AN EXPLORATORY STUDY OF TRAINEE THERAPISTS' EXPERIENCES OF MENTAL IMAGERY IN THERAPY

Danielle Warrington

A thesis submitted in partial fulfilment of the requirements for the degree of

Doctor of Clinical Psychology, the University of Auckland, 2020

Abstract

The consideration and utilisation of imagery in therapy has a vast and rich history and has contributed to the development of psychodynamic, humanistic, and cognitive behavioural therapy traditions. Experimental research has substantiated the importance of imagery in therapy, with findings that suggest imagery has a strong relationship with both memory and emotion, has a greater effect on emotions than verbal processing does, and plays a role in information processing. Yet the psychotherapeutic literature has focused mainly on clients' experiences of imagery in therapy and how imagery can be used as a therapeutic tool, with little consideration of therapists' experiences. The existing research on therapists' imagery, albeit limited, suggests that therapists commonly experience imagery in therapy, and these experiences can inform, enrich, and transform therapeutic processes. However, they can also be challenging and disruptive to therapeutic processes and there is minimal research and training in this area.

This thesis investigated trainee therapists' experiences of imagery when working with clients in therapy: the ways in which they understood these experiences; the impact that these experiences had on the trainee therapists or on the therapeutic processes if any; and the trainee therapists' learning needs in this regard. The investigation involved two studies. The first study involved the collection of quantitative and qualitative data through an online self-report questionnaire that 37 trainee therapists completed. The second study involved follow-up semi-structured interviews with 15 of these trainee therapists and an additional two trainee therapists. Data analysis took a qualitatively driven mixed methods approach, and a method of thematic analysis was used to analyse the qualitative data.

The majority of the trainee therapists reported experiencing imagery. However, many expressed confusion about imagery and their own experience of it. After reflecting on their imagery as part of their participation in this study, they reported finding it helpful in therapy.

They conceptualised their imagery as a way to process client material and gain insight into their clients, develop empathy and connection with clients, and gain insight into their own personal experiences in therapy. Some also reported experiencing problematic intrusive imagery that was difficult to manage and disruptive in therapy. For most, imagery was not addressed in their training and they reported experiencing the interview as a beneficial reflective process. Overall, this thesis study highlights that trainee therapists value their imagery although it can also be a source of difficulty and therapeutic disruption, which is largely unaddressed in training. This understanding contributes to the existing body of research on imagery in therapy and has important implications for the training and supervision of trainee therapists.

Acknowledgements

How can I thank those who have come alongside me and without whom this thesis would not have been possible? Words fall short when I try to express my gratitude. Firstly, I would like to acknowledge and thank those who participated in this thesis study for taking the time to share their personal experiences with me in the midst of the demands of their training. I would like to thank my supervisor Associate Professor Claire Cartwright for her dedication, consistent support, encouragement, expertise, and guidance. I would like to thank my classmates who I had the privilege to journey with through the training. I would like to thank my friends for their love and understanding while I've been immersed in my training and research. I would like to thank my family for their love, practical support, and light relief. Finally, I would like to thank my husband Marc for cheering me on with good humour and forbearance.

Contents

Chapter One: Introduction **1**

Overview of This Study 1

Definition of Imagery 3

Imagery Modalities 4

Historical Background 5

Empirical Research on the Nature, Function, and Impact of Imagery 8

Individual Differences 8

Imagery and Emotion 10

Imagery and Cognition 14

Imagery and Empathy 18

Imagery and Vicarious Trauma 20

Therapeutic Perspectives on Client Imagery 23

Psychodynamic Approaches to Working With Client Imagery 23

Humanistic Approaches to Working With Client Imagery 27

Cognitive and Behavioural Approaches to Working With Client Imagery 28

Contemporary CBT Approaches to Working With Client Imagery 34

Therapist Imagery in Therapy 37

Imagery Arising From What is Articulated 37

Imagery Arising From What is Not Articulated 38

The Use of Therapist Imagery For Transformation 41

Empirical Research on Therapist Imagery 42

Rationale for This Study 47

Chapter Two: Methodology **49**

Situating This Study 50

Theoretical Framework 51

Qualitatively Driven Mixed Methods Research Approach 52

Definition and Characteristics 52

Rationale 52

Trustworthiness of the Research 53

Personal Reflection 55

Chapter 3: Methods **57**

Overview of Mixed Methods Research Design 57
Recruitment 58
Participants 58
Data Collection 59
Phase 1: Questionnaire 59
Phase 2: Interviews 61
Data Analysis 62
Phase 1: Questionnaire 62
Phase 2: Interviews 66
Chapter Four: Results 68
Quantitative Analysis Findings 68
Experience of Imagery 68
Types of Imagery 68
Perceived Frequency and Vividness of Imagery 69
Imagery Experiences When Working Therapeutically 69
Correlations 71
Qualitative Analysis Findings 74
Experiences of Trainee Therapists Who Reported Not Experiencing Imagery 74
Thematic Analysis of Trainees' Experiences and Conceptualisations of Imagery 75
Theme One: Understanding the Client 77
Theme Two: Empathy and Connection 83
Theme Three: Understanding Oneself or Therapy Processes 87
Theme Four: Challenging Imagery 90
Thematic Analysis of Trainee Therapists' Learning Needs 94
Theme One: Acknowledgement in Training 95
Theme Two: Developing an Understanding of Therapist Imagery 96
Theme Three: Developing Awareness and Ability to Reflect on Imagery 96
Theme Four: Learning How to Manage Imagery 97
Theme Five: Learning How to Use Imagery 97
Chapter Five: Discussion 99
Overview 99
Trainee Therapists' Experiences of Imagery 99
Types of Imagery Experienced 99
Frequency and Vividness of Imagery 100

Factors Influencing Trainee Therapists' Imagery 101
The Impact of Trainee Therapists' Imagery 102
Confusion About Imagery 102
Lack of Training and Research on Therapist Imagery 103
Trainee Therapists' Conceptual Understanding 105
Conceptualisation of Therapist Imagery as a Form of Cognition 105
The Facilitative Role of Therapist Imagery as a Form of Cognition 106
Imagery and Countertransference 108
Conceptualisation of Imagery as an Element of Empathy 110
Empathy-Based Stress and Vicarious Trauma 112
Challenges With Trainee Therapists' Interpretations 114
Trainee Therapists Desired to Learn More About Therapist Imagery 116
Clinical and Training Implications 117
Limitations of This Study 118
Further Research 119
Summary of Findings and Conclusions 120
Appendices 122
Appendix A: Advertisement 122
Appendix B: Participant Information Sheet 123
Appendix C: Questionnaire 125
Appendix D: Consent Form 127
Appendix E: Interview Schedule 128
Appendix F: Transcriber Confidentiality Agreement 130
Appendix G: Ethics Approval 131
References 132

List of Tables

Table 1: Measures of Central Tendency for Imagery Ratings in Everyday Life and in Therapy 70
Table 2: Spearman's Rank Correlations 71
Table 3: Point-Biserial Correlations 72
Table 4: Rank-Biserial Correlations 72
Table 5: Trainee Therapists' Experiences and Conceptualisations of Imagery....................77
Table 6: Trainee Therapists' Desired Areas of Learning....................95

List of Figures

Figure 1: Qualitatively Driven Mixed Methods Research Design....................57

Chapter One: Introduction

Overview of This Study

This thesis study investigated trainee therapists' experiences of imagery when working with clients in therapy: the ways in which they understood these experiences; the impact of these experiences on the trainee therapists or on the therapeutic processes if any; and the trainee therapists' learning needs in this regard. This study took a qualitatively driven mixed methods research approach that involved the analysis of qualitative and quantitative data collected from an online questionnaire and follow-up interviews. This thesis study adds to the body of empirical knowledge on therapists' experiences of imagery in therapy, and imagery in therapy more generally.

Mental imagery, commonly referred to as imagery, has been recognised as an important human capacity and has been central in theories of mental function since at least the time of Plato (Kosslyn et al., 2006). The nature of imagery, its mechanisms and functions have been a subject of investigation and controversy in philosophy, psychology, cognitive science, and neuroscience (Pearson & Kosslyn, 2015). However, interest in imagery has waxed and waned because it is an internal process that was, until recently, reliant on introspective research methods (Hackmann et al., 2011). The development of cognitive science and new experimental research methods such as neuroimaging has resulted in a renewed credibility and interest in the investigation of imagery, particularly over the last two decades (Hackmann et al., 2011). Empirical research on imagery and its clinical significance has centred on the role imagery plays in the development and treatment of psychological disorders.

The therapeutic potential of imagery has also been recognised throughout history (Noll, 1985). Imagery has been part of the inception and development of psychodynamic,

humanistic, and cognitive behavioural therapy (CBT) traditions (Thomas, 2016). Psychodynamic approaches have conceptualised imagery as a language of communication between the unconscious and conscious, and a source of symbolised knowledge, transformation, and growth (Kugler, 2008). Humanistic approaches have conceptualised imagery as a means to creatively explore and facilitate self-development, integration, and transformation (Sheikh, 2003). In comparison, CBT approaches have conceptualised imagery as a form of cognition, with representational and associational power, that can be explored and restructured (Hackmann et al., 2011).

There has been some consideration of therapists' imagery in psychodynamic and integrative approaches, which points to its significance because of its potential to enhance and disrupt therapeutic processes (e.g., Kern, 1978; Singer, 2006). However, the empirical research on therapists' imagery is scarce; a search of the literature revealed only three empirical studies that directly investigated therapists' experiences of imagery (Bell et al., 2015; Cartwright et al., 2019; McGown, 2015). These studies suggest that therapists experience imagery when working with clients in therapy, which can be multisensory and trigger emotional reactions. Therapists have different conceptualisations of imagery, although they generally perceive it as helpful to therapeutic processes (Cartwright et al., 2019; McGown, 2015). However, some therapists experience difficulties with imagery that is disturbing or challenging to understand (Cartwright et al., 2019). The studies suggest that there is minimal training on therapist imagery (Bell et al., 2015; Cartwright et al., 2019).

There has been no research on trainee therapists' experiences of imagery in therapy. However, there is evidence suggesting the significance of imagery in therapy, the potency of some therapists' experience of imagery, and the potential facilitative and also the disruptive role therapists' imagery can play in therapeutic processes, so it is important to investigate trainee therapists' experiences of imagery and their learning needs in this regard.

This first chapter provides a definition of imagery and an overview of the relevant literature that contextualises this thesis, including historical developments in the conceptualisation of imagery, relevant empirical research on the nature, function, and impact of imagery, the therapeutic use of imagery, and finally research on therapists' experiences of imagery in therapy. The second chapter outlines the theoretical framework and research methodology, with a rationale for selecting a qualitatively driven mixed methods research approach. The third chapter outlines the research methods used. The fourth chapter presents the results of the study. Finally, the fifth chapter presents a discussion of the results and how they relate to the literature and current understandings. It also describes the implications that the findings may have for therapists' training, supervision, and professional development in reflective practice.

Definition of Imagery

Mental imagery has been described in various ways in the literature and there is ongoing debate over these definitions. In everyday English, the Collins English Dictionary defines imagery as "mental images" (Imagery, 2014) and those images as an "experience of something that is not immediately present to the senses, often involving memory" or "a mental representation or picture … produced by the imagination" (Image, 2014). Imagery, images, and imagination are commonly linked, with a suggestion that imagination implies imagery, which implies the existence of mental images (Hannay, 2014; White, 1990). However, some researchers distinguish between imagery, images, and imagination, and suggest that an image is a representation of something, whereas imagery refers to a broader concept that is multisensory, involves thoughts, emotion, and physiological responses, and can functionally transcend modes of experience (Hover-Kramer & Shames, 1997; Martinson, 1999).

Within the field of psychology, imagery is commonly defined as a "quasi-sensory" and "quasi-perceptual" experience that arises from memory or imagination (Lacey & Lawson, 2013, p.10; Richardson, 1969, p. 2). The definition of imagery that is most commonly referred to is from Kosslyn et al. (2001):

> Mental imagery occurs when perceptual information is accessed from memory, giving rise to the experience of 'seeing with the mind's eye', 'hearing with the mind's ear' and so on. By contrast perception occurs when information is registered directly from the senses. Mental images need not result simply from the recall of previously perceived objects or events; they can also be created by combining and modifying stored perceptual information in novel ways. (p. 635)

Imagery can occur under voluntary control or be spontaneous, arising unexpectedly when sensory representations are induced by involuntary cueing (Pearson & Westbrook, 2015).

Imagery Modalities

There is consensus that imagery encompasses all sensory modalities (Bucci, 2002; Kosslyn et al., 2001; Lacey & Lawson, 2013). Although the external senses, i.e., exteroception (visual, auditory, tactile, olfactory, gustatory), are most commonly referred to in the literature, imagery can also include internal senses, i.e., interoception (e.g., temperature, muscular sensations, hunger, nausea, faintness, pain) and proprioception or kinesthesia (e.g., balance, position, orientation, movement) (Horowitz, 1970; Lacey & Lawson, 2013). Some also refer to a 'felt sense' (Bell et al., 2015; Hackmann et al., 2011). Visual imagery has dominated the literature over other sensory modalities, although there is no evidence to suggest that visual imagery is more frequent or vivid than other sensory modalities in individual experience (Lacey & Lawson, 2013; Pearson et al., 2015).

Historical Background

Mental imagery appears to be an innate human capacity and has been an important phenomenon in human experience throughout history in most cultures that we have knowledge of (Noll, 1985). There is an immense literature on imagery that chronicles and makes sense of this human experience, including ethnographic and historical literatures that contain phenomenological accounts of imagery in traditional cultures (see Noll, 1985 for a review).

Traditionally, the most common form of imagery is visual, often referred to indigenously as 'visions' or 'seeing' (Samuels & Samuels, 1975). These spontaneous or cultivated visions have been understood as a "form of knowing" and have often been given spiritual significance (Samuels & Samuels, 1975, p. 97). As the sensory system enables the world to be perceived, imagery has been understood to enable spiritual perception (Corbin, 1972; Dörnyei, 2020; Sheikh, 2003). In Māori cultural knowledge in Aotearoa New Zealand, one way of understanding visions and seeing is 'matakite', which has been translated into English as "a Māori cultural experience of heightened intuition" (Ngata, 2014, p. 296), "spiritual insight and perception" (Royal, 2003, p. 50), and "revelationary knowledge" (Robinson, 2005, p. 52). Matakite experiences are considered tohunga (a gift) that is significant for the wellbeing of the community (Robinson, 2005).

Imagery has been used for therapeutic purposes throughout history (Sheikh & Jordan, 1983). For example, imagery has been utilised as a means to receive Divine revelation, discernment, and direction in Christianity (Dörnyei, 2020) and it has been utilised to diagnose and treat illness in the healing traditions of shamanism (Achterberg, 1985), in premodern western European medicine (Edwards, 2011; Hergenhahn & Henley, 2013), and within the Māori practice of matakite (Ngata, 2014).

The history of imagery in Western thought begins with Plato (Kugler, 2008). In *The Republic*, Plato presents the allegory of the cave, a story in which he described images as imperfect and misleading shadows and reflections (Plato, 1888). The allegory portrays humans living in a cave of ignorance, where they can only see shadows cast on the cave walls by objects outside. They think these images are real, and only escaping from the cave can lead to the awareness that the images are a deception (Kugler, 2008). Plato's theory of imagery is also depicted by a metaphor of an inner artist painting pictures (images of what we think we see) in the soul (Plato, 1892). He claimed that memory is analogous to a block of wax into which our perceptions and thoughts stamp images (Plato, 1892). Thus, for Plato, imagery is a copy of the material world, which is itself a copy of an ideal located in eternity (MacKisack et al., 2016).

Plato's student, Aristotle, developed a different theory of imagery that moved away from a metaphysical perspective towards a psychological perspective. Aristotle claimed that mental images (phantasma) produced by the imagination (phantasia) are essential to thought: "The soul (phantasmata) never thinks without an image" (Aristotle, 1984b, p. 685). He understood imagery like an echo, "similar in character to the sensation itself" (Aristotle, 1984b p. 681). Aristotle drew a connection between imagery, memory, and emotion: "Memory even of intellectual objects involves an image and the image is an affection[1] of the common sense[2]" (Aristotle, 1984a, p. 715). The view of imagery as representation and imitation carried on through the Middle Ages (Kearney, 2003), although a few figures on the margins of mainstream Western thought radically revised the notion of imagery. For example, Giordano Bruno, a sixteenth-century philosopher, developed a new vision of imagery as a "creative, transformative, and originary power" (Kugler, 2008, p. 81). These

[1] Affection refers to the state induced by sensation or perception (See Bloch, 2007).
[2] The primary sense faculty (See Bloch, 2007).

ideas were radical and condemned as heresy, resulting in Bruno being burnt at the stake (Kugler, 2008).

In the 17th century, René Descartes established existence on the basis of the act of a knowing subject in his statement ‘I think, therefore I am’ (Kugler, 2008). He located the source of meaning, creativity and truth within human subjectivity rather than from the objective world or the transcendent, although he continued to subscribe to the idea of imagery as reflection and imitation (Kearney, 2003).

In the 18th century, John Locke described the mind as a blank slate upon which the “faded impression of the senses” is written (Kugler, 2008, p. 83). He proposed that knowledge is gained through experience and is reflected as mental images, which can be combined into more complex images and serve in the recall of other images (Roeckelein, 2004).

In the late 19th century William James and Wilhelm Wundt, considered to be the founding fathers of psychology, started applying experimental methods to study the theories of philosophers concerning internal processes, including imagery (Mandler, 2007). Francis Galton (1869) was the first to study imagery using a questionnaire to collect qualitative data on experiences of imagery, and he concluded that different types of imagery exist among different people (Galton, 1883). There was increasing controversy towards the end of the 19th century over subjective methods that involved investigating imagery experiences on the basis of introspection (Holt, 1964).

The arrival and growing popularity of the Behaviourist school of thought in American psychology at the turn of the century led to a focus on studying objective and external behaviours and a diminishing interest in imagery, which became largely discredited (Roeckelein, 2004). This view is epitomised in John Watson’s (1913) behaviourist manifesto:

> There is need of questioning more and more the existence of what psychology calls imagery. … I should throw out imagery altogether and attempt to show that practically all natural thought goes on in terms of sensory-motor processes. (p. 816)

At the same time, Oswald Külpe and his colleagues at the Würzburg School advocated for the existence of 'imageless thought' based on experimental findings, which led to the 'imageless thought' debate that lasted throughout the century (Mandler, 2007). Nevertheless, some psychologists outside America (e.g. Bartlett, 1927, 1958; Titchener, 1909) continued to uphold the importance of imagery in thinking, memory, and emotion. The value of imagery also remained alive within clinical writings, which is further described in the section on therapeutic perspectives. The arrival and development of the Cognitive school of thought in psychology and new experimental techniques led to a reawakening of interest in imagery as a legitimate subject for psychological investigation from the 1950s (Roeckelein, 2004).

Empirical Research on the Nature, Function, and Impact of Imagery

Individual Differences

Research has shown that imagery abilities are not universal. Galton (1880), who pioneered the first study of visual imagery, with the *Breakfast table questionnaire*, reported a spectrum of visual imagery experience ranging from an inability to generate visual imagery to highly vivid, almost realistic visual imagery. Zeman et al. (2015) proposed the term 'aphantasia' to refer to the absence of visual imagery after studying 21 individuals who subjectively reported a lifelong absence of visual imagery, half (48%) of whom also reported an absence of imagery in all modalities. Zeman et al. (2016) noted several consistent participant characteristics. Most participants discovered in their teens or twenties that they did not have a visual experience like others who spoke of visualising. However, the participants did report some experience of visual imagery in dreams or involuntary 'flashes'.

