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'Venturing Towards the Dark Side': The Use of Imagery Interventions by Recently Qualified Cognitive–Behavioural Therapists

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Despite the growing recognition of the value of mental imagery within the field of cognitive–behavioural therapy (CBT), there is minimal research relating to clinicians' experiences of using imagery. This paper explores recently qualified CBT therapists' clinical experiences of using imagery and their perception of the role of imagery within their practice. Twelve therapists, qualified within the past 4 years, were interviewed using a semi-structured format, and the resulting transcriptions were analysed using Interpretative Phenomenological Analysis (IPA). The analysis identified six superordinate themes: (1) broad and fluid conception of imagery; (2) the importance given to imagery and the varied rationale for its inclusion; (3) varied application; (4) clinician avoidance and apprehension; (5) personal experience of imagery and impact on use; and (6) limited core training and the potential for future use. The themes, as a whole, described a complex and often dichotomous reaction to imagery amongst the therapists. Although a section of participants reported a natural affinity with imagery, other therapists felt that using, and experiencing, imagery was anxiety provoking and problematic. There was, however, unity in the value placed on imagery, the strong rationale for usage and the importance given to imagery-specific training. Avoidance and apprehension regarding imagery were evident in the majority of participants, and the reasons for such responses included personal, clinical and cultural factors. The overall findings highlight the importance of clinician factors in the way in which imagery is utilized and understood, which has positive implications for training, personal development and future research. Copyright © 2014 John Wiley & Sons, Ltd.

Key Practitioner Message:

- There is a universal recognition of the value of imagery for experiential learning and emotional connection.
- Therapists apply a variety of rationales for using imagery.
- Avoidance of using imagery in CBT practice is widely reported and occurs for a variety of personal and clinical reasons.
- Clinicians' own experience of imagery has a significant influence on the way in which imagery is understood, utilized and experienced in therapy.
- Future training and research in imagery should more explicitly address the clinician factors that can inhibit or facilitate the use of evidence-based imagery interventions.

Keywords: Imagery, Cognitive Behavioural Therapy, Therapist Skills, Interpretative Phenomenological Analysis (IPA), CBT Training

INTRODUCTION

The use of mental imagery has a rich tradition in the general field of psychotherapy and has played a notable role in the early development of both cognitive and behavioural therapies (Beck, 1970; Edwards, 2011; Lazarus, 1977). The recent resurgence of interest in imagery-based research has highlighted its role in psychopathology and symptom maintenance across a variety of disorders and presentations (Hirsch & Holmes, 2007; Holmes & Mathews, 2010). Experimental studies have also demonstrated the unique relationship that imagery has with memory and emotion: for example, imagery has been shown to have a greater impact on emotion than verbal or lexical processing of the same material (Holmes & Mathews, 2005). Such discoveries have led to the development of clinical interventions that utilize

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or target imagery, particularly in the field of cognitive–behavioural therapy (CBT) (see Hackmann, Bennett-Levy, & Holmes, 2011). The increased interest in imagery within CBT has been demonstrated in special editions of journals (e.g., Holmes & Hackmann, 2004) and the publication of a guide to imagery in cognitive therapy (Hackmann *et al*., 2011).

Mental imagery can be defined as a multi-modal, multi-sensory phenomenon that occurs when perceptual information is accessed from memory or imagination, rather than being directly perceived by the senses (Kosslyn, Ganis, & Thompson, 2001). Although imagery is commonly thought of as visual, it is often more helpful for therapists to think of imagery as multi-sensory (e.g., auditory, kinaesthetic and olfactory) in order to enhance the 'felt sense' of imaginal experiences (Hackmann *et al*., 2011). However, there is notable variation in the way authors have emphasized specific qualities or potentials of imagery, both theoretically and clinically (Hackmann *et al*., 2011).

Imagery now has a key role in a number of evidence-based, disorder-specific, CBT models and treatment protocols (e.g., Clark & Wells, 1995; Dugas, Gosselin, Ladouceur, & Freeston, 1998; Ehlers & Clark, 2000). Imagery assessment, elicitation and intervention are included as a core part of the CBT competency framework (Roth & Pilling, 2007). This competency framework has informed the Improving Access to Psychological Therapy (IAPT) programme in England (Department of Health, 2007). In a major initiative to increase service access for people with common mental health problems, thousands of new therapists have been trained within IAPT to provide evidence-based treatments for anxiety and depression in primary care (Clark *et al*., 2009).

Imagery features prominently in CBT-related psychological modalities such as compassion-focused therapy (Gilbert, 2010) and in therapeutic developments such as eye-movement desensitization and reprocessing (EMDR) (Shapiro, 2001). The variety of practices within the imagery literature is indeed vast, ranging from emotional processing of trauma memories via 're-living' (Foa & Kozak, 1986) to the modification of threat-based beliefs via imagery manipulation (Holmes, Arntz, & Smucker, 2007) to the use of imaginal simulation to create 'new ways of being' (Bennett-Levy, Thwaites, Haarhoff, & Perry, 2015; Hackmann *et al*., 2011).

Although there is now a considerable range of possible imagery interventions in which therapists might be trained, experts in the field have identified a potential discrepancy between imagery research and its clinical application. For instance, Hackmann *et al.* (2011, p. xxvii) have written: 'we are aware that many therapists have little knowledge about imagery research, and may use imagery only rarely in their clinical practice.' The observation that clinicians may be neglecting, or perhaps avoiding, imagery raises significant questions about clinical training and client access to evidence-based imagery treatment.

