Chapter 13

Applying Imagery to Treat Past Events

(Fears, Trauma, Posttrauma)

Naturally, therapists treat problems more than they treat happiness and joy. However, in line with the positive psychology orientation, I uphold the importance of focusing not only on difficulties but also on improving happiness and satisfaction. As mentioned in Chapter 3, Selgiman and Csikszentmihalyi (2000, p. 5) described positive psychology as including three temporal aspects: "the valued of subjective experiences…in the past, the ability for flow in the present, and hope and optimism for the future." Following their view, the current part of this book, on therapy, is organised into past, present, and future. When clients bring their past to therapy, it mainly comprises their distressing experiences of fear, trauma, and posttrauma, which lie at the focus of the present chapter. Clients' ability to flow in the present relates to their awareness, skills, and social relationships, which are discussed in Chapters 14 and 15. Therapists' wish to enhance optimism and hope in the future is presented in Chapter 16.

Treating Distressing Past Events

The most common use of imagery in CBT relates to the treatment of fear and anxiety (for example, test anxiety, social and separation anxieties, phobias, panic attacks), trauma (such as crisis or change following divorce or death), and posttrauma (posttraumatic stress disorder – PTSD – following traumatic events like accidents,

terrorist attacks, and so on. (See Chapter 7 regarding treatment of traumatic memories). The definitions of fear and anxiety are often confounded, but in general fear refers to sudden calamity or danger when facing a concrete threat, whereas anxiety refers to a sense of emotional threat with no concrete threat (Beck et al., 1985). Trauma refers to the feeling that a bad event occurred, necessitating new coping. Posttrauma refers to a complex, serious psychological condition that occurs as a result of experiencing a traumatic event (Foa et al., 2000).

Therapists frequently select imagery as a means for exposing clients to traumatic events, helping clients recall memories, and trying to change distorted thoughts and emotions associated with those traumatic incidents. The common characteristic consequence of all these problems – fear, trauma, and posttrauma – is that clients have developed symptoms and avoidance behaviours that interfere with enjoying life in the present.

Beck et al. (1985) as well as Foa et al. (2000) described PTSD as the most serious psychological conditions occurring as result of experiencing a traumatic event or its frightening elements. This condition includes avoidance of thoughts, memories, people, and places associated with the event, as well as emotional numbing and symptoms of elevated arousal. Foa et al. described trauma and posttrauma as complex conditions that can be linked with significant morbidity, disability, and impairment of life functions.

According to White (2007), research indicates that service providers often find it difficult and stressful to treat survivors of trauma because of their resistance to change, their ways of relating to helpers, and the work's emotionally demanding nature. Clients who experienced trauma and developed PTSD often have difficulty taking responsibility for their own lives (Palmer, Brown, Rae-Grant, & Loughlin,

2001). They may frequently exhibit self-destructive behaviours such as substance abuse in order to cope with their feelings (Beutler & Hill, 1992).

Foa, Hearst-Ikeda, and Perry (1995) presented a protocol for treating PTSD based on the assumption that many symptoms persist because clients do not adequately process the trauma. Treatment includes relaxation and imagery exercises, exposure, and cognitive therapy. Clients learn deep muscle relaxation and controlled breathing skills, and then undergo training in imaginal exposure – the use of imagery to bring up traumatic memories and describe them in present tense as if they are happening again. Both the relaxation procedure and the imaginal reliving are audiotaped, and clients listen to the tapes as homework practice. Imagery is employed throughout therapy via imaginal exposure, followed by further cognitive therapy designed to correct distorted beliefs. Chief targets include clients' beliefs about the world's unpredictability, uncontrollability, and dangerousness, as well as any extremely negative beliefs clients hold about themselves. Therapists help clients identify these problematic beliefs, and homework addresses everyday negative thinking. Imagery is used again later to apply cognitive restructuring and to review the skills mastered by the clients in the program.

Foa and her colleagues implemented this protocol for various client disorders and reported positive results for survivors of physical or sexual assault (Foa, Ehlers Clark, Tolin, & Orsillo, 1999; Foa et al., 2000) and for grief symptoms (Shear et al., 2001). Bryant's group also reported positive outcomes for the protocol in various groups, for example for acute stress disorders in firefighters who developed posttrauma (Bryant, 2000; McNally, Bryant, & Ehlers, 2003) and in survivors of industrial or motor-vehicle accidents (Bryant, Harvey, Dang, Sackville, & Basten, 1998). Their results indicated that a combination of prolonged imaginal and in-vivo

exposure with cognitive therapy was more effective in preventing PTSD than was supportive counselling. CBT clients maintained most of their gains and did better than the supportive-counselling group (Bryant, Moulds, Guthrie, & Nixon, 2003).

