CHAPTER 3

Using Imagery in Case Conceptualization

Case conceptualization, or formulation, is a cornerstone of cognitive therapy (Beck, 2020; Butler, 1988; Dudley, Kuyken, & Padesky, 2011). Conceptualization integrates theory and practice in order to organize the information gained in assessment and make sense of the client's problems. A key function is the development of a shared, theory-driven conceptualization of the client's difficulties that will inform planning and structuring treatment. The focus of this chapter is on how we incorporate imagery into case conceptualization and to show why it is important to do so.

There are multiple different models available for case conceptualization as a result of developments in cognitive therapy and the proliferation of new treatments. Kuyken, Padesky, and Dudley (2009) propose a broad typology in which they describe three levels of conceptualization: descriptive, cross-sectional, and longitudinal. However, Hackmann, Bennett-Levy, and Holmes (2011) argue that the role of specific problematic images sometimes gets lost in these broader case conceptualizations and they argue for a more precise focus on imagery (see below for an example). Notwithstanding Hackmann and colleagues' criticisms, the typology offers a useful organizational framework—the following sections show you how to incorporate imagery at each of the three levels, how images add value, and in so doing, ensure that images do not get "lost."

Three Levels of Case Conceptualization

Descriptive conceptualizations, such as Padesky and Greenberger's (1995) "hot cross bun," offer the most basic type of organizational framework in which information is simply grouped together into theoretically relevant categories—for example, thoughts, feelings, physiological sensations and symptoms, and behaviors. These categories are situated within an overarching framework of the environment.

Cross-sectional case conceptualizations focus on current maintaining factors in order to delineate the key processes that are responsible for the client's persisting distress. The majority of the current disorder-specific models of anxiety are cross-sectional. An important point is that these models often go beyond traditional generic models of cognitive therapy and include a wider range of psychological processes, including attention, perseverative thinking, such as worry and rumination; memory biases; and increasingly, representations of the self. However, many cross-sectional conceptualizations do not include information from the past. One of their strengths is the detailed focus on current maintaining processes, which provides specific targets for change.

Longitudinal conceptualizations explicitly demonstrate the links between past experiences and the present. They include information about previous experiences that have shaped underlying beliefs and assumptions, as well as potential activating events and information about the presenting problems. Because of their increased complexity, longitudinal conceptualizations sometimes provide a less detailed representation of the current maintaining processes than cross-sectional conceptualizations. Case conceptualization is an evolving process and Kuyken and colleagues (2009) suggest that it is helpful to think of the three different "levels" as complementary. You can draw upon whichever level best represents the current information and the client's level of understanding rather than them being mutually exclusive.

In their book on imagery, Hackmann and colleagues (2011) suggest that images are incorporated into "microformulations." These are essentially an extension of the classic vicious circle that is traditionally used in cognitive therapy to describe the relationships between thoughts, feelings, and behaviors (and physiology where relevant), but they are organized around a specific image. However, images and imagery have a much wider role to play and can be incorporated across the board in all three different levels of case conceptualization described by Kuyken and colleagues (2009). Imagery has a role to play in the many and various different theoretical models that now underpin case conceptualization in cognitive therapy. We start by looking at how to incorporate imagery into descriptive case conceptualizations,

and then move on to Hackmann and colleagues' microformulations. Then we move beyond these to the next level of cross-sectional case conceptualizations and illustrate how imagery is built into the conceptualization with examples of clients with social anxiety disorder and OCD. Finally, we look at imagery in longitudinal models and consider how we might tie together information from early autobiographical memories and their associated images, with the meanings about self (others and the world) that may be contributing to the difficulties the person is experiencing in the present.

Images in Descriptive and Simple Explanatory Case Conceptualizations

The first step of any intervention is gathering relevant information and organizing it in such a way so that it makes sense to both client and therapist. The conceptual framework for this early information sifting is based on core concepts of thoughts, feelings, and behaviors that are the building blocks of cognitive therapy. They underpin the basic premise that it is the interpretation of events that causes distress and not the events themselves. Descriptive conceptualizations are often particularly useful in the early stages of training when therapists are not familiar with disorder-specific models or more complex cognitive therapy conceptualizations. In the following example, we look at a client describing an episode of health anxiety and see how this information, including some vivid images that the client reports, can be summarized using simple descriptive methods.

THERAPIST: I'd like you to think of a recent example of when you started to worry about your health.

JULIE: I met an old neighbor, Marie, at the store. I haven't seen her for ages and I said, "How are you?" and she said, "You haven't heard, then? Not so great at the moment. Hardeep died a couple of months ago." I felt absolutely awful. I felt really bad that I hadn't known, and I'd greeted her with this big grin because I was pleased to see her. It was really awkward and embarrassing, and right away I could feel my anxiety building. I was feeling hot and I just wanted to get away but I kept thinking, "You can't do that, it would be really rude," so I said that I was really sorry and asked her what had happened, even though I didn't really want to know. He died of cancer and it had all been really quick. I stayed with her as long as I could and then I made an excuse and said I had to pick up one of the kids because I just needed to get home.

THERAPIST: How were you feeling at this point?

JULIE: By that time, I was on the verge of a full-blown panic attack. I just wanted to get home so I could try and get it under control.

THERAPIST: What was going through your mind when you were feeling at your most panicky?

JULIE: Well, you know that I told you I had been to the doctor and she had examined my breasts and told me that she couldn't feel any lumps; well, all I could think of was, "What if she missed something?" They must have missed something with Hardeep because otherwise how could he have died so quickly?

THERAPIST: And while those thoughts were racing through your mind and you were feeling so panicky and desperate to get home, did you have any images or pictures in your mind?

JULIE: I kept seeing my mom at the end, she looked so awful, so frail and ill, and then sometimes just for a moment my face would flash onto hers.

THERAPIST: And how did you feel when your face flashed onto hers?

JULIE: I was just terrified. I just thought, "Me next!"

THERAPIST: That must have been a really frightening thought. Did you notice any sensations in your body when you saw that image of your mom with your face superimposed?

JULIE: Yes, my breasts felt weird and lumpy, as if there were more pressure against my bra. I felt really hot and breathless. I thought I was going to faint, and I wouldn't be able to get home. I just felt so frightened and so alone.

THERAPIST: What did you do to help yourself get home when you were feeling so frightened?

JULIE: I tried talking myself through it and reassuring myself. Telling myself that just because he had cancer it doesn't mean I have it, but it didn't really help because all I could think of was cancer. It was as if there was this thing hammering into my brain saying, "cancer, cancer, cancer."

THERAPIST: Could you hear the word?

JULIE: Sort of, not exactly, but it felt very physical like something drumming into me. So, I had to call Ed, which was really difficult, as he was in a meeting, but he managed to talk me down so that I could get in the car and drive home.

In this excerpt, Julie describes an episode of health anxiety triggered by meeting a neighbor whose husband recently died of cancer. Hearing about this immediately activates all of Julie's health concerns and initiates a stream of negative thoughts about being ill herself. The encounter also

triggers two different images: one of her mother when she was very ill that would sometimes include Julie's face superimposed onto her mother's body and a much vaguer auditory image in which the word "cancer" is experienced as "hammering" into her brain. Julie's description of what happened contains a lot of information and she clearly felt overwhelmed by the situation and her response to it. She also finds herself becoming increasingly anxious as she recounts it to the therapist. Figure 3.1 illustrates how Julie's account can be organized using a descriptive case conceptualization like Padesky and Greenberger's (1995) hot cross bun. The information is organized into categories that clearly distinguish between thoughts, emotions, bodily sensations, and behaviors.

