imagery is one of the creative frontiers of cognitive therapy. Our hope is that this book encapsulates the very real advances that have been made, particularly over the last 10–15 years. These advances point the way for future clinicians and researchers to explore the many gaps in our knowledge, which can potentially enrich and benefit clients and therapists in the future. New technologies, for instance virtual reality (Powers and Emmelkamp 2008), are now available to assist in this endeavour.

50 years ago, in the heyday of behaviourism, imagery was not considered worthy or appropriate for experimental investigation, though interestingly it was incorporated into behavioural treatments such as systematic desensitization. Now the empirical study of imagery links clinical research, cognitive psychology, neuroscience and clinical treatments, creating a body of knowledge that strongly suggests the rich potential of imagery-based interventions in therapeutic practice.

CASE VIGNETTE

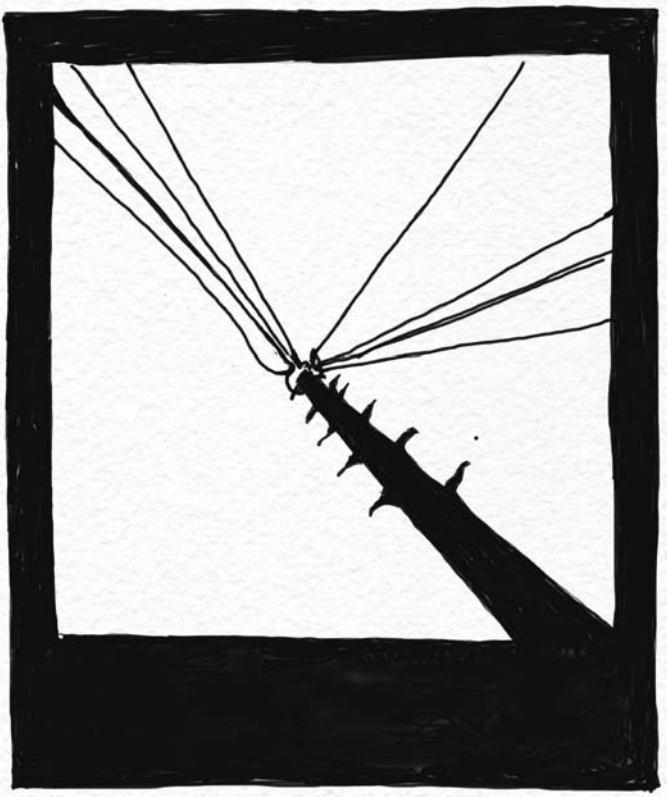
Imagery rescripting: reducing the sense of threat[1]

Jonathan Wheatley, *University College London, London, UK*

This case example shows that many different imagery transformations may need to be experimented with before the patient finds one that works. 'Judy' was experiencing traumatic images of the face of her attacker just before he assaulted her, particularly his 'mad staring eyes.' The intrusion was associated with a strong emotion that Judy described as feeling 'defeated' and a physical sensation of being small and vulnerable. The meaning of this memory was that Judy was weak, powerless and worthless.

During the rescripting Judy initially experimented with different ways of making herself more powerful, but this didn't work for her as she reasoned that if she'd defended herself at the time then her attacker would only have become more violent. Judy tried various ways to protect herself, imagining an iron-gate coming down between them, or a force field protecting her. However this didn't work as she was still able to see his eyes. She then tried putting a pair of sunglasses on his face, which had the effect of making her laugh. She began to play around with ways of making fun of her attacker, eventually imagining him as a cartoon character like 'Desperate Dan', shrinking him down to a few inches high so that he was running around on the kitchen floor. Her attacker was still angry, but was unable to harm her, and although he was still shouting threats and insults all that Judy could 'hear' was a high pitched squeaky voice. By this time Judy had become really engaged with the image and there was a marked shift towards positive affect. She imagined her attacker trying to climb up the cupboards to get at her, but being unable to. She imagined her cat chasing him around the kitchen floor. After visualizing this for a few minutes Judy decided that she now felt safe, but that she didn't want this man in the house any longer, so she imagined scooping him up in a dustpan and dropping him in the bin to be taken away by the dustmen. This rescript was more in line with reality as Judy had ended an abusive relationship with this man two years before.

1 Case treated in Brewin, C.R., Wheatley, J., Patel, T., et al. (2009). Imagery rescripting as a brief stand-alone treatment for depressed patients with intrusive memories. *Behaviour Research and Therapy, 47*, 569–576.



TELEGRAPH POLE : MANY WAYS OF SEEING

References

Achterberg, J. (1985). *Imagery in Healing: Shamanism and Modern Medicine*. Boston: Shambhala.

Aleman, A., Böcker, K. B., Hijman, R., Kahn, R. S., and De Haan, E. H. F. (2002). Hallucinations in schizophrenia: imbalance between imagery and perception? *Schizophrenia Research*, *57*, 315–16.

American Psychiatric Association. (1994). *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.). Washington D.C.: American Psychiatric Association.

Andrade, J., Kavanagh, D. J., and Baddeley, A. (1997). Eye-movements and visual imagery: A working memory approach to the treatment of post-traumatic stress disorder. *British Journal of Clinical Psychology, 36*, 209–23.

Arbuthnott, K. D. and Arbuthnott, D. W. (2001). Guided imagery and memory: Implications for psychotherapists. *Journal of Counseling Psychology, 48*, 123–32.

Arntz, A., Tiesema, M., and Kindt, M. (2007). Treatment of PTSD: A comparison of imaginal exposure with and without imagery rescripting. *Journal of Behavior Therapy and Experimental Psychiatry, 38,* 345–70.

Arntz, A. and Weertman, A. (1999). Treatment of childhood memories: Theory and practice. *Behaviour Research and Therapy*, *37,* 715–40.

Assagioli, R. (1965). *Psychosynthesis.* New York: The Viking Press.

Baddeley, A. D. and Andrade, J. (2000). Working memory and the vividness of imagery. *Journal of Experimental Psychology: General, 129*, 126–45.

Bandura, A. (1986). *Social Foundations of Thought and Action: A Social-Cognitive Theory*. Englewood Cliffs, NJ: Prentice-Hall.

Bandura, A., Adams, N. E., and Beyer, J. (1977). Cognitive processes mediating behavioural change. *Journal of Personality and Social Psychology*, *35*, 125–39.

Barlow, D. H., Hayes, S. C., and Nelson, R. O. (1984). *The Scientist Practitioner: Research and Accountability in Clinical and Educational Settings*. New York: Pergamon Press.

Barnard, P. J. (1999). Interacting Cognitive Subsystems: Modelling working memory phenomena within a multi-processor architecture. In A. Miyake and P. Shah (eds.): *Models of Working Memory: Mechanisms of Active Maintenance and Executive Control*, pp. 298–339. Cambridge, UK: Cambridge University Press.

Barnes, G. (ed.) (1977). *Transactional Analysis after Eric Berne*. New York: Harper and Row.

Beck, A.T. (1967). *Depression: Clinical, Experimental and Theoretical Aspects*. New York: Hoeber Medical Books.

Beck, A. T. (1970). Role of fantasies in psychotherapy and psychopathology. *Journal of Nervous and Mental Disease, 150,* 3–17.

Beck, A. T. (1971). Cognitive patterns in dreams and day dreams. In J. H. Masserman (ed.): *Dream Dynamics: Science and Psychoanalysis*, Vol. 19, pp. 2–7. New York: Grune and Stratton.

Beck, A.T. (1976). *Cognitive Therapy and the Emotional Disorders*. New York: Penguin.

Beck, A.T. (1991). Cognitive therapy as the integrative therapy. *Journal of Psychotherapy Integration, 1,* 191–8.

Beck, A.T., Emery, G., and Greenberg, R. (1985). *Anxiety Disorders and Phobias: A Cognitive Perspective.* New York: Basic Books.

Beck, A.T., Freeman A., and Associates (1990). *Cognitive Therapy of Personality Disorders*. New York: Guilford.

Beck, A. T. and Hurvich, M. S. (1959). Psychological correlates of depression. *Psychosomatic Medicine, 21,* 50–5.

Beck, A. T. and Ward, C. H. (1961). Dreams of depressed patients. Characteristic themes in manifest content. *Archives of General Psychiatry, 5*, 462–7.

Beck, J. S. (1995). *Cognitive Therapy: Basics and Beyond*. New York: Guilford.

Beck, J. S. (2005). *Cognitive Therapy for Challenging Problems*. New York: Guilford.

Beer, R. (2004). *Encyclopedia of Tibetan Symbols and Motifs* (2nd ed.). London: Serindia Publications.

Bennett-Levy, J., Butler, G., Fennell, M., Hackmann, A., Mueller, M., and Westbrook, D. (eds.): (2004). *Oxford Guide to Behavioural Experiments in Cognitive Therapy*. Oxford: Oxford University Press.

Bennett-Levy, J. and Marteau, T. M. (1984). Fear of animals: What is prepared? *British Journal of Psychology, 75*, 37–42.

Bennett-Levy, J. and Thwaites, R. (2007). Self and self-reflection in the therapeutic relationship: A conceptual map and practical strategies for the training, supervision and self-supervision of interpersonal skills. In P. Gilbert and R. Leahy (eds.): *The Therapeutic Relationship in the Cognitive Behavioural Psychotherapies*, pp. 255–81. Hove: Routledge.

Bennett-Levy, J., Thwaites, R., Chaddock, A., and Davis, M. (2009). Reflective practice in cognitive behavioural therapy: The engine of lifelong learning. In R. Dallos and J. Stedmon (eds.): *Reflective Practice in Psychotherapy and Counselling*, pp. 115–35. Maidenhead: Open University Press.