In a controlled study of 58 women with PTSD related to childhood abuse, participants showed significant improvement in affect regulation problems, interpersonal skills deficits, and PTSD symptoms following treatment that integrated CBT with imagery. Gains were maintained at 3- and 9-month follow-ups. These outcomes suggested the value of establishing a strong therapeutic relationship and emotion regulation skills before exposure work among chronic PTSD populations (Cloitre, Koenen, Cohen, & Han, 2002).

Thus, imagery is an essential component for solving problems related to traumatic events. Likewise, exposure is an essential feature for the treatment of PTSD. However, it is not always possible to apply exposure. There are two main ways for using exposure in imagery: one as a preliminary step before in-vivo exposure, and the other when in-vivo exposure is impossible. The next sections present scripts for both types of imagery applications to eliminate clients' PTSD.

Imaginal Exposure Followed by In-Vivo Exposure

When clients are not yet willing to practice in-vivo exposure, imagery can serve as a preliminary step. The case of Sara, who suffered from posttrauma and needed exposure to the feared situation to recover, illustrates such preliminary imaginal exposure for treating PTSD:

> *Sara, age 18, developed PTSD after being involved as a passenger in a car accident one rainy night a year earlier, when her boyfriend drove their car into two elderly pedestrians on the zebra crossing.*

Sara had nightmares, mood swings, and anxiously avoided cars, her boyfriend, nighttime, and pleasurable events.

In early imagery work, Sara practiced relaxation and elicited simple positive memories like recalling breakfast and a nice meeting with a friend.

After three weeks, we started imaginal exposure, with Sara imagining herself entering a car and sitting in the passenger seat next to the driver. She became tense and asked me to hold her hand. We then practiced relaxation again before continuing. Returning to imagery of sitting in the car, I asked her to look at herself and focus on how she looked – her clothes, the expression on her face.

After two more sessions gradually approaching the accident through imagery, Sara was ready to "dive into deep water" by eliciting the memory of the accident. Using details she had disclosed, I asked her to imagine herself entering the car that night – to see the rain and darkness, follow the road nearing the fateful intersection, listen to the song playing on the disc player, and see herself as the car approached the intersection while the traffic light changed. I asked her what was going on, and she started shaking and shouting: "Oh no! Oh, no! We hit something! I can hear the car hitting something! There's so much noise. Shouting! Darkness! Rain! It seems like hell. Something very bad is happening." Trying to imagine the scene in more detail, Sara remembered the raindrops beating down on the car: "I'm so silly. Something bad is happening and I'm counting drops of rain." She felt she was someone else, outside herself: "a third person doing it."

Describing her boyfriend as pale, she said: "I'm afraid to get out of the car. I don't want to see what happened. I don't want to know! Oh, God. What should I do?!" Then she added: "It's strange. Things are happening so fast, and then suddenly so slowly. I'm forcing him to go out. He doesn't want to. Someone is coming over, opening the front door on the driver's side. I'm going to vomit." Sara sounded ready to vomit and ran out to the bathroom. When she returned, she told me: "That was it. Next thing I remember was calling my father." Sara alternated from crying to shouting; tears dripped down her cheeks, and she kept repeating: "We didn't mean to. We didn't notice them. Oh, God."

I held her hand and tried to help her relax. She said it was the first time since the accident that she had faced these pictures again. Until now, she'd refused, and the images came to her at night.

After this imaginal exposure, we talked about the accident, her feelings, and the meaning of the event for her life. We also talked about the fact that it would always remain part of her life, but maybe she could keep it as her past and not as her present reality that followed her everywhere.

Over the next three days, Sara called me several times, asking me to help her use self-talk to reduce her fears, and to check if it was normal to behave as she was.

After two more sessions of imagery exposure, Sara began driving lessons, and her nightmares stopped. All her symptoms finally disappeared after gradual in-vivo exposure to the accident site

together with her father, where she tried to cope with her fears while actually in a car at the site and thinking of the accident.