Organizing the information in this way is a useful first step, particularly when the client (or therapist) feels overwhelmed either by the number of problems or by the amount of information that seems relevant. However, descriptive conceptualizations have only limited explanatory power. The richness of Julie's information indicates that there are several different potential pathways linking thoughts, feelings, and behaviors, and delineating these increases the explanatory power of the conceptualization.

The next step might be a simple vicious circle that draws out one thread and makes precise links between the different components. Figure 3.2 provides an example that focuses on one of the thoughts that Julie identified—the doctor must have failed to diagnose her neighbor's husband early enough and this was why he died so quickly. Julie then jumps to the thought that her doctor may have missed something important and potentially life-threatening, and this triggers a spiral of increasing fear around her health.

Again, this is useful because it starts to pull out the relationships between the different chunks of information—however, it does not distinguish between frightening thoughts about having cancer and the images that Julie reported.

Image-Centric Microformulation

As Hackmann and colleagues (2011) point out, the multiple meanings embedded in images can get lost and it can be helpful to draw up a microformulation that uses the image as its central hub. Figure 3.3 shows an example of how the therapist could do this using Julie's image of her mother as the driving force in the conceptualization.

Figure 3.3 focuses on the image of Julie's mother when she was ill. This image is part of a painful autobiographical memory related to her mother's death, which Julie found traumatic. When her own face is superimposed on the image, this intensifies the danger embodied in the thought "me next?"

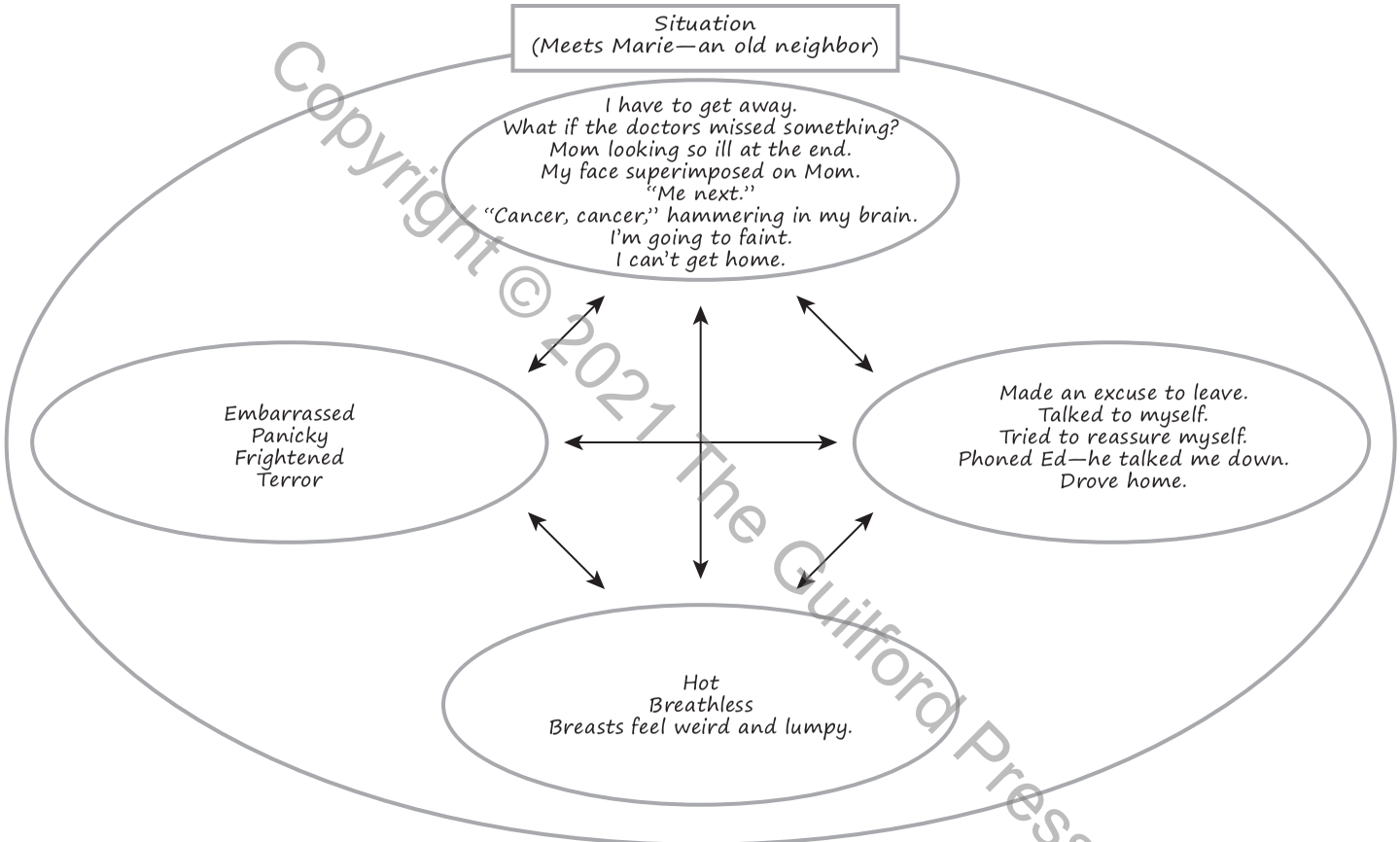

FIGURE 3.1. Descriptive case conceptualization (Julie) using the hot cross bun (Padesky & Greenberger, 1995).

and amplifies her fear into "terror." The rapidly increasing sense of threat produces an attentional shift toward her breasts and Julie then experiences them feeling weird and lumpy, which further intensifies the sense of imminent threat. As well as terror, she experiences overwhelming feelings of being "so alone," which may also be linked to the memory of her mother's death and the sense of abandonment she felt when she lost her. Julie tries to reassure herself, but the intensity of the perceived threat along with the feelings of vulnerability and isolation make this impossible for her, and her