A comprehensive literature search has highlighted the fact that authors have rarely (if ever) asked the following: what kind of training is effective in promoting imagery use by therapists? how do the various conceptualizations of imagery get translated into the clinician's own 'working model' of imagery? or what determines clinicians' decisions to apply or not apply imagery strategies in model-driven protocols or case-based formulations (Salkovskis, 2002)?

Similarly, a literature search has revealed a paucity of research on clinicians' experiences of imagery: the meaning and function they attach to imagery, their use of it personally and professionally, and the barriers that they encounter. There is some evidence to suggest that a professional's own subjective experience of imagery may affect their views and preferences with regard to its use (Reisberg, Pearson, & Kosslyn, 2003). This raises the possibility that CBT therapists' private experiences of imagery could shape their assessment of imagery's role and importance within therapy. There is evidence of some variation in imagery 'skill' or abilities both between and within individuals (Cui *et al*., 2007; Kosslyn, Brunn, Cave, & Wallach, 1984). It appears that imagery ability is not an undifferentiated skill. There are distinct sub-abilities, and individuals vary in these sub-abilities when assessed via self-report measures, spatial ability, performance-related tasks or objective neurological imaging (e.g., Cui *et al*., 2007; Poltrock & Brown, 1984). It is possible that such variability impacts on clinicians' perceptions and use of imagery in their clinical practice.

Accordingly, the central question in this research is as follows: what influences clinicians' use—or lack of use—of imagery in their clinical practice? Due to the lack of extant research in this area, the study adopted an exploratory, qualitative stance, allowing themes to emerge directly from data gained at interview rather than be imposed by the interviewer. The emergent themes included the following: the impact of personal experience of imagery, the impact of training, views about the value of imagery, clinical decision making, the variety of ways that imagery can be applied and so on. Interpretative Phenomenological Analysis (IPA) methodology (Smith, Flowers, & Larkin, 2009) was utilized to facilitate a reflexive account of clinician experience, decision making and attribution of meaning in relation to CBT imagery practice.

To focus the research on a homogenous sample, the study was limited to therapists qualified within the past 4 years. The criteria of 4 years relates to the age of the national IAPT programme (Department of Health, 2007), allowing potential insights into the impact of imagery training within IAPT accredited courses. Selecting recently

qualified therapists also allowed for an investigation into the ways in which imagery has been recently integrated into the individual's professional and theoretical outlook.

METHOD

Recruitment and Participant Information

The study's sampling was designed with a purposive rationale, theoretically consistent with IPA and qualitative research paradigms (Smith, Jarman, & Osborne, 1999). In the context of IPA, 'purposive' relates to an intention to select a sample that 'represents' a particular phenomenon in a particular context, rather than attempting to capture the actuarial experience of an entire population (Smith *et al*., 2009). The sample size of the study was pre-determined at 12, which is numerically large within IPA literature (Smith *et al*., 2009) but was deemed necessary to contain, and explore, the potential variation in perspectives and experience.

Clinicians were recruited via posters in primary-care teams across the north-west region or approached via a nominated 'gate-keeper'. In this study, a 'gate-keeper' was a qualified therapist (not interviewed as part of the sample) who approached other therapists in their local area with information about the study. Such a method was used to ensure the researcher did not directly select the sample and to allow consent to be considered with an individual independent from the research team. The first 12 respondents were recruited without exclusion and without dropout. Participants were all residents in the north-west region of England; this regional area, rather than a single metropolitan centre, was pre-selected to ensure that participants had not all been trained at a single therapy centre (five different therapy centres were recorded).

The eligibility criteria stipulated that participants were all employed as CBT therapists, using CBT as their main modality of therapy. Participants were required to hold post-graduate diplomas in CBT, having completed a year-long training course accredited by the British Association of Behavioural and Cognitive Psychotherapists. Clinical psychologists were excluded from the sampling due to the potential influence of training in other psychotherapeutic orientations and to ensure a relatively homogenous population of therapists solely using CBT.

The sample contained nine women and three men, and the age of the participants ranged from 31 to 59 years (mean age = 43). The participants' prior experience included the following: nursing ($n = 6$), social work ($n = 1$), occupational therapy ($n = 2$) and non-professional primary-care roles created within the National Health Service ($n = 3$). The duration of these previous roles ranged from 2 to 20 years. At the time of interview, all participants had qualified in their CBT studies within the past 4 years (between 2009 and 2012), with post-qualification experience ranging from 4 months to 3 years. The ethnicity of the participants included the following: 'White-British' ($n = 9$), 'White-Irish' ($n = 2$) and 'White-Asian' ($n = 1$).

Data Collection

The interviews were conducted in a semi-structured manner, utilizing an interview schedule (see schedule summary in Table 1). The schedule was informed by a review of relevant literature but was conducted in an open and inclusive manner to allow for emergent themes to develop (Smith *et al*., 2009). All components of the schedule were applied at each interview, but the order and prompts used for each component were individualized to allow for true idiographic engagement (Smith, 1995).

The interviews were conducted by the main author in a setting of the participant's choice and were recorded

Table 1. Interview schedule summary and examples of questions used

1. Concept—How would you define imagery?
2. Use—How do you use imagery in your practice? When do you use imagery?
3. Rationale—Why do you use, or not use, imagery in your practice?
4. Importance—What are your views about the importance of imagery in CBT?
5. Criteria—What affects your decision whether to use, or not use, imagery?
6. Development—What factors have influenced your views and use of imagery? What would help you develop your practice?
7. View of others—How do you think clients experience imagery work? How do you think other clinicians view imagery in CBT?
8. Personal response—What thoughts or emotions do you experience when using or discussing imagery in CBT?
9. Avoidance/barriers—If you have avoided using imagery, what might have affected your choice? Does anything prevent you from using imagery?
10. Personal experience—What is your own experience of imagery? Has this affected your practice and, if so, how?

digitally for verbatim transcription. The interviews were completed in a single encounter, and the duration varied from 25 to 40 min.