Practice: Guidelines. Some important guidelines can help in applying imaginal exposure as a basic training stage to enable clients to later experience in-vivo exposure. First, because a major component of PTSD is avoidant behaviour, therapists should be very careful in exposing clients, ensuring that steps are small, slow, and gradual and that clients are ready and strong enough for them. Too much exposure too fast, without adequate caution, might cause stronger avoidance. Also, longer-lasting avoidant behaviours make exposure training more difficult to begin. Moreover, these sessions elicit deep emotions in clients who have often been feeling numb; therefore, therapists should be ready for intense emotional experiences (several times I found myself crying when I experienced my clients' suffering) and for the need to provide extra support and time in the hours and days after intense sessions. The following specific guidelines can help therapists when applying imaginal exposure:

1. Because of the intensity and severity of posttrauma, verify that clients are able to relax and use imagery. If needed, devote longer time to training (Chapters 9, 10).
2. Before beginning actual imagery work, determine if someone in the client's life can support and help him/her in the days after exposure. This person should be someone with whom clients can share anxiety and stress.
3. Carefully schedule the imaginal exposure session to allot sufficient time for conducting the exercise and for staying longer with clients if necessary afterwards. Keep close touch in the next few days after first exposure.
4. Plan the first imaginal exposure to be slow and gradual, making sure the client is ready to face the memories.

5. Pay attention to changes that emerge when memories are elicited – in clients' tone, mood, and voice, frequently accompanied by crying.
6. Be ready and able to intervene if needed, sometimes by touch or a soft relaxing voice. Support and reinforce clients when necessary.
7. With stronger avoidance, carefully progress only slightly each time, without exposing clients to the whole event at once.
8. In every session, start the imagery exercise from those events to which clients were already exposed and about which they already feel better. Each progressive step in exposure should be repeated several times; single exposure to each stimulus is insufficient.
9. Remember that ups and downs are expected and ensure that clients are not at risk by checking that no new symptoms are developing. However, strong emotions are expected.
10. Terminate each session with relaxation, ensuring clients return to a calm emotional state. Try to connect clients to their strengths and virtues, sense of coping, positive events and emotions, or supportive people – to end sessions with hope and optimism.
11. Give homework assignments including self-reinforcement for the courage to experience the traumatic incident, using positive self-talk. In the first stage of imaginal exposure, clients should not practice exposure alone at home without therapist guidance.
12. Don't expect imagery exercises alone to suffice. Each imaginal exercise should be followed by discussion, interpretation, self-talk, self-efficacy, and other CBT and supportive techniques to ensure clients can use exercises and apply them in-vivo.

13. Verify that therapy is progressing in the right direction: Check if clients stop avoiding stimuli associated with the trauma, if they begin doing new (or old) things, and if symptoms diminish.
14. Remember: Imaginal exposure is a powerful tool and usually has a strong impact on both clients and therapists.

Imaginal Exposure Instead of In-Vivo Exposure

The main difference between imaginal exposure before exposure in-vivo and imaginal exposure alone lies in the concern that the lack of actual in-vivo practice may lead to regression; therefore, when utilising imaginal exposure alone, imagery therapy must be conducted differently to ensure that it will suffice to resolve the problem. There are many benefits to practicing exposure in-vivo: First, clients feel able to cope in real life, which surpasses the feeling they achieve while imagining. Often during imagery work, clients will ask: "Are you sure this really works in life?" Second, once clients are practicing in-vivo exposure, their success serves as reinforcement, which facilitates further progress. During imaginal exposure alone, this reinforcement is unavailable, leaving doubts as to whether or not the problem has been resolved. Such doubts often remain for longer periods without in-vivo exposure.

Combat trauma is a prime example where in-vivo exposure is not feasible. Veteran soldiers cannot return to battlefields; therefore, imaginal exposure must suffice. The following case illustration depicts Saul, a soldier who developed PTSD several years after witnessing his friends' deaths during war:

Saul, age 25, came to therapy feeling responsible for the death of his fellow soldiers – his friends – during a difficult battle because he

couldn't call for help. Among other symptoms, he suffered from sleeplessness, headaches, and mood disturbances.

After learning many details, I asked Saul to imagine himself as a soldier in that battlefield. I used his previous descriptions but asked him to fill in the image's details, like the time of day, the way the place looked, his location among his friends, the weather, the smell of smoke rising up from the ground after bombing and shelling.

I asked him to view himself there, a soldier among soldiers, and describe what was going on around him in present tense. When he did, I could tell he was viewing the scene because he moved his eyes, talked intermittently with silences, cried, and expressed intense emotions like anger. His eyes were lowered most of the time, but he often raised them as if looking at something in the distance.