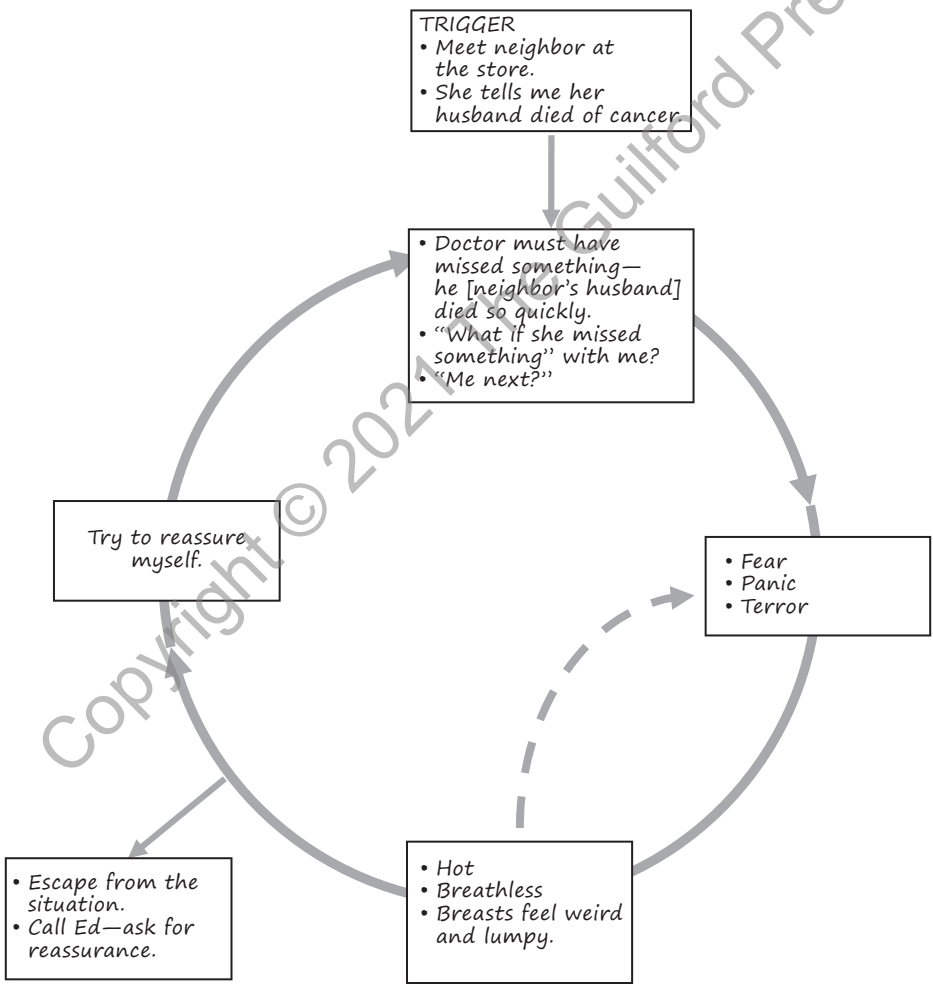

FIGURE 3.2. Simple vicious circle (Julie).

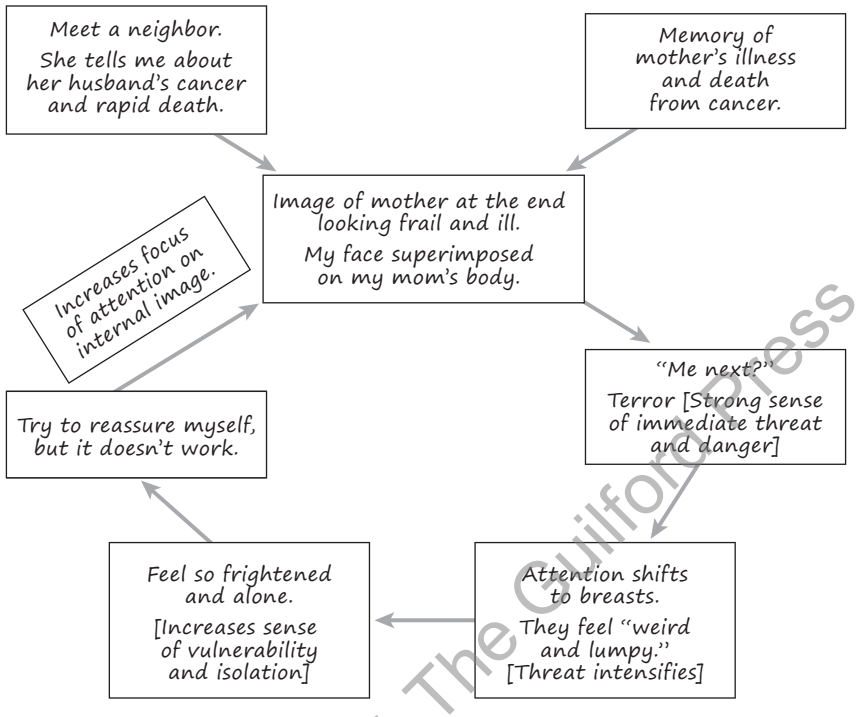

FIGURE 3.3. Using mental imagery as a central hub in case conceptualization (Julie).

only option is to escape from the situation and then seek reassurance from her husband, Ed. If the images of her mother's illness and death are recurrent and intrusive, they may be important maintaining factors in her health anxiety. Exploring the meanings of the images may reveal unresolved issues around her mother's death that could lead to attempts to suppress them because of the associated distress. If this were the case, then escaping from the situation and trying to block or escape the image might contribute to a failure to emotionally process the loss of her mother and further perpetuate Julie's own anxieties about her health.

Formulating the image and its meaning in this way has several benefits. First of all, it integrates potentially complex information in a simple and direct way: it demonstrates why Julie's fear escalates so quickly and may help her to see the link between her mother's death and her own fears in a new way. Second, it identifies areas for further questioning. Is this a recurrent image? What does the image mean to Julie? Is it always the same image? At what point does Julie's face get superimposed onto her mother? Does this always happen? Third, it alerts the therapist to the possibility of additional

intervention targets, such as imagery rescripting to target the memory of her mother's death. Vicious circles, whether they represent pathways from specific negative automatic thoughts or are imagery driven (the microformulations described by Hackmann et al., 2011), go beyond the simple hot cross bun and provide an important way to understand specific links between different components of the cognitive model. As such, you are likely to use them throughout therapy when you want to focus on a particular thought, image, feeling, or problematic behavior. They can be used in parallel with cross-sectional and longitudinal case conceptualizations to unpack specific parts of the model or explore more complex meanings. Cross-sectional conceptualizations, discussed next, take a broader focus in order to model the key maintaining factors that contribute to the persistence of a particular problem or disorder.

Images in Cross-Sectional Case Conceptualizations

The upsurge of disorder-specific models led to the development of effective interventions for a whole range of clinical problems. The strength of these models is their grounding in normal psychological processes (e.g., attention, memory, repetitive perseverative thinking, avoidance) and in understanding when these processes become "dysfunctional." For example, selective attention is an evolved mechanism that allows us to orient toward threat and take appropriate action to protect ourselves. There is nothing "abnormal" about the process. However, in anxiety disorders, selective attention to threat becomes problematic when there is no objective threat or when the individual is constantly overestimating the probability of the threat. In this case, selective attention constantly orients the individual toward the threatening stimulus, be it external (e.g., a spider) or internal (e.g., a bodily sensation), contributes to anxiety, interrupts current activities, and frequently promotes escape or avoidance behaviors.

Although many of the hypothesized maintaining processes in disorder-specific models are transdiagnostic, the models propose that there is value in specifying how they operate and interact with one another in particular disorders. They also propose that there is specificity at the level of content (e.g., thoughts and images) and in some cases, in particular, physiological and behavioral responses. For example, for an individual with health anxiety, fears focused on illness and bodily sensations linked to the feared illness will predominate. Behavioral responses may include repeated checking and reassurance seeking. By comparison, an individual with social anxiety disorder will be concerned about embarrassing and humiliating the self; physical sensations of concern are likely to be those that reveal embarrassment and

anxiety, such as blushing, shaking, and sweating; behavioral responses are more likely to involve avoidance and withdrawal. In some of the disorder-specific models, images are explicitly included, whereas in others they are not. The following sections look at an example of each: social anxiety disorder, where images of the self are a core part of the model (Clark & Wells, 1995), and OCD, where images are included as a form of intrusion but not necessarily conceptualized as distinct from other types of intrusive thoughts (Steketee & Barlow, 2002).