Analysis: Interpretative Phenomenological Analysis

The study employed IPA methodology (Smith *et al.*, 1999). IPA is an ideographic, qualitative approach, which focuses on the participants' subjective 'lived' experience of a given phenomenon (Smith & Osborne, 2003). The structured approach seeks to balance phenomenological description with interpretative insight via an inductive 'double hermeneutic' process that systematizes the researcher's interpretative role (Smith *et al.*, 2009). IPA's aim of negotiating a shared understanding of subjective, and inter-subjective, meaning-making overlaps with the focus of the current project: to understand clinicians' personal experience of using mental imagery in an interpersonal therapeutic context.

There are extensive precedents of the use of IPA in psychological research, including the study of health professionals' experience (e.g., Michie, Hendy, Smith, & Adshead, 2004) and the subjective processes involved in clinical decision making (e.g., Carradice, Shankland, & Beail, 2002). The use of IPA also facilitates an exploration of wider contextual and cultural influences on an individual's process of meaning-making; this is relevant to this study's interest in the professional, cultural and organizational factors that impact on the therapist's own discourse.

The practical analysis of the transcriptions followed the four-stage process detailed in Smith and Osborne (2003). The process involves interpretative coding of the raw data into emergent themes on a case-by-case basis. The patterns of super-ordinate themes are then identified across cases in a master table. The master table, which contains textual extracts of each theme to support their inclusion, is then transformed into a narrative account for presentation.

The primary data analysis was undertaken by the lead author. As is customary in qualitative research, he identified potential biases, assumptions and expectations prior to coding. These included the following: an acknowledgement that he would be interpreting and discussing data from within a CBT paradigm since he was trained in CBT; and an expectation, from anecdotal and personal experience, that participants would report limited imagery skill development within core training and demonstrate the influence of personal factors.

To guard against bias and to enhance the reliability of the analysis, various procedures were used, including the following:

1. Peer review of transcriptions to monitor for researcher bias regarding interview technique.
2. An independent co-rater conducted an audit of identified themes to ensure they were grounded in the raw data. Replicating the approach of Connop and Petrak (2004), the co-rater independently matched the chosen extracts to the identified themes. This was achieved by the co-rater matching text extracts written on cards to the theme headings, which they deemed were evidenced in the extract. Comparing the matched outcomes, there was a 93% level of agreement between the independent co-rater and lead researcher. The differences related exclusively to occurrences of extracts relating to more than a single theme.

Ethics

The study was approved by Bolton University Ethics Committee and was conducted in accordance with British Psychological Society standards (Ethics Committee of the British Psychological Society, 2009).

RESULTS

The final analysis of the data identified six distinct but interacting super-ordinate themes. The themes are summarized in Table 2. They were identified and developed via the emphasis and salience attributed by participants in each interview, as well as the frequency of report. Quoted responses are taken directly from the raw data.

1. Super-ordinate theme—broad and fluid conception of imagery

All of the participants conceptualized imagery primarily as a visual phenomenon, often defining imagery in direct contrast to lexical communication and thought. Although all participants considered imagery to be a multi-sensory integrated phenomenon, the visual modality was given particular salience:

> *P12 'I would consider it would primarily be an image, but it's not always an image, it could be a sense of something, or a sound. It encompasses all of our senses I guess, but I would anticipate that a visual image would be a primary one.'*

A similar universal response was the association made between imagery and memory:

> *P11 'Imagery: I guess it's images based around the retrieval of things that you're aware of, historical things or things you've read about or pictures in your head that you can recall, to reflect a moment or something you remember, rather than something you say.'*

Table 2. Summary of themes

Super-ordinate theme	Sub-themes
Broad and fluid conception of imagery	Imagery most associated with visual modality Imagery conceptualised as multi-modal, multi-sensory Imagery closely associated with memory The conception of imagery broadened following reflection Imagery viewed as a natural, universal process Imagery closely associated with creativity and imagination
The importance of imagery and the varied rationale for its inclusion in CBT	Imagery viewed as important within contemporary CBT practices Perception that imagery is viewed by other professionals/colleagues as insignificant Positive belief in the efficacy of imagery interventions Imagery as emotionally potent (more so than lexical material) Imagery as linking 'head and heart', emotional and rational learning Imagery as facilitating communication and was associated with metaphor Imagery as providing distance for greater perspective Imagery as means to overcome blocks in therapy
Varied application of imagery	Imagery associated with specific protocols/models Imagery associated with trauma and anxiety disorders Protocols both facilitating and inhibiting imagery use Uncertainty regarding imagery interventions Positive impact of additional training (associated with use of positive imagery)
Avoidance and apprehension of imagery work	Avoidance of imagery due to high emotion in self/clients Avoidance of imagery due to perceived lack of experience/skill Avoidance of imagery as 'messy' and uncontained Avoidance of imagery due to external service/professional factors Avoidance of imagery due to concern about client's perception
The personal experience of imagery and its impact on use	Personal experience of imagery positively affecting clinical use (e.g., confidence in relevance and natural style of thought) Personal experience of imagery negatively affecting clinical use (e.g., due to upsetting experiences) Differing perceptions of own imagery ability Clinician's perception of imagery influenced by wider personal factors (e.g., religious practices)
Limited core training and the potential for future use	Perception that core CBT training in imagery was inadequate (e.g., in experiential practice and treated as optional) Wide variation in awareness of evidence base Reflection on imagery, during interview, widened perception of current imagery use and increased perception of potential for future use

Participants who reported a natural felicity with imagery had an inherently broad conception of imagery, which included the following: colours, imagined movement, abstract shapes, metaphors, analogies, nightmares and fantasy. Notably, all of the participants developed their conception of imagery as the interview progressed, and their actual practice was considered. As participants' definition of imagery broadened, this appeared to widen their perception of their own clinical use of imagery interventions.