Thus, their aphantasia seemed to involve the inability to generate voluntary visual imagery rather than a total absence of visual imagery. Greenberg and Knowlton (2014) conducted a study of visual imagery in 101 students and found two 'imageless' participants who had a lower sense of reliving autobiographical memories, with no other evident cognitive or perceptual impairments. This finding is consistent with the estimated aphantasia prevalence rate of 1.9–2.7 percent (Faw, 2009; Greenberg & Knowlton, 2014). Given the lack of neuropsychological study, de Vito and Bartolomeo (2015) suggest that it remains unclear whether the absence of visual imagery is organic or functional. Some suggest that visual imagery experience can remain unconscious (e.g., Church, 2008; Phillips, 2014) and there is some evidence from neurostimulation studies to support this notion (Brogaard & Gatzia, 2017). Aphantasia or low-level visual imagery could be related to the use of alternative imagery modalities. For example, Keogh and Pearson (2017) found that aphantasia was associated with increased spatial imagery.

There are a number of subjective imagery measures, most commonly self-report questionnaires that have built on Galton's *breakfast table questionnaire* and identified individual differences in imagery vividness, control, and modality preference (see McAvinue & Robertson, 2007 for a review). Individual differences have also been measured objectively using the behavioural measures of performance on imagery tasks, neuroimaging, and neurostimulation, and have found that individuals differ in imagery abilities, including imagery generation, inspection, transformation, and maintenance (e.g., Cui et al., 2007; Kosslyn et al., 2004). However, there is some evidence that these imagery abilities can be improved to some extent with practice (see Cumming & Eaves, 2018 for a review). There is also evidence for individual differences in the tendency to use imagery based on cognitive style (see Richardson, 2018 for a review), the strategies used in imagery (e.g., Bergmann et al., 2014), and the affective and physiological impact of imagery (e.g., Smith et al., 2007).

Imagery and Emotion

Imagery is recognised as having a powerful impact on emotion (Holmes & Mathews, 2010; Ji et al., 2016; Wicken et al., 2019). In a review of the literature on the link between mental imagery and emotion, Holmes and Mathews (2010) suggested that imagery evokes emotion in three ways. Firstly, imagery can directly influence the emotional systems in the brain that are responsive to sensory signals such as danger or reward. Secondly, the overlap between the processes involved in both mental imagery and perception can result in responses to imagery 'as if' experiencing real emotion-arousing events. Thirdly, imagery has the capacity to draw on autobiographical memory and reinstate the same emotions associated with that event (Holmes & Mathews, 2010).

The Direct Influence of Imagery on Emotional Systems in the Brain. There is evidence to suggest that imagery can directly evoke emotional states that are responsive to sensory signals such as danger or reward. This notion is central to Lang's (1979) bio-informational theory of imagery, which suggests that mental imagery engages an elaborate propositional network made up of "stimulus propositions", which consists of information about the stimuli and meanings, and "response propositions", such as physiological, emotional, and behavioural responses (p. 500). According to the bio-informational theory of imagery, imagery has the capacity to activate the associative network of stored information (i.e., signal of danger or reward) and rapidly invoke corresponding psychophysiological responses, action mobilisation (i.e., avoid or approach reflexes), and emotion (Lang, 1979). A premise of this theory is that propositional networks can be activated by any matching input, externally or internally (i.e., imagery, feeling state, or any symbolic representation) (Lang et al., 1993).

Lang and colleagues (e.g., Vrana et al., 1986; Vrana & Lang, 1990) tested the bio-informational theory of imagery through a series of experiments and found that mental

imagery of fearful or unpleasant situations was associated with high arousal, heart rate acceleration, and unpleasant affect relative to neutral images. Lang and colleagues (e.g., Lang et al., 1993; Miller et al., 1987; Vrana et al., 1986) also found that good imagery ability was associated with greater physiological reactivity and reported emotional intensity. Subsequent psychophysiological and neuroscience research has demonstrated that imagery can automatically activate the survival circuitry, which is organised into two motivational systems that are associated with unconditioned reflex patterns and emotional arousal (e.g., Costa et al., 2010; Lang & McTeague, 2009; McTeague et al., 2009; Sabatinelli et al., 2006). One motivational system is defensive and associated with reports of unpleasant affect and fight or flight reflexes, and the other motivational system is appetitive and associated with pleasant affect and reward-seeking reflexes (see Lang & Bradley, 2010 for a review). For example, Tiggemann and Kemps (2005) found that vivid food imagery was associated with craving intensity. There is evidence to suggest that basic emotional systems in the brain responsive to sensory cues, such as fear, tend to bypass higher level processing by other cortical areas, such as those involving language, although top-down conscious control is possible (e.g., LeDoux, 2000; Öhman & Mineka, 2001). There is an increasing evidence base supporting the notion that imagery evokes emotion more readily than verbal, language based processing (e.g., Holmes & Mathews, 2005; Holmes et al., 2008b; Mathews et al., 2013).

Imagery and Perception. The second way that imagery may evoke emotion is via its link to actual sensory perception. There is a large body of research that suggests that imagery can be considered as a form of top-down perception (i.e., internally generated) and functions like a “weak form of perception” (Pearson et al., 2015, p. 590) that can even seem “real” (Mathews et al., 2013, p. 224).

Experiments using neuroimaging methods, such as positron emission tomography (PET) and functional magnetic resonance imaging (fMRI), have compared brain activation

during perception and mental imagery of the same information, and shown that imagery draws on many of the same brain regions and neural processes as perception (e.g., Dijkstra et al., 2017; Ganis et al., 2004; Kosslyn & Thompson, 2003). Although most of the empirical studies have focused on the visual modality, there is also evidence for shared neural activation between actual perception and imagery in the auditory modality (e.g., Herholz et al., 2012; Schaefer et al., 2013) and somatosensory modalities (e.g., de Borst & de Gelder, 2017; Schmidt & Blankenburg, 2019). When imagery is emotional in content, studies have found that the brain systems involved in processing emotional information, such as the amygdala, are also engaged in much the same way as actual perception of emotional situations (e.g., Ji et al., 2016; Kim et al., 2007; Zamuner et al., 2017).

Imagery has the capacity to activate similar neural structures to actual like-modality perception. It can mediate effects on the body and affective arousal in similar ways to the actual experience itself, which has resulted in increasing support for the theory of functional equivalence (Kosslyn et al., 2001). The concept of functional equivalence was originally pioneered by Finke (1980), who suggested that “one can think of mental images as being functionally equivalent to physical objects or events” (p. 113). This concept has been applied extensively in sports psychology, which has resulted in growing evidence that imagery rehearsal can improve strength and performance (see Cumming & Ramsey, 2009; Scholefield et al., 2015; Wakefield et al., 2013). A review of this research led to a suggestion that behavioural matching is a more appropriate term than functional equivalence, since the similarities between imagery and the real situation are experienced at the phenomenological level rather than at the neural level (Wakefield et al., 2013).

Several factors may modulate the emotional impact of imagery, and the vantage point of imagery has received particular attention (Blackwell, 2019). Imagery can be viewed from a “field” perspective, in which the situation is viewed through one’s own eyes, or from an

"observer" perspective, in which one is watching the situation or oneself as a bystander (Nigro & Neisser, 1983). There is evidence that field perspective imagery is associated with increased emotional impact compared to observer perspective imagery, albeit with some mixed results in the literature (see Wallace-Hadrill & Kamboj, 2016 for a review). Studies that investigated changing the imagery perspective of negative intrusive imagery (Williams & Moulds, 2008), as well as positive memories and future projections (e.g., Vella & Moulds, 2014), found that shifting from field perspective to observer perspective reduced imagery vividness and affect, although alternatively shifting from observer to field perspective did not consistently lead to increases in imagery vividness and affect.

Imagery and Autobiographical Memory. The third way that imagery may evoke emotion is related to autobiographical memory. Holmes and Mathews (2010) reviewed the literature and suggested that imagery draws on autobiographical memory and can reinstate affective states similar to that which was originally experienced. Conway and colleagues (Conway, 2001; Conway & Pleydell-Pearce, 2000) described autobiographical memory as consisting of two separate memory systems. One system is episodic memory of personal experiences of specific objects, people, places, and events, which consists of sensory-perceptual information. The other system is semantic memory, which consists of conceptual knowledge of facts about the world. Research suggests that episodic memories are typically encoded and retrieved in the form of images (e.g., Butler et al., 2016; Ehlers et al., 2002; Rubin et al., 2008; Tulving, 1984).

Research studies have provided evidence that the neural processes involved in the retrieval of episodic memories overlap with those involved in generating new imagery, and are associated with emotion generation (see Cabeza & St Jacques, 2007; Schacter et al., 2007 for reviews). In their review of the literature, Schacter et al. (2007) suggested that episodic memory forms the building blocks for imagery. Thus, the generation of imagery draws from

relevant autobiographical elements that bring with them the associated emotional responses (Schacter et al., 2007). Furthermore, research suggests that a heightened emotional experience can influence memory encoding and consolidation in a way that makes the autobiographical information most accessible and therefore most likely to be retrieved (see Buchanan, 2007; Holland & Kensinger, 2010 for reviews). When this autobiographical information is then retrieved, it tends to activate associated sensory information, generating a sense of reliving and re-experiencing (Sharot et al., 2004; Talarico et al., 2004). There is also evidence of mood congruent memory images, where emotional states and moods tend to elicit congruent memory images that encapsulate similar content, emotions, and meaning (see Gaddy & Ingram, 2014 for a review). This finding is established in the clinical research literature (e.g., Speckens et al., 2007).

Imagery and Cognition

There is a tradition in philosophical and psychological theories that suggests humans operate with two independent but interactive processing systems, one rapid, intuitive, nonverbal, and imagistic, and the other slow, deliberative, and verbal (see Evans & Frankish, 2009 for a review). Within psychology, these dual process theories initially focused on specific domains of cognition, such as reasoning, decision-making, judgement, learning, and memory (see Gawronski & Creighton, 2013 for a review). Several reviews of these numerous domain-specific dual process theories and the supporting evidence have attempted to unify them into one generic dual process theory that refers to the two processing systems as System 1 and System 2, involving Type 1 and Type 2 processing respectively (e.g., Evans, 2009; Evans & Over, 1996; Sloman, 1996; Stanovich, 1999). Some cognitive psychologists (e.g., Beevers, 2005; Epstein & Epstein, 2016; Evans & Coventry, 2006) and psychotherapists (e.g., Anchin & Singer, 2016; Crisanti, 2019; Jurchiș & Opre, 2018) have explored the implications of dual process theories for therapy.

Cognitive-Experiential Self-Theory. Seymour Epstein (1973, 1994) pioneered a generalised and integrative dual process theory with his cognitive-experiential self-theory (CEST) and provided supporting empirical research. He also considered the implications for therapy (Epstein & Epstein, 2016). CEST is not only a dual process theory of cognition but also a global personality theory that integrates psychodynamic theories, learning theories, phenomenological theories, and cognitive scientific ideas on information processing and emotion (Epstein, 1994, 2014). The operating principles and attributes of the 'experiential system' (System 1) include rapid, automatic, and effortless information processing that is based on drawing associative connections, usually operates outside of awareness, and is only minimally demanding on cognitive resources (Epstein, 2003). The experiential system is thought to encode information in the form of images and it is also capable of abstraction through the use of generalisation, prototypes, metaphors, and narratives (Epstein & Pacini, 1999). It involves holistic responses that are associated with affect and oriented toward immediate action (Epstein, 2014). The experiential system learns from experience and makes connections through association. Its schemas consist of generalisations from past experience (Epstein & Pacini, 2001). The operating principles and attributes of the 'rational system' (System 2), on the other hand, are relatively slow, intentional and analytical; they involve effortful information processing that is based on logical relations between elements, which is more demanding on cognitive resources (Epstein, 2003). The rational system is thought to encode information primarily verbally and involve analytic responses that are affect-free and orientated toward delayed action (Epstein, 2014). It derives its schemas from logical inference (Epstein & Pacini, 2001).

CEST assumes that the experiential system is emotionally driven and associated with the experience of affect whereas the rational system is relatively affect-free, although the experiential system can contribute to emotional responses to language (Epstein & Pacini,

1999). Metaphors and narratives that are presented verbally can engage both the rational and experiential systems by evoking images, associations, and emotions. This can make the information being presented more engaging and comprehensible than if it were only presented verbally (Epstein, 2014). This may have relevance to therapy, as clients' narrative-based descriptions of past experiences may engage both the therapist's rational and experiential processing systems and evoke imagery in the therapist's mind and emotions. Empirical research by Epstein and colleagues provides some support for the operating principles and attributes of the experiential and rational systems and the construct validity of CEST (see Epstein, 2003, 2014 for reviews).

Implications of CEST on the Function of Imagery. CEST proposes that imagery engages the experiential system and functions within it in a similar way to real experience. This is referred to as vicarious experience. Thus, imagery can be responded to as if it were reality (Epstein, 2014). Epstein and Pacini (2001) tested this assumption using the ratio-bias experimental paradigm, which has been shown in other experiments to produce different results when presented in the form of a verbally described situation compared to a real situation. The results showed that participants who visualised the situation being verbally described responded with the same biases that otherwise only occurred in the real situation. This biasing effect did not occur for participants who did not visualise the verbal descriptions. The authors suggested that this finding supports the theory that visual imagery can have a similar effect on thinking and behaviour as if experiencing the real situation (Epstein & Pacini, 2001).

Implications of CEST on the Influence of Experiential Processing. The experiential and rational systems are assumed to operate in parallel, interact simultaneously and sequentially, and influence each other with respect to both content and process (Epstein, 2014). Of particular interest is the influence of the experiential system on the rational system,

as it explains the way in which unconscious information processing can dominate and bias conscious reasoning. The automatic, rapid, and effortless nature of the experiential system also means that it often operates outside of awareness and can influence subsequent processing in the rational system unintentionally and unknowingly (Epstein, 2003). Reflection and insight can enable rational control to be exercised and the experiential system to be corrected (Epstein, 2003). Another reason the experiential system can dominate is that its operation is usually accompanied by affect, so it is likely to be experienced as more compelling than rational processing. Studies have found that experiential processing becomes increasingly dominant with an increase in emotional intensity (e.g., Epstein, 1994; Epstein et al., 1992). This suggests that, as the emotional intensity rises in therapy, a therapist's experiential processing system would likely become more dominant.

Emotional arousal engages the experiential system, which automatically and instantaneously searches its memory for related events and their emotional accompaniments, given that it is an associational learning system (Epstein & Pacini, 1999). The recalled feelings can then influence further processing, associations, and reactions. If the elicited memories are pleasant, the person has thoughts, images, and impulses that promote behaving in ways anticipated to reproduce the feelings. If the memories are unpleasant, the person has thoughts, images, and impulses to behave in ways anticipated to avoid experiencing the feelings. As this sequence of events occurs automatically, people are usually unaware of its operation (Epstein & Epstein, 2016).

Implications of CEST for Understanding Experiential Knowing and Intuition. Epstein (2010) described how the operation of the experiential system accounts for intuition. He suggested that intuition is a subsystem of the experiential processing system that consists primarily of the retrieval of tacit information acquired by automatically learning from experience outside of awareness. Intuition can be valid or invalid depending on the relation

between past experience and present circumstances. Epstein also suggested that intuition can consist of implicit associative learning in entirely new situations unrelated to past experiences through the same principles, the detection of new patterns, and the generation of impressions. Thus, Epstein (2010) suggested that intuition can be defined as, "A sense of knowing based on unconscious information processing" (p. 96). In other words, "Intuition involves a sense of knowing without knowing how one knows" (Epstein, 2010, p. 296), which is experienced as "self-evidently valid" (Norris & Epstein, 2011, p. 718). This theory provides one possible explanation of intuition that may help to understand how a therapist's imagery-based experiential processing system can lead to an intuitive sense of knowing.

Imagery and Empathy

Therapists' empathy for clients in therapy is recognised as an important and complex phenomenon (Dekeyser et al., 2009; Elliott et al., 2011). There are wide-ranging definitions of empathy in the literature although there appears to be a general consensus that empathy consists of two components: affective empathy and cognitive empathy (Davis, 1983; Shamay-Tsoory et al., 2009). Affective empathy refers to the capacity to experience the emotions of another person (Decety & Jackson, 2004). Affective empathy corresponds to emotional contagion, which involves catching the affective state of another but without awareness of the origin of the affective experience source or without maintaining a self-other distinction (Hatfield et al., 2009). Empirical research suggests that the process of emotional contagion involves mimicry, which is the synchronisation of the facial expressions, voice qualities, postures, movements, and behaviours of another person (e.g., Drimalla et al., 2019; Prochazkova & Kret, 2017). It also involves the mirror-neuron system, which involves the same areas of the brain becoming activated in the observer, as if the observer her/himself was acting (see Pfeifer & Dapretto, 2009 for a review). Cognitive empathy refers to the capacity to identify and understand another person's perspective and emotions (Decety & Jackson,

2004). Cognitive empathy corresponds to mentalisation or cognitive perspective-taking, both of which help one to infer another person's affective state, but without necessarily producing an affective response in oneself or emotionally resonating (Jackson et al., 2006).

Some therapists (e.g., Arizmendi, 2011; Berger, 1987) have discussed the importance of therapists' imagery in the development of empathy. For example, Arizmendi (2011) suggested that therapists' imagery is a "crucial element in the transition from simple attunement to empathy" (p. 405). He suggested that imagery represents a cognitive linking mechanism that aids the adoption of another person's perspective and a state of knowing beyond emotional sharing and attunement (Arizmendi, 2011). There are several research studies that have investigated the importance of imagery in empathy (e.g., Decety & Grèzes, 2006; Goyal et al., 2017; Norris & Epstein, 2011). For example, Goyal et al. (2017) examined the relationship between cognitive style, empathy, and willingness to help in two studies. The results of their first study showed that individuals with a tendency for visual cognitive processing were more empathic, as measured by willingness to help, compared to individuals with a tendency for verbal cognitive processing, factoring out social desirability. The results of the second study showed that participants who imagined a scenario using imagery reported higher levels of empathy compared to those participants who only read the story without experiencing imagery (Goyal et al., 2017). In another study, Norris and Epstein (2011) found that an experiential thinking style, which is characterised by imagistic processing, was positively associated with self-reported measures of empathy.

Research provides evidence for a link between autobiographical memory and empathy, as they draw on common brain networks (see Meconi et al., 2019 for a review). For example, Meconi et al. (2019) provided behavioural, electrophysiological and fMRI evidence in support of a direct engagement of autobiographical memory reactivation in empathy.

Imagery and Vicarious Trauma

Therapists' empathic engagement with their clients' traumatic experiences, which involves listening and attunement to, and imagining the clients' descriptions of traumatic events, can result in empathy-based stress (Pearlman & MacIan, 1995; Pearlman & Saakvitne, 1995; Wilson & Thomas, 2004). Various terms have been used to describe this kind of stress including, 'compassion fatigue' (Figley, 1995; Turgoose & Maddox, 2017), 'secondary traumatic stress' (Dutton & Rubenstein, 1995; Figley, 1995), 'vicarious trauma/traumatisation' (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995), and 'traumatic countertransference' (Herman, 1997). These terms are used interchangeably throughout the literature, although they have different definitions, which reflects a lack of conceptual clarity in the literature (Sabin-Farrell & Turpin, 2003).