Bennett-Levy, J., Turner, F., Beaty, T., Smith, M., Paterson, B., and Farmer, S. (2001). The value of self-practice of cognitive therapy techniques and self-reflection in the training of cognitive therapists. *Behavioural and Cognitive Psychotherapy, 29*, 203–20.

Bentall, R. P. (1990). The illusion of reality: A review and integration of psychological research on hallucinations. *Psychological Bulletin, 107*, 82–95.

Bettleheim, B. (1976). *The Uses of Enchantment: The Meaning and Importance of Fairy Tales*. New York: Knopf.

Birrer, E., Michael, T., and Munsch, S. (2007). Intrusive images in PTSD and in traumatised and non-traumatised depressed patients: A cross-sectional clinical study. *Behaviour Research and Therapy, 45,* 2053–65.

Bishay, N. (1985). Therapeutic manipulation of nightmares and the management of neuroses. *British Journal of Psychiatry, 147,* 67–70.

Blackwell, S. E. and Holmes, E. A. (2010). Modifying interpretation and imagination in clinical depression: A single case series using cognitive bias modification. *Applied Cognitive Psychology, 24*, 338–50.

Borkovec, T. D. (2008). Cognitive behavior therapy for generalized anxiety disorder. Workshop presented at the *European Association of Behavioural and Cognitive Therapy Conference*, Helsinki, Finland, September.

Borkovec, T. D., Alcaine, O. M., and Behar, E. (2004). Avoidance theory of worry and generalized anxiety disorder. In R. G. Heimberg, C. L. Turk, and D. S. Mennin (eds.): *Generalized Anxiety Disorder: Advances in Research and Practice*, pp. 77–108. New York: Guilford.

Borkovec, T. D. and Inz, J. (1990). The nature of worry in generalized anxiety disorder: A predominance of thought activity. *Behaviour Research and Therapy, 28,* 153–8.

Borkovec, T. D., Ray, W. J., and Stober, J. (1998). Worry: A cognitive phenomenon intimately linked to affective, physiological, and interpersonal behavioural processes. *Cognitive Therapy and Research, 22,* 561–76.

Bourne, C., Frasquilho, F., Roth, A. D., and Holmes, E. A. (2010). Is it mere distraction? Peri-traumatic verbal tasks can increase analogue flashbacks but reduce voluntary memory performance. *Journal of Behavior Therapy and Experimental Psychiatry*, *41*, 316–24.

Brandon, S., Boakes, J., Glaser, D., and Green, R. (1998). Recovered memories of childhood sexual abuse. Implications for clinical practice. *British Journal of Psychiatry, 172*, 296–307.

Brewin, C. R. (2006). Understanding cognitive behaviour therapy: A retrieval competition account. *Behaviour Research and Therapy*, *44*, 765–84.

Brewin, C. R., Dalgleish, T., and Joseph, S. (1996). A dual representation theory of posttraumatic stress disorder. *Psychological Review, 103*, 670–86.

Brewin, C. R. and Holmes, E. A. (2003). Psychological theories of posttraumatic stress disorder. *Clinical Psychology Review, 23*, 339–76.

Brewin, C. R., Hunter, E., Carroll, F., and Tata, P. (1996). Intrusive memories in depression: An index of schema activation? *Psychological Medicine, 26,* 1271–6.

Brewin, C. R. and Lennard, H. (1999). Effects of mode of writing on emotional narratives. *Journal of Traumatic Stress, 12,* 355–61.

Brewin, C. R. and Patel, T. (2010). Auditory pseudohallucinations in United Kingdom war veterans and civilians with posttraumatic stress disorder. *Journal of Clinical Psychiatry, 71,* 419–25.

Brewin, C. R., Watson, M., McCarthy, S., Hyman, P., and Dayson, D. (1998). Intrusive memories and depression in cancer patients. *Behaviour Research and Therapy, 36,* 1131–42.

Brewin, C. R., Wheatley, J., Patel, T., et al. (2009). Imagery rescripting as a brief stand-alone treatment for depressed patients with intrusive memories. *Behaviour Research and Therapy, 47,* 569–76.

Brown, G. and Kulik, J. (1977). Flashbulb memories. *Cognition, 5*, 73–99.

Brown, W. (1921). The revival of emotional memories and its therapeutic value. *British Journal of Psychology, 1*, 16–19.

Butler, G., Fennell, M. J. V., and Hackmann, A. (2008). *Cognitive-behavioral Therapy for Anxiety Disorders: Mastering Clinical Challenges*. New York: Guilford.

Butler, G. and Hackmann, A. (2004). Social anxiety. In J. Bennett-Levy, G. Butler, M. J. V. Fennell, A. Hackmann, M. Mueller, and D. Westbrook (eds.): *Oxford Guide to Behavioural Experiments in Cognitive Therapy,* pp. 141–60. Oxford: Oxford University Press.

Butler, G. and Holmes, E. A. (2009). Imagery and the self following childhood trauma: Observations concerning the use of drawings and external images. In L. Stopa (ed.): *Imagery and the Threatened Self: Perspectives on Mental Imagery and the Self in Cognitive Therapy,* pp. 166–80. Hove: Routledge.

Carlin, J. (2006). The boy done good. *Observer Sports Monthly*, June, pp. 20–3.

Carroll, J. S. (1978). The effect of imagining an event on expectations for the event: An interpretation in terms of the availability heuristic. *Journal of Experimental Social Psychology, 14*, 88–96.

Cautela, J. R. (1966). Treatment of compulsive behavior by covert sensitization. *Psychological Record, 16*, 33–41.

Cautela, J. R. (1967). Covert sensitisation. *Psychological Reports, 20*, 459–68.

Cautela, J. R., and McCullough, L. (1978). Covert conditioning: A learning-theory perspective on imagery. In J. L. Singer and K. S. Pope (eds.): *The Power of Human Imagination: New Methods in Psychotherapy*, pp. 227–53. New York: Plenum.

Celluci, A. J. and Lawrence, P. S. (1978). The efficacy of systematic desensitization in reducing nightmares. *Journal of Behavior Therapy and Experimental Psychiatry, 9,* 109–14.

Clark, D. M. and Wells, A. (1995). A cognitive model of social phobia. In R. G. Heimberg, M. Liebowitz, D. Hope, and F. R. Schneier (eds.): *Social Phobia: Diagnosis, Assessment and Treatment*, pp. 69–93. New York: Guilford.

Clark, L. P. (1925). The phantasy method of analysing narcissistic neuroses. *The Psychoanalytic Review, 11–12*, 225–32.

Close, H. and Schuller, S. (2004). Psychotic symptoms. In J. Bennett-Levy, G. Butler, M. J. V. Fennell, A. Hackmann, M. Mueller, and D. Westbrook (eds.): *Oxford Guide to Behavioural Experiments in Cognitive Therapy*, pp. 245–66. Oxford: Oxford University Press.

Conway, M. A. (2001). Sensory-perceptual episodic memory and its context: Autobiographical memory. *Philosophical Transactions of the Royal Society of London Series B-Biological Sciences, 356,* 1375–84.

Conway, M. A. and Holmes, E. A. (2005). Autobiographical memory and the working self. In N. R. Braisby and A. R. H. Gellatly (eds.): *Cognitive Psychology*, pp. 507–38. Oxford: Oxford University Press.

Conway, M. A., Meares, K., and Standart, S. (2004). Images and goals. *Memory, 12*, 525–31.

Conway, M. A. and Pleydell-Pearce, C. W. (2000). The construction of autobiographical memories in the self-memory system. *Psychological Review, 107*, 261–88.

Cooper, M., Todd, G., and Turner, H. (2007). The effects of using imagery to modify core emotional beliefs in bulimia nervosa: An experimental pilot study. *Journal of Cognitive Psychotherapy, 21,* 117–22.

Crampton, M. (1969). The use of mental imagery in psychosynthesis. *Journal of Humanistic Psychology, 9*, 139–53.

Cumming, J. and Ramsey, R. (2008). Sport imagery interventions. In S. Mellalieu and S. Hanton (eds.): *Advances in Applied Sports Psychology: A Review*, pp. 5–36. London: Routledge.

Dadds, M. R., Bovbjerg, D. H., Redd, W. H., and Cutmore, T. R. H. (1997). Imagery in human classical conditioning. *Psychological Bulletin, 122*, 89–103.

Dadds, M. R., Hawes, D., Schaefer, B., and Vaka, K. (2004). Individual differences in imagery and reports of aversions. *Memory, 12*, 462–6.

Day, S. J., Holmes, E. A. and Hackmann, A. (2004). Occurrence of imagery and its link with early memories in agoraphobia. *Memory, 12*, 416–27.

de Silva, P. (1986). Obsessional-compulsive imagery. *Behaviour Research and Therapy, 24,* 333–50.

de Silva, P. and Marks, M. (1999). The role of traumatic experiences in the genesis of obsessive-compulsive disorder. *Behaviour Research and Therapy, 37,* 941–51.

Decety, J. and Grezes, J. (2006). The power of simulation: Imagining one's own and other's behavior. *Brain Research, 1079*, 4–14.

Denis, M., Mellet, E., and Kosslyn, S. M. (2004). *Neuroimaging of Mental Imagery*. Hove: Psychology Press.

Desoille, R. (1945). *Le Rêve Eveillé en Psychotherapie*. Paris: Presses Universitaires de France.

Desoille, R. (1965). The directed daydream. Downloaded 12th August 2010 from http://www.synthesis-center.org/articles/0118.pdf

Dowd, E. T. (2000). *Cognitive Hypnotherapy*. Northvale, NJ: Jason Aronson.

