

Working With Imagery to Modify Core Beliefs in People With Eating Disorders: A Clinical Protocol

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Imagery is a relatively novel area of interest in eating disorders (EDs). Clinical experience and some research work indicate that rescripting of early memories may be a useful way to modify core beliefs in EDs. Relevant constructs, as applied in the current paper, are defined and described, including core beliefs, imagery rescripting, and early memories. Existing empirical research on the outcome of imagery rescripting of early memories is outlined, including in EDs. Relevant ED research on images and early memories in EDs is presented. A case is made for applying imagery rescripting to early memories in EDs. The origins and development of a clinical protocol are described. The aim of the protocol is to identify and rescript or modify early memories associated with the core beliefs characteristic of EDs. This process has also been applied in other disorders. Clinical examples illustrate the application of the protocol in EDs, including extracts of dialogue from a clinical case. The paper covers indications for use of the protocol, practical and ethical considerations, its suitability in individual cases, and some final practical tips. These include examples of useful questions to ask patients that facilitate successful rescripting of memories, and thus core belief modification. The paper concludes with some thoughts on future work.

SOME preliminary attention has been paid to the use of imagery in relation to core beliefs¹ in people with eating disorders (EDs; Cooper, Todd, & Turner, 2007; Mountford & Waller, 2006; Ohanian, 2002). Despite this, relatively little has yet been written on the topic. The current paper is concerned with the use of imagery rescripting of early memories in people with EDs. This approach, unlike that of Mountford and Waller, has the explicit aim of modifying the core beliefs of those with EDs. This article will begin with a short summary of ED outcome to set the scene. This will highlight the need for novel approaches to treatment in EDs. A brief overview of the advantages of using imagery strategies, versus more traditional verbal strategies, will be provided. What is meant by imagery rescripting (as well as imagery and early memories), and the effectiveness of imagery rescripting,

in eating and other disorders will be discussed. Particular attention will be given to definitions used in the current paper. Relative to EDs, a much larger literature exists in other disorders. Reference to definitions and outcome in other disorders will, therefore, help contextualize those used here in EDs. With a similar aim, research on relevant constructs (core beliefs, imagery, early memories, and images of early memories) in EDs will then be discussed. A rationale for imagery rescripting of early memories in EDs will be briefly presented. This will be followed by some initial thoughts on how imagery rescripting might work theoretically (in relation to cognitive theory), including in eating, and other disorders. Given that relatively little has been written on exactly how to carry out imagery rescripting in people with EDs, the majority of the paper will then describe a practical protocol. This will describe how to modify core beliefs in EDs, using the technique of imagery rescripting. This involves working with early memories. The methodology is based on that termed “imagery rescripting” by other researchers and clinicians (e.g. Edwards, 2007). It will focus on the rescripting of early childhood memories identified as being associated with patients' core beliefs, as described, for example, by Arntz and Weertman (1999). A similar protocol has previously been described as part of a comprehensive, integrated metacognitive and cognitive therapy treatment for bulimia nervosa (BN) and binge eating (Cooper, Todd, & Wells, 2009). The current description and protocol, however, is designed to be a stand-alone strategy. As such, it might potentially be

¹ *Core beliefs* (a term often used synonymously with negative self-beliefs, schema, or early maladaptive schema) is typically taken to refer to beliefs about the self that develop early in life, and that are central to the individual's core psychopathology. These beliefs are inflexible, persistent, applied across a wide range of situations in the individual's life, and resistant to change. There are technical differences in their respective definitions (see Beck, Freeman, & Associates, 1990). For example, core beliefs about others and the world have also been identified (see Padesky, 1994). In the current paper, the terms will be used synonymously, as is usual in clinical practice, with the preferred term being *core beliefs*.

integrated with a range of different treatment approaches. Detailed clinical material, taken from the author's experience with patients with EDs, will be used to illustrate the application of the protocol. Information on expected response and outcome will also be included.