Images in Conceptualizing Social Anxiety Disorder

Negative, distorted mental images of the self are a feature of all current cognitive models of social anxiety disorder (Clark & Wells, 1995; Rapee & Heimberg, 1997; Hofmann, 2007). They are core to Clark and Wells's (1995) model, which underpins one of the most effective recent treatments recommended by the National Institute for Health and Care Excellence (NICE; 2013) in the United Kingdom. Clark and Wells argue that individuals hold dysfunctional assumptions about the meaning of appearing anxious ("I'll look weird," "People will think I'm weak") and social performance ("I must always be witty and entertaining," "I must never allow any pauses in the conversation, or people will think I'm boring"). The consequences of failing to meet these standards lead to catastrophic predictions, such as "I will never have any friends" and "People will reject me."

These assumptions lead individuals to perceive social situations and interactions as threatening rather than sources of pleasure and reward. This activates a stream of negative thoughts and images that produce anxiety and often trigger observable physiological symptoms, such as blushing, shaking, and sweating. In turn, these initiate the use of safety behaviors aimed at preventing the feared catastrophes (e.g., monitoring what the person is saying, or how he or she is coming across; trying to hide blushing or sweating; rehearsing what to say). All of these factors interact to create a high degree of self-consciousness. When socially anxious individuals turn their attention on the self, many of them have a negative, distorted image of the self that further amplifies anxiety. Some of these images are based on early aversive experiences, such as bullying (Hackmann et al., 2000), whereas others represent negative meanings about the self without necessarily being tied to a specific autobiographical memory. The content of these images can be highly idiosyncratic, but there are common themes around perceiving the self as inadequate, less important than other people, weird, or unacceptable. For those who do not report any images, there is often a "felt sense" that encapsulates a similarly negative view of self.

In terms of case conceptualization, the model explicitly identifies negative images of self at its center. The following dialogue, together with Figure 3.4, illustrates how to assess and conceptualize self-imagery in social anxiety disorder. In common with most of the disorder-specific CBT models of anxiety, the conceptualization is based on a detailed description of a specific situation. In this instance, Ben describes what happened when he was waiting to give a verbal report in a meeting at work.

THERAPIST: Can you think of a recent situation in which you started to feel socially anxious?

BEN: Yes, that's easy. I was in a meeting last week and I was waiting to do a report on my sector and the anxiety just built up and up. I don't know how I managed to stay there and do it.

THERAPIST: I'd like to go through that situation in detail so that I can get a clear picture of what was happening. Is that okay?

BEN: Yes, sure. I'd been feeling apprehensive all morning because I knew it was coming up. We have these meetings every week, but I only have to do the report once every quarter. So, most of the time I can get away with just sitting and listening, but this time I knew I was going to be in the spotlight.

THERAPIST: When did you notice the anxiety starting to get worse?

BEN: I'd been feeling anxious ever since I got up that morning, but about an hour or maybe a bit less before the meeting, it really kicked in. I had to go to the bathroom twice in about 20 minutes, which was embarrassing because I thought everyone had noticed and would think, "What's wrong with him?"

THERAPIST: What was going through your mind while you were waiting for it to start?

BEN: I started thinking, "Oh no, what if I can't do it, what if I dry up? I'm going to make such a fool of myself."

THERAPIST: And how did that make you feel?

BEN: Hot and sweaty, and that feeling as if I was going to need to go to the bathroom again.

THERAPIST: What happened when you went into the meeting?

BEN: I sat near the door in case I needed to go out and once I sat down it was a bit easier because people were coming in and shuffling about and chatting to each other. So, I had a chat with Mel, who was sitting next to me. She knows a little bit about my problems and she said, "Don't worry, Ben, you'll be fine," which was sweet and a bit comforting. But my anxiety just kept coming in waves.

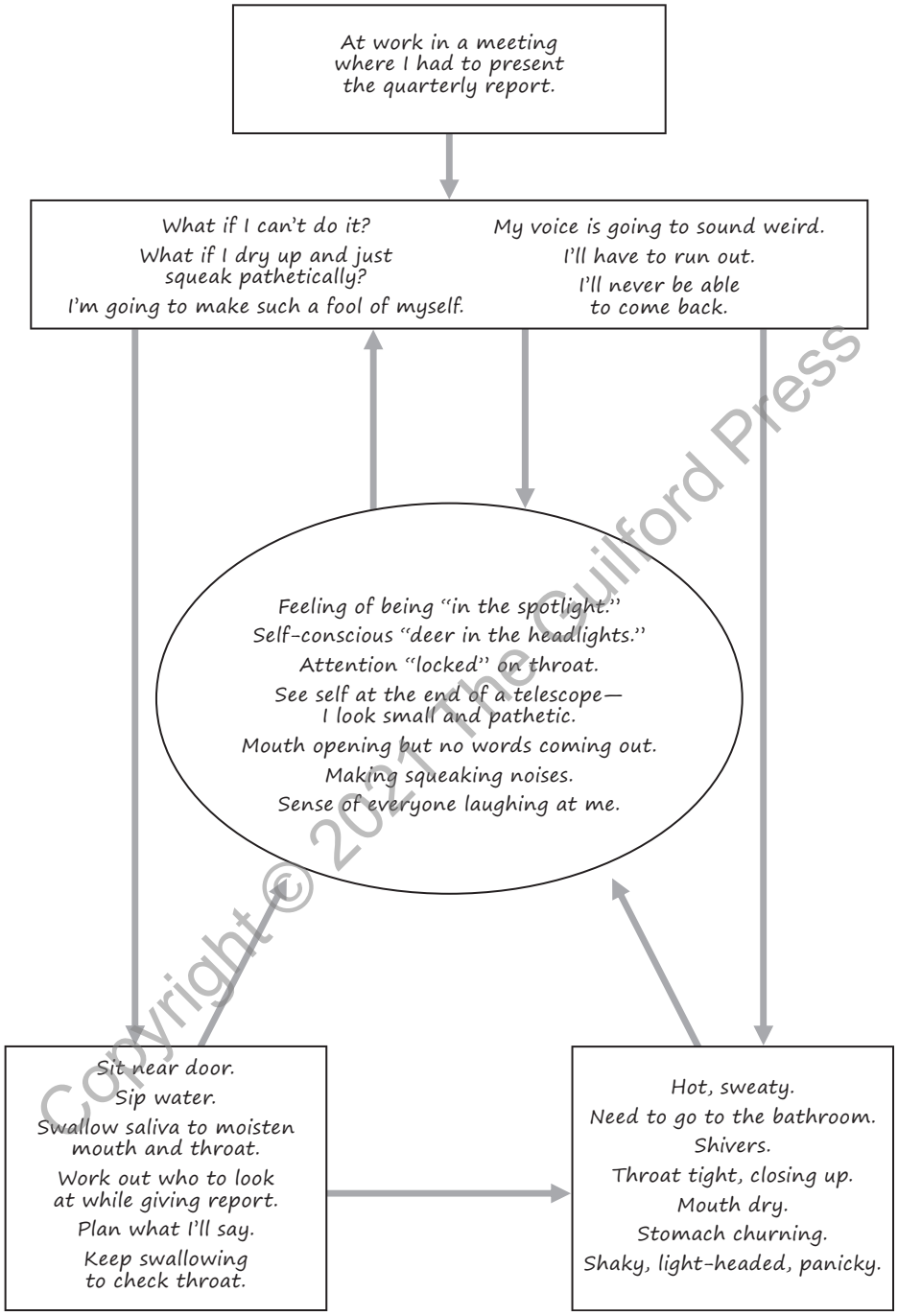

FIGURE 3.4. Case conceptualization of social anxiety (Ben) based on Clark and Wells's (1995) model.

THERAPIST: Can we focus on the worst part of the meeting, Ben? What was happening?