Edwards, D. J. A. (1989). Cognitive restructuring through guided imagery: Lessons from Gestalt therapy. In A. Freeman, K. M. Simon, L. E. Beutler, and H. Arkowitz (eds.): *Comprehensive Handbook of Cognitive Therapy*, pp. 283–97. New York: Plenum.

Edwards, D. J. A. (1990). Cognitive therapy and the restructuring of early memories through guided imagery. *Journal of Cognitive Psychotherapy: An International Quarterly, 4*, 33–50.

Edwards, D. J. A. (2007). Restructuring implicational meaning through memory-based imagery: Some historical notes. *Journal of Behavior Therapy and Experimental Psychiatry, 38*, 306–16.

Ehlers, A. and Clark, D. M. (2000). A cognitive model of posttraumatic stress disorder. *Behaviour Research and Therapy, 38*, 319–45.

Ehlers, A., Clark, D. M., Hackmann, A., et al. (2003). A randomized controlled trial of cognitive therapy, a self-help booklet, and repeated assessment as early interventions for posttraumatic stress disorder. *Archives of General Psychiatry, 60,* 1024–32.

Ehlers, A., Clark, D. M., Hackmann, A., McManus F., and Fennell, M. (2005). Cognitive therapy for post-traumatic stress disorder: Development and evaluation. *Behaviour Research and Therapy, 43,* 413–31.

Ehlers, A., Hackmann, A., and Michael, T. (2004). Intrusive re-experiencing in posttraumatic stress disorder: Phenomenology, theory, and therapy. *Memory, 12,* 403–15.

Ehlers, A., Hackmann, A., Steil, R., Clohessy, S., Wenninger, K., and Winter, H. (2002). The nature of intrusive memories after trauma: the warning signal hypothesis. *Behaviour Research and Therapy, 40*, 995–1002.

Ellenberger, H. F. (1970). *The Discovery of the Unconscious: The History and Evolution of Dynamic Psychiatry*. New York: Basic Books.

Espie, C. A., Brooks, D. N., and Lindsay, W. R. (1989). An evaluation of tailored psychological treatment of insomnia. *Journal of Behavior Therapy and Experimental Psychiatry, 20,* 143–53.

Eyck, L. L. T., Labansat, H. A., Gresky, D. M., Dansereau, D. F., and Lord, C. G. (2006). Effects of directed thinking on intentions to engage in beneficial activities: Idea generation or mental simulation? *Journal of Applied Social Psychology, 36*, 1234–62.

Ferenczi, S. (1924/1950). On forced phantasies. In J. Rickman (ed.): *Further Contributions to the Theory and Technique of Psycho-Analysis*, pp. 68–77. New York: Brunner/Mazel.

Ferenczi, S. (1930/1955). The principle of relaxation and neocatharsis. In M. Balint (ed.): *Final Contributions to the Problems and Methods of Psycho-analysis*, pp. 108–25. New York: Brunner/Mazel.

Foa, E. B. and Kozak, M. J. (1986). Emotional processing of fear: exposure to corrective information. *Psychological Bulletin, 99,* 20–35.

Foa, E. B., Molnar, C., and Cashman, L. (1995). Change in rape narratives during exposure therapy for posttraumatic stress disorder. *Journal of Traumatic Stress, 8,* 675–90.

Foa, E. B. and Rothbaum, B. O. (1998). *Treating the Trauma of Rape: Cognitive-Behavior Therapy for PTSD*. New York: Guilford.

Foa, E. B., Rothbaum, B. O., Riggs, D. S., and Murdock, T. B. (1991). Treatment of posttraumatic stress disorder in rape victims: A comparison between cognitive-behavioral procedures and counseling. *Journal of Consulting and Clinical Psychology*, *59*, 715–23.

Foa, E. B., Steketee, G., Turner, R. M., and Fischer, S. C. (1980). Effects of imaginal exposure to feared disasters in obsessive-compulsive checkers. *Behaviour Research and Therapy, 18*, 449–55.

Forbes, D., Phelps, A., McHugh, A. F., Debenham, P., Hopwood, M., and Creamer, M. (2003). Imagery rehearsal in the treatment of posttraumatic nightmares in Australian veterans with chronic combat-related PTSD: 12-month follow-up data. *Journal of Traumatic Stress, 16,* 509–13.

Forbes, D., Phelps, A., and McHugh, T. (2001). Treatment of combat-related nightmares using imagery rehearsal: A pilot study. *Journal of Traumatic Stress, 14,* 433–42.

Freeman, A. (1981). The use of dreams and images in cognitive therapy. In G. Emery, S. Hollon, and R. Bedrosian (eds.): *New Directions in Cognitive Therapy: A Casebook,* pp. 224–38. New York: Guilford.

Freeman, A. and White, B. (2002). Dreams and the dream image: Using dreams in cognitive therapy. *Journal of Cognitive Psychotherapy: An International Quarterly, 16,* 39–53.

Freeston, M. (1999). Images and obsessions. Paper presented at the *British Association of Behavioural and Cognitive Psychotherapy Conference*, Bristol, UK, July.

Fromm, E. (1968). Dissociative and integrative processes in hypnoanalysis. *The American Journal of Clinical Hypnosis, 10*, 174–7.

Garry, M., Manning, C. G., Loftus, E. F., and Sherman, S. J. (1996). Imagination inflation: Imagining a childhood event inflates confidence that it occurred. *Psychonomic Bulletin and Review, 3*, 208–14.

Gendlin, E. T. (1978). *Focusing*. New York: Everest House.

Gerard, R. (1961). Symbolic visualization—A method of psychosynthesis. Downloaded 12th August 2010 from http://www.synthesiscenter.org/articles/0112.pdf

Germain, A., Krakow, B., Faucher, B., et al. (2004). Increased mastery elements associated with imagery rehearsal treatment for sexual assault survivors with PTSD. *Dreaming, 14,* 195–206.

Giesen-Bloo, J., van Dyck, R., Spinhoven, P., et al. (2006). Outpatient psychotherapy for borderline personality disorder: A randomized clinical trial of schema-focused therapy versus transference-focused psychotherapy. *Archives of General Psychiatry, 63*, 649–58.

Gilbert, P. (ed.) (2005a). *Compassion: Conceptualisations, Research and Use in Psychotherapy*. Hove: Routledge.

Gilbert, P. (2005b). Compassion and cruelty: A biopsychosocial approach. In P. Gilbert (ed.): *Compassion: Conceptualisations, Research and Use in Psychotherapy*, pp. 9–74. Hove: Routledge.

Gilbert, P. (2009). *The Compassionate Mind*. London: Constable.

Gilbert, P. (2010). *Compassion-focused Therapy: Distinctive Features*. Hove: Routledge.

Gilbert, P., Baldwin, M. W., Irons, C., Baccus, J. R., and Palmer, M. (2006). Self-criticism and self-warmth: An imagery study exploring their relationship to depression. *Journal of Cognitive Psychotherapy: An International Quarterly*, *20*, 183–200.

Gilbert, P. and Irons, C. (2004). A pilot exploration of the use of compassionate images in a group of self-critical people. *Memory, 12*, 507–16.

Gilbert, P. and Irons, C. (2005). Focused therapies and compassionate mind training for shame and self-attacking. In P. Gilbert (ed.): *Compassion: Conceptualisations, Research and Use in Psychotherapy*, pp. 263–325. Hove: Routledge.

Gilbert, P. and Procter, S. (2006). Compassionate mind training for people with high shame and self-criticism: Overview and pilot study of a group therapy approach. *Clinical Psychology and Psychotherapy, 13*, 353–79.

Gillespie, K., Duffy, M., Hackmann, A., and Clark, D. M. (2002). Community based cognitive therapy in the treatment of post-traumatic stress disorder following the Omagh bomb. *Behaviour Research and Therapy, 40*, 345–57.

Goodwin, G. M. and Holmes, E. A. (2009). Bipolar anxiety. *Revista de Psiquiatria Y Salud Mental*, *02*, 95–8.

Goulding, M. M. and Goulding, R. L. (1979). *Changing Lives Through Redecision Therapy*. New York: Brunner/Mazel.

Greenberg, L. S. (2004). Emotion–focused therapy. *Clinical Psychology and Psychotherapy, 11*, 3–16.

Greenberger, D. and Padesky, C. A. (1995). *Mind over Mood: Change how You Feel by Changing the Way You Think.* New York: Guilford.

Greitemeyer, T. and Würz, D. (2006). Mental simulation and the achievement of health goals: The role of goal difficulty. *Imagination, Cognition and Personality, 25*, 239–51.

Grey, N. and Holmes, E. A. (2008). 'Hotspots' in trauma memories in the treatment of post-traumatic stress disorder: A replication. *Memory, 16,* 788–96.

Grey, N., Holmes, E. A., and Brewin, C. R. (2001). Peritraumatic emotional "hot spots" in memory. *Behavioural and Cognitive Psychotherapy, 29*, 367–72.

Grey, N., Young, K., and Holmes, E. (2002). Cognitive restructuring within reliving: a treatment for peritraumatic emotional "hotspots" in posttraumatic stress disorder. *Behavioural and Cognitive Psychotherapy 30,* 37–56.

Grey, S. and Mathews, A. (2000). Effects of training on interpretation of emotional ambiguity. *The Quarterly Journal of Experimental Psychology A, 53*, 1143–62.

Grunert, B. K., Smucker, M. R., Weis, J. M., and Rusch, M. D. (2003). When prolonged exposure fails: adding an imagery-based cognitive restructuring component in the treatment of industrial accident victims suffering from PTSD. *Cognitive and Behavioral Practice, 10,* 333–46.

Grunert, B. K., Weis, J. M., Smucker, M. R., and Christianson, H. F. (2007). Imagery rescripting and reprocessing therapy after failed prolonged exposure for post-traumatic stress disorder following industrial injury. *Journal of Behavior Therapy and Experimental Psychiatry, 38,* 317–28.