Using unorganised narrative and often incomplete sentences, Saul described how many soldiers were attacked and injured, and he was told to call for help using the communication equipment he carried on his back. However, when he tried to activate it, it wouldn't work. As he told me this, Saul began crying and repeating many times: "And I couldn't. I just couldn't." I instructed him: "Focus on your hands, your fingers, and the equipment that's near you on the ground. Describe what's happening." At first, he talked about himself in third-person voice: "There's a soldier there. He can't move." I kept saying: "That soldier is you. Tell me what you are feeling. Tell me what you are doing." He said his hands were shaking and I told him: "You are there

now. Speak in present tense. Look at your hand. There is a battle. What do you see?"

As he described trying to activate his equipment, he was flooded with emotion: "My hands are shaking, and I can't steady them. I'm trying to activate the transceiver and I can't. There are whistles of bullets around. Terrible smell. I must get help. I can't get in touch with anyone. It's not working. Oh, help!" He repeated again and again: "It's not working. It's broken! What should I do? How can I get help? There's no one to help me!"

I asked him to focus on his shaking hands, his fingers, to describe the emotion. He used words like: "Disaster! Impossible! Helpless!"

He told me he could not activate the machine. He could not send for help.

As the battle ended and the rest of the corps returned to base, Saul checked the transceiver and it worked. He felt wracked with guilt, with a sudden knowledge that it was his fault friends were dying because he had not reached assistance.

The next few nights following this imaginal exposure, Saul could not sleep and cried copiously. He called me several times, and once I initiated a call to check on him. In the next therapy sessions, we came back again and again to the equipment failure scenario. Each time we practiced this imagery exercise, it became easier for him to talk. We focused on his hands, his actions, his surroundings, his emotions, and his concern for his friends. Again and again, we checked his automatic

internal thoughts during that time, verifying that he genuinely cared for his friends and wanted to help and rescue them.

After repeating this exercise several times, Saul told me that nobody ever blamed him; nobody even knew that he couldn't work the equipment, and he didn't know if any help was really available. But his job was to activate the machine, and he was a good soldier, so he felt awful that he hadn't. He felt so bad that he never attended the corps reunion or, even more painful to him, his dead friends' memorial ceremonies on Memorial Day.

The whole process lasted several weeks, with us returning to elicit different images from the war, and repeating work on the traumatic picture until Saul could cope better. After several weeks, when Saul was able to view the war images feeling sad but not crying or panicking, we ended the imagery session with him imagining two Sauls – the past soldier and the present student – talking. I asked Soldier Saul to tell Student Saul how terrible his experience had been, and he did. Student Saul told Soldier Saul that it really was inconceivably terrible and that young people should enjoy life rather than fight, and that bad things happen in war, and that people sometimes feel helpless but what happened was not something he had planned or desired.

Due to the lack of in-vivo exposure in Saul's case, I needed to repeat the exposure exercises and discourse between Soldier Saul and Student Saul, to ensure that he could deal calmly with this memory and not avoid it.

Next, as follow-up to the imagery work using reflection, interpretation, and meaning-making , we discussed life, beliefs, and responsibility. We worked on cognitive restructuring: Bad things happened, but he did not do them intentionally. He could not cope perfectly but wanted to. He could not save his friends but yearned to. (A detailed example of cognitive restructuring is presented later in this chapter.)

Saul was in therapy for eight months when Memorial Day arrived, and for the first time he participated in his fallen friends' ceremony at the military cemetery.

As seen in this example, there was no way for Saul to experience exposure in-vivo. Therefore, I needed to ensure that imaginal exposure would be adequate to elicit and maintain change.

The principles of imaginal exposure in such cases are similar to those described above for use in imaginal exposure followed by exposure in-vivo. However, when imaginal exposure cannot be followed by in-vivo exposure, several adaptations are required to enhance change and prevent regression, as seen in the next section.

Practice: Guidelines. In cases without in-vivo exposure, all 14 of the steps are similar to the previous guidelines for imaginal exposure that does precede in-vivo exposure. However, when in-vivo exposure is lacking, additional exercises should be inserted before Step 11, as follows:

10.1. Due to the lack of subsequent in-vivo exposure, repeat the imaginal exposure many times to ensure that change really occurs. Do not expect the first one or two exercises to suffice.