All participants viewed imagery as a universal, natural, everyday process and not related solely to psychopathology:

P5 'We're not human if we don't do that.'

All participants shared the belief that individuals differ in the intensity, clarity and frequency of their lived experience of imagery:

P3 'It can be very fleeting, we might not see an image like a television screen image, it might be more of a felt sense that you might just have an idea in mind that kind of almost feels like a bit of an image but not really quite, if you were to describe it as such, wouldn't have that clarity, for some people they are able to experience images more clearly.'

In general, participants viewed imagery as serving a 'cognitive' function analogous to verbal automatic thoughts, rather than considering imagery as a motor-sensory mechanism. Imagery was also seen as a continuous process that occurred both inside and outside of conscious awareness and voluntary control. No clinicians viewed imagery as inherently 'meaningless', but the focus on the content or the appraisal of the image varied (often depending on the disorder considered). Notably, certain image-based phenomenology, such as dreams and fantasy, were not deemed part of the remit of CBT:

P2 'I couldn't think, from CBT terms, when I'd ever heard the term day-dreams used and what that was a symptom of and whether it was a symptom.'

Many of the participants associated imagery with 'imagination', the ability to create and mentally invent. For some, this creative association provided imagery with its attraction, excitement and fluid, generative nature. For others, it was this very quality that was problematic and unpinned image-based psychopathology:

P6 'She was quite an imaginative person anyway—that's part of the reason why she had a fear of the dark, it was running wild with her!'

2. Super-ordinate theme—the importance of imagery and the varied rationale for its inclusion in CBT

All the participants viewed imagery as an important subject within contemporary CBT theory and practice and an integral area for future development:

P3 'I think it could be quite pivotal. I think it is kind of central to helping people to connect and make that kind of understanding and I think you could really develop it in a way that could be much more helpful for people.'

There was a sense of commitment to the development of imagery within each participant's individual practice and a general theme that CBT felt fundamentally lacking without the use of imagery:

P12 'If I haven't used imagery work in a week, looking back I would probably think I hadn't done as much work as I could have done.'

Notably, participants who lacked confidence and experience in using imagery, and who acknowledged their avoidance of imagery in clinical practice, continued to view imagery as key element of CBT.

In contrast to the participants' own estimation of imagery's value, there was a majority belief that image-based interventions were not deemed important by colleagues, their clinical services or health sciences in general. The reasons suggested included negative associations with alternative health practices, a perceived lack of evidence base and lack of personal experience of imagery. Many felt the recent growth in CBT image-based research to be a progressive development, offering a kind of professional 'permission' to use imagery more in their practice.

P3 'In lots of circles they are not really deemed to be something that are clinical and scientific, but now I think we are starting to see with neuroscience and other things we can see the effects actually on brain chemistry and physiology.'

A recurrent theme was the belief in the efficacy of image-focused interventions. The majority of participants reported to have personally observed positive outcomes when working directly with imagery. Such outcomes included a reduction in the presence or frequency of problematic imagery and also improvements in general symptom levels and well-being.

P5 'Sometimes you can get a far, far better result with the pictures and the images that they're feeding back as well.'

The reasons given for this efficacy were manifold but focused on the following themes: (a) emotional connection; (b) depth of engagement and communication; (c) facilitation of greater perspective; and (d) means of overcoming blocks in therapy. The following section looks at these sub-themes in turn.

(a) The most recurrent and strongly stated theme was the relationship imagery has with emotion. Images were seen as more emotionally potent, in both negative and positive valences, than lexical equivalents.

P2 'I think it's more powerful in terms of the emotional response I've seen in clients and the emotional response or autonomic response that I personally feel.'

For many clinicians, this connection provided a real bridge between mind and body, illustrating the link between cognitive processes and physiological responses. Imagery was seen as part of a reciprocal process between 'head' and 'heart', yet clinicians stressed imagery's capacity for 'heart-focused' emotional processing, as opposed to rational learning. Ultimately, imagery was seen to play an important role in reversing the perceived neglect of body and emotion associated with traditional cognitive techniques:

P3 'Because I think it's almost for some people like a eureka moment. So for some people just using the cognitive stuff they can rationalise that and they can make sense of that and they can see that and understand it but they don't really feel it and I think you have to be able to make people feel something.'

(b) Participants spoke of imagery as facilitating communication in an immediate manner. Imagery was deemed to function as a means of gaining greater access to the client's emotional world, frame of reference and direct experience. Clinicians felt that this improved the therapeutic relationship, aiding empathy and authentic communication. Similarly, imagery was also used to deepen a client's recall of events, providing memories with sensory detail to gain fresh insight and work with emotion 'live' in session. Other clinicians focused on the potential for playfulness, humour and flexibility afforded by the use of imagery. This included the use of metaphor and analogy, which was seen to act as a cognitive 'bridge' to new perspectives or adding additional layers of meaning:

P8 'I'd try and use imagery in other stuff so it kind of helps their understanding to sort of bed their understanding down, it's another layer for them of it really. For other people I think it's been like a non-threatening way using sort of general metaphors.'