Hackmann, A. (1998). Working with images in clinical psychology. In A. S. Bellack and M. Hersen (eds.): *Comprehensive Clinical Psychology*, Vol. 6, pp. 301–17. Amsterdam: Elsevier.

Hackmann, A. (2005). Sleep and PTSD. Paper presented at the *British Association for Behavioural and Cognitive Psychotherapy Conference*, University of Canterbury, Canterbury, UK, July.

Hackmann, A., Clark, D. M., and McManus, F. (2000). Recurrent images and early memories in social phobia. *Behaviour Research and Therapy*, *38,* 601–10.

Hackmann, A., Ehlers, A., Speckens, A., and Clark, D. M. (2004). Characteristics and content of intrusive memories in PTSD and their changes with treatment. *Journal of Traumatic Stress*, *17,* 231–40.

Hackmann, A. and Holmes, E. A. (2004). Reflecting on imagery: A clinical perspective and overview of the special issue on mental imagery and memory in psychopathology. *Memory, 12,* 389–402.

Hackmann, A., Holmes, E. A., and Day, S. J. (2009). Imagery and the vulnerable self in agoraphobia. In L. Stopa (ed.): *Imagery and the Threatened Self: Perspectives on Mental Imagery and the Self in Cognitive Therapy*, pp. 112–36. Hove: Routledge.

Hackmann, A., Surawy, C., and Clark, D. M. (1998). Seeing yourself through others' eyes: a study of spontaneously occurring images in social phobia. *Behavioural and Cognitive Psychotherapy, 26*, 3–12.

Hagenaars, M. A., Brewin, C. R., van Minnen, A., Holmes, E. A., and Hoogduin, K. A. (2010). Intrusive images and intrusive thoughts as different phenomena: Two experimental studies. *Memory, 18*, 76–84.

Hannah, B. (1981). *Encounters With the Soul: Active Imagination as Developed by C.G. Jung*. Boston: Sigo Press.

Haraguchi, J. (2009). *Imitatio sanctorum* through devotional performance for rich and poor girls in seventeenth-century Florence. Downloaded on 22 March 2010 from http://www.newbury.org/conf-inst/2009proceedings.pdf

Hardy, L. and Callow, N. (1999). Efficacy of external and internal visual imagery perspectives for the enhancement of performance of tasks in which form is important. *Journal of Sport and Exercise Psychology, 21*, 95–112.

Harper Collins (1995). *Collins English Dictionary.* London: HarperCollins.

Harvey, A. G., Clark, D. M., Ehlers, A., and Rapee, R. M. (2000). Social anxiety and self-impression: cognitive preparation enhances the beneficial effects of video feedback following a stressful social task. *Behaviour Research and Therapy, 38*, 1183–92.

Heron, J. (1974). *Co-Counselling*. London: British Postgraduate Medical Federation.

Heron, J. (1978). *Co-Counselling Teachers Manual*. London: British Postgraduate Medical Federation.

Heron, J. (1998). *Co-Counselling* (3rd ed.). Downloaded 5th July 2010 from http://www.human-inquiry.com/98manual.htm

Hirsch, C. R., Clark, D. M., Mathews, A., and Williams, R. (2003). Self-images play a causal role in social phobia. *Behaviour Research and Therapy, 41*, 909–21.

Hirsch, C. and Holmes, E. A. (2007). Mental imagery in anxiety disorders. *Psychiatry*, *6,* 161–5.

Hirsch, C., Meynen, T., and Clark, D. M. (2004). Negative self-imagery in social anxiety contaminates social interactions. *Memory, 12,* 496–506.

Hoffart, A., Sexton, H., and Hackmann, A. (2006). Interpersonal fears among patients with panic disorder with agoraphobia. *Behavioural and Cognitive Psychotherapy, 34,* 359–63.

Holmes, E. A., Arntz, A., and Smucker, M. R. (2007a). Imagery rescripting in cognitive behaviour therapy: Images, treatment techniques and outcomes. *Journal of Behavior Therapy and Experimental Psychiatry, 38*, 297–305.

Holmes, E. A., Brewin, C. R., and Hennessy, R. G. (2004). Trauma films, information processing, and intrusive memory development. *Journal of Experimental Psychology: General, 133*, 3–22.

Holmes, E. A., Coughtrey, A. E., and Connor, A. (2008a). Looking at or through rose-tinted glasses? Imagery perspective and positive mood. *Emotion, 8*, 875–9.

Holmes, E. A., Crane, C., Fennell, M. J. V., and Williams, J. M. G. (2007b). Imagery about suicide in depression - 'Flash-forwards'? *Journal of Behavior Therapy and Experimental Psychiatry, 38*, 423–34.

Holmes, E. A., Creswell, C., and O'Connor, T. G. (2007c). Posttraumatic stress symptoms in London school children following September 11th 2001: An exploratory investigation of peri-traumatic reactions and intrusive imagery. *Journal of Behavior Therapy and Experimental Psychiatry, 38,* 474–90.

Holmes, E. A., Geddes, J. R., Colom, F., and Goodwin, G. M. (2008b). Mental imagery as an emotional amplifier: Application to bipolar disorder. *Behaviour Research and Therapy, 46,* 1251–8.

Holmes, E. A., Grey, N., and Young, K. A. D. (2005). Intrusive images and "hotspots" of trauma memories in posttraumatic stress disorder: An explanatory investigation of emotions and cognitive themes. *Journal of Behaviour Therapy and Experimental Psychiatry, 36,* 3–17.

Holmes, E. A., James, E. L., Coode-Bate, T., and Deeprose, C. (2009a). Can playing the computer game 'Tetris' reduce the build-up of flashbacks for trauma? A proposal from cognitive science. *PLoS ONE, 4*, e4153 doi:4110.1371/journal.pone.0004153

Holmes, E. A., Lang, T. J., and Deeprose, C. (2009b). Mental imagery and emotion in treatment across disorders: Using the example of depression. *Cognitive Behaviour Therapy, 38*, 21–8.

Holmes, E. A., Lang, T. J., Moulds, M. L., and Steele, A. M. (2008c). Prospective and positive mental imagery deficits in dysphoria. *Behaviour Research and Therapy, 46*, 976–81.

Holmes, E. A., Lang, T. J., and Shah, D. M. (2009c). Developing interpretation bias modification as a 'cognitive vaccine' for depressed mood: Imagining positive events makes you feel better than thinking about them verbally. *Journal of Abnormal Psychology, 118*, 76–88.

Holmes, E. A. and Mathews, A. (2005). Mental imagery and emotion: A special relationship? *Emotion, 5*, 485–97.

Holmes, E. A. and Mathews, A. (2010). Mental imagery in emotion and emotional disorders. *Clinical Psychology Review, 30*, 349–62.

Holmes, E. A., Mathews, A., Dalgleish, T., and Mackintosh, B. (2006). Positive interpretation training: Effects of mental imagery versus verbal training on positive mood. *Behavior Therapy, 37*, 237–47.

Holmes, E. A., Mathews, A., Mackintosh, B., and Dalgleish, T. (2008d). The causal effect of mental imagery on emotion assessed using picture-word cues. *Emotion, 8*, 395–409.

Holmes, E. A. and Steel, C. (2004). Schizotypy: A vulnerability factor for traumatic intrusions. *Journal of Nervous and Mental Disease*, *192,* 28–34.

Holmes, P. S. and Collins, D. J. (2001). The PETTLEP approach to mental imagery: A functional equivalence model for sports psychologists. *Journal of Applied Sports Psychology, 13*, 60–83.

Horowitz, M. J. (1970). *Image Formation and Cognition*. New York: Appleton-Century-Crofts.

Hughes, T. (2007). *The Spoken Word: Ted Hughes: Poetry in the Making (Audiobook)*. BBC: British Library.

Hunt, M., Bylsma, L., Brock, J., et al. (2006). The role of imagery in the maintenance and treatment of snake fear. *Journal of Behavior Therapy and Experimental Psychiatry, 37,* 283–98.

Hunt, M. and Fenton, M. (2007). Imagery rescripting versus in vivo exposure in the treatment of snake fear. *Journal of Behavior Therapy and Experimental Psychiatry 38,* 329–44.

Hyman, I. E. and Pentland, J. (1996). The role of mental imagery in the creation of false childhood memories. *Journal of Memory and Language, 35*, 101–17.

Jackson, S. W. (1990). The imagination and psychological healing. *Journal of the History of Behavioral Sciences, 26*, 345–58.

Janet, P. (1903). *Les Obsessions et la Psychestemie*, Vol. 1, Paris: Alcan.

Janet, P. (1914). Psychoanalysis. *Journal of Abnormal Psychology, 9,* 1–35.

Jaycox, L. H. and Foa, E. B. (1998). Post-traumatic stress disorder. In A. S. Bellack and M. Hersen (eds.): *Comprehensive Clinical Psychology*, Vol. 6, pp. 499–517. Amsterdam: Elsevier.

Jellinek, A. (1949). Spontaneous imagery: A new psychotherapeutic approach. *American Journal of Psychotherapy, 3*, 372–91.

Johles, L. (2005). How to use drawings within a CBT-framework: Workshop presented at the *5th International Congress of Cognitive Psychotherapy*, Gotenburg, Sweden, June.

Johnson, M. K. (1983). A multiple-entry, modular memory system. In G. H. Bower (ed.): *The Psychology of Learning and Motivation: Advances in Research and Theory*, Vol. 17, pp. 81–123. New York: Academic Press.

Johnson, M. K. (1997). Source monitoring and memory distortion. *Philosophical Transactions of the Royal Society of London Series B-Biological Sciences, 352*, 1733–45.