10.2. Aim for clients not only to maintain but also to generalise learning. This can be accomplished by overlearning, by repeating the imagined situation

in several variations, or by designing different but similar exposure exercises (e.g., Saul can imagine standing on the battlefield in an upcoming war and losing his voice so he cannot call for help).

10.3. Once change begins, design homework assignments where clients imagine themselves practicing activities (e.g., Saul can imagine himself meeting his friends who did survive).

Imagery As a Way to Elicit Memories and Remember Forgotten Material

Posttrauma begets multiple symptoms. Fears, anxieties, and other symptoms decrease clients' subjective well-being (as in the case of Saul), and clients also exhibit avoidant behaviour (as in the case of Sara). Both Saul and Sara suffered from impinging memories through nightmares and other PTSD symptoms, and their imaginal exposure focused on increasing their ability to withstand recurrent or intrusive memories.

However, sometimes clients with PTSD suffer from the absence of memories or false memories that cause distress, calling for imagery therapy to enhance clients' ability to recall and bring up memories. As a case illustration, we will return to Ricky, who first came to therapy for fears following her son's suicide (see Chapter 7). After dealing with that, Ricky asked to continue therapy. Because she suffered from multiple problems, we decided to tackle them one by one. The training session presented next related to her guilt feelings regarding her father's death:

Ricky said her father died "because of her" but could not add any relevant information other than the fact that she was sexually abused by her alcoholic father from age 11 to 13, when he died of liver

problems. She never told anyone about her abuse and had many guilt feelings as well as problems in intimate relationships.

I thought that Ricky's guilt feelings related to three different issues: One – her fear that her father died because of something she did. Two – her feelings of relief at his death because he would no longer molest her. Three – her guilt feelings that she had agreed to accept him and his touch in a way that she should not have. I thought that I should treat her guilt feelings about being responsible for his death first, because this seemed to be the easiest of the three. The aim of the session presented below, therefore, was to help Ricky elicit forgotten details of her father's death by recalling the events of that entire day, to eliminate her feelings of culpability. Only later did I discover that Ricky felt responsible because he died the same night he had visited her room to try to have intercourse with her, but left suddenly because he felt ill.

I asked Ricky to participate in an imagery session recalling those memories. Already trained in relaxation, she could easily close her eyes and bring up images. She told me that she remembered waking up that morning to bedlam, so I asked her to try and remember: "You just woke up, you enter the living room. You hear voices. What's going on? Tell me what's happening in the room." Ricky started telling details about her confusion at first, when she saw her father lying supine, an ambulance outside the living room window, people wearing white running all around, and her mother crying. She described her confusion and fear, not understanding what was wrong.

I asked her what was going on in her mind, what thoughts she had, what feelings she had. She said: "It's because of me. I pushed him last night. It's my fault. I did something wrong to him." I asked her where this thought was coming from, how it was her fault. She replied: "He always told me that he felt good because I was there. He needed me. That he couldn't make it without me. So I probably didn't do enough…" This was important, but I decided we would deal with it later while treating her abuse, instead of disrupting the current flow of imagery about his death.

I asked her to try and listen to what the doctors told her mother at the hospital and whether anyone mentioned what was wrong with him. She replied: "They said all his systems crashed, and his liver was completely destroyed by alcohol." I saw tears of sadness and mourning in her eyes, but I also knew she was relieved he could no longer visit her room.

I asked Ricky to listen to her mother and the doctors discussing his death. After repeating what she thought they'd said, Ricky could admit that he had been hospitalised before and that doctors had long warned her parents that he was putting himself at serious risk by drinking so much. To help Ricky accept that her father was responsible for his own death through alcoholism, and no one else, I asked her to imagine talking with the doctors, her mother, her siblings, and finally even her father. Each of the figures had to tell her why her father died, and each had to respond to her claim that she was responsible for his death. In the last imagery session, while she imagined talking with her

dead father, she heard him saying: "I had many bad things in my life. You were the only good thing that happened to me. You gave me a reason to live longer." She was then confused and alternated between crying and laughing. I asked her to repeat each answer and see how much she agreed with it, until she was able to accept what they said.

I next asked Ricky to elicit a picture of young 13-year-old Ricky, to talk with older present-day Ricky. Today's Ricky told Young Ricky: "You cannot possibly be responsible. You are only a little girl. You should be busy playing with your friends and not coping with your family's problems. It was never your fault. You were the victim. You were not responsible."