BEN: That was the few minutes just before my slot was coming up. I just kept thinking, "Oh no, I can't do this. My voice is going to sound weird—all high and squeaky. What if I can't think of anything to say?" That was ridiculous because I had the report in front of me and I'd written a summary of what the report said, so if worst came to worst I could literally just read it out loud. But then I'd think, "What if I dry up and I just can't speak at all, I'm going to look like such a fool."

THERAPIST: What was the worst that you thought could happen?

BEN: I think it's the fear that I'd just totally dry up. I could imagine these sort of pathetic little squeaking sounds coming out of my mouth. I think then it would get so bad that I would just have to run out of the room. If I did that, I can't imagine how I would ever come back.

THERAPIST: When you were worried that you would dry up and that your voice would come out sounding all high and squeaky, did you notice any sensations in your body?

BEN: Yes, I was already feeling hot one minute and shivery the next, but my throat got tighter and tighter, and my mouth was really dry. I had to keep sipping water.

THERAPIST: Any other sensations?

BEN: Just my stomach churning and the worry that I'd need to rush to the bathroom. And I felt sort of shaky and light-headed.

THERAPIST: And as you were worrying that you might dry up and you had all those unpleasant sensations of dry mouth and tight throat, did you do anything to try to stop it from happening?

BEN: I was going over and over what I was planning to say in my head. And I was trying to moisten my mouth—taking sips of water and trying to get the saliva going. I was also trying to work out who to look at while I was talking. I thought it would be good to focus on a friendly face and not on one of the sales guys, because they are always cracking jokes. They'd crucify me if I dried up, and I'd never hear the end of it. I was thinking about what excuse I could make if I had to get out that wouldn't make me look like a complete and utter idiot. You know that would be totally humiliating.

THERAPIST: While you are worrying about all of these things—drying up, having to run out of the room, and the fear of humiliating yourself—along with all the physical symptoms, what happens to your attention?

BEN: I was mainly focused on my throat. I kept swallowing to check whether it had gotten drier or whether I'd managed to lubricate it a bit.

THERAPIST: Did you become more self-conscious when that was happening?

BEN: Yes, I felt like a deer caught in the headlights and that just got worse and worse because when you start doing the report everyone *is* looking at you and I felt trapped.

THERAPIST: When you're feeling like a deer trapped in the headlights and that everyone is looking at you, do you ever have an image of how you're coming across?

BEN: I feel as if I'm looking at myself down the wrong end of a telescope, so I'm in the distance looking really small.

THERAPIST: Can you describe what you look like in this image?

BEN: I'm small and I look pathetic. I've got my mouth open and I'm trying to speak but no words come out.

THERAPIST: Can you hear anything in this image?

BEN: Yes, these squeaking noises come out of my mouth and I feel as if everyone around me is looking at me and they are all about to burst out laughing.

THERAPIST: Can you hear them laughing?

BEN: No, it's that moment of quiet just before the laughter bursts out, but that makes it even worse because I know it's about to happen and I can't do anything to stop it.

THERAPIST: When you're sipping water and swallowing to moisten your throat and planning what to say, does that make you focus more or less on yourself?

BEN: I become completely locked onto my throat. It's like a really powerful magnet pulling me toward it. I can't focus on anything else.

THERAPIST: And how does that make you feel?

BEN: Really panicky.

THERAPIST: How does that affect your attention?

BEN: I suppose I just focus more and more on myself.

THERAPIST: How do you think that trying to moisten your mouth and swallowing, and rehearsing what you are going to say affects your anxiety?

BEN: I've never really thought about it. I suppose I'm just so focused on trying to get through it. But my anxiety doesn't get any better, so I guess it's not helping my anxiety. On the other hand, it may well get even

worse if I didn't do any of those things. I feel I'm hanging by a thread at the best of times.

THERAPIST: When you see that picture of yourself from the wrong end of a telescope with your mouth opening and gaping and you hear those squeaky noises, does it seem more or less likely that you'll dry up and only be able to make squeaking noises and have to rush out of the room?

BEN: Oh, much more likely. Sometimes I feel as if it must have already happened because it seems so real.

Ben describes a pattern that is typical for people with social anxiety disorder. He starts by describing a period of anxious apprehension before he goes to the meeting. Once he is in the meeting room, he reports a stream of negative thoughts related to his principal concerns: "I won't be able to speak" and "I'll make a fool of myself." At this point, we do not have much information about Ben's beliefs and assumptions. However, the detailed examination of the meeting provides rich information about his fears and about some of the relationships between different components of the model. Ben's dry mouth and the feeling of his throat closing up are linked directly to his fears about being unable to speak in public. They also feature in the image he has of himself "squeaking" and being unable to speak. His anxiety initiates a number of safety behaviors (e.g., trying to moisten his throat, rehearsing what to say) to try to prevent his fears from being realized. His negative thoughts and predictions, his anxiety symptoms, and his safety behaviors all intensify his internal self-focus. When this happens, Ben has an image of himself looking very small (down the wrong end of a telescope) and opening and shutting his mouth while squeaking noises emerge. This image both represents Ben's worst fears and is probably used to infer what other people see when they watch and listen to Ben when he is nervous.

The case conceptualization, based on Clark and Wells's (1995) model, is shown in Figure 3.4. The image in this conceptualization is multidimensional. Ben describes seeing himself as if he is looking down the wrong end of a telescope—in other words, he is very small and a long way away. This image may be related to childhood memories of feeling embarrassed or humiliated in front of his peers. If it is associated with a memory, the "observer perspective" might originally have been Ben's way of trying to distance himself from the emotional impact of reliving this experience. Alternatively, seeing himself as small and far away could be a way of expressing the sense of vulnerability and helplessness that many clients feel when they are extremely anxious in social situations. Clear identification of such images in the initial case conceptualization is critical to achieving two key

treatment aims: (1) developing a "realistic" image of self, and (2) processing the environment rather than the self (Clark & Wells, 1995).

The amplification of emotion through images (Holmes & Mathews, 2010) contributes to imagined scenarios often feeling more "real" than ones that are simply described in words. Ben's image creates a vivid representation of his fear that he might "dry up" and be unable to speak, or that his voice will sound "weird." This image intensifies the sense of threat and becomes the data that he uses to infer how he is coming across to others—that is, Ben believes that what other people see when they look at him is the same as his internally constructed image. As well as seeing an image of himself, Ben feels as if other people are about to laugh at him. This powerful sense of a group being poised to laugh and ridicule him probably increases the believability of the visual image in which he sees himself behaving in a way that he judges as humiliating. Representations of the self, often in the form of a visual or multisensory image, are critical to understanding social anxiety disorder and often act as the "dynamo" driving the more familiar maintaining processes that are also captured by Clark and Wells's (1995) model. The absence of a clear conceptualization of the self in earlier models may help to explain why cognitive-behavioral treatments of social anxiety disorder based on the generic cognitive model (thoughts, feelings, and behaviors) had only modest success (e.g., Heimberg & Juster, 1995).