Compassion fatigue has been described as the stress, exhaustion, and empathic strain caused by working with distressed or traumatised clients (Figley, 1995; Turgoose & Maddox, 2017). Secondary traumatic stress has been described as the symptoms experienced by therapists working with traumatised clients that are similar to those seen in people with post-traumatic stress disorder (PTSD), but at subclinical levels, and these symptoms can include intrusive imagery related to the clients' traumatic disclosures (Chrestman, 1999; Figley, 1995; Wilson & Lindy, 1994). Vicarious trauma may include PTSD-like symptoms, but also includes the transformation in therapists' systems of meaning, values, and beliefs, and in the way they view themselves, others, and the world (Pearlman & McIan, 1995; Pearlman & Saakvitne, 1995). In their discussion of vicarious trauma, McCann and Pearlman (1990) suggested that intrusive imagery, as well as other PTSD-like symptoms, can alter the therapist's imagery system of memory, whereby the client's trauma memories become incorporated into the therapist's memory system.

There is a large number of research studies investigating therapists' experiences of vicarious trauma, secondary traumatic stress, and compassion fatigue that demonstrate the negative effects of working with clients who have experienced trauma. Within this body of research, there are three studies that considered therapists' experience of intrusive imagery. Wilson and Thomas (2004) conducted a questionnaire study, using self-report measures and open-ended questions, which 345 therapists completed. They found that 90.5% of the therapists reported that they had felt overwhelmed by a client's trauma story, 82% reported difficulty getting client trauma images out of their mind, 89.9% reported strong emotional reactions that lasted beyond the therapy session, 78.9% experienced a form of empathic strain, and 81.4% reported difficulties in maintaining boundaries and managing countertransference in therapy. Although the role of therapist imagery was not investigated, the authors suggested that the imagery content of the trauma story can lead to the therapist experiencing intense emotional reactions, empathic strain, and countertransference responses, such as the therapist withdrawing or over-identifying with the client, which can rupture the therapeutic alliance (Wilson & Thomas, 2004).

In a second study, Arnold et al. (2005) interviewed 21 therapists about the effects of working with clients who had experienced trauma. Content analysis revealed that 19 therapists (90%) had experienced intrusive imagery of their clients' trauma at some stage during their careers. Some therapists noted that they had experienced a greater frequency of intrusive imagery early in their careers. Fifteen (7%) said that they had experienced negative emotional responses during and/or after therapy sessions. Seven (33%) described negative physical responses such as exhaustion or pain, and some reported that these negative effects made it difficult to empathise with their clients. In an earlier study, Steed and Downing (1998) interviewed 12 therapists about the effects of working with trauma and seven (33%)

reported intrusive imagery. Some of the therapists reported using self-protective coping strategies to manage their intrusive imagery.

Some therapists (e.g., McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995) have suggested that the generation of trauma-related imagery when listening to clients' descriptions of traumatic experiences is a key component of the development of their own trauma-related symptoms and vicarious trauma. Empirical research demonstrates that visualising verbal descriptions of a traumatic event can have a more significant emotional impact and result in intrusive imagery compared to merely processing the verbal descriptions without imagery (Krans et al., 2010). Empirical research also suggests that state dissociation when listening to verbal descriptions of a traumatic event can lead to increased perpetual priming and more distressing intrusive imagery (Dorahy et al., 2016).

The research (e.g., Pearlman & MacIan, 1995) and clinical literature (e.g., Neumann & Gamble, 1995) on vicarious trauma and secondary traumatic stress suggests that trainee therapists and new therapists are more vulnerable to experiencing trauma-related symptoms and vicarious trauma. Previous clinical studies that examined the effects of trauma work on therapists and trainee therapists using questionnaires and rating scales (e.g., Adam & Riggs, 2008; Chrestman, 1999; Pearlman & MacIan, 1995) found that trainee therapists or newer therapists experienced greater difficulties with trauma-related symptomatology, such as overwhelming distress, negative coping strategies, disrupted schemas, and intrusions, compared to more experienced therapists. Previous questionnaire studies suggest that trainee therapists (e.g., Adams & Riggs, 2008; Jenkins & Baird, 2002) and therapists (e.g., Pearlman & MacIan, 1995) who have experienced traumatic experiences themselves may be more vulnerable to developing trauma-specific symptoms and experiencing difficult countertransference reactions.

Therapeutic Perspectives on Client Imagery

The therapeutic potential of imagery has been recognised within psychodynamic, humanistic, and CBT traditions (Singer, 2006; Thomas, 2016). Particular therapists within each tradition pioneered developments in imagery-based work with clients. This section examines how client imagery has been conceptualised and used within these different therapeutic traditions. The experimental research discussed in the previous section has demonstrated the unique and strong relationship that imagery has with emotion and memory, and the role it plays in information processing. This has led to increasing interest in the importance and application of client imagery in contemporary extensions of CBT, which will also be briefly examined (Hackmann et al., 2011).

Psychodynamic Approaches to Working With Client Imagery

The importance of imagery has been recognised within the psychodynamic approach since the inception of psychoanalysis at the end of the 19th century. There has been a long history of exploration and utilisation of imagery throughout the development of psychodynamic theory and therapy. The key applications of imagery within psychodynamic theory and therapy are briefly examined below.

Psychoanalysis. Sigmund Freud (1910) credited Joseph Breuer with being the first doctor to utilise clients' imagery in treatment through hypnosis. In the early stages of his own work, Freud utilised hypnosis to uncover and work with clients' imagery, which he believed revealed unconscious thoughts, internal conflicts, and illness (Singer, 2006). For example, he discussed cases in which disorders of internal organs activated 'diagnostic' dream images (Freud, 1976). Freud later developed an alternative technique of pressing clients' foreheads to elicit repressed memory imagery of early traumatic experiences, which he believed contributed to their symptoms (Freud, 1955). Although Freud (1976) recognised imagery as

"the royal road to the unconscious" (p. 570), he later abandoned imagery processes, moving away from imagery association to a verbal free association technique (Suler, 1989).

Jungian Psychology. Similar to Freud, Carl Jung viewed imagery as symbolic and as the language of communication between the conscious and unconscious. However, Jung separated himself from Freud's view of imagery as representations of primal instincts and repressed features, and considered imagery to be an essential part of human reality, a dominant role of the psyche, and a source of meaning, creativity, guidance, and spiritual synthesis (Gordon, 1972; Kugler, 2008). Also, in contrast to Freud, Jung believed that underneath "the personal unconscious" (Jung, 1959, p. 8) is a deeper transpersonal and objective dimension, which he termed the "collective unconscious" (Jung, 1959, p. 16). He theorised that the collective unconscious consists of universal instincts and 'archetypes', that is, symbolic imagery with universal meanings across cultures that are inherited from our ancestors and provide a source of guidance and transformation (Ivey et al., 2012). According to Jung, an individual's imagery can reflect these universal 'archetypes' and help the individual to transcend conscious knowledge and subjectivity and move into yet unknown depths (Kugler, 2008).

Jung gave great importance to imagery in therapy and developed a therapeutic technique called 'active imagination' (Jung, 1960). The technique of active imagination consists of inviting the client's unconscious to arise through imagery, followed by the client "coming to terms with the unconscious" (Jung, 1960, p. 88). In active imagination, the therapist directs the client to meditate while remaining free from any goal, then invite images to appear and watch them without intervening. The therapist encourages the client to talk to the images or to question them (Hackmann, 1998). Jung believed that the imagery evoked in active imagination symbolises aspects of personal growth and simply bringing the imagery to awareness and reflecting on it is therapeutic (Dietrich, 2016). Jung gave less emphasis on

interpretation by the therapist, but rather emphasised the importance of the client being encouraged to allow her/his imagery to unfold and deliver up its meaning. Jung's belief that the person who produced the imagery was the best interpreter of the imagery was a radical departure from the Freudian psychoanalytical tradition (Thomas, 2016). However, Jung did emphasise the usefulness of the therapist contextualising the client's imagery by integrating it with 'archetypes' to derive meaning, and transforming the insights and wisdom gained into committed action outside of the therapy sessions (Dietrich, 2016).

Interestingly, Jung personally experienced very vivid and powerful imagery (Lachman, 2010; Thomas, 2016). Jung wrote about attempting to translate his own emotions into images, "to find the images which were concealed in the emotions", and as a result he was "calmed and reassured" (Jung, 1961, p. 177). Through his own use of imagery, Jung "learned how helpful it can be, from the therapeutic point of view, to find the particular images which lie behind emotions", which if left in the unconscious could give rise to neurotic symptoms (Jung, 1961, p. 177). Jung has become recognised as one of the most influential figures in understanding imagery and symbolism in therapy (Hall et al., 2006; Sheikh & Jordan, 1983). Some researchers have suggested that Jung established the legitimacy of the imagination and imagery as a valid way to produce knowledge (e.g., Dietrich, 2016; Sheikh, 2003).

Waking-Dream Therapy. A number of therapists, significantly influenced by Jung, continued to explore the use of narrative imagery in therapy. The most prominent of these approaches include Desoille's (1961, 1965) directed daydream, Fretigny and Virel's (1968) oneirodrama, and Leuner's (1977, 1978) guided affective imagery. These approaches are referred to as waking dream therapy or oneirotherapy. The term oneirotherapy comes from the Greek word oneiros, which means dream (Much & Sheikh, 2019; Sheikh & Jordan, 1983). The waking dream therapies guide the client into deep relaxation before presenting

standard symbolic scenes from which the client spontaneously develops extended waking dreams, also referred to as fantasies (Much & Sheikh, 2019; Sheikh, 2003). This imaginary state involves multisensory imagery that includes an experiential sense of movement and autonomic and affective responses that have a life-like quality (Much & Sheikh, 2019). This process is considered to be the vehicle to access, process, transform, and resolve unconscious intrapsychic elements and conflicts, in order to improve the client's symptoms (Sheikh, 2003; Sheikh & Jordan, 1983). For example, the waking dream techniques can facilitate age regression, where clients detach from the present reality, relive significant past events and emotionally overcome the situation (Sheikh & Panagiotou, 1975). In the final stages of therapy, the client is helped to cultivate alternative possibilities at an imaginary level, then implement these learnings into daily life (Sheikh & Jordan, 1983).

Eidetic Psychotherapy. In contrast to the narrative approaches, several therapists developed more structured imagery techniques, for example, Akhter Ahsen's (1968) eidetic psychotherapy. Eidetic imagery is understood to be vivid, affect-laden imagery that is capable of eliciting strong psychosomatic responses (Ahsen, 1974). Ahsen proposed a three-dimensional model of imagery, where significant life events are triadically represented by eidetic imagery (I), a somatic response pattern (S), and meaning (M) (Ahsen, 1984). Ahsen developed a systematised approach of eliciting and manipulating eidetic imagery (Ahsen, 1974). The procedures involve structured directive instructions to repeatedly access imagery segments as a primary focus in therapy. Ahsen believed eidetic imagery to be an important source of information, specifically on the patterns underlying clients' symptoms. For example, he understood that fixed images represent psychic conflicts that need to be emotionally overcome. The efficacy of Ahsen's methods were reported in cases involving psychosomatic, phobic, hysterical, or psychotic symptoms (e.g., Sheikh & Panagiotou, 1975; Sheikh, 2019).

Humanistic Approaches to Working With Client Imagery

Humanistic psychology arose in the 1960s in response to the perceived limitations of the psychoanalytic and behavioural approaches at that time, which were considered to be overly deterministic and problem-focused (Watson et al., 2011). In general, humanistic psychotherapies highlight the creative use of clients' imagery as the "royal road to integration" (Perls, 1969, p. 66) and a way for clients to realise, express, and develop their potential rather than analysing their unconscious or modifying their behaviour (Cain et al., 2016; Thomas, 2016). Although Carl Rogers' person-centred approach initially discounted using any kind of technique, subsequent developments established the legitimacy of using imagery as a way to actively help clients access and symbolise their experience, find meaning, and realise their potential (Sheikh, 2003). Although humanistic psychotherapies draw heavily on Jung's work, a more active and directive approach is taken to the therapeutic use of imagery, resulting in numerous techniques and procedures. The key ones are examined below.

Gestalt Therapy. One of the most influential contributors to the use of imagery within the humanistic approach was Fritz Perls, the founder of Gestalt therapy (Hall et al., 2006). The focus of Gestalt therapy is bringing the client's attention to the full range of her/his experiences in the moment, including her/his imagery, thoughts, feelings, and bodily sensations (Finlay, 2016). In Gestalt therapy, the client's imagery is thought to express neglected or repressed parts of the self. Guided visualisations, such as the well-known 'empty chair' technique, are used to bring clients' bodily and affective experiences into the here-and-now to increase the clients' awareness and understanding (Ronen, 2011). For example, clients are encouraged to imagine scenes from the past or future to uncover their fears and expectations so that they can confront and process them and find meaning from them (Finlay, 2016; Hall et al., 2006). Research studies indicate the effectiveness of imagery-based Gestalt

techniques (Brownell, 2016). Gestalt techniques share commonalities with the psychodynamic, cognitive, and behavioural techniques used to overcome fear.

Psychosynthesis. Roberto Assagioli (1965) developed psychosynthesis, which is a humanistic and transpersonal approach that focuses on enhancing the personal and spiritual potential of clients (Moleski et al., 2019). Assagioli utilised spontaneous and directed imagery in a structured way to increase the clients' awareness and understanding of their inner processes, work through conflicts on a symbolic level, and find guidance and transformation by realising their higher nature and purpose in life (Crampton, 1969; Sheikh & Panagiotou, 1975). Assagioli noted that imagery is particularly beneficial because of its capacity to tap into aspects of the total personality and bring integration between different levels of sensation, emotion, cognition, intuition, and creativity (Thomas, 2016).

Focusing. Carl Rogers and Eugene Gendlin collaborated in developing the 'focusing' technique, which Gendlin (1978) presented, to guide the client into obtaining a bodily 'felt sense' of some problem, situation, or symptom, through the use of imagery to concretise and clarify. The client's felt sense is developed by working with the client's imagery and attending to associated images, words, and feelings to gain further insight (Gendlin, 1996). Microprocess research on focusing-orientated experiential therapy suggests that the focusing technique can bring relief, a sense of meaning and movement, and improve symptoms (see Krycka & Ikemi, 2016 for a review).

Cognitive and Behavioural Approaches to Working With Client Imagery

From the inception of behaviour therapy as it is known today, which emerged in the 1950s, and cognitive therapy in the 1960s, client imagery has been used in a directive, focused, and controlled way. Behaviour therapy draws from learning theory and classical and operant conditioning to change specific learned behavioural responses to stimuli. Within behaviour therapy, imagery is conceptualised as a concrete representation with the power to

act as both real-life stimuli and behavioural responses in behaviour modification (Hackmann, 1998). Cognitive therapy took a step further and conceptualised imagery as both representational and associational. Within cognitive therapy, appraisals mediate between the stimuli and the behavioural responses (Hackmann et al., 2011). These appraisals include "meanings, significances, and imagery" and are the primary target for change (Beck, 1976, p. 32). Beck's development of cognitive therapy initially relied on his clients being able to share their cognitions, a process significantly aided by imagery (Beck, 1970). Beck identified imagery as a form of cognition, functionally equivalent to thoughts, which can precipitate and maintain psychological problems (Beck et al., 1985). He suggested that clients' imagery can be explored to clarify problems, access personal meanings, and help with formulation, then worked with either directly or indirectly at the level of cognitive process to facilitate transformation and change (Beck, 1970, 1976). Beck's observations laid the foundation for working with imagery in cognitive therapy, then his acceptance of behavioural contributions led to the integration of cognitive and behavioural approaches (Hackmann et al., 2011; Rachman, 2015). A wide range of imagery-based techniques have been developed within CBT. The main behavioural and CBT techniques are examined below.

Systematic Desensitisation. Joseph Wolpe, a South African psychiatrist, developed the method of systematic desensitisation in the 1950s to treat phobias and anxiety. Systematic desensitisation involves establishing a hierarchy of fears consisting of imagined situations associated with increasing levels of fearfulness. Graded exposure to the feared situations is paired with relaxation exercises including guided imagery until fearfulness is reduced (Wilkins, 1971; Wolpe, 1958). At the time, the technique was considered one of the most effective therapy interventions available, particularly for phobias (Smith & Glass, 1977). Researchers give credit to Wolpe for legitimising the consideration of internal processes in behavioural approaches (Sheikh & Jordan, 1983). A number of behaviourists subsequently

developed additional techniques to modify behaviour, which involve the manipulation of imagery, as outlined below.

Covert Conditioning. Covert conditioning refers to a set of therapy imagery-based procedures that are based on the principles of classical and operant conditioning to increase or decrease certain target behaviour patterns. Target behaviours include overt behaviours (e.g., actions) or covert behaviours (e.g., thoughts, images, feelings, and physiological responses) (Hersen & Rosqvist, 2005). These behaviours can be strengthened or reduced by imagining them then using either positive or negative reinforcement or punishment. For example, a client working toward weight control may imagine somebody vomiting over the food about to be eaten (Curwen et al., 2000). The most extensive development and use of such techniques has been by Joseph Cautela in the treatment of various maladaptive approach behaviours, such as smoking, drinking, obesity, compulsive stealing, and problematic sexual behaviours (e.g., Cautela, 1966, 1967, 1971).

Emotional Flooding and Imaginal Exposure. Thomas Stampfl and Donald Levis (1967) introduced emotional flooding (also referred to as implosive therapy, exposure therapy, or prolonged exposure therapy) to treat trauma, phobias, and anxiety. Exposure to the original trauma or feared stimulus is engaged in through imagery with the use of relaxation techniques. This imaginal exposure technique is based on the idea that the fear response and adrenaline have a time limit and the client will eventually calm down, realise that fear is unwarranted, and unlearn defensive behaviours (Hackmann, 1998). Studies on the effectiveness of this technique at the time reported significant improvements in clients' symptoms (e.g., Hogan, 1966; Hogan & Kirchner, 1968; Levis & Carrera, 1967). Imaginal exposure techniques are still widely used to promote habituation and the extinction of conditioned fear responses, with a strong evidence base for treating anxiety disorders (see Zinbarg et al., 2006) and trauma (see Foa et al., 2007).

Eye Movement Desensitisation and Reprocessing. Francine Shapiro (1989, 1995) developed the therapy called eye movement desensitisation and reprocessing (EMDR), which involves bilateral eye movements, or alternative intermittent bilateral stimulation, while recalling trauma memories (van Den Hout et al., 2012). Several meta-analyses comparing the effectiveness of PTSD treatments have found EMDR to be among the most effective treatments for PTSD (e.g., Bradley et al., 2005; Seidler & Wagner, 2006). It has been difficult to establish why EMDR works, but it is believed to work through imaginal exposure to traumatic, stimulating communication between the left and right brain hemispheres, and/or by taxing the working memory during recall through moving the eye, which results in trauma memories becoming less vivid and less emotional (van Den Hout & Engelhard, 2012).

Imagery in Motivating and Facilitating Behavioural Change. Many imagery-based behavioural techniques have been developed that are based on operant learning principles, such as imagined behavioural experiments (see Curwen et al., 2000; Hackmann, 1998 for reviews). For example, in the context of behavioural activation in treating depression or building distress tolerance skills, clients can struggle to enact new behaviours. Imagery can facilitate the transition from planning to enacting new behaviours by allowing clients to pre-experience the new adaptive behaviour and its impact (Saulsman et al., 2019). Palmer and colleagues developed a number of imagery techniques to help motivate and encourage reluctant clients to face up to and deal with their problems (Milner & Palmer, 2003; Palmer & Neenan, 1998). For example, one technique involves inviting clients to visualise their future based on avoiding their problem (inaction imagery) in contrast to another view of their future based on dealing with their problem (action imagery) (Curwen et al., 2000).