(c) Although there was a universal acknowledgement that imagery is accompanied by high levels of emotion and increased engagement, participants conversely reported that imagery provided a form of detachment: a means to gain a distanced perspective that facilitated objectivity and broader insight. In apparent contrast to aspects of sub-theme (a), the imagery was often understood to take the individual away from the present moment. This form of distancing was, however, frequently discussed as a positive quality:

P8 'It's taking the focus off somebody in a way so they can sort of stand back and join in a conversation about things in terms of imagery it seems to help people in certain ways.'

(d) Working with imagery was repeatedly referred to as a means of overcoming blocks in therapy. Imagery was often used to facilitate approach behaviour via imaginal enactment and preparation or when direct exposure techniques were impossible or unacceptable. Used in this way, participants felt that imagery instilled hope and future potential by visualizing possibilities beyond the confinement of present difficulties. Many clinicians also utilized imagery when attempting to engage clients with avoided or blocked emotion, or when clients had difficulty accessing cognitions. Imagery appeared to offer both clients and clinicians alternative routes of thought and communication when lexical means were inadequate:

P6 'Often if people are struggling with thoughts if they can't access cognitions, I often get people…I ask them if they have an image. I think that's always a good one for people who are struggling to get a cognition.'

3. Super-ordinate theme—varied application of imagery

Although the current research is focused on the therapists' subjective experience, a discussion of the practical application of imagery highlighted a number of important themes that offered wider insight into the participants' meaning-making.

Participants predominantly associated imagery use with post-traumatic stress disorder re-living, manipulation of social anxiety imagery and imaginal exposure for generalized anxiety disorder and phobias. Imagery was also frequently assessed in panic disorder and obsessive–compulsive disorder, but there was less evidence of intervention with these presentations. Notably, participants initially associated imagery interventions with anxiety disorders, rather than mood or Axis II disorders (Fourth Edition of the Diagnostic and Statistical Manual of Mental Disorders; American Psychiatric Association, 2000). However, as the interview progressed, many of the participants conceptualized imagery as essentially a trans-diagnostic phenomenon, which had the consequence of widening their awareness of the potential for imagery intervention. The most prominent association was that of imagery and trauma, which was mentioned by all participants:

P2 'I'm probably more inclined to ask if people are being assessed and I expect trauma, because that is somehow instilled in me more than it is in other disorders.'

A further theme was the likelihood that participants would assess for imagery in the early stages of therapy but would be less likely to pursue this with image-focused interventions. Participants frequently encouraged clients

to use imagery to access contextual details of recent 'concrete' examples during assessment or to illustrate key CBT concepts within the socialization process. Formulation itself was deemed to involve aspects of mental imagery: visually mapping out maintenance factors to allow clients to 'picture' connections within their memory. The majority of participants, however, felt their practical use of imagery to be 'limited'.

One key sub-theme was the influence of model-driven protocols on the participants' use of imagery. Analysis of the data highlighted a seemingly contradictory sense that treatment protocols both facilitated and restricted practice. For some participants, the protocols increased clinician confidence in using imagery, prompted exploration of imagery and provided specific 'contained' imagery interventions, which increased the likelihood of imagery use. This was particularly relevant for clinicians less inclined towards imagery. For other participants, the focus on protocols had a constraining effect, creating anxiety when using imagery outside of these boundaries:

> *P8 'A bit hesitant about it, as if it's almost stepping outside of what's you know, the approved guidelines of what we should be doing, almost venturing towards the dark side!'*

Participants who felt imagery to be a natural aspect of their own cognitive style reported to use imagery without recourse to protocols or diagnosis: as an integral aspect to all of their therapy.

A final theme in the application of imagery was the use of positive and negative imagery. The majority of participants focused on negative, intrusive imagery (imagery as 'symptom') with the intention to reduce its presence or impact. With only a single exception, the practitioners using imagery in a positive valence had specific training on imagery use within compassionate focused therapy (Gilbert, 2010) or in the context of EMDR (Shapiro, 2001). These practitioners actively stimulated imagery to engender positive affect or soothing mentalities, often associating imagery with the potential to heal, modulate and transform emotion.

> *P10 'positive imagery is that sort of healing process I suppose, or that soothing process, you know, to try and address the distress or to try and introduce a different image so that they can feel that they can handle something.'*

4. Super-ordinate theme—avoidance and apprehension of imagery work

Despite the importance placed on imagery, all participants reported some form of imagery avoidance within their own work. Extreme levels of avoidance were evident in four participants, with all participants reporting hesitancy or anxiety when using imagery for a variety of personal, clinical and service factors.

A clear link was made by participants between their perceived lack of imagery skill and their avoidance of imagery use. Participants often cited a perception of personal limitation in terms of applied skill and ability:

> *P8 'It's a technical weakness, you know, rather than an unwillingness.'*

For others, their limited confidence stemmed simply from a lack of practice and familiarity, and a subsequent lack of observable evidence in its efficacy. A number of participants also made a clear link with a lack of theoretical clarity and their anxiety in clinical practice:

> *P7 'Yeah, mainly I don't know what I'm doing, that's what causes the anxiety! Maybe not quite knowing whether I understand it fully as well, I suppose. When we talk about imagery, what's meant by that? It's just kind of I don't know what I'm doing, I don't know what it is!'*

The potential for raising high affect in clients was the most commonly cited reason for caution, apprehension and avoidance in imagery use. Clinicians described imagery as potentially 'scary', 'overwhelming' and 'draining' for clients and often feared a destabilizing impact on clients, particularly in the context of trauma. Clinicians also identified concerns regarding the negative emotional cost on themselves when using imagery and spoke of personal dilemmas of balancing their own self-care with the potential benefit for the client.