Johnson, M. K. and Multhaup, K. S. (1992). Emotion and MEM. In S. A. Christianson (ed.): *Handbook of Emotion and Memory*, pp. 33–66. Hillsdale, NJ: Lawrence Erlbaum Associates.

Jones, L. and Stuth, G. (1997). The uses of mental imagery in athletics: An overview. *Applied and Preventive Psychology, 6*, 101–15.

Jung, C. G. (1916/1960). The transcendent function. *The Collected Works of C. G. Jung, volume 8: The Structure and Dynamics of the Psyche*, (2nd ed.), pp. 67–91. London: Routledge and Kegan Paul.

Jung, C. G. (1935). *Analytical Psychology: its Theory and Practice (The Tavistock Lectures, delivered 1935, Reprinted 1990)*. London: ARK Routledge.

Jung, C. G. (1977). *Memories, Dreams, Reflections*. Glasgow: Collins Fount.

Kamphuis, J. H. and Telch, M. J. (2000). Effects of distraction and guided threat appraisal on fear reduction in exposure-based treatments for specific fears. *Behaviour Research and Therapy, 38,* 1163–81.

Kavanagh, D. J., Andrade, J., and May, J. (2005). Imaginary relish and exquisite torture: The elaborated intrusion theory of desire. *Psychological Review, 112*, 446–67.

Kavanagh, D. J., Freese, S., Andrade, J., and May, J. (2001). Effects of visuospatial tasks on desensitization to emotive memories. *British Journal of Clinical Psychology, 40*, 267–80.

Kellner, R., Neidhardt, J., Krakow, B., and Pathak, D. (1992). Changes in chronic nightmares after one session of desensitization or rehearsal instructions. *American Journal of Psychiatry, 149,* 659–63.

Kelly, G. (1955). *The Psychology of Personal Constructs (Vols. 1 and 2)*. New York: Norton & Co.

Kennerley, H. (1996). Cognitive therapy of dissociative symptoms associated with trauma. *British Journal of Clinical Psychology, 35*, 325–40.

Kennerley, H. (2000). *Overcoming Childhood Trauma*. London: Constable Robinson.

Kennerley, H. (2009). Cognitive therapy for post-traumatic dissociation. In N. Grey (ed.): *A Casebook of Cognitive Therapy for Traumatic Stress Reactions*, pp. 93–110. Hove: Routledge.

Kimball, M. (2000). From 'Anna O.' to Bertha Pappenheim: Transforming private pain into public action. *History of Psychology, 3*, 20–43.

Kline, M. V. (1952). Visual imagery and a case of experimental hypnotherapy. *The Journal of General Psychology, 46*, 159–67.

Kline, M. V. (1968). Sensory hypnoanalysis. *International Journal of Clinical and Experimental Hypnosis, 16*, 86–100.

Kline, M. V. (1976). Emotional flooding: A technique in sensory hypnoanalysis. In P. Olsen (ed.): *Emotional Flooding*, pp. 96–124. New York: Human Sciences Press.

Kolb, D. (1984). *Experiential Learning: Experience as the Source of Learning and Development*. Englewood Cliffs, NJ: Prentice Hall.

Kopp, R. (1995). *Metaphor Therapy: Using Client-Generated Metaphors in Psychotherapy*. New York: Brunner/Mazel.

Korrelboom, K., de Jong, M., Huijbrechts, I., and Daansen, P. (2009). Competitive memory training (COMET) for treating low self-esteem in patients with eating disorders: A randomized clinical trial. *Journal of Consulting and Clinical Psychology, 77*, 974–80.

Korrelboom, K., Marissen, M., and van Assendelft, T. (2011). Competitive memory training (COMET) for low self-esteem in patients with personality disorders: A randomized effectiveness study. *Behavioural and Cognitive Psychotherapy*, *39*, 1–19.

Korrelboom, K., van der Gaag, M., Hendriks, V. M., Huijbrechts, I., and Berretty, E. W. (2008). Treating obsessions with competitive memory training: A pilot study. *The Behavior Therapist, 31*, 29–35.

Korrelboom, K., van der Weele, K., Gjaltema, M., and Hoogstraten, C. (2009b). Competitive memory training (COMET) for treating low self-esteem: A pilot study in a routine clinical setting. *The Behavior Therapist*, *32*, 3–9.

Kosslyn, S. M. (1980). *Image and Mind*. Cambridge, MA: Harvard University Press.

Kosslyn, S. M. (1994). *Image and Brain: The Resolution of the Imagery Debate*. Cambridge, MA: MIT Press.

Kosslyn, S. M., Ganis, G., and Thompson, W. L. (2001). Neural foundations of imagery. *Nature Reviews: Neuroscience, 2,* 635–42.

Kosslyn, S. M., Thompson, W. L., Kim, I. J., and Alpert, N. M. (1995). Topographical representations of mental images in primary visual-cortex. *Nature, 378*, 496–8.

Koster, E. H. W., Fox, E., and MacLeod, C. (2009). Introduction to the special section on cognitive bias modification in emotional disorders. *Journal of Abnormal Psychology, 118*, 1–4.

Krakow, B., Germain, A., Warner T., et al. (2001a). The relationship of sleep quality and posttraumatic stress to potential sleep disorders in sexual assault survivors with nightmares, insomnia and PTSD. *Journal of Traumatic Stress*, *14,* 647–65.

Krakow, B., Hollifield, M., Johnston, L., et al. (2001b). Imagery rehearsal therapy for chronic nightmares in sexual assault survivors with posttraumatic stress disorder: A randomized controlled trial. *Journal of the American Medical Association, 286,* 537–45.

Krakow, B., Kellner, R., Pathak, D., and Lambert, L. (1995). Imagery rehearsal treatment for chronic nightmares. *Behaviour Research and Therapy, 33,* 837–43.

Krakow, B., Kellner, R., Pathak, D., and Lambert, L. (1996). Long-term reduction of nightmares with imagery rehearsal treatment. *Behavioural and Cognitive Psychotherapy, 24,* 135–48.

Krakow, B. and Zadra, A. (2006). Clinical management of chronic nightmares: Imagery rehearsal therapy. *Behavioural Sleep Medicine, 4,* 45–70.

Kuyken, W. and Brewin, C. R. (1994). Intrusive memories of childhood abuse during depressive episodes. *Behaviour Research and Therapy*, *32,* 525–8.

Kuyken, W. and Howell, R. (2006). Facets of autobiographical memory in adolescents with major depressive disorder and never-depressed controls. *Cognition and Emotion*, *20,* 466–87.

Kuyken, W., Padesky, C. A., and Dudley, A. (2009). *Collaborative Case Conceptualization: Working Effectively with Clients in Cognitive-behavioral Therapy*. New York: Guilford.

Lakoff, G. and Johnson, M. (1980). *Metaphors We Live By.* Chicago: University of Chicago Press.

Lang, P. J. (1979). A bio-informational theory of emotional imagery. *Psychophysiology*, *16*, 495–512.

Lang, P. J. (1985). The cognitive psychophysiology of emotion: Fear and anxiety. In A. H. Tuma and J. Maser (eds.): *Anxiety and the Anxiety Disorders*, pp. 131–70. Hillsdale, NJ: Lawrence Erlbaum Associates.

Lang, P. J. (1994). The motivational organization of emotions: Affect-Reflex connections.. In S. van Goozen, N. E. van de Poll, and J. A. Sergeant (eds.): *Emotions: Essays on Motion Theory*, pp. 61–93. Hillsdale, NJ: Lawrence Erlbaum Associates.

Lang, T. J., Moulds, M. L., and Holmes, E. A. (2009). Reducing depressive intrusions via a computerized cognitive bias modification of appraisals task: Developing a cognitive vaccine. *Behaviour Research and Therapy, 47*, 139–45.

Layden, M. A., Newman, C. F., Freeman, A., and Morse, S. B. (1993). *Cognitive Therapy of Borderline Personality Disorder*. Boston: Allyn and Bacon.

Lazarus, A. (1977). *In the Mind's Eye: The Power of Imagery for Personal Enrichment*. New York: Guilford.

Lazarus, A. A. (1968). Learning theory and the treatment of depression. *Behaviour Research and Therapy, 6,* 83–9.

Lee, D. A. (2005). The perfect nurturer: A model to develop compassionate mind within the context of cognitive therapy. In P. Gilbert (ed.): *Compassion: Conceptualisations, Research and Use in Psychotherapy*, pp. 326–51. Hove: Routledge.

Lemogne, C., Piolion, P., Friszer, S., et al. (2005). Episodic autobiographical memory in depression: Specificity, autonoetic consciousness, and self-perspective. *Consciousness and Cognition*, *15,* 258–68.

Leuner, H. (1969). Guided affective imagery (GAI): A method of intensive psychotherapy. *American Journal of Psychotherapy, 23*, 4–21.

Leuner, H. (1978). Basic principles and therapeutic efficacy of guided affective imagery (GAI). In J. L. Singer and K. S. Pope (eds.): *The Power of Human Imagination: New Methods in Psychotherapy*, pp. 126–66. New York: Plenum.

Levis, D. J. (1980). Implementing the technique of implosive therapy. In A. Goldstein and E. B. Foa (eds.): *Handbook of Behavioral Interventions*, pp. 92–151. New York: Wiley.

Lewin, K. (1946). Action research and minority problems. *Journal of Social Issues, 2*, 34–46.

Libby, L. K., Shaeffer, E. M., Eibach, R. P., and Slemmer, J. A. (2007). Picture yourself at the polls–visual perspective in mental imagery affects self-perception and behavior. *Psychological Science, 18*, 199–203.

