Available online at www.sciencedirect.com
ScienceDirect
Journal of Behavior Therapy and Experimental Psychiatry 38 (2007) 297–305
JOURNAL OF behavior therapy and experimental psychiatry
www.elsevier.com/locate/jbtep

Imagery rescripting in cognitive behaviour therapy: Images, treatment techniques and outcomes

Emily A. Holmes[a,*,1], Arnoud Arntz[b], Mervin R. Smucker[c]

[a]*Department of Psychiatry, University of Oxford, Warneford Hospital, Oxford OX3 7JX, UK*
[b]*Department of Clinical Psychological Science, University of Maastricht, The Netherlands*
[c]*Department of Psychiatry, Medical College of Wisconsin, USA*

Abstract

Although imagery rescripting has long been part of cognitive behaviour therapy (CBT), recent years have seen a growing interest in the use of imagery rescripting interventions in CBT, especially with patients who struggle with distressing, intrusive imagery. This growth in the clinical applications of imagery has led to the creation of the current special issue of collected papers on imagery rescripting, which is designed to: (a) present research and clinical applications of imagery rescripting techniques to problematic mental imagery, (b) consider problematic imagery across a wide range of psychological disorders that might be a target for imagery rescripting (including novel areas such as mental contamination, bulimia and suicidality), (c) explore a variety of imagery rescripting techniques in the treatment of PTSD, as well as depression, social phobia, and snake phobia, and (d) stimulate interest for future treatment innovation in the use of imagery rescripting techniques to address other clinical disorders. The aim of this editorial is to summarise the collected papers presented and the links between them. A working definition of two types of imagery rescripting is provided, along with a heuristic framework for conceptualising the range of imagery techniques in cognitive therapy.

Keywords: Mental imagery; Imagery rescripting; Intrusion; PTSD; Depression; Suicide

*Corresponding author.
E-mail address: emily.holmes@psych.ox.ac.uk (E.A. Holmes).
[1]Emily A Holmes was supported by a Royal Society Dorothy Hodgkin Fellowship award and by a grant from the John Fell OUP Research Fund.

0005-7916/$ - see front matter © 2007 Elsevier Ltd. All rights reserved.
doi:10.1016/j.jbtep.2007.10.007

Although the use of imagery as a therapeutic strategy in treating affectively distressed patients has been advocated by clinicians across a variety of theoretical orientations, mental imagery is becoming one of the "hot topics" in modern cognitive behaviour therapy (CBT). Imagery interventions in CBT are based on the premise that mental imagery has a powerful impact on emotion, and that mental imagery in a clinical setting can be a powerful psychotherapeutic tool for alleviating emotional distress.

Since its inception, cognitive therapy has emphasised the role of mental imagery (Beck, 1976). Contending that mental activity may take the form of words and phrases (verbal cognitions) or images (visual cognitions), Beck observed that affective distress can be directly linked to visual cognitions—as well as to verbal cognitions—and that modifying upsetting visual cognitions can lead to significant cognitive and emotional shifts (Beck, Emery, & Greenberg, 1985). Similarly, in his work with traumatic memories, Smucker (1997) noted that since much of the cognitive-affective disturbance associated with intrusive trauma-related memories is embedded in the traumatic images themselves, directly challenging and modifying the traumatic imagery becomes a powerful, if not preferred, means of processing the traumatic material. Other CBT clinicians and researchers have likewise found that intrusive, affect-laden images can cause significant distress across psychological disorders, including post-traumatic stress disorder and depression (see Hackmann & Holmes, 2004; Hirsch & Holmes, 2007 for reviews). Kosslyn, Ganis, and Thompson (2001) further observed that while mental images often take a visual form, they may include other sensory modalities as well, such as auditory, olfactory, and kinaesthetic.

Imagery rescripting interventions have long been part of CBT, and psychotherapy more broadly (Edwards, 2007, this volume). The earliest known form of imagery rescripting appears to have been employed in the latter part of the 19th century by Pierre Janet (1919), a prominent French physician, who used a procedure called "imagery substitution" (i.e., replacing one image with another) with hysterical patients (see Van Der Kolk & Van Der Hart, 1989, for a more detailed description of Janet's work). In the late 20th and early 21st centuries, there has been a renewed interest in the use of imagery rescripting with traumatic memories, which includes the seminal work of Arntz and Weertman (Arntz & Weertman, 1999; Weertman & Arntz, 2007) and Smucker and colleagues (Rusch, Grunert, Mendelsohn, & Smucker, 2000; Smucker & Dancu, 1999/2005; Smucker, Dancu, Foa, & Niederee, 1995; Smucker & Niederee, 1995). Yet, in spite of this recent burgeoning of interest in intrusive imagery, little research has directly addressed the relationship between mental imagery and emotions. With the growing use of mental imagery by cognitive-oriented clinicians, it is especially important to consider the theoretical rationale and cognitive science supporting the clinical use of imagery as well as its relevance for CBT.

The current special issue—"Imagery Rescripting in Cognitive Behavior Therapy: Images, Treatment Techniques and Outcomes"—presents research and clinical applications related to imagery rescripting techniques, and offers a theoretical rationale for its use. The Imagery Rescripting (IR) techniques addressed are those in which either (1) a pre-existing negative mental image (IR "Type A") is transformed into a more benign image (i.e., negative image to positive image rescripting), or (2) a new positive image (IR "Type B") is constructed afresh to capture those positive meanings needed to counteract the key psychological concerns for a patient (i.e., using a fresh positive image to rescript negative schematic beliefs). In the latter case, there need not be an underlying negative image that is repeatedly troubling the patient.