> *P5 'You can actually get kind of pulled into their world and their image, and it's making sure that you stay quite separate, because you've got to keep yourself grounded, obviously, and make sure you're safe.'*

Similarly, personal fears were expressed about the constitution or character of imagery. Imagery was deemed to be 'messy' and uncontained and less controlled and more diffuse than verbal language. There was often a sense that this character of imagery had the potential to lead therapy into unexpected areas, moving the focus away from the clinician's sense of competency and confidence:

> *P1 'Maybe I'm worried the client could run away with it and I wouldn't know what they are doing and I wouldn't know what to do with it.'*

A further sub-theme was the avoidance of imagery due to perceived client factors. The results focused on a concern that clients would find imagery work inherently

'whacky', 'fringe' or uncomfortable. Participants were able to acknowledge a projection of their fears onto clients with regard to imagery work:

> *P1 'Because it feels weird to me I would worry it might seem weird to a client but actually if they were experiencing the imagery it probably wouldn't, but because I don't it feels weird to me.'*

The majority of respondents highlighted instances of clients responding with resistance, embarrassment and even hostility. There was a general sense that clients had differing personal cognitive styles, which would influence their receptivity to imagery work. Therapists observed wide variations of individual difference in aptitude for imagery, which they often relate to 'natural' preferences or predilections:

> *P3 'Some people find it really hard to see in that way, some people are quite concrete in their thinking, some people it would really put them off and would actually be the obstacle to the therapy.'*

A further sub-theme evident within the data was the avoidance of using imagery with specific disorders, diagnoses or areas of difficulty. Avoidance was particularly related to depression, physical or sexual abuse, severe trauma, anger and any form of sexual imagery. Clinicians also expressed caution when working with psychosis, substance abuse or bi-polar disorder. The rationale for avoidance related to a perceived lack of evidence-base in these presentations and, more frequently, to concerns regarding problematic emotional regulation and increased risk following imagery work. Some clinicians reported that it was simply a lack of personal and professional association between certain presentations and imagery that caused the neglect:

> *P9 'I think that's one of the things that stops me, I just seem to forget, I think. That's not much of an excuse is it! I think I do just sometimes forget about it.'*

Other barriers to imagery work related to external, organizational factors. A frequent theme was that of limited time constraints within short-term therapy. Clinicians expressed concern that image-focused work requires additional preparation time or de-briefing or would have too much emotional impact on the clinicians when working with high throughput:

> *P2 'I see six patients a day and if I was to start off with this imagery work and go through everybody and if there was quite a lot of intensive trauma behind it and if you were rooting it back to kind of autobiographical experiences, then I would imagine I would be feeling pretty sick by lunch time or emotionally drained.'*

5. Super-ordinate theme—the personal experience of imagery and its impact on use

One of the clearest themes identified was the variation in personal experience of imagery in the participants themselves. The data showed dichotomous results, mirroring the perception (introduced above) that clients were divided in their abilities and willingness to engage in imagery. The data implied a surface correlation between the clinician's own experience of imagery and their use of image-based interventions.

Six of the interviewees professed a personal affinity, skill and interest in imagery. They spoke of imagery as being integrated within their natural personality and meaning-making. Notably, such participants spoke about imagery as undifferentiated from their everyday thought and as synthesized within their sense of their own emotions and physical body:

> *P3 'It feels quite natural to me, it feels like it makes sense, it feels like I understand it at a visceral level, that I can make that connection.'*

This positive personal experience of imagery was hypothesized by clinicians as a salient reason for their clinical application of imagery. Such experience provided participants with a sense of confidence and faith in the relevance of imagery and increased the frequency of their usage:

> *P11 'Style, yeah, perhaps it's just trying to make it how I would want it, I guess…for me, if I have more meaning through imagery it makes sense to use that I guess.'*

Other clinicians, who regarded themselves as strong imagers, identified their own experiences had made them more cautious of using imagery, often due to an instance of upsetting or overwhelming imagery in their own lives. A further consequence of having a natural affinity with imagery was that its use in therapy was deemed 'automatic', with the clinician often less aware of their choices and rationale for using imagery.

Participants who experienced less personal imagery felt themselves to be lacking creatively and imaginatively: as a form of deficit. These participants viewed imagery as a concept and experience at odds with their natural style, and as a phenomenon closed and separate to them.

> *P1 'I do think it's my own almost blankness in my mind, in that respect, that makes it really difficult to understand.'*

This group of participants made frequent reference to being 'concrete' and 'verbal' in thinking style. They also

spoke of feeling 'fraudulent' and 'afraid' when using imagery and viewed the lack of personal experience of imagery as having a direct effect on their clinical confidence:

> *P1 'That's the concrete thinker in me, I quite like to be able to experience it, even if you've not got the clinical disorders you can experientially……I always feel a bit fraudulent….how would I help someone with that if I don't really get it?'*

It is of note that a number of these respondents, even whilst doubting their own experience of imagery and noting high levels of apprehension, have been able to develop confidence in using imagery from additional, experiential, training (e.g., EMDR).

Participants also understood that their preferences, with regard to imagery, were influenced by various personal influences external to CBT. These factors included previous careers, interests in art and use of meditation. Two respondents highlighted the influence of their personal religious beliefs and disciplines, from Sufi and Buddhist traditions, which include visualization practices. Other participants reported a longstanding inherent interest in imagery, which had led them to explore the topic in the personal life and later integrate it into their clinical work:

> *P3 'It is more my own interest, I've never had any real training in it but I've read books from, you know say from about 14-15, reading books on associated topics and then went off and did additional training in other things like hypnotherapy in my own time so that was…so all these areas outside for what I do as a job, I'm fascinated by it anyway.'*

6. Super-ordinate theme—limited core training and the potential for future use

All participants reported that their core CBT training contained minimal references to imagery. It was felt that imagery was introduced as an optional or specialist interest, rather than as an integral part of CBT.

