J. Behav. Ther. & Exp. Psychiat. 40 (2009) 352–358

Contents lists available at ScienceDirect

Journal of Behavior Therapy and Experimental Psychiatry

journal homepage: www.elsevier.com/locate/jbtep

Vividness of mental imagery in Posttraumatic Stress Disorder (PTSD): The role of depression

Thanos Karatzias [a,*], Kevin Power [b], Keith Brown [c], Theresa McGoldrick [c]

[a] Faculty of Health, Life & Social Sciences, Edinburgh Napier University, Comely Bank Campus, Crewe Road South, Edinburgh EH4 2LD, Scotland, UK
[b] Department of Psychology, NHS Tayside Psychological Therapies Service & University of Stirling, UK
[c] NHS Forth Valley, Behavioural Psychotherapy Service, UK

ARTICLE INFO

Article history:
Received 25 July 2008
Received in revised form 6 January 2009
Accepted 2 February 2009

Keywords:
PTSD
Mental imagery
Depression

ABSTRACT

The present study aimed to investigate demographics, trauma variables, PTSD symptomatology, co-morbid psychopathology, dissociation and personality variables as correlates of vividness of imagery (i.e. general ability to imagine objects) in people with PTSD. Participants were 98 outpatients with PTSD who completed a number of self- and assessor-rated measures. Vividness of imagery was assessed using the Betts' Questionnaire Upon Imagery (QMI). Regression analysis showed that the only statistically significant predictor of mental imagery was depression, as measured by the Montgomery Asberg Depression Rating Scale (MADRS). The implications of these results for the management of depression in people with PTSD are discussed.

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1. Introduction

"Imagery encompasses memories and dreams as well as spontaneously triggered and deliberately self-generated images" (Hackmann & Holmes, 2004). The clinical phenomena of Posttraumatic Stress Disorder (PTSD) involve re-experience of trauma often through intrusive images (APA, 1994). Therefore, mental imagery is at the core of this condition. Intrusive mental images in PTSD are unintentionally retrieved meaningful fragments of the traumatic memory. They lack contextual information, such as time, and they incorporate threatening meanings to the physical integrity or the sense of self

* Corresponding author. Tel.: +44 131 455 5345.
E-mail address: t.karatzias@napier.ac.uk (T. Karatzias).

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doi:10.1016/j.jbtep.2009.02.002

(Hackmann & Holmes, 2004). However, a small number of images may not be accurate representations of the traumatic events and the content of such images is greatly influenced by past experiences (Holmes, Grey, & Young, 2005). Generally speaking, it can be challenging to treat traumatic mental images in people with PTSD and there is evidence to suggest that traumatic intrusive images could still be automatically triggered post-intervention (Hackmann, Ehlers, Speckens, & Clark, 2004). There is also evidence to suggest that cognitive capacity to control mental images can influence physiological responses (Laor et al., 1998) and emotional regulation in people with PTSD (Laor et al., 1999).

Mental imagery techniques are frequently used in the treatment of psychological trauma (e.g. Gilbert & Irons, 2005). In Imaginal Exposure (IE), for example, patients are asked to recall the details of the traumatic event while at the same time focusing their attention on feelings, thoughts, and emotions. Exposure to such memories may result in reduction of fear and avoidance, which are common characteristics in all anxiety disorders (Foa et al., 1999), including PTSD. Intrusive images in PTSD tend to be re-experienced in the same way as they were experienced peri-traumatically, despite contradiction of original appraisals by later evidence (Ehlers & Clark, 2000). Cognitive restructuring or image rescripting during reliving therapy are used to help patients acquire a more up-dated and accurate account of the traumatic events (e.g. Ehlers, Clark, Hackmann, McManus, & Fennell, 2005). There is evidence to suggest that intrusive images peak at the very time when a coherent and structured narrative of the traumatic events is about to emerge (van der Kolk & Fisler, 1995). Psychological therapy for PTSD may also involve work on the meanings attached to traumatic events, a notion first introduced by A.T. Beck, the founder of cognitive therapy. Meanings attached to the events could be accessed through mental images as well as memories, dreams and verbal thoughts (Beck, 1976). Thus, imagery techniques are important in accessing and transforming the meaning behind traumatic memories (Hackmann, 1998), particularly those associated with child sexual abuse (Smucker, Dancu, Foa, & Niederee, 1995). Smucker and Dancu (2005) describe the three phases of imaginal rescripting used in the treatment of PTSD following childhood sexual abuse. In phase 1, the patient is re-experiencing the traumatic event from the child's perspective through imaginal exposure. In the second phase, patients are invited to imagine themselves entering the abuse scene and viewing the abuse from an adult's perspective. In so doing, they intervene to confront the perpetrator and rescue the child. The purpose of this stage is to replace victimisation imagery with mastery/coping imagery. In the third phase, patients are asked to imagine themselves as nurturing, calming, and reassuring the child after the abuse has occurred (i.e. compassionate imagery).

"Vividness" of imagery has been described as "the cornerstone topic in the study of mental imagery" (Hackmann & Holmes, 2004), although relatively little is known about the topic. Generic research on imagery mostly derives from cognitive psychology and addresses areas such as the nature of mental representation (Kosslyn, 1994), rather than the experience of mental images (Bywaters, Andrade, & Turpin, 2004). Very little is also known on the correlates of vividness of mental imagery, particularly in clinical populations, including PTSD. Cornoldi, de Beni, and Cavedon (1992) have concluded that the vividness of imagery is determined by characteristics of the image such as shape, colour, detail, context and generality. It has also been shown that self-rated image vividness is associated with general performance on cognitive and perceptual tasks (McKelvie, 1995). Baddeley and Andrade (2000) have shown that vividness of imagery requires visuo-spatial working memory resources for the maintenance and manipulation of visual memory, which originate from long-term memory. Finally, Bywaters et al. (2004) have shown that low mood is associated with enhanced vividness imagery.

In this study, we set out to investigate demographics, trauma variables, PTSD symptomatology, comorbid psychopathology, dissociation and personality variables as correlates of vividness of mental imagery in people with PTSD.

2. Method

2.1. Participants & procedure

Participants in this study were 98 individuals with PTSD. They were outpatient referrals in a waiting list of an NHS psychological trauma clinic in Scotland. They were considered suitable for study

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