Lichstein, K. L. and Rosenthal, T. L. (1980). Insomniacs' perceptions of cognitive versus somatic determinants of sleep disturbance. *Journal of Abnormal Psychology, 89,* 105–7.

Lilley, S. A., Andrade, J., Turpin, G., Sabin-Farrell, R., and Holmes, E. A. (2009). Visuospatial working memory interference with recollections of trauma. *British Journal of Clinical Psychology, 48*, 309–21.

Lyubomirsky, S. (2007). *The How of Happiness*. London: Sphere.

Lyubomirsky, S. and Nolen-Hoeksema, S. (1995). Effects of self-focused rumination on negative thinking and interpersonal problem-solving. *Journal of Personality and Social Psychology, 69*, 176–90.

MacLeod, A. K., Coates, C., and Hetherton, J. (2008). Increasing well-being through teaching goal-setting and planning skills: Results of a brief intervention. *Journal of Happiness Studies, 9,* 185–96.

MacLeod, C., Koster, E. H. W., and Fox, E. (2009). Whither cognitive bias modification research? Commentary on the special section articles. *Journal of Abnormal Psychology, 118*, 89–99.

Madewell, J. and Shaughnessy, M. F. (2009). An interview with John Wymore: Current practice of Gestalt therapy. *North American Journal of Psychology* [online]. Downloaded 13 August 2009 from http://findarticles.com/p/articles/mi_6894/is_3_11/ai_n42379454/

Marks, I. M. (1978). Rehearsal relief of a nightmare. *British Journal of Psychiatry, 133,* 461–5.

Marks, I. M., Lovell, K., Noshirvani, H., Livanou, M., and Thrasher, S. (1998). Treatment of post-traumatic stress disorder by exposure and/or cognitive restructuring: A controlled study. *Archives of General Psychiatry, 55,* 317–25.

Martin, M. and Williams, R. (1990). Imagery and emotion: clinical and experimental approaches. In P. Hampson, P. J. Marks, F. David, and J. T. E. Richardson (eds.): *Imagery: Current Developments*, pp. 268–306. Florence, KY: Routledge.

Mathews, A. and Mackintosh, B. (2000). Induced emotional interpretation bias and anxiety. *Journal of Abnormal Psychology, 109*, 602–15.

Mathews, A. and MacLeod, C. (2002). Induced processing biases have causal effects on anxiety. *Cognition and Emotion, 16*, 331–54.

May, J., Andrade, J., Kavanagh, D., and Penfound, L. (2008). Imagery and strength of craving for eating, drinking and playing sport. *Cognition and Emotion, 22*, 633–50.

May, J., Andrade, J., Panebokke, N., and Kavanagh, D. (2004). Images of desire: Cognitive models of craving. *Memory, 12,* 447–61.

May, J., Andrade, J., Panebokke, N., and Kavanagh, D. (2010). Visuospatial tasks suppress craving for cigarettes. *Behavior Research and Therapy*, *48,* 476–85.

Mazzoni, G. and Memon, A. (2003). Imagination can create false autobiographical memories. *Psychological Science, 14*, 186–8.

McDougall, W. (1921). The revival of emotional memories and its therapeutic value (III). *British Journal of Psychology*, *3*, 23–9.

Meier, D. (2003). *Healing Dream and Ritual: Ancient Incubation and Modern Psychotherapy* (3rd ed.). Einsiedeln: Am Klosterplatz.

Miller, G. A., Levin, D. N., Kozak, M. J., Cook, E. W., McLean, A., and Lang, P. J. (1987). Individual differences in imagery and the psychophysiology of emotion. *Cognition and Emotion, 1*, 367–90.

Mohlman, J. and Zinbarg, R. E. (2000). What kind of attention is necessary for fear reduction? An empirical test of the emotional processing model. *Behavior Therapy, 31*, 113–33.

Mooney, K. A. and Padesky, C. A. (2000). Applying client creativity to recurrent problems: Constructing possibilities and tolerating doubt. *Journal of Cognitive Psychotherapy: An Intenational Quarterly*, *14*, 149–61.

Moreno, J. L. (1939). Psychodramatic shock therapy: A sociometric approach to the problem of mental disorders. *Sociometry, 2*, 1–30.

Morrison, A. P. (2004). The use of imagery in cognitive therapy for psychosis: A case example. *Memory, 12,* 517–24.

Morrison, A. P., Frame, L., and Larkin, W. (2003). Relationships between trauma and psychosis: A review and integration. *British Journal of Clinical Psychology, 42,* 331–53.

Morrison, A. P., Haddock, G., and Tarrier, N. (1995). Intrusive thoughts and auditory hallucinations: A cognitive approach. *Behavioural and Cognitive Psychotherapy, 23,* 265–80.

Morrison, A. P., Wells, A., and Nothard, S. (2002). Cognitive and emotional predictors of predisposition to hallucinations in non-patients. *British Journal of Clinical Psychology, 41*, 259–70.

Morrison, N. and Westbrook, D. (2004). Obsessive-compulsive disorder. In J. Bennett-Levy, G. Butler, M. J. V. Fennell, A. Hackmann, M. Mueller, and D. Westbrook (eds.): *Oxford Guide to Behavioural Experiments in Cognitive Therapy,* pp. 101–20. Oxford: Oxford University Press.

Murphy, S., Nordin, S. M., and Cumming, J. (2008). Imagery in sport, exercise and dance. In T. Horn (ed.): *Advances in Sport and Exercise Psychology*, 3rd ed., pp. 297–324. Champagne, IL: Human Kinetics.

Murray-Jobsis, J. (1986). Hypnosis with the borderline patient. In E. T. Dowd and J. M. Healy (eds.): *Case Studies in Hypnotherapy*, pp. 254–73. New York: Guilford.

Muse, K., McManus, F., Hackmann, A., Williams, M., and Williams, M. (2010). Intrusive imagery in severe health anxiety: Prevalence, nature and links with memories and maintenance cycles. *Behaviour Research and Therapy*, *48*, 792–8.

Nayani T. H. and David, A. S. (1996). The auditory hallucination: a phenomenological survey. *Psychological Medicine*, *26,* 177–89.

Neff, K. (2003). Self-compassion: An alternative conceptualization of a healthy attitude towards oneself. *Self and Identity*, *2*, 85–101.

Neidhardt, E. J., Krakow, B., Kellner, R., and Pathak, D. (1992). The beneficial effects of one treatment session and recording of nightmares on chronic nightmare sufferers. *Sleep, 15,* 470–3.

Nelson, J. (2001). *An Investigation of Imagery in Insomnia.* M.Sc. Thesis, Oxford University.

Neuner, F., Schauer, M., Klaschik, C., Karunakara, U., and Elbert, T. (2004). A comparison of narrative exposure treatment, supportive counselling, and psycho-education for treating

posttraumatic stress disorder in an African refugee settlement. *Journal of Consulting and Clinical Psychology, 72*, 579–87.

Nigro, G. and Neisser, U. (1983). Point of view in personal memories. *Cognitive Psychology, 15,* 467–82.

O'Craven, K. M. and Kanwisher, N. (2000). Mental imagery of faces and places activates corresponding stimulus-specific brain regions. *Journal of Cognitive Neuroscience, 12*, 1013–23.

Oberhelman, S. M. (1983). Galen, on diagnosis from dreams. *The Journal of the History of Medicine and Allied Sciences, 38*, 36–47.

Obsessive-Compulsive Cognitions Working Group (1997). Cognitive assessment of obsessive-compulsive disorder. *Behaviour Research and Therapy, 35,* 667–81.

Öhman, A. and Mineka, S. (2001). Fears, phobias, and preparedness: Toward an evolved module of fear and fear learning. *Psychological Review, 108*, 483–522.

Osman, S., Cooper, M., Hackmann, A., and Veale, D. (2004). Spontaneously occurring images and early memories in people with body dysmorphic disorder. *Memory, 12*, 428–36.

Öst, L. G. (1989). One-session treatment of specific phobias. *Behaviour Research and Therapy, 27*, 1–7.

Ottaviani, R. and Beck, A. T. (1987). Cognitive aspects of panic disorders. *Journal of Anxiety Disorders, 1,* 15–28.

Padesky, C. A. (1990). Schema as self-prejudice. *International Cognitive Therapy Newsletter*, 5/6, 16–17.

Padesky, C. A. (1993). Socratic questioning: Changing minds or guided discovery? Paper presented at the *European Congress of Behavioural and Cognitive Therapies*, London, September.

Padesky, C. A. (1994). Schema change processes in cognitive therapy. *Clinical Psychology and Psychotherapy*, *1*, 267–78.

Padesky, C. A. (2005a). The next phase: Building positive qualities with cognitive therapy. Paper presented at the *5th International Congress of Cognitive Psychotherapy*, Gotenburg, Sweden, May.

Padesky, C. A. (2005b). Constructing a new self: A cognitive therapy approach to personality disorders. Workshop presented at the *Institute of Education*, London, UK, May.

Padesky, C. and Mooney, K. (2000). Applying client creativity to recurrent problems: constructing possibilities and tolerating doubt. Workshop presented at *Camp Cognitive Therapy*, Palm Springs, CA, February.

Padesky, C. A., and Mooney, K. A. (2005). Cognitive therapy for personality disorders: Constructing a new personality. Workshop presented at the *5th International Congress of Cognitive Psychotherapy*, Gotenburg, Sweden, May.

Paivio, A. (1971). *Imagery and Verbal Processes*. New York: Holt, Rinehart, and Winston.

Parkinson, L. and Rachman, S. J. (1981). The nature of intrusive thoughts. *Advances in Behaviour Research and Therapy, 3,* 101–10.

Pennebaker, J. W. (1997). Writing about emotional experiences as a therapeutic process. *Pyschological Science, 8*, 162–6.