Eliciting Diagnostic Imagery. Hackmann et al. (2011) argued that an assessment of clients' imagery needs to be a part of any comprehensive assessment, given that imagery is

understood as a form of cognition that can reflect the clients' assumptions, beliefs and meaning systems. Hackmann et al. (2011) described the therapist's role as helping clients examine their imagery (e.g., associated affect, body sensations, thoughts, memories) and making sense of the content of their imagery (e.g., what it means about the self, other people, the world, and the future), as well as determining the client's metacognitive beliefs about having the imagery (e.g., believed as real or unquestionably valid). This work considers autobiographical imagery and thematic meanings rather than symbolic meanings (Freeman, 1981; Hackmann, 1998; Thomas, 2016).

Imagery Rescripting. Imagery rescripting was developed by Smucker and his colleagues (e.g., Smucker et al., 1995, 2002; Holmes et al., 2007) to transform the imagery content in the treatment of PTSD symptoms and trauma-related beliefs. It draws on the previously developed methods of imaginal exposure and covert conditioning discussed earlier. The client is encouraged to recall a memory image as if it were happening in the present tense, with particular attention to details within the imagery to increase the vividness of the imagery. Particular attention is also given to the client's associated thoughts and emotions. The client is guided to then modify the image with mastery or coping imagery. For example, by visualising her/himself as an adult entering into the scene (Holmes et al., 2007; Simos, 2002) or visualising a 'survivor' self coming to the aid of the 'victim' self (Smucker & Dancu, 2005). Imagery rescripting is also generally used to transform aversive memories and any distressing problematic imagery into more benign forms in a wide range of disorders (Fidaleo et al., 1999; Morina et al., 2017). Such techniques have been combined with exposure treatment in the treatment of PTSD (Long & Quevillon, 2009).

Changing Imagery Perspective. Changing the perspective of the imagery is a technique for enabling a different perspective or focus to modulate the emotional impact of the imagery and to help change appraisals and facilitate cognitive shifts (Hackmann, 1998;

Holmes et al., 2008a). One technique used is to invite the client to shift from observer perspective to field perspective so that the client no longer observes her/himself from an external point of view, which is often associated with distorted imagery, but rather focuses on looking out on the external environment and observing the true reactions of others, which is hypothesised to facilitate emotional processing (see Burnett Heyes et al., 2017). Another technique is to invite the client to see the image as just an image that can be adapted. For example, viewing an upsetting image within a box that is closed or on a television screen. In these cases, the meaning of having the imagery is changed and it becomes less significant (Hackmann, 1998). Similar techniques can be used for intrusive and traumatic images to alter them and keep them manageable (Hackmann, 1998).

Time Projection Imagery. Another technique to reduce the negative impact of imagery is to elaborate on the context in which it appears (Hackmann et al., 2011). Negative imagery often stops at the worst point, so encouraging the client to run her/his imagery past the worst point to unfold what might happen next and in years to come can help the client to keep the situation in perspective (Curwen et al., 2000). Lazarus (1989) described this technique as 'time projection imagery', where the client is guided backwards to relive past events or forwards to see that s/he will be able to overcome and survive the current situation.

Positive Imagery. Techniques have been developed that focus on generating positive imagery rather than reducing the impact of negative imagery, particularly when the client has an absence of positive imagery (Hackmann et al., 2011; Thomas, 2016). For example, within the experience of depression and hopelessness, clients can be prompted to generate positive imagery, which can have a motivating or calming effect (Curwen et al., 2000; Hackmann, 1998). In this case, a client can be asked to imagine the details of a situation in the future when the depression is over (Hackmann, 1998), or visualise a scene, real or imaginary, that is positive or pleasant and zoom in to focus on aspects of it. This technique is also considered to

be a good cognitive distraction technique (Curwen et al., 2000). Encouraging the generation of positive imagery has been used to enhance goal setting, skill development, and problem-solving (see Hackmann et al., 2011).

Contemporary CBT Approaches to Working With Client Imagery

There are a number of therapies that have sought to extend traditional CBT to increase its effectiveness by integrating aspects from psychodynamic and humanistic or other therapeutic approaches and emphasising contextual and experiential change strategies (Carvalho et al., 2017). There is debate over whether these new developments represent mere extensions of CBT or more radical departures from it (see Herbert & Forman, 2011). Many of these new therapies focus more on the context, processes, and function of clients' internal experiences, including imagery, rather than on the content per se (Herbert & Forman, 2011; Thomas, 2016). Experiential and metacognitive processing are often targeted, with the help of imagery, to process emotion, engage information processing that is not readily accessible to conscious awareness, and change how clients relate to their difficult inner experiences (Hayes, 2004). Particular attention is often paid to transforming meaning, and metaphoric imagery is used to achieve this by providing a conceptual bridge from a problematic interpretation to a new perspective on the experience (Stott et al., 2010). Stott et al. (2010) developed a conceptual framework, building on Lakoff and Johnson's (1980) work as well as more recent work in psychology, cognitive neuroscience, and artificial intelligence to explain why metaphor may trigger therapeutic change. They suggested that metaphors allow clients to use familiar sensory and motor experiences to understand, use, and modify more abstract concepts. New research and theoretical developments have led to a range of new imagery methods and techniques within new CBT therapies, some of which are examined below.

Schema Therapy. Schema therapy, developed by Jeffery Young in collaboration with colleagues, integrates concepts and techniques from CBT, psychodynamic, interpersonal, and

humanistic therapies to address chronic complex psychological problems rather than acute symptoms (Young et al., 2003). The schema concept refers to the underlying maladaptive patterns of behaviour and interaction that consist of a complex cluster of cognitions, emotions, sensations, meaning, and reaction tendencies, which have become entrenched given intense or repetitive prior experiences (Young et al., 2003). Schema therapy provides a way to identify such schemas and guide clients to develop more functional ways to get their emotional needs met (Young et al., 2003). Within schema therapy, imagery is conceptualised as a way to attend to information and emotional processing that is not readily accessible to conscious awareness (Martin & Young, 2010).

Schema therapy incorporates an imagery assessment to activate the client's central schemas by accessing a schema-related childhood experience through guided imagery. This enables therapists to obtain insight into the origin of clients' schemas (Young et al., 2003). Clients are guided to relax, then let a problematic emotion, somatic sensation, or visual image of themselves come to mind. They are invited to remember a situation in childhood where they had the same emotion, sensation, or image and report on the sensory features of the memory image in detail in the present tense to make the imagery as vivid and emotional as possible. As the clients experience emotions associated with their schemas, their coping styles, characteristic modes, and patterns in the therapeutic relationship are observed. Once the imagery reliving comes to an end, discussion is facilitated, in which the clients verbalise their sense of self and others during the worst moments of the imagined situation, which provides an individualised formulation of the activated schema (Young et al., 2003).

Within schema therapy, experiential techniques use imagery and dialogue to explore and synchronise the link between emotions and cognitive changes (Martin & Young, 2010). Central experiential techniques include imagery rescripting and empty chair imaginal dialogues, which have both been previously discussed. Within Schema therapy, these

techniques help clients to access, express, and process their emotions while their unmet needs are met in therapy, which brings about emotional change (Young et al., 2003). This process also changes the meaning of memory representations of negative events into a more functional direction, while the memory of what actually happened remains intact (Arntz, 2012).

Compassion Focused Therapy. Compassion focused therapy (CFT) is an integrated and transdiagnostic approach to address shame and self-criticism, which was developed by Paul Gilbert in response to observing clients' difficulties generating affiliative feelings for themselves (Gilbert, 2000, 2010, 2014). Compassion mind training is central to CFT and uses imagery to access and alter clients' neurophysiological systems that underpin the affect of self-soothing (Gilbert, 2010). Compassionate mind training draws on evidence-based interventions common to other therapy approaches, such as mindfulness and attention training, imagery rescripting, mentalisation and perspective-taking, and positive imagery to practice cultivating compassion as a self-identity (Gilbert, 2014). For example, in one exercise, the therapist guides the client to explore her/his ideal compassionate other who is capable of fulfilling the soothing needs of the client in order to generate experiences of compassion and compassionate self-relating (Gilbert, 2009). In another exercise, the client is guided to imagine her/himself as a compassionate person and practice compassion for others, taking on compassionate facial expressions, body postures, voice tones, and styles of thinking (Gilbert, 2009). Another exercise involves working with the client's metaphoric imagery of her/his inner critic to 'mentalise the critic' and change the way the client relates to it (Gilbert, 2014). This process may also lead to rescripting emotional memories to recode these memories with the new affect processing system of the affiliative system (Gilbert, 2014).

Therapist Imagery in Therapy

Interest in imagery in the psychotherapeutic literature has centred on clients' experiences of imagery rather than on therapists' experiences. However, there has been some consideration of therapists' imagery in the psychodynamic and integrative literature. Increasing emphasis on the centrality of the therapeutic relationship in the effectiveness of therapeutic work and in the process of change may have contributed to this consideration of therapist imagery (Castonguay et al., 2006).

Imagery Arising From What is Articulated

Within the psychodynamic and integrative literature, some therapists have described experiences of imagery arising out of their attempts to imagine their clients' lived experiences in order to understand and empathise. Edelson (1993) described cultivating a listening practice of consciously transforming clients' descriptions into multisensory imagery to gain a felt sense of the client's experience. He instructed trainee therapists in this process to, "Ask yourself as you listen to the [client]: Can you see what they are doing? Hear what they are saying?" (Edelson, 1993, p. 317). Levenson (2003) compared this process to being a filmmaker who transforms scripts into visual images in order to create mental representations of the client material and a coherent narrative. He described how this process enables right-brain processing, which facilitates the perception of "patterns within a holistic framework" and comprehension of the client's sensory experience, emotions, and meanings (Levenson, 2003, p. 238). This process has also been referred to as "vicarious introspection" and considered synonymous with empathy, as it involves sensing and understanding another person's inner experience (Grotstein, 1981, p. 123; Kohut, 1959, p. 459).

Levenson (2003) argued that the cultivation of imagery narratives not only facilitates the mental representation of what the client has articulated in therapy, but can also reveal what has not been said. He suggested that the client's "gapped narrative" can reveal what the

client omitted, perhaps that which is too anxiety-provoking and left out, dissociated, repressed, or unattended (Levenson, 2003, p. 234).

Gardner (1989) and Finlay (2015) described metaphoric imagery experiences that integrated clients' descriptions, captured complexity, and enabled bodily felt senses to arise, as well as new understanding and insight into the clients. Finlay (2015, 2016), an integrative therapist, described making use of her own experiences by using the focusing technique to obtain a felt sense and metaphoric image in order to empathise with, understand, and interpret the client's experience.

Imagery Arising From What is Not Articulated

Most of the psychodynamic literature on therapist imagery focuses on that which relates to unarticulated material, rather than what has been articulated, in therapy. Some therapists (e.g., Jung, 1968; Cwik, 2011; Shaverien, 2007) have conceptualised imagery as a bridge between the conscious and unconscious. Lothane (2007) explained that imagery can be a product of preconscious or unconscious mental activity that emerges into consciousness. Ogden (1994) suggested that imagery can be a symbolic expression of unconscious processes and experience. Some therapists have described accessing unconscious material through their own imagery, which involves not just listening to what is said in therapy, but "listening to what is just below the surface waiting to be said" (Cwik, 2017, p. 107), listening with the third ear, and seeing with the mind's eye (Gardner, 1989; Reik, 1948).

Countertransference-Generated Imagery. Some therapists (e.g., Kern, 1978; Ross & Kapp, 1962) have described their imagery arising out of and illuminating unrecognised transference-countertransference interactions. Some therapists (e.g., Ross & Kapp, 1962; Shaverien, 2007) have suggested that some countertransference responses may emerge in the form of imagery in the therapist's inner experience. Samuels (1985) suggested that countertransference responses to unconscious communication from the client may be

understood as imagery, given that it is imaginal by nature and occurs without a direct stimulus.

Psychodynamic therapists (e.g., Jacobs, 1983; Kern, 1978) have described countertransference-generated imagery as either reflecting the therapist's unresolved issues or reflecting something about the client. Kern (1978) wrote about imagery experiences that reflected his own unresolved issues and defensive responses in therapy. Although his imagery in therapy reflected his client's descriptions, he noticed that it also included background elements from his own memories. He initially interpreted this imagery as his attempt to "vicariously introspect" and empathise with his clients (p. 27). However, after reflecting, he noticed that his imagery contained personal content related to his own childhood difficulties and unresolved issues, and came to perceive that aspects of his imagery were countertransferential and were influencing his responses to his client. Kern (1978) and others (e.g., Cooper, 2008) have stressed the potential for some countertransference-generated imagery to disrupt empathy and therapeutic processes, and the importance of self-reflection to ensure that countertransference distortions are overcome and empathy is restored.

Shaverien (2007) wrote about countertransference-generated imagery that reflected and clarified something about her clients. For example, she described working with a client who had endured psychological and verbal abuse from her mother. The client was unable to become fully aware of this given her fragile state. Shaverien experienced a repeated auditory image of the phrase, "mirror, mirror on the wall, who is the fairest of us all?" – the words from the wicked stepmother in the story of *Snow White* (2007, p. 417). After struggling to make sense of this, Shaverien disclosed her auditory image to the client. In response, the client reported that these were the very words her mother had repeatedly said to her as a child. Shaverien (2007) perceived that this allowed her to have a much greater understanding

of how the client experienced her mother, and the mother's continued influence in the client's life.

Imagery Arising From the Intersubjective Third. Ogden (1994, 2004) and some other therapists have conceptualised therapists' imagery as a co-construction, jointly created by the therapist and the client unconsciously. This conceptualisation comes from the notion that the therapeutic relationship involves not only the subjectivities of the therapist and the client, but also a third intersubjectivity, referred to as the intersubjective analytic third, or the third (Cwik, 2017; Ogden, 1994). This intersubjective third is a natural function of the interactive field. According to Ogden (1994, 2001), therapists can only gain access to the intersubjective third and the unconscious experiences of their clients by getting a sense of their own unconscious experience in and of the third through their own reveries. Ogden (2001) defines reveries as the ordinary and unobtrusive thoughts, feelings, images, and bodily sensations that do not seem particularly connected to client material at the time. According to this perspective, the therapist's reveries are understood as manifestations of the unconscious interplay between the therapist and client and symbolisations of the unrecognised and unarticulated experiences of the client that are unconsciously communicated (Ogden, 2004). Ogden (1979) argued that the mechanism by which the client unconsciously communicates to the therapist is projective identification. Projective identification involves the client projecting unwanted unconscious aspects of the self into the analyst, and in turn the therapist's unconscious processes this material (Ogden, 1979).

Mental States. Some therapists have focused on the receptive state of mind that enables the emergence of imagery, among other associations in the therapist's inner experience. These mental states have been referred to as waking-dreaming (Ogden, 2008), associative dreaming (Cwik, 2011), free association (Ross & Kapp, 1962), free-floating attention (Reik, 1948), and a reverie state (Ogden, 2001). Therapists describe an altered state

of consciousness (e.g., Ogden, 1997, 2001; Singer, 2006) and evenly hovering attention on the client's expressions and descriptions, as well as the therapist's own inner experiences, including imagery (e.g., Reiser, 1999; Schust-Briat, 1996).

The Use of Therapist Imagery For Transformation

Some therapists (e.g., Cwik, 2017; Ogden, 2001; Shaverien, 2007) have argued that the imagery and other reveries that emerge in the therapist's inner experience provide an opportunity for symbolisation, deeper understanding, and transformation. The process of symbolisation is described as involving the accumulation of raw sensory impressions, which are stored and linked over time. They may then be developed internally by the therapist to extract some sense of what may be happening in the third and in the client, then transformed into symbolic representations, and made sense of through primarily verbally based formulations and interpretations (Diamond, 2014; Ogden, 2001). The process of engaging with therapist imagery and other associations has been described as a form of active imagination (Cwik, 2011; Shaverien, 2007).

Therapists' use of their own receptive mental experiences, including imagery and other associations, is thought to mediate emergent consciousness in the client and transformation in the third and in the client. Shaverien (2007) and Cwik (2011) have argued that the therapist's symbolisation process helps to develop the client's capacity for symbolic and reflective thought. Diamond (2014) argued that clients can observe (unconsciously, pre-consciously, and sometimes consciously) and internalise the therapist's efforts to attend to, regulate, and utilise her/his own mind to understand the client and as a result develop a greater capacity for self-insight. The therapist's receptive state and use of her/his own inner experiences has been likened to Winnicott's (1945) concept of holding and Bion's (1962) idea of containment (Diamond, 2014; Grotstein, 2007).

Ogden (2004) described his view of an unfolding and transformative process in which he used his imagery to recognise and verbally symbolise what was occurring in the therapeutic relationship at an unconscious level with a client. He described experiencing mechanical-like imagery and sensations of "bumping up against immovable, mechanical inhumanness" (p. 179). Ogden struggled to make sense of this confusing imagery, but believed that with time it gave him insight into the nature of the client's experience. Ogden used his experience to acknowledge how the client may have been feeling. Ogden believed this helped the client to become more aware of his own feelings and feel them in such a way that he felt less disconnected from himself and Ogden, which Ogden thought led to a transformation in their relatedness (Ogden, 2004).

Empirical Research on Therapist Imagery

Three empirical research studies that investigated therapists' imagery in therapy were identified. Before examining these, however, an earlier study by Samuels (1985), which does not meet the standards of empirical research, will be considered. Although Samuels (1985) did not address therapists' imagery directly, he investigated his own theory that some countertransference reactions in the therapist are best understood as resulting from unconscious communications from the client and hence, can be used in therapy, and also that the concept of countertransference is linked to the *mundus imaginalis* (the imaginal world). Samuels sent a questionnaire to 32 therapists whom he had supervised, asking them to write about any countertransference reactions they had experienced that they considered to result from the unconscious communication of their clients, as opposed to resulting from their own unresolved issues. Twenty-seven psychotherapists responded, providing 57 cases. Samuels reported that these cases included 76 countertransferential reactions in total. Although Samuels did not provide any details of how he analysed the questionnaire data, he interpreted the countertransference reactions (bodily, affective, and behavioural responses and

phantasies) as imagery arising in the therapist's mind in the absence of a direct stimulus, which reflected an unarticulated state within the client (Samuels, 1985). Samuels suggested that the clients' unconscious communications appeared in the therapist's inner world through imagery (Samuels, 1985). Thus, he suggested that therapists' imagery can provide a useful source of knowledge about the client. Samuels also suggested that the therapeutic relationship can be understood as being situated within the imaginal realm where the therapist can imagine thinking, feeling, or behaving as if s/he were the client. Thus, he suggested that therapists' imagery provides an avenue of communication that can improve the connection between the therapist and client. However, Samuels' research methods were biased to confirm his hypothesis, including the use of leading questions in his questionnaire.

Bell et al. (2015) interviewed 12 recently qualified CBT therapists about their experiences of using imagery as a therapeutic technique in therapy. The study also investigated therapists' personal experiences of imagery and how that influenced their use of imagery with clients in therapy. Interpretative phenomenological analysis of the interview transcriptions revealed that all the therapists conceptualised imagery as a multisensory phenomenon, although the visual modality was given particular salience. Their conceptualisation and definition of imagery developed and broadened as the interviews progressed, given it was the first time many of the therapists had reflected on imagery in any depth. All the therapists valued imagery, had a strong rationale for the utilisation of imagery with clients in therapy, and believed in the importance of imagery-specific-training. However, there was varied practical application of imagery in therapy, which was related to the therapists' personal experiences of imagery. Half of the therapists described a personal affinity with imagery, which they understood to be a salient reason for their use of it with clients. However, other therapists described upsetting or overwhelming vivid imagery experiences, which led to caution and avoidance of using imagery with clients. The therapists

who experienced less imagery, thought that the use of imagery in therapy was at odds with their natural style. However, those who received additional training gained confidence to use imagery with clients in therapy. Some therapists described various external factors that influenced the development of their confidence, such as meditation practice, which influenced their exploration of imagery and subsequent use of it within their clinical work. Nevertheless, all the therapists reported some form of avoidance and apprehension of imagery work in therapy, which was linked to their perceived competency. All the therapists reported limited training on imagery, with only minimal reference to it, which they perceived to limit their confidence and later experimentation in imagery work with clients.