After this dialogue, I asked Ricky to imagine standing in front of the mirror, looking at herself today, and telling herself that her father drank himself to death, and it was no one else's fault. Ricky said those words to herself, and then after terminating that imagery exercise I asked her to repeat the words aloud to me. She turned to me and said loudly: "You know what? It really is true! It was never my fault! He died because of himself! He was responsible for his own death! If he cared about us, he wouldn't have drunk so much to begin with."

When asked about her feelings, she blurted out: "Children should not be blamed for their parents' behaviour." I felt this was the beginning of the process of changing her misconceptions regarding her role in the abuse.

In several more sessions, we kept returning to the images of Ricky facing her father, herself in the mirror, the whole world, and telling

them: "My father died because he drank too much. It's very sad." She reached the point where she could say that this sentence felt right, that she was not having any guilt feelings, and that she would never let her own children take responsibility for her behaviour.

Thus, therapy with Ricky aimed to elicit memories in order to process problematic issues concerning those memories. She had developed negative automatic thoughts and emotions relating to these earlier events, and imagery work helped her elicit past memories and deal with the trauma those memories evoked.

Practice: Guidelines. In applying imagery to elicit forgotten material, therapists should take several steps after checking that clients are ready for this treatment:

- Ask clients to describe past events in present tense and to complete details of events as vividly as possible.
- Focus on the main dilemmas that you believe are responsible for the trauma (e.g., difficulties recalling events, fear of being exposed to events, guilt relating to events) while reassuring clients that they are currently safe and protected.
- Try to tackle guilt feelings by exaggerating and externalising the events' paradoxical tenets, to help clients realise there should not be guilt feelings (see courtroom exercises below).
- Ask clients to create dialogue between two separate aspects of the self (e.g., current and past) or with figures involved in the situation, repeating variations until clients can accept what happened.
- Bring clients to the present and have them describe events again, after having undergone changes in thoughts and emotions.
- Ask clients to forgive themselves or others and accept how they behaved.

- Have clients describe a safe present environment.

Using Imagery for Cognitive Restructuring of Past Trauma

Many client disorders relate to basic, automatic, dysfunctional beliefs (Alford & Beck, 1997; Beck 1999a, 1999b). Therefore, cognitive restructuring is an important CBT technique when helping clients establish new, more appropriate beliefs about themselves and the world. I next describe cognitive restructuring as applied via imagery training to another chapter in Ricky's therapy – treatment of her posttrauma from experiencing sexual abuse by her father:[1]

> *To treat Ricky's abuse posttrauma, we followed steps similar to those used for treating her father's death – Ricky practiced relaxation and described details so I could lead her in imaginal exercises, and I reassured her that whenever images became overly stressful she could stop. I asked her to participate in imagery sessions recalling memories of herself as a young girl who was very confused and torn. On the one hand, she enjoyed her father's attention that she craved, and she deeply wanted to make him happy. On the other hand, she feared him and felt intense stress, confusion, and guilt when he approached her sexually. Although by this time Ricky was well experienced at relaxation and imagery, it was extremely hard for her to elicit pictures of herself during inappropriate sexual experiences with her father. Apparently, the mixture of guilt, shame, and anger confused her. She moved between anger at herself, anger at her mother, and, only later, anger at her father. I decided it was not necessary to describe the sexual events in detail; instead, I asked her to focus on her emotions,*

thoughts, and sensations in an attempt to clarify her feelings, let her express them, and help her identify and differentiate all those feelings. In paradoxical imagery exercises repeated over several sessions, I asked Ricky to imagine she was in court, listening to the judge blame her for having sex with her father. This exercise aimed to increase cognitive dissonance regarding her emotions; help her stop blaming herself and start supporting, comforting, understanding, and accepting herself; and foster new meaning for the abuse experience rather than guilt. Indeed, the more she imagined hearing the judge accuse her of cooperating with her father's sexual demands, the easier it became for Ricky to say: "But how could I resist my father? Little girls should obey their fathers! I wanted to do what he wanted me to! I wanted to be a good girl!" Another time she said: "I didn't know it was wrong. He was smiling and happy!"

After beginning to learn to justify her behaviour as that of a young girl caught in an impossible situation, we continued working on reconstructing her thoughts through other variations of imaginary dialogue. The main work centred on dialogue between the 11- or 12-year-old Ricky and the current Ricky, focusing on reassuring statements by the older woman, herself already a mother, telling the young girl: "It is the father's responsibility to make sure his children are protected and not vice versa." Ricky needed to hear herself repeatedly to begin believing that she was too young to make choices, that children need to obey parents, that she did nothing wrong, and that the only blame was her father's.