Perls, F. S. (1969). *A life chronology*. Retrieved 3 October 2007 from http://www.gestalt.org/fritz.htm

Perls, F.S. (1971). *Gestalt Therapy Verbatim.* New York: Bantam.

Perls, F. S. (1973). *The Gestalt Approach and Eye Witness to Therapy*. New York: Bantam Books.

Pillemer, D. (1998). *Momentous Events, Vivid Memories.* Cambridge, MA: Harvard University Press.

Pinkola Estés, C. (1998). *Women who Run with the Wolves: Contacting the Power of the Wild Woman.* London: Random House.

Pintar, J. and Lynn S. J. (2008). *Hypnosis: A Brief History*. Chichester: Wiley-Blackwell.

Pitman, R. K. (1993). Posttraumatic obsessive-compulsive disorder: A case study. *Comprehensive Psychiatry 34,* 102–7.

Porter, K. (2003). *The Mental Athlete: Inner Training for Peak Performance in all Sports*. Champaign, IL: Human Kinetics.

Power, M. J. and Dalgleish, T. (1997). *Cognition and Emotion: From Order to Disorder*. Hove: Psychology Press.

Powers, M. B. and Emmelkamp, P. M. G. (2008). Virtual reality exposure therapy for anxiety disorders: A meta-analysis. *Journal of Anxiety Disorders, 22,* 561–9.

Pratt, D., Cooper, M. J., and Hackmann, A. (2004). Imagery and its characteristics in people who are anxious about spiders. *Behavioural and Cognitive Psychotherapy, 32,* 165–76.

Prince, M. (1909). The unconscious, chapters 4 and 5. *Journal of Abnormal Psychology, 3*, 391–426.

Rachman, S. (1980). Emotional processing. *Behaviour Research and Therapy, 18*, 51–60.

Rachman, S. (2001). Emotional processing, with special reference to post-traumatic stress disorder. *International Review of Psychiatry, 13*, 164–71.

Rachman, S. J. (2006). *The Fear of Contamination; Assessment and Treatment.* Oxford: Oxford University Press.

Rachman, S. J. (2007). Unwanted intrusive images in obsessive compulsive disorders. *Journal of Behavior Therapy and Experimental Psychiatry, 38,* 402–10.

Rachman, S. J. and Hodgson, R. J. (1980). *Obsessions and Compulsions.* Engelwood Cliffs, NJ: Prentice Hall.

Ree, M. and Harvey, A. (2004). Insomnia. In J. Bennett-Levy, G. Butler, M. J. V. Fennell, A. Hackmann, M. Mueller, and D. Westbrook (eds.): *Oxford Guide to Behavioural Experiments in Cognitive Therapy,* pp. 287–308. Oxford: Oxford University Press.

Resick, P. A. and Calhoun, K. S. (2001). Posttraumatic stress disorder. In D. H. Barlow (ed.): *Clinical Handbook of Psychological Disorders: A Step-by-Step Treatment Manual* (3rd ed.), pp. 60–113. New York: Guilford.

Resick P. A. and Schnicke M. K. (1993). *Cognitive Processing Therapy for Rape Victims: A Treatment Manual*. Newbury Park, CA: Sage.

Reyher, J. (1963). Free imagery: An uncovering procedure. *Journal of Clinical Psychology, 19*, 454–9.

Reyher, J. (1978). Emergent uncovering psychotherapy: The use of imagoic and linguistic vehicles in objectifying psychodynamic processes. In J. L. Singer and K. S. Pope (eds.): *The Power of Human Imagination: New Methods in Psychotherapy*, pp. 51–93. New York: Plenum.

Roediger, H. L. and McDermott, K. B. (1993). Implicit memory in normal human subjects. In H. Spinnler and F. Boller (eds.): *Handbook of Neuropsychology*, Vol. 8, pp. 63–131. Amsterdam: Elsevier.

Rosner, R. I. (2002). Aaron T. Beck's dream theory in context: An introduction to his 1971 article on cognitive patterns in dreams and daydreams. *Journal of Cognitive Psychotherapy: An International Quarterly, 16,* 7–21.

Rosner, R. I., Lyddon, W. J., and Freeman, A. (2002). Cognitive therapy and dreams: Introduction to the special issue. *Journal of Cognitive Psychotherapy: An International Quarterly,* 3–6.

Rosner, R. I., Lyddon, W. J., and Freeman, A. (2004). *Cognitive Therapy and Dreams*. New York: Springer.

Rothschild, B. (2000). *The Body Remembers: The Psychophysiology of Trauma and Trauma Treatment.* New York: Norton.

Salkovskis, P. M. (2002). Empirically grounded clinical interventions: Cognitive-behavioural therapy progresses through a multi-dimensional approach to clinical science. *Behavioural and Cognitive Psychotherapy, 30*, 3–9.

Salkovskis, P. M., Clark, D. M., Hackmann, A., Wells, A., and Gelder, M. G. (1999). An experimental investigation of the role of safety-seeking behaviours in the maintenance of panic disorder with agoraphobia. *Behaviour Research and Therapy, 37*, 559–74.

Salkovskis, P. M., Hackmann, A., Wells, A., Gelder, M. G., and Clark, D. M. (2007). Belief disconfirmation versus habituation approaches to situational exposure in panic disorder with agoraphobia: A pilot study. *Behaviour Research and Therapy, 45,* 877–85.

Samuels, M. and Samuels, N. (1975). *Seeing with the Mind's Eye: The History, Techniques and Uses of Visualization*. New York: Random House.

Sanders, D. and Wills, F. (2005). *Cognitive Therapy: An Introduction* (2nd ed.). London: Sage.

Schacter, D. L., Addis, D. R., and Buckner, R. L. (2007). Remembering the past to imagine the future: The prospective brain. *Nature Reviews Neuroscience, 8*, 657–61.

Segal, Z. V., Teasdale, J. D., and Williams, J. M. G. (2002). *Mindfulness-Based Cognitive Therapy for Depression: A New Approach to Preventing Relapse*. New York: Guilford.

Shamdasani, S. (2005). 'Psychotherapy' The invention of a word. *History of the Human Sciences, 18*, 1–22.

Shapiro, F. (1996). Eye movement desensitization and reprocessing (EMDR): Evaluation of controlled PTSD research. *Journal of Behavior Therapy and Experimental Psychiatry, 27*, 209–18.

Shapiro, F. (2001). *Eye Movement Desensitization and Reprocessing: Basic Principles, Protocols, and Procedures* (2nd ed.). New York: Guilford.

Sheikh, A. A. (ed.) (1984). *Imagination and Healing.* Amityville, NY: Baywood.

Sherman, S. J., Cialdini, R. B., Schwarztman, D. F., and Reynolds, K. D. (1985). Imagining can heighten or lower the perceived likelihood of contracting a disease: The mediating effect of ease of imagery. *Personality and Social Psychology Bulletin, 11*, 118–27.

Shorr, J. E. (1983). *Psychotherapy through Imagery* (2nd ed.). New York: Thieme-Stratton.

The Shorter Oxford English Dictionary (1973). (3rd ed.). Oxford: Oxford University Press.

Shulman, B. and Mosak, H. (1988). *Manual for Life Style Assessment.* New York: Accelerated Development.

Silberer, H. (1909/1951). Report of a method of eliciting and observing certain symbolic hallucination-phenomena [trans.]. In D. Rapaport (ed.): *Organization and Pathology of Thought: Selected Sources*, pp. 195–207. New York: Columbia University Press.

Silverman, L. H. (1987). Imagery as an aid in working through unconscious conflicts: A preliminary report. *Psychoanalytic Psychology, 4*, 45–64.

Singer, J. L. (1974). *Imagery and Daydream Methods in Psychotherapy and Behavior Modification*. New York: Academic.

Singer, J. L. (2006). *Imagery in Psychotherapy*. Washington, D.C.: American Psychological Association.

Singer, J. L. and Pope, K. S. (eds.) (1978). *The Power of Human Imagination: New Methods in Psychotherapy*. New York: Plenum.

Slade, P. D. and Bentall, R. P. (1988). *Sensory Deception: Towards a Scientific Analysis of Hallucination.* Croom Helm: London.

Smucker, M. R. and Dancu, C. (1999). *Cognitive-behavioral Treatment for Adult Survivors of Childhood Trauma: Imagery Rescripting and Reprocessing*. Northvale, NJ: Jason Aronson.

Smucker, M. R., Dancu, C., Foa, E. B., and Niederee, J. L. (1995). Imagery rescripting: A new treatment for survivors of childhood sexual abuse suffering from post-traumatic stress. *Journal of Cognitive Psychotherapy: An International Quarterly, 9,* 3–17.

Smucker, M. R. and Niederee, J. L. (1995). Treating incest-related PTSD and pathogenic schemas through imaginal exposure and rescripting. *Cognitive and Behavioral Practice, 2,* 63–92.

Somerville, K., Cooper, M., and Hackmann, A. (2007). Spontaneous imagery in women with bulimia nervosa: An investigation into content, characteristics and links to childhood memories. *Journal of Behavior Therapy and Experimental Psychiatry, 38,* 435–46.

Speckens, A., Ehlers, A., Hackmann, A., and Clark, D. M. (2006). Changes in intrusive memories associated with imaginal reliving in posttraumatic stress disorder. *Journal of Anxiety Disorders, 20*, 328–41.

Speckens, A., Ehlers, A., Hackmann, A., Ruths, F., and Clark, D. M. (2007). Intrusive memories and rumination in patients with posttraumatic stress disorder: A phenomenological comparison. *Memory, 15,* 249–57.