> *P8 'It's almost as if it was an advanced technique, or as an add-on. But to me it seemed not like that at all.'*

If imagery was discussed during training, many participants felt the lack of experiential practice limited confidence and future experimentation. Participants felt they were simply asked to screen for problematic imagery at assessment, whilst intervention techniques were limited to disorder-specific protocols (see discussion above). Many of the respondents felt they had belatedly discovered the relevance of imagery, creating a sense of unstructured, piecemeal, learning, which remained a source of frustration:

> *P2 'It's one of those things which made me think, oh yeah, why did I not think of that before? It wasn't as if it was… I wasn't shocked by the idea and it made a lot of sense, but I couldn't understand why I'd not got there earlier.'*

The reliance on independent learning was viewed as a factor that created considerable variation in imagery competency. Further training, specifically EMDR and compassion-focused therapy, was deemed by interviewees to have the most impact on learning and skill acquirement. Other factors included the encouragement or reluctance of supervisors to discuss imagery.

There was a notable variability in the awareness of the available literature and evidence base for imagery in CBT. The clinicians least aware of the extant literature were those who felt that they used imagery naturally and frequently. All clinicians, however, stated that they would welcome more research on imagery and were keen to use imagery more in their own practice. Although ideas for skills development included the pro-active use of supervision, a recurrent theme was the requirement of future training with a definite experiential focus.

A final discernible theme was the influence of the interview itself on the participants. The reflection afforded by the interview was the first time many of the participants had considered their imagery use in any depth. As discussed above, participants notably widened their concept of imagery and increased their appreciation of the role of imagery in psychopathology as the interview progressed. For participants who regarded themselves as frequent users of imagery, there was a notable reflection on the potential to use imagery more systematically and with a considered rationale. Other participants, who had initially underestimated their own clinical use of imagery, were encouraged when considering their potential for future development:

> *P1 'I am talking to clients about images more than I thought I was in the different disorders and therefore the scope for me to use imagery work is probably bigger than maybe I realised.'*

DISCUSSION

As outlined in the introduction, mental imagery has become more prominent in CBT theory and research in the past 20 years. This is evidenced in the increased inclusion of imagery in treatment protocols, disorder-specific models, experimental research and core-competency frameworks (Roth & Pilling, 2007). The current research found that recently qualified therapists shared this estimation of

imagery's importance, unanimously valuing imagery as an integral component of contemporary CBT practice. The research also found, however, considerable variation in participants' confidence, conceptual understanding and practical utilization of imagery, with some clinicians reporting high levels of aversion to imagery use. Numerous reasons were given for such variation, including personal, clinical and professional factors. This discrepancy, between imagery research and clinician understanding and application, is explored below. The nature, implications and potential remedy of such individual variance and avoidance will also be discussed.

Clinicians valued imagery for similar salient reasons, particularly referencing imagery's close association with emotion and the depth, flexibility and creativity that its use affords within the therapeutic dialogue. Participants also valued imagery as a form of 'bridge' between 'head' and 'heart' learning, spanning the gap between rational and emotional processing, which has been acknowledged and explored in cognitive literature (Stott, 2007; Teasdale & Barnard, 1993). It is notable that participants acknowledged the influence of recent developments in CBT, including 'third-wave' modalities, or approaches such as EMDR, which have integrated imaginal approaches in their explicit targeting of this 'head–heart lag' (e.g., Lee, 2005). Imagery was often valued in its capacity to provide greater experiential emphasis on body and emotion in-session, acting as dynamic means to communicate and explore body sensation. Used in this way, imagery appeared to provide participants with a truly integrated and holistic means of CBT treatment, perhaps addressing the criticism of CBT as reductive in its Cartesian dualism (Moloney & Kelly, 2008). However, despite the use of imagery for such integration, participants also utilized imagery for seemingly contradictory means. Although experience-near in its intensity and character, imagery was also elicited to gain a distanced and de-centred perspective. This finding can be perhaps understood in the context of the 'reflective stance' advocated by Hackmann *et al*. (2011), but the contradiction in experience and utilization deserves future exploration and comment.

Despite such universal acceptance of imagery's importance, the research highlighted the apparent dichotomy of personal experiences when using imagery. One group of participants experienced imagery as enjoyable, creative and natural, whereas another found imagery uncomfortably messy, overwhelmingly emotional and unintegrated into their approach to CBT. One key influencing factor was the participant's own subjective experience of imagery. There appeared a correlation between the ease with which participants experienced mental imagery in their own lives and their affinity with its therapeutic application (i.e., people who perceived themselves to be poor imagers found the application of imagery problematic). This finding could perhaps be conceptualized and explored further within the framework of variations in individual cognitive 'style' (Pashler, McDaniel, Rohrer, & Bjork, 2008), or within the context of variations in individuals' imagery ability (Kosslyn *et al*., 1984). Although the findings reinforced previous assertions that an individual's subjective experience of imagery can have a bearing on their professional preferences and outlook (Reisberg *et al*., 2003), there was no evidence that poor imaging ability related to a negative perception of its clinical worth. It was, however, notable that despite a clinician's personal preference and ability, an upsetting experience of personal imagery appeared to have a negative impact on subsequent clinical use, which again highlights the potential impact of clinician factors on the therapeutic practice.