Images in Conceptualizing Obsessive–Compulsive Disorder

In Chapter 2, we looked at how assessing Donna's intrusive images of harming her baby provided a more detailed account of her problems. The key intrusive images were Donna seeing herself drop the baby, hearing the thud as Cora hit the floor, and the flashing horror-movie style images as she saw herself stabbing Cora. Compulsions represent an attempt either to prevent the feared event from taking place, or to put it right if it does take place. In Donna's case, she deliberately created an image of Cora surrounded by "holy light" in an attempt to protect her. However, one unintended consequence of this attempt to "prevent" or "put it right" is for Donna to conclude that she is a bad mother because it is her role to protect her daughter and Cora should not have to be "protected from her." Steketee and Barlow's (2002) model for OCD incorporates information about predisposing factors, such as biological risk factors (other family members who have suffered from OCD or anxiety), the environmental context, and core beliefs based on early experiences. It also includes beliefs and assumptions relevant to OCD, such as perfectionism, overestimation of the importance of thoughts, beliefs

around responsibility, the importance of certainty, and the need to control one's thoughts.

In Donna's case, the therapist discovered that her father has a history of OCD predominantly focused on checking. He had witnessed a house fire as a child and Donna remembers that he focused on fire safety in the home with frequent checking and reminders to turn off electrical devices at night. Both parents were loving and protective of Donna. She said that they were religious and had strong moral codes in which they stressed the importance of making sure that you were doing the "right thing" and taking responsibility for your actions. Donna also remembers her mother telling her to pray when she was a child and had done something wrong so that "God would make her a better person." Donna's negative view of self and her view that she is a bad person are clearly linked to her intrusive images, but the precise nature of the relationship is not clear yet. The following dialogue explores it further.

THERAPIST: I'd like to start by exploring a bit more about the things that start the whole cycle off for you. You said that sometimes seeing Cora immediately triggers the images of dropping or hurting her, but this doesn't always happen.

DONNA: That's right. It's really weird. Sometimes I can just pick her up and cuddle her and feel okay, then other times, the moment I go into her room, say to pick her up from a nap, I'll get a flash of doing something.

THERAPIST: That unpredictability must be hard to cope with.

DONNA: Yes, it is. When I have a few hours or occasionally a day when it doesn't happen or doesn't happen so often, I think I'm getting on top of it. But then when I get a bad one, I feel as if I'm never going to shake it.

THERAPIST: Let's try to think about whether there are any patterns, or anything you can recognize that makes it more or less likely that you'll respond this way to Cora. Does anything come to mind when you think about it like this?

DONNA: Well, I guess when I'm having a bad day and I'm tired or feeling low, it's more likely. I did suffer from some mild postnatal depression after she was born because it was a difficult birth and that's when it all started, really.

THERAPIST: So, things like tiredness and your mood will influence it?

DONNA: Yes, I guess so. Then I suppose I've never been a very confident person and when I have to ask for a lot of help, I feel really stupid and as if I'm not fit to have a baby, so I guess that makes me more worried that I won't be able to look after her.

THERAPIST: Is that thought about not being fit to have a baby different from the one we talked about last week when you said that you didn't "deserve" to have Cora?

DONNA: (*Pauses.*) I think it is. Yes, it sort of feels different.

THERAPIST: Can you tell me a bit more about that? In what way do those two thoughts feel different?

DONNA: Well, the one about not deserving Cora is more upsetting. I get that really strongly when the OCD is bad, so I suppose the more I see myself doing something bad to her, the more believable it becomes. The one about not being fit to be a mother is more background, it's sort of there all the time and maybe links to me generally not being very confident and not having a good opinion of myself.

THERAPIST: Let's concentrate a bit more about the thought you have about not deserving to have Cora. When you have that thought, do you ever get an image of yourself as a nondeserving mother?

DONNA: (*Laughs ruefully.*) I don't know why I'm laughing 'cuz I really don't find it funny, but now that you ask me that, it seems really silly saying it out loud, but I do get an image. I haven't really thought about it like this, but you know that TV series *Orange Is the New Black*? Well, some of the women in there have harmed their children and the image I get is of me in an orange jumpsuit with my hands behind my back, cuffed, and I see myself doing that sort of weird shuffle that people have to do when their hands are tied behind their backs. But it's ridiculous because I would be in a U.K. prison and they don't wear those orange jumpsuits.

THERAPIST: Can you see that image now?

DONNA: Yes.

THERAPIST: Donna, can you close your eyes and just focus on seeing yourself like that? (*Pauses.*) How are you feeling right now?

DONNA: Sad (*pause*) and I'm ashamed, and I feel really guilty.

THERAPIST: What does that image tell you about yourself?

DONNA: That I'm a bad person, that I can't be trusted.

THERAPIST: And how does that feel?

DONNA: It's horrible. I've tried to be good, but I can't be. No matter how hard I try, I'll always mess up.

THERAPIST: What would have to change for you to be "good," Donna?

DONNA: Well, I'd have to stop having these awful thoughts and I'd have to be able to take care of Cora properly, on my own for a start.

THERAPIST: Can you get an image of yourself doing that, looking after Cora? (*Pauses.*) What would that be like?

DONNA: I can see myself holding her, but it's like at the back of my mind I'm fending off the bad images and so I can't just relax.

THERAPIST: Okay, open your eyes. So, the image of caring for Cora and being the mother that you want to be is linked to a sort of background noise containing the frightening images of harming her. Have I got that right?

DONNA: Yes, I guess so. I hadn't really thought about it like that, but I think they are linked and then as soon as one of them breaks through, it makes me feel I can never be a good mother.

THERAPIST: When do you get the image of yourself in the orange jumpsuit?

DONNA: I think that tends to come later on when I'm feeling worn out and hopeless about the situation, and I'm thinking about what will happen.

THERAPIST: This is really hard for you because it sounds as if the thing you most want to be—a good mother—then triggers the obsessional thoughts of harming Cora that feed your belief that you are a bad mother and don't deserve her. And then that all makes you feel down and you said that feeling down seems to make the obsessional thoughts and images more likely to come into your mind.

DONNA: (*Sighs.*) You're absolutely right. It's as if I'm stuck in this hellish cycle that I can't escape from.

THERAPIST: Okay, well, let's add all this new information to the diagram and then we can put our heads together and figure out how we start to break it up so that you can get on with your life and enjoy being a mom to Cora.

DONNA: That would be good.

The conceptualization shown in Figure 3.5 suggests many areas for further investigation. Donna's image of herself in the orange jumpsuit conveys powerful meanings about her view of self and encapsulates feelings of worthlessness, shame, and guilt. As well as understanding self-perception's maintaining role, it would be helpful to explore its origins. Has her upbringing produced a highly dichotomized view of self as either "good" or "bad"? Have her parents' religious beliefs and strict moral code led her to strive for an unattainable ideal self that she has constantly failed to achieve? Are there specific autobiographical memories that feed this view of self? In this example, negative, dysfunctional views of self feed into a secondary cycle in which Donna's best efforts to be a good mother render her vulnerable to intrusive thoughts about harming Cora. This provides her with