In the last imagery session redressing this issue, Ricky faced her father and told him: "You know, I did enjoy it – not the sex, but the fact you wanted me. I was your child. I wanted you to want me – but not in this way. I was naive and abused. You were a bad father. I will never do what you did – I will always be a good mother to my children."

Another example of cognitive restructuring can be drawn from the story of 24-year-old Michele, who experienced survivor guilt after a fatal car accident while touring overseas:

Michele was driving with her boyfriend beside her, and a group of four friends drove behind them in another car. The roads were long, the landscape monotonous, the trip lasted many hours, and they hurried to their next stop. After a while, Michele and her boyfriend realised that the other car had dropped out of sight, and they stopped to wait. When the other car did not arrive, they drove back and found there had been an accident. The driver probably fell asleep while driving. All four of their friends were thrown out of the car. The driver died, and the other passengers were injured but survived.

Immediately after this traumatic event, all these youngsters flew home. About four months later, Michele came to me, reporting nightmares, weight loss, and incessant crying. She was obsessed with guilty thoughts: She had stayed alive; she was the one who had suggested they take such a long route; she had driven too quickly and hadn't waited for them, and so on.

After three weeks of talking about the accident, I suggested imagery to reduce her guilt feelings. Following relaxation training and imaginal

exercises, we started imagery sessions using Professor Dumbledore's magical thought extraction exercise that I described in Chapter 12 (Newell & Heyman, 2005; Rowling, 2000). I asked Michele to imagine putting Dumbledore's wand next to her head and taking out a long, grey thought, which floated out of her mind like a thread. She told me the thoughts were: "You were irresponsible! You wanted to drive for too long a time! You drove too fast! You caused his death."

We then started tackling these thoughts, one by one, through Socratic questioning: "If you are irresponsible, why did the other driver have the accident and not you? If you drove too fast, why did he lose control of his car while you drove yours well? If you stayed awake and kept driving and he did not ask to stop and rest, why are you irresponsible and not him?" It was not easy for Michele to answer the questions because she had become accustomed to blaming herself instead of him and because she felt bad blaming a dead person.

I then asked her to try and imagine her dead friend, the driver of the second car, coming alive and having a conversation with her while he drove: "What is he telling you?" She replied that he told her he was tired, it was a boring drive, it was too long, he needed a break. I then asked her if he had actually told her all of that, or if she had just imagined it. She said he had never said any of that to anyone. "So, he is not the one who said that, but you think that was what he was wishing, right? Could you now turn to him and ask him what he wanted?"

With my instruction, Michele started talking with her dead friend, asking him what he felt like before the accident. I asked her: "What are you answering him when he says he is tired?" Immediately Michele replied: "Let's stop. It's irresponsible to drive when tired. Don't put yourself and others at risk!"

I turned to her and asked her if she believed that this is what she would have genuinely answered if he had complained of fatigue, and she said she was absolutely sure she would have. In response, I posed the question: "Then whose responsibility is it for not expressing what was needed?"

I asked her to imagine talking with him again and telling him what she felt. She said: "I am so sorry you did not say anything! I feel so guilty! I wanted you to stay alive! I would have stopped if I knew!"

Again, I posed the question: "So who is responsible for driving while tired?" She did not reply, and this time I asked her to hold a conversation between two parts of herself: the part that is very angry at him because he ruined their trip, died, and left them feeling guilty – and the part that felt guilty. She started talking as if she were these two parts and really expressed anger at him.

At last, she turned to me and said: Well, I guess it is his fault, not mine. Maybe I should feel sad and grieved, and not guilty. I tried to be responsible. I even offered to drive but he refused. It is him, not me!'

This case example demonstrates the importance of imagery therapy for the cognitive restructuring necessary to facilitate change processes. Thus, while using cognitive restructuring in imagery, therapists need first to let clients face - see, read

or confront - their misconceptions, then to help clients understand that the thoughts are not functional, and then to enable clients find new, more functional, adaptive thoughts to replace the earlier ones. Arguing between the diverse thoughts, exaggerating one kind of thought, or increasing irrational thoughts to a ridiculous point can contribute to clients' ability to find new, more adequate thoughts (in Michele's case, sorrow and sadness rather than guilt and blame).