In a small qualitative study of therapist imagery, McGown (2015) interviewed five psychotherapists, who experienced spontaneous imagery when working with clients, about their experiences. The theoretical background of these therapists included drama therapy, transactional analysis, and integrative approaches with varying emphases on humanistic and psychodynamic traditions and attachment theory. The interpretative phenomenological analysis identified that the therapists all described experiencing multisensory imagery in therapy, which they conceptualised as a relational phenomenon and an act of co-creation. All of the therapists described having a personal affinity with imagery, but for some this at times conflicted with their professional identities, reflecting a gap in the therapists' training on the integration of imagery in clinical practice. The therapists understood their imagery in different ways. It was commonly understood in terms of transference-countertransference, although the therapists had multi-layered perspectives. Some understood their imagery as a way of "knowing", which they linked to "intuition" (pp. 132-133). In the interpretive phenomenological analysis (IPA), McGown used her own imagery as "an instrument of knowing", which she perceived as "an alternative model of knowing which goes beyond conscious cognitive-analytical knowing" (McGown, 2015, p. 130). Another way the

therapists in the study understood their imagery was as an intermediary agent, either as a transitional object or as a bridge between the non-verbal and verbal. Some therapists understood their imagery as a spiritual phenomenon. All of the therapists believed that their imagery facilitated therapeutic processes, and perceived its facilitatory role in a number of different ways. Some saw their imagery as a source of insight that informed or guided them in their work with clients. Some understood their imagery as a form of containment and holding, for example one therapist described his imagery containing different thoughts in therapy over time, which helped to increase his capacity to remain in uncertainty. Some therapists perceived that their imagery facilitated connection with the client and deepened the therapeutic bond, for example by creating a sense of intimacy or playfulness. Some also identified challenges that arose from their imagery, such as managing disorientating and confusing imagery, which led them to take a cautionary approach to disclosure of their imagery in therapy to avoid shaming the client or rupturing the therapeutic alliance. This thesis study suggests the potency of some therapists' imagery and the potential facilitative role imagery can play in informing and transforming therapeutic processes.

More recently, Cartwright et al. (2019) conducted an online questionnaire survey of 43 therapists' experiences and conceptualisations of imagery. The therapists were mostly psychologists who had been practicing as therapists for two to 35 years. The therapists reported varied experiences of imagery. Although visual imagery was most common, other sensory modalities were also reported. Around one-third of the therapists rated the vividness and frequency of their imagery in everyday life as low (rating 1 or 2 on a 5-point scale). The therapists generally considered their imagery to be helpful rather than problematic (with an average rating of 4.3 on a 5-point scale, with 0 being more problematic and 5 being more helpful), although many therapists reported little training in this regard.

The therapists were asked to provide one or two recent examples of experiences of imagery in therapy. Thematic analysis of these reports revealed that in almost half of the reports, the therapists perceived that their imagery, which was mostly metaphoric or symbolic, provided new perspectives on clients' experiences and issues. Within this theme, the therapists perceived that their imagery led to insights into the client and aided formulation. In almost half of the reports, therapists perceived that their literal imagery of clients' descriptions in therapy elicited emotional reactions that facilitated a sense of connection, empathy, or engagement with clients. Within this theme, some therapists described multisensory imagery including bodily responses that related to the clients' experiences like "empathic representations" and some therapists described metaphoric or symbolic imagery that reflected the clients' experiences (Cartwright et al., 2019, p. 231). In almost a quarter of the reports, therapists who had a psychodynamic and integrative background described their imagery as reflecting their own personal experiences or reactions in therapy, some of which could be considered countertransferential. Some of the imagery described in this theme contained autobiographical elements from the therapists' own lives and in some instances the context was challenging interpersonal processes in therapy. No CBT therapists wrote about personal imagery or imagery that reflected the therapeutic relationship or countertransference.

Some therapists experienced difficulty, especially in the case of literal imagery relating to clients' trauma experiences. The authors concluded that therapists' experiences of imagery are common, often lead to emotional and bodily reactions, have the potential to facilitate insight into the client, and increase a sense of empathy, connection, and engagement in therapy (Cartwright et al., 2019). Therapists' imagery can also reflect their own personal experiences within the therapeutic relationship and countertransference (Cartwright et al., 2019).

Rationale for This Study

Imagery has been recognised as an innate and significant human capacity throughout history (Kosslyn et al., 2006). The therapeutic potential of imagery has also been recognised and this understanding has contributed to the development of psychodynamic, humanistic, and CBT traditions (Singer, 2006; Thomas, 2016). Psychodynamic approaches have viewed the potential of imagery as a bridge between the unconscious and conscious and a source of transformation (Kugler, 2008). Humanistic approaches have emphasised the potential of imagery as a creative and transformative process to help clients access their experiences, find meaning, and realise their potential (Sheikh, 2003). CBT approaches have acknowledged imagery as a form of cognition with representative and associational power (Hackmann et al., 2011). The growing body of empirical research on imagery, which links clinical research, cognitive psychology, neuroscience, and clinical treatments has substantiated the rich potential of imagery in therapy (Hackmann et al, 2011). The research demonstrates that imagery has a strong relationship with both memory and emotion and can affect emotions more powerfully than verbal processing (Holmes & Mathews, 2005, 2010; Mathews et al., 2013). Imagery can function like a weak form of perception (Pearson et al., 2015). Imagery also plays an important role in information processing, experiential knowing, and intuition (Epstein, 2003, 2010). This growing body of research has led to increasing interest in working with imagery in therapy (Hackmann et al., 2011).

However, the research and psychotherapeutic literature has mainly focused on clients' experiences of imagery in therapy and how imagery can be used as a therapeutic tool, with little consideration of therapists' experiences of imagery. The small amount of psychotherapeutic literature and research in this area however suggests that therapists' imagery may be helpful to the therapeutic process but may also be challenging and interfere with the therapeutic process. It is therefore important to develop further understanding of the

potential power of therapists' and also trainee therapists' imagery to facilitate and also disrupt therapeutic processes. Given that it is often difficult for trainee therapists to attend to the process level as well as the content level when working therapeutically (Niemi & Tiuraniemi, 2010; Teyber et al., 2010), a greater understanding of their experiences of imagery and their learning needs in this regard could have important implications for the training and supervision of trainee therapists.

In response to the absence of literature on trainee therapists' experiences of imagery, this thesis has sought to address this gap in the literature by aiming to explore trainee therapists' experiences and conceptualisations of imagery in therapy, the impact of these experiences, and trainees' learning needs in this regard. The following chapter will provide the specific research questions and an overview of the methodology.

Chapter Two: Methodology

This thesis aimed to explore trainee therapists' experiences of imagery when working with clients in therapy; the ways in which they understood these experiences; the impact that these experiences had on the trainees or on therapeutic processes, if any; and trainees' learning needs in this regard. The research questions that guided this thesis were:

1. Do trainee therapists' experience imagery when working with clients in therapy and if so, what types of imagery?
2. What is the impact of trainee therapists' experiences of imagery on the trainees or on therapeutic processes?
3. How do trainee therapists conceptualise and interpret their imagery?
4. What are trainee therapists' learning needs regarding their imagery experiences in therapy?

Given the exploratory nature of this thesis study, a qualitatively driven mixed methods approach was used to provide a comprehensive and in-depth understanding of trainee therapists' imagery experiences and conceptualisations. Qualitative and quantitative data were collected from 39 trainee therapists enrolled in New Zealand post-graduate psychology (clinical psychology and counselling psychology) training programmes. Thirty-seven trainees completed an online questionnaire then 15 of these trainees, along with an additional two trainees were interviewed.

This chapter situates the study and its methodology in the literature, outlines the theoretical framework, and provides a rationale for selecting a qualitatively driven mixed methods approach. The next chapter outlines the methods, including research design, recruitment of participants, participant demographics, and the process of data collection and analysis.

Situating This Study

In the 19th century, the study of imagery in the field of psychology was largely done through the process of introspection to investigate subjective experiences of internal processes (Hall et al., 2006). Psychologist Francis Galton (1869) was the first to study imagery by developing a questionnaire to collect qualitative data comparing the experiences of visual imagery of scientists, artists, children, and statesmen. Psychologist George Betts (1909) expanded on Galton's questionnaire and was the first to use quantitative research methods to investigate students' and trained psychologists' experiences of imagery in their everyday lives. Following the development of behaviourism in psychology in the first half of the twentieth century, with its theoretical orientation toward positivist empirical research methods, the study of subjective phenomena such as imagery was rejected given its inherent methodological limitations (Pearson, 2014). In the last decade, new research methods, including behavioural, neuroimaging, and neurostimulation measures, have permitted objective investigation of the nature and function of imagery, which has resulted in a surge of empirical research (Pearson et al., 2015; Roeckelein, 2004). Yet reviews of the literature on imagery and the methodologies used emphasise the importance of investigating the phenomenological characteristics of imagery, that is, how imagery is subjectively experienced (Ahsen, 1995; Marks, 1999). Regarding subjective measures of imagery experience in psychology, Roeckelein (2004), a research psychologist, suggested that questionnaires are excellent in terms of economy and scope, particularly integrating qualitative and quantitative approaches, but weak in control and interpretation of the meaning of responses. Thus, he recommended follow-up semi-structured interviews to understand and elaborate on questionnaire responses (Roeckelein, 2004). In-depth responses are particularly useful given the multidimensional and complex nature of imagery, which often evokes personal feelings and meanings (Richardson, 1969). The importance of gaining in-depth

responses is recognised in previous studies of therapists' imagery in therapy, as it enables more in-depth analysis and understanding, which is particularly important given the nature of therapy and the potential effect of therapists' imagery on therapy processes (e.g., Cartwright et al., 2019).

A review of the literature on therapists' experiences of imagery found only three empirical studies. The first study is based on qualitative data collected through semi-structured interviews with 12 recently qualified CBT therapists (Bell et al., 2015). The second study is based on qualitative data collected through semi-structured interviews with five therapists (McGown, 2015). The third study is based on qualitative and quantitative data collected through a questionnaire survey of 43 therapists (Cartwright et al., 2019). This current thesis study builds on these three studies by seeking to gain an in-depth understanding of the experiences and conceptualisations of imagery amongst trainee therapists. There is an absence of any research literature on trainee therapists' experiences of imagery, which is a phenomenon that may be significant, even difficult, and of a sensitive nature to trainee therapists.

Theoretical Framework

A critical realist perspective underpins this thesis study. This perspective integrates a realist ontology (acknowledgement of a reality that exists independently of our perceptions, theories, and constructions) with an interpretivist epistemology (acceptance that our knowledge and understanding of reality is partial, incomplete and fallible, and there are different valid accounts of any phenomenon) (Braun & Clarke, 2013; Maxwell & Mittapalli, 2016). This perspective acknowledges the value of understanding different perspectives and that our understanding of these perspectives can be more or less correct (Maxwell & Mittapalli, 2016). Thus, this thesis study acknowledges the reality of imagery and the value of an interpretive perspective for studying trainee therapists' different experiences and

understandings. Critical realism is recognised as a productive stance for mixed methods research, which can facilitate an effective collaboration between qualitative and quantitative research (Maxwell & Mittapalli, 2016). This thesis study assumes a value-laden axiology (Creswell & Plano Clark, 2011). This recognises the role of the researcher's values in influencing the research and the importance of self-reflection to ensure the trustworthiness of the research. The self-reflective stance taken is outlined below.

Qualitatively Driven Mixed Methods Research Approach

Definition and Characteristics

Mixed methods research is defined by its utilisation of both a qualitative and quantitative approach within one research study, which involves the collection, analysis, and integration of quantitative and qualitative data to meet the needs of the research questions (Hesse-Biber, 2018; Morse & Niehaus, 2009; Creswell & Plano Clark, 2011). In qualitatively driven mixed methods research, there is a qualitative foundation and the quantitative component takes a secondary role to provide supplementary information in answering the research questions (Morse & Cheek, 2014; Mason, 2006). Thus, a qualitatively driven mixed methods research approach prioritises the interpretivist epistemology and methodology, which privileges the exploration and understanding of how individuals experience and make meaning of phenomenon within their social world (Hesse-Biber, 2018). This approach recognises the context and the subjectivity of the researcher in the research process (Braun & Clarke, 2013).

Rationale

A qualitatively driven mixed methods research approach was considered the most appropriate for this thesis study for five reasons that are drawn from Greene et al.'s (1989) well-recognised justifications for mixing methods. Firstly, the approach was guided by the

aim of the research and the research questions (Tashakkori & Creswell, 2007). The exploratory nature of the study determined the overall inductive direction consistent with a qualitative approach (Mason, 2006). Yet the research questions guiding this thesis study are four-fold. Firstly, quantitative and qualitative components can be combined to address each research question more comprehensively (Tashakkori & Creswell, 2007). Additional information obtained from quantitative components can enhance description and complement qualitative data (Morse & Niehaus, 2009). The second reason for using mixed methods is 'triangulation', where the utilisation of more than one method to study the same research question can bring convergence and corroboration (Greene et al., 1989; Hesse-Biber, 2010). Findings from a questionnaire can be compared, contrasted, and validated with the findings from interviews. The third reason is 'development', where the findings from a questionnaire can inform follow-up questions in interviews (Bryman, 2006a; Greene et al., 1989). The fourth reason is 'initiation', where findings from a questionnaire and follow-up interviews can raise contradictions or paradoxes that can be examined for more in-depth understanding (Bryman, 2006a; Greene et al., 1989). The fifth is 'expansion', where combining methods can extend the scope of the study (Bryman, 2006a; Greene et al., 1989). Qualitative and quantitative data from a questionnaire can provide a general understanding and follow-up interviews can provide more in-depth understanding.

Trustworthiness of the Research

In qualitatively driven mixed methods research, quality criteria associated with the dominant qualitative method is considered appropriate and can be used to assess both qualitative and quantitative components of the study (Bryman, 2006b; O'Cathain, 2016). Commonly used criteria for determining the trustworthiness of qualitative research were introduced by Lincoln and Guba (1985). Their criteria of credibility, transferability,

dependability, and confirmability continue to be widely recognised and accepted in qualitative research (Creswell, 2012; Morse, 2015; Tolley et al., 2016).

Credibility is the truth of the findings, including an accurate understanding of the context and attention to all relevant voices (Tolley et al., 2016). To be credible, the research findings must be grounded in, and substantiated by the data (Tolley et al., 2016; Tashakkori & Teddie, 2008). In this thesis study, credibility refers to the confidence with which the findings accurately reflect the participants' experiences and understandings of imagery. To establish credibility in this thesis study, several steps were taken. The two-phase sequential research design enabled reflection time after the participants had completed the questionnaire, as well as the cross-checking of data by asking similar questions in both the questionnaire and interviews. Quantitative and qualitative elements also enabled triangulation of data. The sequential design provided an opportunity for divergent experiences and interpretations within each theme from the questionnaire data to be explored in more depth in the interviews. Regular review of the research processes and debriefing with my primary supervisor provided an external credibility check. My primary supervisor reviewed the data coding to ensure the codes represented the data accurately. My primary supervisor also reviewed the development of the themes and the write-up of the findings to ensure that the findings and interpretations were valid and represented the participants' reported experiences and views.

Dependability refers to whether the research process is consistent with accepted standards for particular methodologies and methods (Tolley et al., 2016). To establish dependability, this thesis study used specific, well-established procedures for data collection and analysis in a transparent process. The research procedures were documented and reviewed by my primary supervisor. This process is outlined in the Data Collection and Data Analysis sections.

Confirmability refers to the degree to which the findings could be confirmed by others, are clearly derived from the data, and reflect the participants' ideas rather than the researcher's ideas (Tolley et al., 2016; Watkins & Gioia, 2015). In this thesis study, continuous self-reflection helped to strengthen confirmability. I observed and documented my own role in the research process and perspectives in a journal. This included personal expectations, assumptions, biases, and responses during the process of data collection, analysis, and interpretation of data, which was discussed with my primary supervisor. This is elaborated on in the following section. To enhance confirmability, verbatim quotes from the participants' responses were used in the analysis and reporting to directly connect interpretations with what the participants actually said.

Transferability refers to the extent to which the research findings are able to have relevance in their particular field of research as well as being applicable to others (Tolley et al., 2016; Watkins & Gioia, 2015). In this thesis study, transferability refers to the data being applicable to trainee therapists and therapy training programmes. To establish transferability, the characteristics of the participants and thick descriptions, including contextual information, were reported so that the findings can be meaningful to others.

Personal Reflection

Throughout my formative years, I had a rich inner life filled with imagination and accompanying imagery. Additionally, imagery seemed to be important within my family and community. I can remember others' experiences of imagery being shared and discussed. For example, my mother and father would share the metaphoric visual imagery of how they understood something. With reflection, I have come to understand that within my family and community, metaphoric and symbolic imagery was valued as a way of synthesising ideas, gaining insight into situations, and finding meaning. My largely positive experience of imagery shaped my belief in the significance of imagery, my appreciation of it, and my

interest in imagery. Yet when I commenced this research study, I initially could not identify any experiences of spontaneous imagery in my daily life or when working with clients in therapy, perhaps because my attention was focused on the content of therapy and my coursework. However, I could deliberately generate very faint imagery. Through my research, I became increasingly aware of my experiences of literal and symbolic imagery in everyday life and when working with clients in therapy. Alongside my research, I reflected on my own experiences of imagery, which were mostly non-intrusive, useful, and of interest to me. My initial unawareness at the beginning of this thesis study and my process of discovery may have influenced my research process, data collection, and data analysis. For example, through the data collection phase I worked with the assumption that other trainees might not have experienced spontaneous imagery or might not have reflected on their experience or understanding, which influenced some of the wording in the questionnaire and follow-up questions. To manage my personal biases, I regularly met with my supervisor through all stages of the research process. During these meetings, the research process was reviewed and my personal experiences and responses were also discussed.

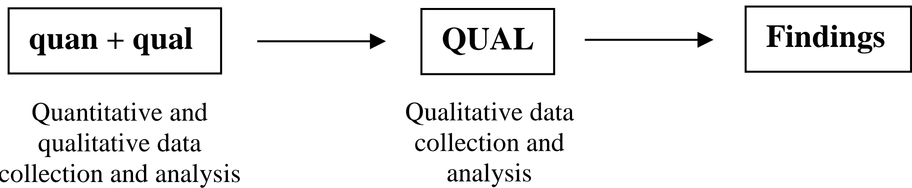
Chapter 3: Methods

Overview of Mixed Methods Research Design

To fulfil the aims of the study, a qualitatively driven mixed methods approach to data collection and analysis was employed. The research design is shown in Figure 1 below. The first study (hereby referred to as Phase 1) involved the collection of quantitative and qualitative data through a questionnaire that 37 trainee therapists completed. Descriptive statistics were used for quantitative data analysis and thematic analysis was used for qualitative data analysis. The purpose of Phase 1 was to gain a general understanding of the participants' experiences and conceptualisations of imagery, gather contextual information, and assist with the gathering of a subsample of participants for follow-up in-depth interviews. Phase 1 of this thesis study also provided key questions that could be expanded on in the interviews. The second study (hereby referred to as Phase 2) involved in-depth interviews with a subset of 15 participants from Phase 1, along with two additional trainee therapists. The interviews were recorded and transcribed by a professional transcriber and the same method of thematic analysis, which is described later in the chapter, was used to analyse the interview data. The purpose of Phase 2 was to gain more in-depth understanding, and compare and contrast some of the data on those questions that appeared to cover the same material from Phase 1 and 2.