EDs are often hard to treat successfully. Cognitive behavior therapy (CBT) has had some success, particularly for bulimia nervosa (BN; e.g., Agras, Walsh, Fairburn, Wilson, & Kraemer, 2000), but overall outcomes are less than optimal, especially when long-term outcome is considered (e.g., Fairburn & Harrison, 2003). Compared to BN, therapy for anorexia nervosa (AN), at least in systematic research trials, often results in poor outcome. This is true both in the short term, as well as over the longer term (e.g., Pike, Walsh, Vitousek, Wilson, & Bauer, 2003). One approach to improve outcome involves revision and elaboration of older cognitive-behavioral models of EDs (Jansen, 2001) and translation of these developments into clinical practice (e.g., Cooper, 2003; Cooper, Wells, & Todd, 2004; Cooper, Todd, Turner, & Wells, 2007; Waller et al., 2007). An important aspect of this is now often considered to be the identification of core beliefs: their role in the development and maintenance of EDs, and the application of this understanding to clinical work. An integral part of these developments is incorporation of core beliefs into an overall formulation of EDs. Here they are assigned a role either in the development of EDs (Waller et al., 2007) or one in which they also play an important maintaining function (Cooper, in press). They also play a role as one significant module to be added to transdiagnostic treatment in some cases (Fairburn, Cooper, & Shafran, 2003). To date, much core belief work in EDs has drawn on well-established strategies devised for personality disorders (e.g., Beck et al., 1990), and other long-standing difficulties (e.g., Young, 1990). Padesky (1994) provides a useful overview of how schema (or core belief) change might be achieved, and some of these methods have been adapted for EDs (e.g., Cooper, Todd, & Wells, 2000). These include historical tests of core beliefs and continuum work. Importantly, in the current context, however, all these strategies rely primarily on verbal methods. Anecdotally, clinicians have found these useful in EDs, but have also identified some important limitations (e.g., Cooper et al., 2009). In particular, while considerable change can be made in "rational" beliefs (when one considers the belief logically, or rationally), this change does not always extend to "emotional" beliefs (when one considers how one feels, irrespective of what is logically believed). As a result, patients may report that although they know logically (i.e., when they think about it rationally), that a belief about the self is no longer true, they still feel and behave, and remain convinced deep inside, that it is true. Few traditional methods of modifying core beliefs, in eating or other disorders, employ imagery-

based strategies. The potential advantages of imagery-based strategies, compared to verbal strategies, will be considered in more detail below.

In a number of disorders, attention has turned to the therapeutic use of imagery (e.g., Holmes, Arntz, & Smucker's, 2007, special issue of the *Journal of Behaviour Therapy and Experimental Psychiatry*) as a nonverbal strategy for producing change. This applies to core beliefs as well as other cognitive behavioral constructs. It has been recognized for some time that imagery may have greater power than verbal representation (for example, in facilitating some forms of learning; Paivio, Smythe, & Yuille, 1968). Singer (1974, 2006) provides a useful history of mental imagery in relation to the development of modern psychotherapy. Edwards (2007) suggests that its origins go back to Janet (1889) and use of "imagery substitution," the practice of which may involve (under hypnosis) visualization of early negative or traumatic early memories followed by their transformation into more positive images. A widely cited example from Janet (Marie) is not dissimilar in content to the current practice of imagery rescripting of early memories. Indeed, it is described as such by van der Hart and Friedman (1989). However, the theoretical mechanisms hypothesized to be responsible for change as outlined by Janet are not consistent with those that might be proposed by modern-day CBT. The role of imagery in assisting emotional change formed part of behavior therapy, notably in systematic desensitization (Wolpe, 1958). Visualization is an important technique in Gestalt therapy (Perls, 1970). However, the therapeutic use of imagery has only begun to be extensively explored in CBT.

It has been proposed that imagery, compared to verbal representation, has a special relationship to emotion. Evidence is now rapidly accumulating in support of this notion (Holmes & Mathews, 2005). For example, research has demonstrated how use of mental imagery compared to use of a verbal sentence produced a greater emotional response, even though the material being processed was the same (Holmes, Mathews, Mackintosh, & Dalgleish, 2008). A number of different applications of imagery have been described historically in CBT. Beck, Emery, and Greenberg (1985), for example, used imaginal exposure of anxious images, imagining of worst scenarios, and substitution of positive imagery for feared situations. Of particular interest here, however, is the relatively recent application of imagery rescripting to treat childhood memories (with the aim of modifying core beliefs), for example, as part of cognitive therapy for personality disorders (e.g., Arntz & Weertman, 1999).

As suggested above, imagery rescripting is not a completely new treatment strategy (Edwards, 2007). Edwards described its precursors, early origins, and subsequent integration into mainstream CBT. He noted

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