Speckens, A., Hackmann, A., Ehlers, A., and Cuthbert, B. (2007). Intrusive images and memories of earlier adverse events in patients with obsessive compulsive disorder. *Journal of Behavior Therapy and Experimental Psychiatry, 38,* 411–22.

Stampfl, T. and Levis, D. J. (1967). Essentials of implosive therapy: A learning theory based on psychodynamic behavioural therapy. *Journal of Abnormal Psychology, 72,* 496–503.

Starr, S. and Moulds, M. (2006). The role of negative interpretations of intrusive memories in depression. *Journal of Affective Disorders*, *93*, 125–32.

Steel, C., Mahmood, M., and Holmes, E. A. (2008). Positive schizotypy and trait dissociation as vulnerability factors for post-traumatic distress. *British Journal of Clinical Psychology, 47,* 245–9.

Steel, C., Wykes, T., Ruddle, A., Smith, G., Shah, D. M., and Holmes, E. A. (2010). Can we harness computerized cognitive bias modification to treat anxiety in schizophrenia? A first step highlighting the role of mental imagery. *Psychiatry Research, 178,* 451–5.

Stott, R., Mansell, W., Salkovskis, P., Lavender, A., and Cartwright-Hatton, S. (2010). *Oxford Guide to Metaphors in CBT: Building Cognitive Bridges.* Oxford: Oxford University Press.

Stuart, A. D. P., Holmes, E. A., and Brewin, C. R. (2006). The influence of a visuospatial grounding task on intrusive images of a traumatic film. *Behaviour Research and Therapy, 44*, 611–19.

Suler, J. R. (1989). Mental imagery in psychoanalytic treatment. *Psychoanalytic Psychology, 6*, 343–66.

Swan, W. (2008). C.G. Jung's Psychotherapeutic technique of active imagination in historical context. *Psychoanalysis and History, 10*, 185–204.

Tarrier, N., Pilgrim, H., Somerfield, C., et al. (1999). A randomized trial of cognitive therapy and imaginal exposure in the treatment of chronic posttraumatic stress disorder. *Journal of Consulting and Clinical Psychology, 67,* 13–18.

Taylor, E. (2000). Psychotherapeutics and the problematic origins of clinical psychology in America. *American Psychologist, 55*, 1029–33.

Taylor, S. E. and Pham, L. B. (1999). The effect of mental simulation on goal-directed performance. *Imagination, Cognition and Personality, 18*, 253–68.

Taylor, S. E., Pham, L. B., Rivkin, I. D., and Armor, D. A. (1998). Harnessing the imagination: Mental simulation, self-regulation, and coping. *American Psychologist, 53*, 429–39.

Teasdale, J. D. (1993). Emotion and two kinds of meaning: Cognitive therapy and applied cognitive science. *Behaviour Research and Therapy, 31,* 339–54.

Teasdale, J. D. (1997). The relationship between cognition and emotion: The mind-in-place in mood disorders. In D. M. Clark and C. G. Fairburn (eds.): *The Science and Practice of Cognitive Behaviour Therapy*, pp. 67–93. Oxford: Oxford University Press.

Teasdale, J. D. (1999). Emotional processing, three modes of mind and the prevention of relapse in depression. *Behaviour Research and Therapy, 37*, 53–77.

Teasdale, J. D. and Barnard, P. J. (1993). *Affect, Cognition and Change: Re-modelling Depressive Thought.* Hove: Lawrence Erlbaum Associates.

Thorpe, S. J. and Salkovskis, P. M. (1995). Phobic beliefs: Do cognitive factors play a role in specific phobias? *Behaviour Research and Therapy, 33*, 805–16.

Torey, Z. (1999). *The Crucible of Consciousness: A Personal Exploration of the Conscious Mind.* Melbourne: Oxford University Press.

Van der Hart, O. (1985a). Metaphoric and symbolic imagery in the hypnotic treatment of an urge to wander: A case report. *Australian Journal of Clinical and Experimental Hypnosis, 13*, 83–95.

Van der Hart, O. (1985b). Metaphoric hypnotic imagery in the treatment of functional amenorrhea. *American Journal of Clinical Hypnosis, 27*, 159–65.

Van der Hart, O. and Brown, P. (1992). Abreaction re-evaluated. *Dissociation, 5*, 127–40.

Van der Hart, O., Brown, P., and Van der Kolk, B. A. (1989). Pierre Janet's treatment of post-traumatic stress. *Journal of Traumatic Stress, 2*, 379–95.

Van der Hart, O. and Horst, R. (1989). The dissociation theory of Pierre Janet. *Journal of Traumatic Stress, 2*, 397–412.

Van der Hart, O. and Van der Velden, K. (1987). The hypnotherapy of Dr. Andries Hoek: Uncovering hypnotherapy before Janet, Breuer, and Freud. *American Journal of Clinical Hypnosis, 29*, 264–71.

Van der Kolk, B. (1994). The body keeps the score: Memory and the evolving psychobiology of post-traumatic stress. *Harvard Review of Psychiatry, 1,* 253–65.

Vijselaar, J. and Van der Hart, O. (1992). The first report of hypnotic treatment of traumatic grief: A brief communication. *The International Journal of Clinical and Experimental Hypnosis, 11*, 1–6.

Vrana, S. R., Cuthbert, B. N., and Lang, P. J. (1986). Fear imagery and text processing. *Psychophysiology, 23*, 247–53.

Ward, C. H., Beck, A. T., and Roscoe, E. (1961). Typical dreams: Incidence among psychiatric patients. *Archives of General Psychiatry, 5,* 606–15.

Watkins, J. G. (1971). The affect bridge: A hypnoanalytic technique. *International Journal of Clinical and Experimental Hypnosis, 19*, 21–7.

Watkins, J. G. (1978). *The Therapeutic Self*. New York: Human Sciences Press.

Watkins, J. G. (1992). *Hypnoanalytic Techniques: The Practice of Clinical Hypnosis,* Vol 2. New York: Irvington.

Watkins, J. G. and Johnson, R. J. (1982). *We, The Divided Self*. New York: Irvington.

Watkins, M. (2003). *Waking Dreams* (3rd ed.). Putnam, CT: Spring Publications.

Watkins, M. M. (1984). *Waking Dreams.* Dallas, TX: Spring Publications.

Watts, F. N. (1997). Thoughts and Images. In J. M. G. Williams, F. N. Watts, C. MacLeod, and A. Mathews (eds.): *Cognitive Psychology and Emotional Disorders:* (2nd ed.), pp. 169–89. Chichester: Wiley.

Weertman, A. and Arntz, A. (2007). Effectiveness of treatment of childhood memories in cognitive therapy for personality disorders: A controlled study contrasting methods focusing on the present and methods of focusing on childhood memories. *Behaviour Research and Therapy, 45,* 2133–43.

Wegner, D. M. (1994). Ironic processes of mental control. *Psychological Review, 101*, 34–52.

Weitzman, B. (1967). Behaviour therapy and psychotherapy. *Psychological Review, 74,* 300–17.

Wells, A. (1997). *Cognitive Therapy of Anxiety Disorders: A Practice Manual and Conceptual Guide*. Chichester: Wiley.

Wells, A. (2000). *Emotional Disorders and Metacognition: Innovative Cognitive Therapy*. Chichester: Wiley.

Wells, A. and Clark, D. M. (1997). Social phobia: a cognitive approach. In G.C.L. Davey (ed.): *Phobias: A Handbook of Theory, Research and Treatment*, pp. 3–26, Chichester, UK: Wiley.

Wells, A. and Hackmann, A. (1993). Imagery and core beliefs in health anxiety: Content and origins. *Behavioural and Cognitive Psychotherapy, 21,* 265–73.

Westbrook, D., Kennerley, H., and Kirk, J. (2007). *An Introduction to Cognitive Behaviour Therapy: Skills and Applications*. London: Sage.

Wheatley, J., Brewin, C. R., Patel, T., et al. (2007). 'I'll believe it when I can see it': Imagery rescripting of intrusive sensory memories in depression. *Journal of Behavior Therapy and Experimental Psychiatry, 38*, 371–85.

Wheatley, J., Hackmann, A., and Brewin, C. R. (2009). Imagery rescripting for intrusive sensory memories in major depression following traumatic experiences. In N. Grey (ed.): *A Casebook of Cognitive Therapy for Traumatic Stress Reactions*, pp. 78–92. Hove: Routledge.

Wheeler, M. A., Stuss, D. T., and Tulving, E. (1997). Toward a theory of episodic memory: The frontal lobes and autonoetic consciousness. *Psychological Bulletin, 121*, 331–54.

Wild, J., Hackmann, A., and Clark, D. M. (2007). When the present visits the past: Updating traumatic memories in social phobia. *Journal of Behavior Therapy and Experimental Psychiatry, 38,* 386–401.

Wild, J., Hackmann, A., and Clark, D. M. (2008). Rescripting early memories linked to negative images in social phobia: A pilot study. *Behavior Therapy, 39,* 47–56.

Williams, M., Teasdale, J., Segal, Z., and Kabat-Zinn, J. (2007). *The Mindful Way through Depression: Freeing Yourself from Chronic Unhappiness.* New York: Guilford.

Witztum, E., Van der Hart, O., and Friedman, B. (1988). The use of metaphors in psychotherapy. *Journal of Contemporary Psychotherapy, 18,* 270–90.

Wolpe, J. (1958). *Psychotherapy by Reciprocal Inhibition*. Stanford, CA: Stanford University Press.

Young, J. E. (1999). *Cognitive Therapy for Personality Disorders: A Schema-focused Approach* (3rd ed.). Sarasota, FL: Professional Resource Press.

Young, J. E., Klosko, J. S., and Weishaar, M. E. (2003). *Schema Therapy: A Practitioner's Guide*. New York: Guilford.

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