The frequency and level of use of imagery in therapy also appeared varied in the extreme: ranging from the perception of constant use to complete avoidance. All participants, however, identified areas of apprehension and examples of avoidance, often relating similar variables (in addition to the factors raised above). Reasons for avoidance frequently related to the potential for destabilizing clients by increasing affect and raising risk. Subsequently, client factors such as resilience and receptivity were carefully considered when applying imagery. These clinical decisions were, however, also influenced by a nexus of personal, cultural and role-based associations with regard to imagery. Practical service factors (such as limited session lengths) also played an important role in creating aversion. A key clinician factor, shared by many of the participants, was the fear that applying imagery interventions could raise unwanted affect in themselves. Again, service factors, such as the emotional demands of high client throughput, compounded these concerns. To our knowledge, such findings offer the first evidence of imagery avoidance within a CBT setting and suggest a significant variance in application of imagery interventions across therapists.

The 'special relationship' between imagery and emotion (Holmes & Mathews, 2010), as reflected in the practitioners' responses, requires further comment. Although the potential for imagery to cause high emotion in clients and clinicians was the salient cause for aversion in participants, this very potential was identified as imagery's most important characteristic when considering clinical value. Working with raised affect is integral to various conceptions of emotional processing (e.g., Teasdale, 1999) and is seen to be a key ingredient of meaningful learning and change within CBT (Butler, Fennell, & Hackmann, 2008). Imagery's capacity to activate such levels of emotion, whilst causing apprehension in some therapists and posing difficulties within service restrictions, offers the potential to increase the pace, efficacy and emotional processing of traditional CBT treatment. This has already been demonstrated in the recent trials for imagery-focused treatment in depression (Brewin *et al*., 2009). The issue of clinician avoidance of imagery, due to factors above, therefore warrants further

study and intervention if such important innovations are to be adopted and offered to clients on a wider scale.

There was a similar surface contrariety when participants discussed imagery's link to memory: imagery was valued for facilitating access to upsetting client memories yet frequently avoided because of its very capacity to do so. One factor that appeared to facilitate the use of imagery, despite such concerns about accessing unwanted emotion and memories, was the explicit inclusion of such techniques within disorder-specific models and protocols. The use of such models afforded 'permission' to use imagery, whilst providing a containing framework for clinical application. For a number of clinicians, imagery was only considered when included in disorder-specific models (e.g., post-traumatic stress disorder; Ehlers & Clark, 2000). Whilst facilitating imagery use, the reliance on such models appears to have narrowed the potential for trans-diagnostic intervention, reducing participants' awareness of developments in disorders 'not associated with imagery', such as depression (Brewin *et al*., 2009). These findings highlight the potential for increased training in specific 'stand-alone' imagery techniques and the formulation of problematic imagery outside of disorder-specific models (Hackmann *et al*., 2011).

The coverage of imagery in core training was deemed universally lacking. Importantly, clinicians who had initially found imagery to be alien and aversive had been able to develop a sense of proficiency and confidence following additional training where imagery skills were valued and taught (e.g., compassion-focused therapy). Additional training, more than any other factor, was deemed to be the most important cause of perceived changes in imagery ability. Further imagery-specific training, with a definite experiential focus, was identified by all clinicians as desirable with regard to both perceived clinical need and personal interest. The data suggest that training needs may well vary between individuals, depending on personal 'style' and experience of imagery, a finding that might prove fruitful to explore and incorporate in future training programmes. Further larger scale research might also be fruitful to explore the influence of clinicians' professional backgrounds before CBT training; no clear patterns emerged, but the study is limited by the number of participants and its sampling (e.g., there were no clinical psychologists in the sample).

It is of note that participants reported that the interview had provided space to appraise their understanding and use of imagery for the first time. This reflection generated genuine insight that, in itself, has implications for training and supervision; indeed, the value of such self-reflection has been highlighted as an under-developed potential within psychology (Bennett-Levy, Thwaites, Chaddock, & Davis, 2009). For participants comfortable with imagery, reflection provided scope to widen their range of imagery techniques and to evidence, and make explicit, the rationale for use. For participants less confident about imagery, there was an increased awareness of actual use, which, in turn, widened the potential for even further usage. All clinicians noticeably widened their conceptualization of imagery during the interview, which had a direct influence on their perceived use and aptitude. Such findings support the need for imagery to be included in core CBT training whilst also suggesting that psycho-education and open discussion may prove useful for clinicians to explore, and potentially re-appraise, many of the personal and professional associations made with imagery.

It is recognized that the small sample size limits the generalizability of the findings, yet, as Smith *et al*. (1999) have asserted, IPA studies are focused on the specific qualities of individual and shared subjective experience. The varied and rich themes identified in this exploratory study provide the scope for large-scale quantification and also demonstrate the potential of phenomenological research in the lived experience of CBT therapists, particularly when learning or utilizing specific skills. Further research is indicated to assess whether the factors highlighted above are stable over time, valid across a wider population of both recently qualified and experienced clinicians, and whether such factors would be amenable to intervention and training. It would also be of interest to explore these factors in clinical psychologists to ascertain whether their use of imagery when applying CBT is influenced by their wider training. The research findings are positive in highlighting the scope for individual change and learning, yet also suggest that access to evidence-based treatments is currently being restricted by clinician variables. Future research might also explore whether the clinician factors discussed above are replicated within client populations and therefore how best a pedagogy for imagery teaching could be developed in the service of both clients and clients. The creation of a measure for competency in the application of imagery in CBT is also perhaps indicated in what could be a rich vein of future research.

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