Practice: Guidelines. Some important guidelines can help in applying imagery for cognitive restructuring:

- Before starting imagery sessions, be sure you are aware of clients' misconceptions or automatic thoughts.
- Design imaginal situations that offer clients opportunities to express all their misconceptions, and allocate enough time for clients to fully express and confront all these misconstructions. Good methods include:
  - Put the client on trial so that all the distorted as well as rational thoughts can be voiced in court (judge vs. defendant or prosecutor vs. defence attorney).
  - Exaggerate situations so much that clients can see that their perceptions are unrealistic (e.g., tell Michele that he died because she was supposed to have seen in her mind's eye that the other driver was tired, or because she should have driven both cars simultaneously, or because she is a super-capable woman and he was only a man).
  - Divide clients into two figures or parts, and instruct them to dialogue or argue with each other (child self vs. current self, victim vs. perpetrator).

  - Clients, not you, should be the one to reflect on how wrong or distorted their thoughts are, in order to effectively change them. You can use Socratic questioning to help confront clients with paradoxical thoughts and to reflect new, rational, mediated thoughts back to clients.
- Repeat these imaginal situations in multiple variations, until clients feel confident in their changed thought patterns.
- Try to reinforce clients' belief in the new, mediated thoughts that have developed using methods where clients:
  - Practice taking the voice of these rational thoughts and persuading you of their validity.
  - Tell you about the change by giving a lecture, presenting it, or explaining it.
  - Perform homework assignments where they tell themselves or others about the change.
- Remember that imagery work must be followed up, as always, by discussion of the change, reflection on the reason for change, and examination of that change's meaning. Be sure clients are confident about the longevity of the change before continuing to work on cognitive restructuring of other past events.

Summary

Imagery is a strong technique to be applied when treating past events, trauma, and posttrauma. Indeed, to work with these types of past problems, therapists cannot achieve effective outcomes without imagery. The focus of imagery training may differ

in various sessions, including emotional expression (as suggested in Chapter 5) as well as imaginal expression, recalling memories, and cognitive reconstruction as suggested here. Therapists can use their own imaginations to lead clients where they need to go in order for change to occur, designing customised imagery to meet clients' particular needs.

However, it is important to remember that treating past events will neither begin nor end with imagery. It is only one technique or tool within an entire repertoire that enables the expression of emotion, exposure to traumatic past memories, or recollection of repressed ones, and work on changing thoughts and designing new beliefs. Discussion as well as additional CBT and supportive techniques should be an integral part of the process.

Practice: Guidelines for Choosing Between Options

Although the guidelines for all imaginal exercises regarding fear, trauma, and posttrauma are similar, I presented separate guidelines in this chapter for each option and integrated case studies for each. To determine the optimal type of imaginal exercise targeting past events, therapists should ask:

- What is the unique feature of this specific case, in addition to the symptoms the client presents and the fear and anxiety the client experiences?
- Does it relate to the traumatic memory itself, and to the development of avoidance of that memory, which prevents progress? If so – then the imaginal exercise should address gradual exposure as suggested in the first two sets of guidelines in this chapter.

- Does the main feature relate to lack of memories, or to difficulties remembering? If so – then help the client elicit and recollect detailed descriptions of the image, attempting to imitate reality as much as possible.
- Does it relate to guilt, shame, or other negative thoughts? If so – then focus not on exposure but rather on the confrontation between different figures or sides, like the client's present versus past or the confrontation of thoughts versus feelings.

Footnotes

[1]As mentioned above, Ricky's complex therapy was lengthy (about two years) and combined CBT, imagery, and positive psychology to systematically address her multiple problems, one by one. After comprehensively treating her father's death, Ricky wanted to start treating her posttrauma stemming from her abuse. I persuaded her to postpone this treatment for several weeks because I worried that such a lengthy focus on negative, distressing events would be overwhelming. First, for several weeks we worked on positive exercises to increase her happiness at work and with her daughter. During this time, I verified that she was really handling the previous issues (her father's death) and ensured that she could also find time to enjoy her family and work life. Only then did I agree to begin work on her traumatic two years of childhood abuse.

We decided to divide each session into two parts: one addressing her early abuse and one focusing on developing positive skills in her present life: talking with her daughter, taking time to promote and elicit positive emotions instead of dwelling only on her difficult sad past, developing social contacts, and engaging in fun leisure activities to enhance well-being and maintain the strength necessary to cope with the difficulties she was encountering in therapy and in her life.