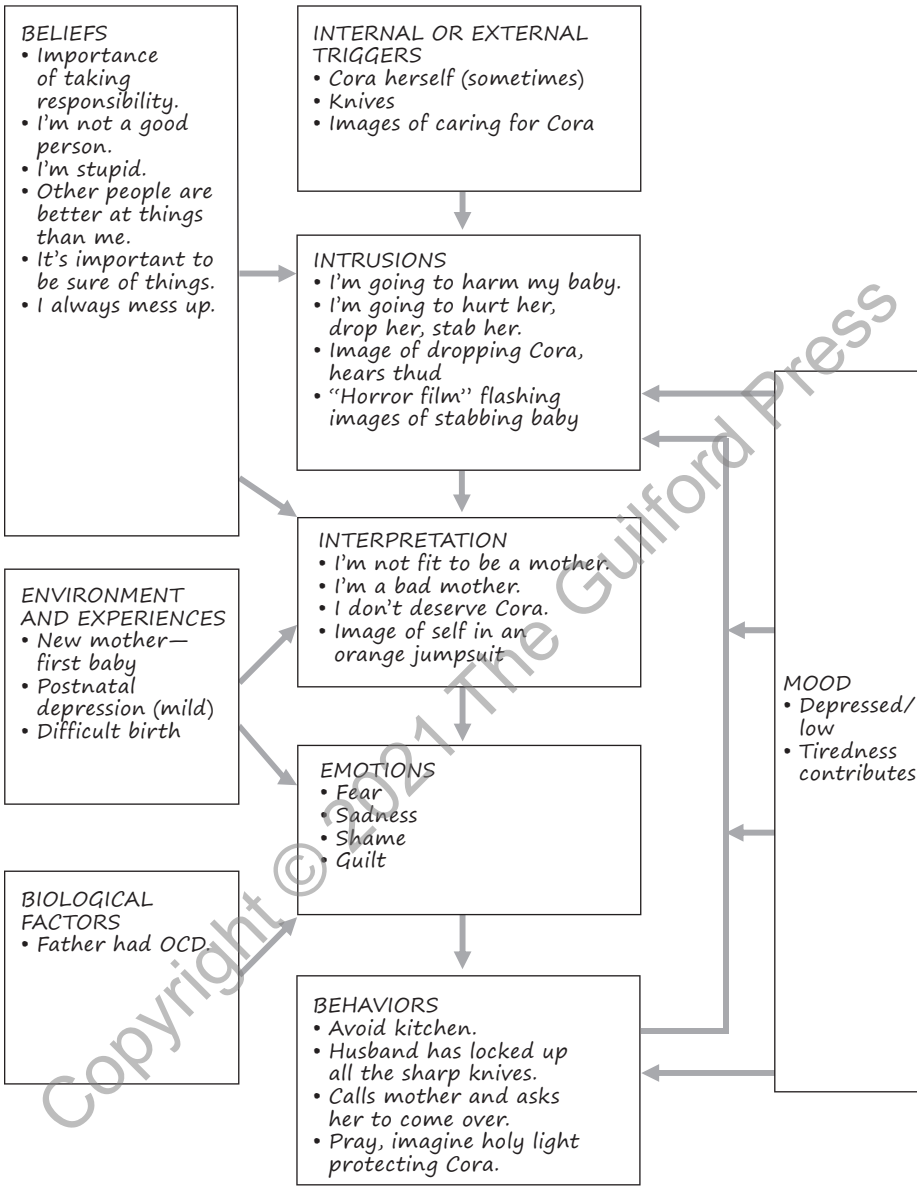

FIGURE 3.5. Case conceptualization of Donna's obsessive–compulsive symptoms. Based on Steketee and Barlow (2002).

evidence that she is constantly failing to reach her aspirations. Intervention may include psychoeducation, exposure plus response prevention directly targeting the intrusive thoughts and images, and possibly imagery rescripting of early memories. The therapist will probably have to spend some time helping Donna to develop a more robust sense of self to break the secondary maintenance cycle. Donna provides a nice link to conceptualizations that focus explicitly on the role of past experiences in the formation of beliefs and assumptions.

Images in Longitudinal Case Conceptualizations

Focusing on a specific situation is often the most effective way to develop an accurate conceptualization. This is because the client is more likely to provide specific rather than generic information ("I worry about what people think," "I always feel low when I imagine her"). Cross-sectional conceptualizations provide information about the client's problems in the present, although, as we have seen, some incorporate components of relevant information from the past. By comparison, longitudinal formulations start from the premise that it is helpful to understand links between past and present from the outset—both for the client and for the therapist. Beck and colleagues' book *Cognitive Therapy of Depression* (1979), which initiated the cognitive therapy revolution, provides the template for this approach. Cross-sectional and longitudinal conceptualizations are not mutually exclusive, and in practice can complement each other. In Donna's case, information on her beliefs about responsibility and the rigidity of her parents' moral code helps us to understand some of the processes driving her OCD, such as the way she responds to the intrusive thoughts and images.

In longitudinal formulations, information about current maintenance factors sometimes lacks sufficient detail or discriminatory power. However, in the third edition of *Cognitive Behavior Therapy: Basics and Beyond*, Judith Beck (2020) describes her own version of the (traditional) cognitive conceptualization that incorporates relevant childhood data along with core beliefs and assumptions, as well as compensatory strategies—for example, driving oneself to work extremely hard to "compensate" for the core belief "I'm not good enough." The current maintaining cycles are represented by separate threads comprising the situation, the automatic thought, and the meaning of the automatic thought followed by the emotion and the behavior. This template for conceptualization is extremely useful because it allows the therapist to represent different emotions—for example, many depressed people also experience anxiety and agitation that are maintained by factors separate from those contributing to depression. It also provides an

opportunity to contrast instances of the same mood states so that clients can start to discover meanings or themes that underpin their distress.

The longitudinal model provides the scope for a set of hypotheses about potential vulnerability factors that may contribute to relapse in the future, so working on these may help to reduce the risk of relapse. Longitudinal conceptualizations are rooted in autobiographical memory and the development of the self, and therefore provide plenty of scope for incorporating images that embody these relationships. We can illustrate this with Mary, who is the head of an accounts department in a large multinational company. She has experienced several episodes of depression and even when she is not depressed, she struggles with dysphoric mood. Mary was academically successful and gained a promotion quickly when she joined the company. She knows that she is good at her job and that she is extremely knowledgeable, but she is terrified of making a mistake or doing something wrong, so she spends excessive amounts of time checking her work.

Mary frequently feels threatened by the other senior managers, most of whom are men. She is hypersensitive to criticism and spends a long time ruminating over any comment that she perceives as a criticism. She said that she never knows how to respond when this happens, and she is either too passive or too aggressive. Both ways of responding trigger Mary's self-critical thoughts and she frequently tells herself that she is "stupid" or that she "doesn't know how to behave" and that there is something "wrong" with her. This leads to drops in mood and can trigger an episode of depression.

Mary is married to a supportive husband and they are considering having a family. She described her own parents as "wanting the best for her," but not being very affectionate. Although she won many prizes at school, she always felt she was expected to do better. Her father was a critical man, who never had a good word to say about anybody. Her mother was concerned with appearances and with making a good impression. However hard she tried to please her mother, Mary felt she was always falling short. Similar to Sarah in Chapter 1, Mary "heard" her self-critical thoughts being spoken in her father's voice. The more she tuned into this, the more she became aware that there was a persistent running commentary based around her being "stupid, useless, bad at her job," and so on. Mary realized she had internalized the endless diatribe and invective that her father had directed at the world, as well as more specific criticisms that he had made of her.

Mary also described a visual image of herself siting alone in her bedroom after she had received her exam results when she was 16 years old. Despite Mary getting A's in every subject, Mary's mother had not praised her or acknowledged how well she had done. Instead, Mary remembers her mother telling her that her hair looked like a mess and to go and tidy it up

before they went out. Mary recalls sitting in her bedroom choking back sobs and feeling utterly alone and stupid for having expected anything different from her mother. She can remember a bitter taste in her mouth as if she had been sick, even though she had not vomited. When she is criticized at work, she reexperiences this visual image, and if she feels really bad, she sometimes gets the taste of bile in her mouth. Figure 3.6 shows a longitudinal conceptualization of Mary's difficulties. This differs from the standard cognitive therapy conceptualization described above in that it uses two vicious circles at the bottom of the diagram to illustrate the contrasting pathways to low mood in one cycle and to anxiety and agitation in the other.

