

Imagery Rescripting of Early Traumatic Memories in Social Phobia

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Negative self-images appear to play a role in the maintenance of social phobia and research suggests they are often linked to earlier memories of socially traumatic events. Imagery rescripting is a clinical intervention that aims to update such unpleasant or traumatic memories, and is increasingly being incorporated in cognitive behavioral therapy programs. In previous research, we have found that imagery rescripting was superior to a control condition in terms of its beneficial effects on negative beliefs, image and memory distress, fear of negative evaluation, and anxiety in social situations. In this article, we describe our imagery rescripting procedure. We consider the importance of updating negative imagery in social phobia, the theoretical basis for imagery rescripting, directions for future research, and how to conduct imagery rescripting, including potential problems and their solutions.

IN social situations, patients with social phobia often experience distorted, negative images or impressions of how they fear they will come across to other people (i.e., Hackmann, Clark, & McManus, 2000; Hackmann, Surawy, & Clark, 1998). Research has reported that the negative images/impressions are often linked in meaning and content to early socially traumatic (embarrassing/humiliating) events clustered around the onset of the disorder (Hackmann et al., 2000). In the treatment of social phobia, it is necessary to update these negative images because they maintain social anxiety. They cause patients to feel more anxious and to perform less well than when they hold benign imagery in mind (e.g., Hirsch, Clark, Mathews, & Williams, 2003). Further, the negative imagery prevents patients from disconfirming their social fears, which can include, for example, a fear of running out of things to say or of blushing, of people noticing and then concluding that they are inadequate or incompetent.

Negative imagery appears to maintain social fears for a number of reasons. First, patients believe their negative self-images are a true reflection of how they come across to other people. They therefore think they come across much worse than they actually do, which reinforces rather than disconfirms their perception of performing inadequately. Second, negative imagery motivates patients to use safety-seeking behaviors, which can interfere with

their social performance and make them appear less interested in other people than they really are (Alden & Taylor, 2004; Clark & Wells, 1995; Hirsch, Meynen, & Clark, 2004; Rapee & Heimberg, 1997). Third, negative self-imagery blocks positive interpretation bias (Hirsch, Mathews, Clark, Williams, & Morrison, 2003). This means when faced with an ambiguous social cue, such as a smile from a conversational partner, patients with social phobia are unlikely to make a positive interpretation about the smile and so miss opportunities to benefit from the very feedback that could help them to reevaluate their fears and reduce their anxiety. Fourth, negative imagery facilitates selective retrieval of negative memories (Stopa & Jenkins, 2007) and there is evidence that judgments about the future probability of an event are influenced by the accessibility in memory of past instances (Tversky & Kahneman, 1974).

Several cognitive behavioral therapy (CBT) programs for social phobia include present-focused techniques to correct distorted self-images, such as videofeedback, surveys, and behavioral experiments. These techniques are employed almost immediately in cognitive therapy for social phobia (Clark, 1999) because of the pivotal role negative imagery has in maintaining patients' social fears, avoidance, and anxiety. Given that the images are often linked in meaning and content to distressing memories, it also makes sense to treat the origins of the images, particularly if patients continue to experience negative imagery following intervention with these present-focused techniques.

Imagery rescripting describes a set of related therapeutic procedures that focus on changing unpleasant memories (Stopa, 2009). The procedure is also known as imagery with rescripting (e.g., Arntz & Weertman, 1999),

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and throughout this paper, we use these terms interchangeably. Imagery rescripting techniques have been used as major components of CBT programs for borderline personality disorder (Giesen-Bloo et al., 2006), bulimia (Cooper, Todd, & Turner, 2007), and posttraumatic stress disorder arising from childhood sexual abuse (Smucker & Neiderdee, 1995). Turning to social phobia, Clark and colleagues have recently incorporated imagery rescripting techniques into their cognitive therapy program, particularly for patients who have made only modest improvements with present-focused techniques. A recent trial (Clark et al., 2006) found that this integrated cognitive therapy program was superior to exposure therapy, and the authors speculated that the overall beneficial effects of cognitive therapy for social phobia were partly due to the use of imagery rescripting. To formally test the role of imagery rescripting per se, Wild, Hackmann, and Clark (2007, 2008) conducted two studies that assessed the effects of imagery rescripting alone in unselected populations of patients with social phobia. Wild et al. (2007) reported pre- and post-rescripting results in 14 patients with social phobia with whom they developed the approach. Imagery rescripting alone was associated with significant improvements in patients' negative social beliefs, the vividness and distress of their image and early memory, and in self-report measures of social anxiety. Wild et al. (2008) then compared a session of imagery rescripting with a control session in which images and memories were explored without being updated. Measures were taken before each session and 1 week later. The imagery rescripting session was associated with significantly greater improvement in negative beliefs, image and memory distress and vividness, fear of negative evaluation, and anxiety in feared social situations.

In this paper we describe in detail our procedure of imagery rescripting for social phobia, which includes a cognitive restructuring component, and which demonstrated effectiveness in Wild et al. (2007, 2008). We first present the theoretical basis for the technique, then a description of how to conduct it, followed by clinical examples, how to address potential problems, and directions for future research.

Theoretical Basis

The theoretical basis for employing imagery rescripting in the treatment of patients with social phobia lies in the link between their recurrent imagery in the present and their past socially traumatic events. We define a socially traumatic event to be an extremely unpleasant social event in which the individual experiences intense anxiety and perceives concurrent ridicule or rejection by others, such as being bullied at school, performing poorly in a meeting at work, and believing that colleagues or peers are silently

ridiculing the individual, or being humiliated for exhibiting signs of anxiety, for example. These events go beyond feeling as though a social performance situation has gone badly and include perceptions of humiliation, ridicule, intense criticism, or rejection.

Hackmann et al. (2000) reported that recurrent imagery and past socially traumatic events were often linked in theme and content. In fact, the recurrent images tend to be visualizations of aspects of memories for past socially traumatic events. That is, the images are derived from past memories. These images appear to be triggered in different social situations by cues that match the original event in some way. Like intrusive images in posttraumatic stress disorder (PTSD), images in social phobia heighten anxiety and remind the patient of past danger. The patient approaches current social situations as if the contingencies that appeared in the past event are still relevant, typically expecting people to respond to them in the same way as they did in their memory of the socially traumatic event. Just as the memory images have similar cues to the past event, they also carry a similar meaning to the original memory, an "encapsulated belief" that captures the meaning of both (Wild et al., 2008).

Wild et al. (2007, 2008) reported that sometimes patients recalled catastrophic outcomes linked to their earlier memory that may not have happened in the way they had thought. This was discovered when patients relived their earlier event with the therapist as part of the imagery rescripting session. For example, one patient had a recurrent image of looking as though he was curled up in a shell, frightened, and incapable. This linked to a memory of when he was 16 years old in sixth form (i.e., Grade 11):

A group of children upon seeing the patient in the canteen said, "Hey, there's Katy's brother. They don't look related." The patient blushed, felt frightened and diminished. His sister was popular and outgoing. When he heard the comment, "They don't look related," he interpreted this as meaning that he had failed to meet their expectations and they were rejecting him. Thinking this, he quickly left the canteen. However, there was no clear evidence at the time that he was being rejected and there were many other instances when he had good, protracted interactions with these children. Nevertheless, his encapsulated belief captured the essence of social rejection: "I'm odd and a failure, incapable, and less than what people expect. People will see I am less than expected, and reject me."

For other patients, the early rejection did occur but they are no longer rejected in a similar manner as adults. However, their encapsulated belief retains the much

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