Figure 1

Qualitatively Driven Mixed Methods Research Design



Recruitment

It was a criterion that participants were currently enrolled in a post-graduate psychology (clinical or counselling) training programme in New Zealand. Following ethics approval, the advertisement (see Appendix A) with a link to the participant information sheet (see Appendix B) and the online questionnaire (see Appendix C) was emailed to trainee therapists through New Zealand post-graduate clinical and counselling psychology training programmes and the New Zealand College of Clinical Psychologists (NZCCP) student members email lists. Upon completing the questionnaire, the participants were given the opportunity to enter a prize draw to win one of four NZ$100 supermarket vouchers. Participants were also invited to take part in a follow-up interview at a location of their choice or via telephone or skype and receive a NZ$40 supermarket voucher for their time.

Participants

In total, 39 trainee therapists, 34 (87.2%) females and five (12.8%) males, participated in the study. Thirty-seven trainees participated in Phase 1 of the study; 15 of these trainees, as well as two additional trainees participated in Phase 2. Demographic data were collected in the questionnaire study. The age of the participants ranged from 23 to 48 years (*M* = 30.0 years, *SD* = 5.7). All but one participant indicated their ethnicity. Of these, 28 (75.7%) identified as Pākehā (New Zealand European), four (10.8%) identified as Māori, one (2.8%) identified as Asian, one (2.8%) identified as a Pacific Islander, one (2.8%) identified as African, and one (2.8%) identified as South American. The majority (35 participants) (94.6%) were enrolled in a clinical psychology training programme and two (5.4%) participants were enrolled in a counselling psychology training programme. Seven (18.9%) participants were in their first year of their post-graduate training programme, four (10.8%) were in their second year, 25 (67.7%) were in their third year, and one (2.7%) was in her/his fourth year, averaging at 2.5 years (*SD* = 0.8). The number of half-year semesters working

with clients completed ranged from one to six (*M* = 3.4 semesters, *SD* = 1.6). The estimated number of clients worked with ranged from one to 50 (*M* = 21.5 clients, *SD* = 15.1) and the estimated client sessions observed ranged from one to 100 (*M* = 16.4 sessions observed, *SD* = 19.9). Of the 36 participants who named their main treatment approach, the majority (83.3%) reported mostly training in CBT, three participants (8.3%) reported mostly training in Acceptance and Commitment Therapy, two (5.6%) reported mostly training in humanistic approaches, and one (2.8%) reported mostly training in Dialectical Behavioural Therapy.

Data Collection

Phase 1: Questionnaire

The online questionnaire was designed to take approximately twenty minutes to complete and consisted of 23 questions including rating scales, closed-ended questions, and open-ended questions (see Appendix C). The questionnaire opened to the participant information sheet, which participants were asked to read before beginning the questionnaire. Once they proceeded to the questionnaire, the first 10 questions elicited demographic information. The participants were then given the following definition of mental imagery:

> Some people experience mental imagery. Mental imagery can be visual and involve seeing pictures in the mind's eye, or it can involve sounds, smells, tastes or physical sensations. Some people also describe having a 'felt sense'. We are interested in the mental imagery – images, sounds, smells, tastes, physical sensations, felt senses – that trainee therapists experience, particularly in therapy. Not everybody experiences mental imagery. If you do not experience mental imagery, we are still interested in your experience. We want to understand the experiences of those who have mental imagery and those who don’t.

Following the definition, participants were asked to rate the frequency and strength/vividness of their imagery in everyday life on a 5-point Likert scale (from ‘not at all’ to ‘very much’). They were then asked to indicate in a checkbox if they experience imagery or something that fits with the definition, which led to conditional branching in the questionnaire. If participants reported that they do not experience mental imagery, they were asked if they had heard the terms “mental imagery or visualisation” before and to describe what they thought they meant. They were asked to describe what their experience had been when asked to visualise or imagine something and comment on other internal experiences they had experienced when working with clients, if any.

If participants reported experiencing imagery, they were asked to describe the type/s of imagery they most commonly experience. They were provided open spaces to describe one or two experiences of imagery when working therapeutically with a client, including what happened in the session, how they felt and responded, any positive or negative effects, and how they understood or interpreted this experience. Given the exploratory nature of this thesis study, participants were asked to rate on a 5-point Likert scale their level of agreement with four items related to their personal experience of imagery in therapy; namely, the level to which participants viewed imagery in therapy as helpful and problematic, the level to which they had discussed their imagery in supervision or with peers, and the level to which participants had learnt about imagery in their training. Participants were then asked how their cultural identity had influenced their experience and understanding of imagery, if at all. Lastly, participants were asked to write about any other experiences or ideas they were not able to express and what they would like to learn concerning therapists’ imagery.

The online questionnaire ended by thanking participants for taking the time to participate in the study and inviting them to provide their email address to enter the prize

draw to win one of four NZ$100 supermarket vouchers. Participants were then invited to provide their email address if they were willing to take part in a follow-up interview.

Phase 2: Interviews

Initially 21 participants indicated their willingness to be interviewed; 15 of these engaged and were interviewed. Two additional participants were interviewed but did not complete the questionnaire, at their request. A standardised email was sent to willing participants thanking them for their interest and inviting them to suggest a suitable time and location to meet. The interviews were semi-structured and consisted of similar questions to cross-check data from the questionnaire, follow-up questions to build on the questionnaire data for more in-depth understanding, and new questions to extend the scope of the study (see Appendix E). Five interviews were carried out face-to-face and twelve interviews were carried out over Skype. Participants were encouraged to talk about their experiences and understanding of imagery through their life generally. They were then asked for specific instances when working therapeutically with clients including how their imagery influenced them and their understanding or interpretation of their experience. Participants were asked how their experience and understanding of imagery had changed across their training, circumstances in which they were more or less likely to experience imagery, the importance of imagery to them, and how their cultural identity had influenced their experience and understanding, if at all. They were asked follow-up questions about what they had learned about therapists' imagery through their training and what they would like to learn. Lastly, they were given the opportunity to share any additional ideas. Participants were thanked for their contribution to the research and given a NZ$40 supermarket voucher.

Data Analysis

Phase 1: Questionnaire

*The w*ritten responses, excluding demographic data, added up to 6,191 words and varied in length from 10 to 884 words (*M* = 281.4 words, *SD* = 216.9). Ten participants provided one report of a situation in which they had experienced imagery in (*M* = 134 words) and 12 participants provided two reports (*M* = 137 words). This resulted in 34 reports in total.

Quantitative Analysis: Descriptive Statistics. Nominal data were collected for the following demographic variables: gender; ethnicity; type of training programme; qualification structure; and whether or not participants experience imagery. Ordinal data were collected for therapeutic approach rankings and Likert scale variables measuring: frequency of imagery; strength/vividness of imagery; level to which imagery is perceived as helpful; problematic; discussion in supervision or with peers; and training. Interval data were collected for the following demographic variables: age; year in professional training; number of semesters working with clients; estimated number of clients worked with; and estimated number of client sessions observed.

All nominal, ordinal, and interval data were exported from Qualtrics as an Excel spreadsheet file and entered into version 26 of the Statistical Package for the Social Sciences (SPSS) for analysis. Given the exploratory nature of this thesis study, exploratory data analysis was undertaken. Exploratory data analysis involves a range of methods to develop a deeper understanding of the data, discover patterns, investigate a variety of possible relationships, and generate hypotheses (Perti & Hevey, 2010). Descriptive statistics were developed to analyse the basic features of the data. Nominal and ordinal data were analysed using non-parametric statistics. However, given that methodology research has shown that Likert scale data can be analysed using parametric statistics (e.g., Norman, 2010; Carifio & Perla, 2008; Sullivan & Artino, 2013), data from the Likert scales were analysed using

parametric statistics, along with the interval data. Scatter plots were constructed to verify the linearity of the relationship between variables before measuring correlations (Sheskin, 2004).

Measures of correlation were used to analyse the relationships between variables and determine the strength, direction, and significance of these relationships. The effect sizes were determined using Cohen's (1992) widely used benchmarks, which refer to effect sizes as small ($\rho = 0.1$), medium ($\rho = 0.3$), and large ($\rho = 0.5$). The Spearman's rank correlation was used to determine the strength and direction of association between demographic aspects (interval variables) and aspects of subjective imagery experience (Likert scale variables). The Spearman rank correlation does not assume any assumptions about the distribution of the data and is the appropriate measure of correlation when the variables are measured on a scale that is at least ordinal (Sheskin, 2004). The point-biserial correlation was used to measure the strength and direction of association between demographic aspects and aspects of imagery experience, where one variable is measured on an interval scale and one variable is represented on a dichotomous scale (e.g., two categories) (Sheskin, 2004). The rank-biserial correlation was used to measure the strength and direction of association between demographic aspects and aspects of imagery experience, where one variable is measured on an ordinal scale and one variable is represented on a dichotomous scale (Sheskin, 2004).

Qualitative Analysis: Thematic Analysis. The participants' reported experiences and conceptualisations of imagery and their reported areas of desired learning were separately analysed using a method of thematic analysis described by Braun and Clarke (2006). Thematic analysis is a commonly used method to provide a rich and detailed account of the data, by highlighting similarities and differences across the data set and capturing the complexities (Braun & Clarke, 2013). The analysis adhered to Braun and Clarke's (2006) six-step process as explained below.

Step One: Familiarisation with the data. Initially, the completed questionnaires were exported from the Qualtrics website as an Excel spreadsheet and the qualitative data was transferred to Word files, which were printed. Repeated reading of the data allowed for familiarisation with the breadth and depth of the content and the structure of the responses. Initial ideas and patterns in the data were noted on the margin of the printed documents (Braun & Clarke, 2006).

Step Two: Coding. The initial ideas and patterns noted were sorted into initial codes according to the content and meaning, specifically the types of imagery, context, responses, and interpretations, then separately for the areas of desired learning. Once these initial codes were generated, different coloured highlighters were used to systematically code the data sets. This process created two comprehensive lists of codes relating to the participants' experiences and conceptualisations of imagery and the areas of desired learning. The lists of codes were analysed and sorted into groups of related codes and distinct categories. The initial codes and categories were reviewed by my primary supervisor and the relationships between the codes were discussed.

Step Three: Generating Initial Themes. Once the final codes and distinct categories were agreed upon, broader provisional themes were generated that encapsulated the essence of the data, codes, and categories. The relationships between the codes and between themes were considered and discussed with my primary supervisor. This process resulted in six initial themes regarding participants' experiences and conceptualisations of imagery:

1. Imagery provides a way of processing, knowing, guiding, and remembering
2. Imagery provides insight into the client
3. Imagery facilitates a sense of connection and empathy
4. Imagery provides insight into the therapist
5. Imagery provides insight into the therapeutic process

6. Imagery can be challenging.

Regarding the areas of desired learning, five initial themes were generated:

1. Acknowledgement in training
2. Developing an understanding of therapists' imagery
3. Developing awareness and an ability to reflect on imagery
4. Learning how to manage imagery
5. Learning how to use imagery.

Step Four: Reviewing Themes. The analysis was checked to confirm that the coded data within each theme were appropriate and the themes captured the data and addressed the research questions of interest. The analysis was reviewed by my primary supervisor to check that the data coded under each of the themes were appropriate, and indeed that the themes themselves were credible. The themes were refined in consultation with my primary supervisor. Where there was overlap between the data under separate themes, consideration was given over the merging of themes. As a result, in relation to the participants' experiences and conceptualisations of imagery, the first two themes were merged and the fourth and fifth themes were merged. Finally, the data sets were re-read to check that the themes were coherent and were a valid representation of the data.

Step Five: Defining and Naming Themes. In this phase, the essence of each theme was identified and the final themes were defined and named. The final themes regarding participants' experiences and conceptualisations of imagery were:

1. Understanding the client
2. Empathy and connection
3. Understanding oneself or therapeutic processes
4. Challenging imagery.

The final themes regarding the areas of desired learning were:

1. Acknowledgement in training
2. Developing an understanding of therapist imagery
3. Developing awareness and an ability to reflect on imagery
4. Learning how to manage imagery
5. Learning how to use imagery.

Step Six: Reporting. A precise account of each theme was written up, using quotes to capture the story. Connections were drawn between the data and the research questions.

Phase 2: Interviews

As the two phases of the study were conducted sequentially, the findings from Phase 1 fed into the analysis of the interview data. Firstly, the interviews were transcribed verbatim by a professional transcriber who had signed a confidentiality agreement. The interview data were then analysed using the same six-step method of thematic analysis described above in Phase 1, with the themes generated in Phase 1 held in mind. The data from the participants' reported experiences and conceptualisations of imagery, areas of desired learning, and other comments were coded and collated separately. The coded data relating to the participants' experiences and conceptualisations of imagery and the areas of desired learning were collated into themes consistent with those defined in Phase 1. Given that similar themes emerged in the thematic analyses of the interview data, the interview data and questionnaire data were combined to complete the thematic analyses. Divergent experiences, ideas, and conceptualisations within each theme were discussed with my primary supervisor and subthemes were identified to account for different ideas and meanings. The subthemes identified within each theme were:

1. Understanding the client
    - Processing and understanding the clients' descriptions

- Insight into the client

2. Empathy and connection
   - Facilitating empathy or connectedness
   - Personal memories and emotional connection
3. Understanding oneself or therapeutic processes
   - Insight into self
   - Insight into therapy processes
4. Challenging imagery
   - Intrusive imagery
   - Disrupting the therapeutic relationship
   - Disrupting the therapy processes.

The findings from Phase 2 were integrated into the report presenting the findings from Phase 1. This resulted in one report presenting the findings from Phase 1 and Phase 2 of the study.

Chapter Four: Results

This chapter presents the findings from the quantitative and qualitative analyses of the trainee therapists' experiences and conceptualisations of imagery and their desired areas of learning, as reported in the questionnaire and interviews. Quotes are provided to give a sense of the trainees' views and experiences.

Quantitative Analysis Findings

Experience of Imagery

In the questionnaire, the trainee therapists were asked whether they experience imagery or not, which led to conditional branching in the questionnaire. The majority of trainees (83.8%) reported experiencing imagery. Six trainees (16.2%) reported not experiencing imagery, although four of these trainees reported elsewhere in the questionnaire or follow-up interviews that they did experience imagery. This may reflect the trainees' uncertainty about the definition of imagery or changes in their awareness or perception of their experience over the course of the research study. This is elaborated on in the next section on the findings from the qualitative analysis.

Types of Imagery

The trainees who reported experiencing imagery were asked in the questionnaire to briefly describe the types of imagery they most commonly experience. Of the 22 trainees who responded to this question, all but one (95.5%) reported experiencing visual imagery. Six trainees (27.3%) reported only experiencing visual imagery, and 15 trainees (68.2%) reported experiencing visual imagery as well as other modalities, including "tactile" or "physical sensations" (N = 11), "auditory" (N = 5), "olfactory" (N = 2), and "felt sense" (N = 3). The one trainee who did not report visual imagery described experiencing "felt senses".

Perceived Frequency and Vividness of Imagery

In the questionnaire, the trainee therapists rated the perceived frequency and vividness of their imagery in everyday life on a 5-point scale ranging from 1 (*not at all*) to 5 (*very much*). All the trainees responded to this question and the vast majority (94.6%) reported experiencing imagery in their everyday life (rating above 1 on a 5-point scale), although with much variation in frequency (M = 3.05, SD = 1.18). Over one-third of the trainees (37.8%) rated the frequency of their imagery in everyday life as low (1 or 2 on a 5-point scale) and almost one-third (32.4%) rated it as high (4 or 5 on a 5-point scale). Two trainees (5.4%) reported that they did not experience imagery in their everyday life at all (1 on a 5-point scale). On average, the trainees rated the strength/vividness of their imagery in everyday life as moderate (M = 2.86, SD = 1.27). Almost half (48.7%) of the trainees gave a low rating (1 or 2 on a 5-point scale) while approximately three-tenths (29.7%) of the trainees gave a high rating (4 or 5 on a 5-point scale). See Table 1.

Imagery Experiences When Working Therapeutically

The trainees who reported experiencing imagery in the questionnaire were asked to rate four items about their experience of imagery when working with clients on a 5-point scale ranging from 1 (*not at all*) to 5 (*very much*). The 23 trainees who completed this section perceived their imagery to be helpful (M = 3.52, SD = 1.27) rather than problematic (M = 1.87, SD = 0.81). They reported some discussion about their experiences of imagery in clinical supervision or with colleagues or classmates (M = 2.35, SD = 1.30) and very little or no training in understanding and managing their imagery (M = 1.57, SD = 0.95).

Table 1

Measures of Central Tendency for Imagery Ratings in Everyday Life and in Therapy

Items	N	Mean (SD)	Median	Mode	Range	Percent who rated 1* or 2	Percent who rated 3	Percent who rated 4 or 5*
Imagery in everyday life								
I experience mental imagery in everyday life	37	3.05 (1.18)	3	2	1-5	37.8%	29.7%	32.4%
My mental imagery is strong/vivid	37	2.86 (1.27)	3	2	1-5	48.7%	21.7%	29.7%
Imagery in therapy situations								
Overall my mental imagery is helpful	23	3.52 (1.27)	4	4	1-5	21.7%	21.7%	56.5%
Overall my mental imagery is problematic	23	1.87 (0.81)	2	1	1-3	73.9%	26.0%	0.0%
I talk about my experiences of mental imagery in clinical supervision or with colleagues or classmates	23	2.35 (1.30)	2	1	1-5	60.9%	13.0%	26.0%
I have had training in understanding and managing mental imagery	23	1.57 (0.95)	1	1	1-4	87.0%	4.3%	8.7%

* All items measured on a 5-point scale ranging from 1 (*not at all*) to 5 (*very much*).

Correlations

Table 2

Spearman's Rank Correlations

	N	Age	Year in programme	Semesters working with clients	Number of clients	Number of client sessions observed	Frequency of imagery rating	Vividness of imagery rating	Helpfulness of imagery	Problematic imagery	Discussion of imagery	Training on imagery
Age	37	–										
Year in programme	37	.51** (.00)	–									
Semesters working with clients	37	.34* (.04)	.69** (.00)	–								
Number of clients worked with	37	.35* (.04)	.69** (.00)	.70** (.00)	–							
Number of client sessions observed	37	.20 (.25)	.53** (.00)	.54** (.00)	.54** (.00)	–						
Frequency of imagery rating	37	-.21 (.21)	.07 (.67)	-.09 (.59)	.09 (.61)	.05 (.79)	–					
Vividness of imagery rating	37	-.34* (.04)	-.12 (.49)	-.31 (.07)	-.20 (.07)	.09 (.62)	.72** (.00)	–				
Helpfulness of imagery rating	23	.03 (.88)	.11 (.61)	-.07 (.76)	.07 (.76)	-.04 (.85)	.67** (.00)	.31 (.15)	–			
Problematic imagery rating	23	-.12 (.60)	-.27 (.22)	.01 (.95)	-.15 (.95)	.29 (.18)	.06 (.78)	.28 (.20)	-.04 (.86)	–		
Discussion of imagery rating	23	.16 (.46)	.56** (.01)	.40 (.06)	.35 (.06)	.42* (.05)	.44* (.04)	.35 (.10)	.25 (.26)	-.01 (.99)	–	
Training on imagery rating	23	-.17 (.45)	.14 (.54)	.17 (.45)	.13 (.45)	-.15 (.48)	-.01 (.98)	-.08 (.71)	.17 (.60)	-.01 (.96)	.26 (.24)	–

**Correlation is significant at the 0.01 level (2-tailed).

*Correlation is significant at the 0.05 level (2-tailed).