The longitudinal conceptualization summarizes Mary's experiences with her parents of never feeling good enough that led to her beliefs about being a "failure" and being "stupid." These beliefs are also represented visually in the image that Mary has of herself in her bedroom after her mother's response to her exam results. This image sums up the feeling Mary has of never being good enough in whatever she does, but also drives the strategy of working harder and harder in the hope that eventually she will win her parents' approval and love. The conceptualization also includes two maintenance cycles, one of which illustrates how Mary becomes anxious and agitated. In this example, the trigger is a catastrophic image of making a mistake. Mary sees herself at a tribunal investigating fraudulent practice. This initial image triggers a further series of catastrophic images representing the consequences of the tribunal (e.g., dismissal from her job, shame, breakdown of her marriage). The whole cycle then confirms her core belief that she is a failure and feeds into the second maintenance cycle in which she attacks and criticizes herself. In the second cycle, Mary hears the criticisms and attack on herself in her father's voice—in other words, she experiences an auditory image that constantly replays her self-critical thoughts, leading to depression, despair, and hopelessness that leads in turn to social and emotional withdrawal.

From Conceptualization to Treatment Planning

The examples above show how images play an important role in maintaining distress and in confirming negative, dysfunctional beliefs about the self. Traditional cognitive therapy techniques, such as thought challenging, can produce changes in image frequency, probably through changing the meanings associated with the images. However, verbal interventions do not always have a significant impact on meanings embodied by images and in some cases, it is simply more efficient to work directly with the image from the start. For many clients, however, a course of treatment is likely to

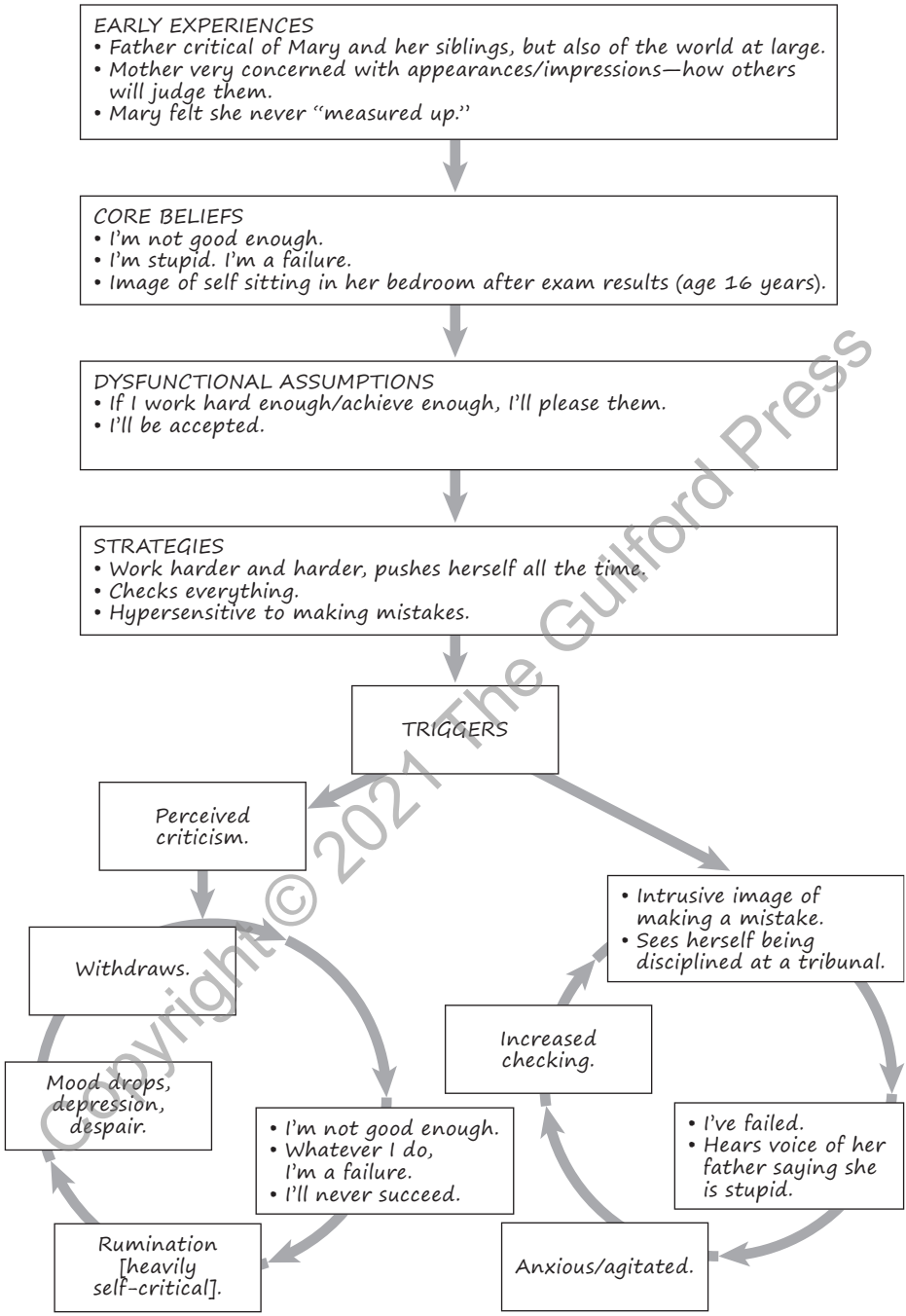

FIGURE 3.6. Incorporating imagery in a longitudinal case conceptualization (Mary).

combine the more familiar established cognitive therapy techniques with one or more of the imagery interventions described in subsequent chapters.

In Mary's case, using evidence-based cognitive therapy for depression (e.g., NICE, 2009, 2018) would involve starting treatment with behavioral activation to improve mood before challenging negative automatic thoughts. Even if she successfully challenges her negative thoughts, Mary may still experience the common problem of realizing intellectually that she is not "stupid" but still "feeling stupid." Behavioral experiments can go some way to shifting the emotional component of the belief (Bennett-Levy et al., 2004). However, tackling images and the associated autobiographical memories that have shaped Mary's view of herself might also be necessary.

The combination of cognitive reappraisal techniques, such as thought challenging, behavioral experiments, and specific imagery techniques, offers powerful interventions to tackle enduring negative beliefs about the self. Negative rumination is ubiquitous in depression and other forms of perseverative thinking—worry and post-event processing all significantly contribute to distress. In Mary's case, knowing that she hears her self-critical thoughts in her father's voice offers an important additional target for intervention: changing the form of the image (e.g., reducing the volume or turning her father into a cartoon character with a high squeaky voice), or using imagery rescripting to alter the meanings drawn from some of her early memories. Working with images helps us to think about both content (e.g., Mary seeing herself in her bedroom) and the form in which images present themselves. Both offer potential targets for intervention to help people understand and recover from their distress.

Summary

This chapter illustrated various ways to incorporate imagery into case conceptualizations, starting with the simplest descriptive conceptualizations and moving through cross-sectional to longitudinal conceptualizations. Whatever the type, the function of conceptualization is the same: to help both client and therapist to make sense of the client's problems and plan the most effective intervention.

The following chapters provide detailed accounts of imagery intervention techniques and start by looking at some imagery exercises that therapists can use to prepare clients for using imagery or to achieve goals, such as creating a sense of safety.