Table 3

Point-Biserial Correlations

	Experiences imagery (*0=no; 1=yes*)
Training Programme (*0=counselling psych; 1=clinical psych*)	-.09 (.58)
Ethnicity (*0= non-Pākehā; 1=Pākehā*)	-.02 (.90)
Age	.03 (.89)
Year in Programme	.26 (.12)
Number of semesters working with clients	-.04 (.80)
Estimated number of clients worked with	.01 (.94)
Estimated number of client sessions observed	-.29 (.08)

Table 4

Rank-Biserial Correlations

	Experiences imagery (*0=no; 1=yes*)	Training programme (*0=counselling psych; 1=clinical psych*)	Ethnicity (*0= non-Pākehā; 1=Pākehā*)
Experiences imagery (*0=no; 1=yes*)	–	–	–
Training programme (*0=counselling psych; 1=clinical psych*)	-.09 (.58)	–	–
Ethnicity (*0= non-Pākehā; 1=Pākehā*)	-.02 (.09)	.16 (.35)	–
Frequency of imagery rating	.42** (.00)	-.19 (.26)	.02 (.89)
Vividness of imagery rating	.34* (.04)	-.30 (.08)	-.14 (.41)
Helpfulness of imagery rating	.27 (.22)	-.28 (.19)	-.02 (.94)
Problematic imagery rating	-.05 (.82)	.24 (.27)	.07 (.76)
Discussion of imagery rating	.25 (.25)	-.37* (.09)	-.07 (.77)
Training on imagery rating	.15 (.49)	.15 (.49)	-.17 (.44)

**Correlation is significant at the 0.01 level (2-tailed).

*Correlation is significant at the 0.05 level (2-tailed).

Spearman's rank correlation coefficients were calculated to examine the relationships between five demographic variables and six imagery rating scale variables, which are shown in Table 2 above. The statistically significant and meaningful results are also reported below. The results indicated that the trainees' perceived frequency of imagery experiences in everyday life was positively correlated with their perceived imagery vividness ($\rho = .72$, $p < .01$), positively correlated with their perceived helpfulness of imagery ($\rho = .67$, $p < .01$), and positively correlated with their perceived level of discussion in supervision or with peers ($\rho = .44$, $p < .05$). The results indicated that the trainees' perceived imagery vividness was negatively correlated with their age ($\rho = -.34$, $p < .05$). The results also indicated that the trainees' perceived level of discussion about imagery in supervision or with peers was positively correlated with their stage in their training programme ($\rho = .56$, $p < .01$) and positively correlated with the estimated number of client sessions that the trainees had observed ($\rho = .42$, $p < .05$).

Point-biserial correlation coefficients were calculated to examine the relationships between the demographic variables and one dichotomous variable (experience of imagery), which are shown in Table 3 above. The results indicated no statistically significant and meaningful correlations.

Rank-biserial correlation coefficients were calculated to examine the relationships between three dichotomous variables (experience of imagery, training programme, and ethnicity) and six imagery rating scale variables, which are shown in Table 4 above. The statistically significant and meaningful results are reported below. The results indicated that the type of therapy training programme that the trainees were enrolled in was correlated with their perceived level of discussion about imagery in supervision or with peers ($r_{rb} =-.37$, $p < .05$). That is, counselling psychology training was associated with a greater perceived level of discussion about imagery in supervision or with peers compared to clinical psychology

training. This finding, however, needs to be regarded with caution due to the small sample size ($n = 2$) of trainees who were enrolled in a counselling psychology training programme. The results also indicated that the trainees' report of whether or not they experience imagery was positively correlated with their perceived imagery vividness ($r_{rb} = .34$, $p < .05$) and frequency ($r_{rb} = .42$, $p < .01$).

Qualitative Analysis Findings

Experiences of Trainee Therapists Who Reported Not Experiencing Imagery

The six trainees (16.2%) who reported in the questionnaire that they did not experience imagery were asked if they had heard the terms "mental imagery or visualisation" before and to describe what they thought these terms mean. Half said that they had not heard of these terms before and expressed uncertainty over their meaning, although when asked to imagine or visualise something, two of these trainees reported being "able to do so with no issues" (P.33) and that it was "easy to do" (P.25). One trainee described this as "hard because I don't have a vivid imagination" (P.5).

All three of the trainees who had not heard the terms "mental imagery or visualisation" participated in follow-up interviews and reported that after completing the questionnaire and reflecting, they realised that they do experience imagery. For example, one trainee said, "Prior to this conversation I hadn't thought about the concept or recognised my imagery, but visualising and imagining things has always been part of my day-to-day life, it was just unconscious" (P.33). Another trainee who wrote in the questionnaire, "I have no idea what [imagery] is or what it means … I think it means something akin to psychotic phenomena, déjà vu, or matakite", later described a shift in her/his understanding and said in an interview, "I previously said I don't get [imagery] … I now liken imagination and visualisation to going to the gym and working out a muscle. That muscle has grown but I still

struggle with it … I have become more conscious of it, but it's something that I have to practice … its very vague, very faint." (P.5).

Half of the six trainees who reported not experiencing imagery had heard of the terms "mental imagery or visualisation", but reported having "difficulty" visualising or imagining something. For example, one trainee described this as a "difficult, effortful process" (P.34).

Thematic Analysis of Trainees' Experiences and Conceptualisations of Imagery

In the questionnaire study, trainee therapists were asked to write about one or two experiences of imagery when working therapeutically with clients, including the situation, their imagery experience, how they felt and responded, any positive or negative effects of their imagery, and how they understood or interpreted this experience. Twelve trainees did not respond to this open-ended question, and most of these trainees (75%) rated the frequency (M = 2.33, SD = 0.49) and vividness (M = 2.08, SD = 0.51) of their imagery in everyday life as low. In the questionnaire, 14 trainees provided two reports and six trainees provided one report, resulting in 34 reports. In the interviews, 17 trainees provided an additional 39 reports, resulting in a total of 73 imagery reports from the questionnaire and interviews. In the interviews, the trainees also elaborated on 13 reports from the questionnaire, which were only counted once. Forty-seven reports (64.4%) described literal imagery (e.g., of the client's description of a life event), 19 reports (26.0%) described imagery that symbolised or was a metaphor for some aspect of the client's experience, and seven reports (9.6%) described both literal and symbolic or metaphoric elements.

As discussed in the method section, the thematic analyses in Phase 1 and in Phase 2 were conducted sequentially. Phase 1 of the study, which involved the collection and initial analysis of data from the questionnaire, was completed before Phase 2 of the study, which involved the collection and analysis of data from in-depth interviews. Similar themes

emerged in the initial analysis of the interview data to those that emerged from the thematic analysis of the questionnaire data, so the questionnaire data and interview data were combined in the thematic analyses.

Prior to presenting the results of the thematic analysis, it is important to note that the trainees expressed tentativeness in their responses in Phase 1 and Phase 2 of the study. Most of the trainees reported that therapists' imagery was not addressed in their training programmes and that they were previously "unaware" of their imagery, had "not reflected on it", or had "not talked about it" until participating in the study. For example, one trainee said, "I hadn't thought about [my imagery] before. It's just the way I think. I don't think about my imagery, like I don't think about breathing, I just do it" (P.15). Another trainee said, "I've probably heard of [the term mental imagery] before but not paid much attention to it. The first time I thought about it was when I saw your study pop up" (P.28).

Some trainees further reported that answering the questions was "challenging" and many were "not sure how to make sense of" or interpret their imagery experiences. Many commented on the interview process leading to their increased awareness and understanding of imagery. For example, one trainee said, "When I read about this study I thought I didn't have any imagery, the imagery was unconscious but suddenly I realised actually I do have imagery, I think in imagery, the interview process has helped me become aware" (P.29). Another trainee said, "Before this interview, [imagery] wasn't something that I was aware of or thought would be interacting with my practice" (P.36). Another said, "I haven't given it a lot of thought, I haven't had a lot of space to explore it, although [participation in the study] has been a really helpful process. I know more about myself now" (P.38).

Only three trainees reported therapists' imagery being "acknowledged" in their training and reflection on imagery experiences being "encouraged". For example, one trainee described a "reflective process" being facilitated in her/his training to "process" and "make

sense of" a "disconcerting" imagery experience, which led to insights "on how I had been feeling about the client and how to better manage the therapy relationship" (P.13). Despite the trainees' tentativeness in their descriptions and interpretations of their imagery experiences, four themes and nine subthemes emerged in the thematic analysis of their reported experiences and conceptualisations of imagery, which are presented in Table 5 below.

Table 5

Trainee Therapists' Experiences and Conceptualisations of Imagery

Number of reports	Theme	Subtheme
53	Understanding the client	Processing and understanding clients' descriptions
		Insight into the client
41	Empathy and connection	Facilitating empathy or connectedness
		Personal memories and emotional connection
29	Understanding oneself or therapeutic processes	Insight into self
		Insight into therapy processes
21	Challenging imagery	Intrusive imagery
		Disrupting the therapeutic relationship
		Disrupting therapy processes

Theme One: Understanding the Client

In 53 of the 73 reports of imagery experiences (20 from the questionnaire and an additional 33 from the interviews), trainee therapists described literal, metaphoric, or symbolic imagery experiences that they perceived as "helpful" in understanding something about the client. In this theme, trainees interpreted their imagery as a way to "process" and "understand" client material. Trainees also interpreted their imagery as a source of new insight into the client, such as highlighting risk. This understanding and new insight aided formulation and at times influenced directions taken in therapy.

Processing and Understanding Clients' Descriptions. In the majority of the reports within this theme, trainees described literally "imagining" or "visualising" in the "mind's eye" clients' descriptions most commonly of distressing experiences. The trainees considered this as a "natural", "normal", and "inevitable" way to process information and understand something about the client, which some trainees linked to "intuition". For example, one trainee assessed a client who gave "detailed and horrific" accounts of "how he was abused and locked in the dog cage" as a child then as an adult, "how he locked his partner in a cage in the bush as punishment", which the trainee "vividly pictured happening" and in response "felt sad". The trainee interpreted this imagery and subsequent "emotional response" as "the process of me listening to and understanding the client and the impact of the abuse through the client's life", which contributed to the trainee's "process of formulation" (P.29). Another trainee spoke about "picturing" a client's descriptions of a key memory of being lost at a fair as a young child during an assessment and said, "I could see the fair and her looking around for her dad. I had such a strong image in my head of what it was like for her". This helped the trainee "quickly conceptualise and understand" the scenario. The trainee interpreted the imagery as "an important way of knowing" the client's experience and "core issues", and as "a tool for memory" to carry this understanding throughout therapy (P.39).

Some trainees described naturally elaborating upon and "filling in the gaps" when literally imagining clients' descriptions, which helped trainees "see more clearly" and gain a "better understanding" of the client's experience. For example, one trainee who reported "photographic" visual, auditory, and tactile imagery, imagined a client's account of being drunk and punching someone at a party "like watching a TV show" and, in the absence of information, "filled in the blanks". S/he understood this "as a form of intuition". The trainee said, "I automatically created what I thought the party looked like and so I imagined her outside in blue coloured clothes with her hair tied back punching another person". Although

the trainee considered these details to be "slightly off" and "inaccurate", s/he perceived that "filling out the picture" brought "clarity" on the situation, including on the client's feelings of "anger" and "guilt". This elaborated imagery helped the trainee make "connections, understand the problem, and … remember this more easily" throughout the therapy session. The trainee perceived that the emergence of this imagery was influenced by her/his own "active engagement" in the session (P.35). Similarly, another trainee "embedded elements" when "vaguely imagining" a client's "factual" and "emotionless" description of childhood sexual abuse "playing out" visually and audibly as if "through the client's eyes". The trainee described feeling emotionally distant and "in my head" at the time. The elaborated imagery enabled the trainee to "put the picture together of what had happened, consolidate ideas, and understand" the impact of "others brushing [the abuse] under the rug" (P.36). Some trainees recognised potential problems with "unconsciously imagining" details beyond the clients' descriptions. For example, one trainee working with a child with separation anxiety triggered by the Christchurch earthquakes said, "imagery helped me put myself in her shoes to understand what she went through" although the trainee also recognised that s/he was "making up details and relying on imagination and assumptions" in session. S/he understood that the imagery functioned to provide an "intuitive sense" of the client's experience, which needed to be verified. So, s/he responded by "checking in and asking questions to make sure that I was not just projecting on the client" (P.33).

Trainees also described imagery functioning to "highlight gaps" or "discrepancies" in client descriptions or their own understanding. For example, one trainee described discussing with a client his sexual offence in a forensic setting, "visualising" the chain of events, "incorporating" information by "fitting it into the picture, then seeing the gaps". The trainee said, "I pictured him in his room, gaming alone … then I pictured blackness until I pictured family members assaulting him" when they discovered him. The trainee interpreted this

imagery as "helpful" in highlighting the "missing" information, which guided the trainee's follow-up questions in session and led to considerations about the client's suppression and minimisation. The trainee perceived that the vividness of her/his imagery was influenced by the "emotional content" even if the client was "detached" from this (P.29). Another trainee, who likened imagery to a "puzzle" that revealed her/his lack of understanding, described coming to the end of an initial assessment session with only a "vague picture of a group of girls and [the client] by herself and things being said" with sounds of "muffled tones and vocal patterns". The trainee perceived that the "bitsy" imagery revealed that s/he had "missed something and hadn't grasped how [the client's] anxiety was presenting." The trainee responded with further questions to gain "more information" until the "picture was pieced together" and the trainee was confident that s/he "ultimately understood" (P.33). Another trainee visualised a client's account of witnessing a "railway crossing incident between a car and train", which helped the trainee understand that what the client was describing was "implausible" and consider the meaning of this story for the client (P.32).

Insight into the Client. Trainees described imagery that they perceived provided them with new insights into the client. Many of these reports described metaphoric or symbolic imagery. For example, one trainee who was struggling to establish rapport in an initial assessment with a client who "could not identify his emotions", described "seeing a monkey on [the client's] back". The trainee interpreted the imagery as symbolising the client's "agitation and feeling of being weighed down" (P.15). A number of trainees described having spontaneous imagery of the client's home during therapy, when the client had not described such details. The trainees thought this imagery represented their understanding of the client. For example, one trainee described, "building up a full picture of [a client's] house" that symbolised aspects of the client's childhood history. The trainee visualised the client "sitting in the lounge room alone surrounded by books because that's all

she's got to fill her world". The trainee perceived that the imagery "played a big role in terms of the way I pulled lots of ideas together", which led to "insight" into the role of "neglect" in the client's early life (P.38).

Many trainees described imagery that they perceived provided new insights that influenced their responses in therapy. For example, in a situation when a client described experiencing anxiety, one trainee "vividly saw a large, long dark tunnel with a light at the end and a dark shadow figure running towards the light but on the spot". The trainee perceived that this imagery led to an insight that the client was feeling stuck. S/he viewed the imagery as a helpful "metaphor" and responded by sharing it with the client as a way of acknowledging and validating the client's experience of anxiety (P.30). Another trainee built a grief narrative with a client whose four miscarriages had triggered obsessive and compulsive symptoms, and the trainee experienced vivid visual and physiological imagery. The trainee said, "Being able to vividly visualise meant that I stayed within that memory with her longer… to help her elaborate on certain details, thoughts, emotions, and sensory aspects. I could sense the heaviness and difficulty and tension". The trainee interpreted the vividness of the imagery as "highlighting [the client's] emotional hotspot", which provided insight into the significance of the client's loss. The trainee believed that this provided her/him with "a deeper understanding" of the client's grief". The trainee responded to this insight by extending the session and scheduling longer appointments for their subsequent work together (P.11).

Some trainees described imagery that they perceived provided key insights such as possible risk issues that influenced the trainees' responses in therapy. For example, one trainee wrote about experiencing spontaneous imagery of a "noose around my neck" with a "choking feeling" and "panic response" during an assessment when a client disclosed suicidal thoughts but denied suicide intent. The trainee thought the imagery may have been a

“countertransference response” to the client’s “projective identification”, which alerted the trainee to the client’s possible undisclosed suicide intent. S/he responded by further assessing the client’s risk and concluded that his risk of suicide was not imminent but needed ongoing monitoring (P.21). Another trainee reported imagery like a “movie in my head” of a client’s domestic abuse, such as “a knife being thrown at her while holding her baby”. The trainee wrote, “picturing that scenario helped me understand the client’s world and realise she didn’t know [domestic abuse] was not okay”. The trainee elaborated in a follow-up interview that the imagery enabled her/him to realise the seriousness of the domestic abuse beyond what the client communicated verbally and emotionally in session. The trainee said, “Given the client wasn’t as upset as I would expect, my imagery definitely helped raise alarm bells that something wasn’t quite right … It helped me understand the level of risk”. In response, the trainee acknowledged the abuse, explored the client’s supports, and together they developed a safety plan (P.36).

Other trainees described imagery that they perceived provided insights that influenced their formulations. For example, one trainee described assessing a boy with social anxiety and anger problems and spontaneously visualising “him as a baby” with “his dad holding him on his knee and rocking him”. The trainee perceived that the imagery symbolised what the client “might have missed” and “might need”. This informed the trainee’s “understanding and formulation”, which considered the possible role of “disrupted attachment” (P.13). Another trainee working with a client with body dysmorphia got “particularly strong images” of the client as a child as the client described hating her body, given the role she believed it played in her adoption and subsequent abuse from her adoptive family. The trainee described an emotional response of “caring concern” and perceived that the imagery gave “salience” and “drew attention” to the significance of the client’s interpretation of her abuse. The trainee perceived that the imagery provided her/him with an insight into the client’s sense of

"responsibility" and "shame", which informed the trainee's formulation and treatment planning (P.29).

In this theme, trainee therapists described experiencing mainly visual imagery, at times involving other sensory modalities, which was generally triggered by the clients' presentations, emotional states, and verbal descriptions of often distressing experiences. The trainees valued the role that they perceived imagery played in processing and understanding client material and providing insights into the client. The trainees recognised that their imagery influenced their formulations, responses, and directions taken in therapy.

Theme Two: Empathy and Connection

In 41 of the 73 reports of imagery experiences (16 from the questionnaire and an additional 25 from the interviews), trainee therapists described literal, metaphoric, or symbolic imagery experiences that increased their sense of "empathy" or "connection" with the client. Some trainees perceived an improved therapeutic relationship as a result. In comparison to the first theme, this theme goes beyond understanding something about the client and includes a sense of enhanced engagement or connection.

Facilitating Empathy or Connectedness. The trainees described imagery playing a role in their sense of the client's experience and an increased sense of empathy or connection with the client. For example, in the questionnaire, one trainee described building a trauma narrative with a client and "painting a vivid picture" of the client's detailed description of the room in which the abuse occurred; who was there, the weather, as if being "completely in the client's shoes". The trainee reported subsequently "feeling what the client may have been feeling at the time (scared, frightened, upset, worried)". The trainee perceived that the imagery was "helpful to relate to the client and facilitated an empathetic and genuine response" (P.7). Another trainee who had "developed a particularly strong relationship" with a client with complicated grief reported putting her/himself "in the client's shoes" when she

described, with heightened emotion and “sobbing”, visiting her late husband’s gravesite. The trainee said, “Imagery played a role in putting myself in the client’s shoes and seeing [the situation] in my imagination through her eyes so that I was there. I saw the grass, the weeds, and the graves, felt the cold drizzly weather”. In response, the trainee felt a “sense of the heaviness and difficulty and tension”, experienced a “wave of sadness all of a sudden”, and “welled up with tears”. The trainee perceived that the imagery helped her/him to get a “sense of [the client’s] emotions: scared, sad, anxious, and guilty”, to empathise and feel “really connected with her in that moment”, which the trainee believed “developed rapport” (P.15). Another trainee “imagined visually and physically” a client’s account of being held hostage in a burning house and experienced a physical fear response with a “tight chest, racing heart, shortness of breath”, and subsequently “emotionally imagined the client’s fear at the time”. The trainee perceived the imagery enabled her/him to “connect with the client on an emotional level and genuinely convey understanding that this was a really difficult experience”, which the trainee believed helped to “contain [the client’s] emotions” in session (P.32).

Some trainees understood these imagery experiences as “countertransference”, where countertransference had been addressed in their training. For example, one trainee reported visual and tactile imagery of a client’s claustrophobia and wrote in the questionnaire, “I pictured the scene and felt a tightness in my chest and noticed changes in my heart rate, sweating … I interpreted it as a form of countertransference”. The trainee responded by sharing this experience with the client and used it to validate “how dreadful it would be for [the client] to have to endure this”. The trainee believed that her/his imagery and response provided “a good way for my client and me to connect” and “a way of holding the client” (P.3).

Several trainees described imagery eliciting empathy after previously being unable to empathise or connect with the client. For example, one trainee described working with a man convicted of murder and visualising his “childhood abuse story ... watching his mother get beaten by his father, her hair put through the ringer washing machine and the blood on the hallway walls”. In response, the trainee felt “horror and shock”, and “a great deal of empathy and sadness for him while in the room”, which enabled the trainee to “connect with a man who had done some bad things”. In a follow-up interview, the trainee explained that the imagery enabled her/him to hold a “more comprehensive picture” of the client beyond his offences, including seeing him as a vulnerable child, which the trainee “could identify with”. The trainee perceived that this generated a “protective mummy reaction” (P.23). Another trainee reported imagining a client’s account of being raped as vividly as “a television broadcast” and believed the imagery enabled her/him to “understand the client’s experience and generate empathy” and “compassion”, “with a desire to care for him”, after previously being unable to empathise with this client given his murder conviction (P.29).

Some trainees described metaphoric or symbolic imagery that facilitated a sense of the clients’ experiences and emotions and an increased sense of empathy. For example, one trainee reported working with a sex offender and visualising him “pulling his hat down and running off” when they discussed material of a sexual nature. The trainee interpreted this as symbolising the client’s discomfort and “shame”, which elicited “empathy”. The trainee responded by slowing the pace of the session (P.23). Another trainee described visualising a wolf, which s/he perceived as symbolising the client’s “depression and anxiety”. The trainee “imagined the client in a tent in the middle of a forest and a wolf coming in and trying to eat him”, which the trainee experienced as “scary”. The trainee thought that this might represent the client’s feelings of being “under threat … hopeless and helpless”, which helped her/him to “understand how [the client] was feeling and empathise”, and offer “validation” (P.25).

Personal Memories and Emotional Connection. Some trainees described imagery that drew from their own autobiographical memories, which they perceived to facilitate an increased sense of connection with the client. For example, one trainee assessed a client presenting with post-traumatic stress, with a history of gang-related abuse and home invasions, and pictured her/himself in the home invasion scene, but in her/his own family home as a child, answering the door with a knife in hand. The trainee said, "I just felt as if I was in her shoes basically, I felt stunned, frightened that people were after me even though I knew that was her". The trainee thought that unintentionally drawing from personal memories enabled her/him to "more easily imagine what it would have been like to be her" and "empathise". The trainee believed this influenced her/him taking on an advocacy role for more support for the client (P.25). Another trainee who was working with a client in the process of separating from her partner, described "combined images of what [the client] described" with associated personal memory images. The trainee thought that her/his own "shared experience" of relationship breakdown and separation elicited "flashbacks" of "similar circumstances in [her/his] own history". The trainee "identified" with the client and felt a "sense of empathy", which influenced the trainee's "genuine validation" (P.23).

In this theme, trainee therapists described literal, metaphoric, and symbolic imagery of the clients' experiences, which were mostly traumatic, distressing, emotionally evocative, or meaningful. The trainees' imagery took various vantage points and at times drew from their autobiographical memories. The trainees perceived that the imagery facilitated an experiential understanding of their client's experience. The trainees described emotional and at times physical responses to their imagery in session, which some associated with countertransference, where countertransference had been addressed in their training. The trainees valued the role they perceived imagery played in facilitating empathy or connection with their clients.

Theme Three: Understanding Oneself or Therapy Processes

In 29 of the 73 reports of imagery experiences (eight from the questionnaire and an additional 21 from the interviews), the trainee therapists described imagery experiences that reflected their own personal experience of the therapeutic relationship or therapy processes, which at times influenced the trainees' responses. The majority of the reports within this theme described metaphoric or symbolic imagery. Some trainees interpreted their experiences as countertransference responses.

Personal Insight. Trainees described metaphoric or symbolic imagery that they believed helped them identify their own emotions. Most often, the contexts were challenging assessments or therapy situations. For example, in the questionnaire, one trainee described "working with a man convicted of rape" who asked the trainee personal questions. S/he wrote, "I had a felt sense of needing to pull my arms around myself to protect myself and I visualised checking that the windows and doors in my home were secured properly (which I actually did for several nights afterwards)." The trainee perceived that the imagery "alerted me to the inappropriateness of his questions" and that "I felt vulnerable and hyper-vigilant". The trainee took this to supervision for advice on how to respond (P.23). Another trainee described spontaneous imagery of her/his supervisor watching during a challenging session, which s/he thought reflected that s/he was "feeling anxious and critiqued" at the time (P.21).

Often trainees described imagery containing autobiographical memories, which they believed helped them to understand their personal experience of the therapeutic relationship with their clients and therapy processes. For example, one trainee described visual imagery of a personal memory of her "husband getting a fishhook lodged in his leg while on holiday", which the trainee interpreted as a metaphor for how s/he was feeling about the client. S/he wrote, "I got this image of the fishhook in my husband's leg. It was a metaphor for a feeling that my client was under my skin and that it was going to be painful to get her out. I felt

trapped." The trainee reported discussing this experience in class and in personal therapy, which helped her/him make sense of the "disconcerting image" and identify how s/he "had been feeling about the client" (P.13). In the follow-up interview, the trainee said, "The imagery helped me think about and understand the dynamic … I didn't have much support in my internship and I was anxious that my client's risk to herself was escalating, she was in a lot of unwanted pain" and "I got hooked in and couldn't let go". The trainee perceived that this insight "made me tread with caution … think about how to best manage the therapy relationship and be sensitive to her fear of abandonment" (P.13).

Some trainees described imagery experiences that they thought reflected their positive experience of therapy situations. For example, one trainee who was "doing cognitive restructuring" with a client wrote, "I felt warm, with bright visual imagery in my head, surging energy, and shortness of breath", which s/he understood as reflecting her/his "enjoyment of the therapeutic process" (P.6). Some trainees described imagery that contained positive autobiographical memories, which reflected their positive experience of therapy situations. For example, one trainee who was discussing a client's leadership role in her whānau (extended family) and hapū (sub-tribe), reported experiencing a "felt sense" of being on Māori coastal land, with spontaneous visual and olfactory imagery that drew from positive memories from a holiday. The trainee was tentative when exploring her/his understanding although s/he wondered if the imagery reflected her/his positive experience and "admiration" of the client. The trainee linked this experience to "a positive countertransference response" (P.21).

Insight into Therapy Processes. Some trainees described imagery experiences that they believed provided insight into therapy processes. For example, one trainee described working with a client who had experienced trauma and visualising a "lockable cabinet in the basement of a house where the client keeps that trauma". As the client described her difficult

relationship with her mother and the impact of this on her negative core beliefs, the trainee "had an image of a big coin … sitting on the client's lap". The trainee spontaneously visualised "slowly turning this coin over", which s/he interpreted as a guide to explore "the flipside of the coin that connection was really important to [the client]". The trainee perceived that this imagery was influenced by the "deepening emotional space" and provided a sense of orientation in the therapy session (P.38). Another trainee described working with "an extremely violent young man" convicted of aggravated robberies, who did not want to talk in session. The trainee described "trying to go deeper" to understand the client's offending, then visualising the client "beating" her/him, with a feeling as though "a carpet was pulled from under me". The trainee understood this imagery "as a protection" and a "guide" to "back off" and not "keep pushing" (P.8). The imagery may have also reflected the trainee's fear of the client.

Several trainees considered their imagery to be a countertransference response, where countertransference had been addressed in their training. For example, one trainee reported "picturing being in the kitchen cooking dinner" during a session when a client was going over the same information repeatedly, which highlighted to the trainee that the "conversation was starting to dwindle" and s/he was "feeling aloof" and "not being present". This prompted the trainee to "refocus on the client and take more control of the session". With reflection, the trainee thought the imagery might have been a "countertransference response" that provided a source of information about the trainee (P.11).

In this theme, the trainee therapists described imagery experiences that they perceived to symbolise their own experience. The trainees believed that the imagery provided insight into how they were personally feeling in therapeutic situations, which were often difficult. Some imagery contained autobiographical elements and evoked associated emotions that highlighted certain themes and helped trainees understand their experiences. Some trainees

understood their imagery experiences as countertransference, where countertransference had been addressed in their training.

Theme Four: Challenging Imagery

In 21 of the 73 reports of imagery experiences (11 from the questionnaire and 10 from the interviews), the trainee therapists described imagery experiences that were personally challenging and evoked distress. In comparison to the difficult imagery described in previous themes, this theme refers to imagery that trainees believed was not beneficial in any way, but rather “problematic” and “negative”. Most of the reports within this theme described literal imagery, often in the context of working with trauma or in challenging therapeutic situations. Trainees described having difficulty managing the imagery in session and some trainees described experiencing ongoing intrusive imagery outside these sessions. Some trainees described the imagery disrupting their sense of connection to the client or the therapeutic process.

Intrusive Imagery. Trainees described “difficult” imagery experiences that they were unable to manage in session, which evoked strong emotional responses. For example, one trainee pictured a client’s descriptions of “bashing somebody … until his face felt soft” in her/his mind’s eye as a “spotlight honed in … just on the chin going soft” with “dark all around in my mind”, which the trainee experienced as “hideous” and “anxiety” provoking. S/he described having difficulty getting “distance” from the narrowing “spotlight” in her/his mind’s eye, suddenly “welling up” with tears, and struggling to manage her/his emotions and regain composure in the session. The trainee thought her/his heightened “emotions influenced the vividness” of the imagery of the client “bashing” the other person (P.38).

Some trainees described upsetting imagery experiences affecting their concentration in session. For example, one trainee described struggling “to block horrific images” of a client’s childhood sexual abuse, which the trainee experienced as “upsetting” and

“overwhelming”. The trainee described the imagery as “unclear”, because s/he “just couldn’t imagine” how that could happen, so s/he got “hooked” on seeking “visual clarity” within the session, trying to “comprehend”, which was “distracting” and “frustrating”, and led to “confusion” in the session. The trainee interpreted the imagery as “inappropriate” and “unhelpful”, yet it had a “strong pull” that s/he could not “switch off” in the session (P.39). Another trainee reported “strong, vivid images … like watching a movie” of a client’s physical and sexual abuse by others and a “strong emotional reaction” of “distress”. S/he said, “It affected my concentration. It was hard to be present because I was caught up in the imagery and my own emotional response to it”. Perceiving this to be inevitable, s/he said, “I can’t change the fact that I think very visually … it’s just something that I will get used to with time … I can’t turn it off” (P.15).

Some trainees reported struggling to manage intrusive imagery outside of sessions. For example, in the questionnaire, one trainee described having “a strong emotional response” and ongoing intrusive imagery of a client’s descriptions of traumatic experiences. S/he wrote, “I visualised this in quite a lot of detail in my mind’s eye. But it felt fractured, like a trauma memory … This stayed with me for a few days and the visual memory comes back” (P.18). Another trainee described ongoing “vivid imagery” of a client’s “awful experience” in childhood of tripping and killing the class pet at school. S/he said, “In my mind it was as if I had experienced that particular incident and felt an increased heart rate, a sense of disgust and fright and fear … it was quite a vivid experience and has stuck with me”. The trainee said s/he remained “very focused” on the client in session but still experiences intrusive imagery of the death of the animal and associated fear despite ending therapy with this client (P.32). Another trainee described “difficult intrusive imagery” when working with “a client who was kind of hateful towards” the trainee. The trainee thought that they “didn’t have a good relationship”, which caused her/him stress. S/he described getting “revolting

images" of the client's provocative statements in session, then ongoing "intrusive" imagery and "dreams about him being in my life, outside my house … He was like this intrusive ominous presence". In response, the trainee "felt pretty yuck". S/he thought that the imagery was "triggered by stress" and that her/his dreams were "little pieces of everything put together" (P.13).

A few trainees understood their intrusive imagery experiences as vicarious trauma. For example, one trainee reported "really strong images" of a client's "difficult abuse narrative" in session, then "intrusive imagery" of the "physical and sexual abuse" afterwards. S/he wrote online, "I found myself feeling quite disturbed that evening because I could not get the images out of my head". In a follow-up interview, the trainee elaborated, "I had a very strong emotional reaction … I was surprised when I went home and sobbed over it. I was really distressed … really down, my mood dropped a lot". The trainee took this experience to supervision and made sense of it as "vicarious trauma" (P.15). In the questionnaire, one trainee described "vivid" imagery of a client's sexual abuse as if standing "completely in the client's shoes" and in response felt "scared, frightened, upset, worried". The trainee wrote, "I was unable to protect myself and keep my distance to mitigate experiencing vicarious trauma", which had an ongoing impact on the trainee. The trainee thought more experience would "desensitise" her/him (P.7).

Disrupting the Therapeutic Relationship. Some trainees described imagery eliciting negative emotions that undermined their sense of connection with clients. At times, some thought this disrupted the therapeutic relationship. For example, one trainee who had "built a solid therapeutic relationship" and "good rapport" with a client in a forensic setting over several months, reported experiencing "brief flashes" of visual imagery when discussing the client's violent crimes in more detail. This led to an emotional response of "disgust of what he had done toward his victims" and a sense of "cognitive dissonance, where these feelings

were in contrast to how I had felt toward him previously". The trainee described responding by making "an effort not to appear judgemental or uncomfortable towards him", although s/he "quickly moved through the discussion" and thought the imagery had a "negative effect" on developing the therapeutic relationship (P.8). In another situation where imagery was "unhelpful" when trying to develop rapport, the trainee was working with a young man charged with sexual offences against children and visualised his offences, which the trainee experienced as "horrific". In response, s/he felt "disgusted" and "worried" about containing this reaction, the client noticing, and "disrupting the therapeutic relationship". The trainee understood that imagery functions to facilitate "connection", but has the equal potential to "disrupt" connection when it evokes negative emotional reactions (P.8).

Some trainees described the reinforcing interplay between heightened emotions and imagery, which disrupted the trainees' sense of connection. For example, one trainee wrote online about working therapeutically with a male client at his home, feeling "threatened" and "vulnerable", and subsequently experiencing visual and tactile imagery. This led to the trainee feeling "wary" and "reluctant to engage", which made it "challenging to maintain desire for rapport" (P.6). Another trainee described working with a young boy and feeling "frustration and anger" towards the boy's parents. The trainee reported increasingly "vivid images" of the client's descriptions of their interactions, which the trainee thought heightened her/his own anger and "judgement" of the parents. The trainee thought this was "unhelpful" in influencing her/his interpretation and ability to stay present with the client and his needs (P.4).

Disrupting Therapy Processes. Some trainees described imagery negatively influencing therapy processes. For example, one trainee working with a child with a fear of vomiting "saw a picture of vomit covering [the client's] entire room". The trainee interpreted this imagery as "helpful" for understanding the client's "catastrophic interpretation of how

awful it would be to vomit" and to "empathise", but "unhelpful for me being able to distance myself from the client's distorted/unhelpful beliefs". As a result, the trainee thought that s/he "bought into the client's interpretation … along with the frustration, helplessness, and catastrophic beliefs", which made it "harder to challenge the client's beliefs/ideas" (P.24). Another trainee described assessing a client with a trauma history of neglect, physical and sexual abuse, and ongoing domestic violence, and seeing "strong" images "like movie reels of abuse". The trainee became "completely absorbed in [the imagery]" and felt "lost". The trainee perceived the imagery to be "problematic in terms of containment". Consequently, s/he delved "too deep" and went "way off course" during the assessment session, which ran over time. With reflection, the trainee wondered if her/his own sense of "helplessness" led to her/his reliance on imagery as the "guide" in session (P.8).

In this theme, trainee therapists described distressing intrusive imagery that was difficult to manage both in session and at times outside session. Some trainees understood their experience as vicarious trauma. The trainees described strong emotional and physiological responses, which for some, disrupted their sense of connection and engagement with the client and for some, disrupted the therapy processes.

Thematic Analysis of Trainee Therapists' Learning Needs

As noted previously, the trainees were asked what they would like to learn about therapists' imagery in the questionnaire and interviews. Twenty-five (67.6%) trainees responded to this question in the questionnaire and identified specific areas of desired learning. Fifteen of these trainees elaborated on their answers in follow-up interviews. Two additional trainees who were interviewed also identified specific areas of desired learning. The 27 responses fell into five themes, shown in Table 6 below. Most trainees described multiple learning needs, commenting on more than one theme.

Table 6

Trainee Therapists' Desired Areas of Learning

Theme	Number of trainees
Acknowledgement in training	10
Developing an understanding of therapist imagery	12
Developing awareness and an ability to reflect on imagery	10
Learning how to manage imagery	8
Learning how to use imagery	15

Theme One: Acknowledgement in Training

Ten trainee therapists described wanting therapists' imagery to be "acknowledged" and "normalised" in their training. Most trainees said that therapists' imagery was not acknowledged in their training programmes. Consequently, some trainees said they felt "too shy or embarrassed to discuss experiences of imagery" (P.29). For example, one trainee said, "It would be nice if there was an acknowledgement that [imagery] is a useful thing to discuss and that it isn't an indication that there is something 'wrong' with you" (P.13). The trainees believed that acknowledgement would validate "the importance of trainees' experiences" (P.36) and provide a "safe" environment in which trainees "could feel comfortable or confident enough to discuss" their experiences of imagery (P.5). Many of the trainees commented on how "helpful" the interview was in providing a space to talk about their experiences, which some said they had never done before and would like to do more. For example, one trainee said, "The interview has been really a helpful process. It doesn't feel safe to stick up my hand in class and talk about this because I'm not used to talking about it, bringing something so personal into a professional space" (P.39).

Theme Two: Developing an Understanding of Therapist Imagery

Twelve trainees indicated that they wanted to understand therapists' imagery and its role in therapy on a conceptual level. For example, one trainee said, "I would like to learn about what [imagery] is and how it works" (P.6). Some trainees wanted to learn about the "meaning" of imagery. For example, one trainee said, "I would like to know what it means" (P.33). Some trainees wanted to learn about the potential benefits and problems of therapists' imagery. For example, one trainee said, "What are the costs and benefits of imagery" (P.14). Some trainees believed that having a theoretical framework or model to understand therapists' imagery would be helpful. For example, one trainee said, "I would like to learn about different ways of understanding imagery, because my interpretation of my imagery is based on my own experience. As countertransference is taught using the TA (Transactional Analysis) model, it would be helpful to have a model or framework to think about imagery, based on the literature" (P.8). Another trainee said, "I really appreciated learning how to use the PAC (Parent-Adult-Child) model to think about countertransference. Something like that would be helpful to understand the concept of therapists' imagery" (P.39).

Theme Three: Developing Awareness and Ability to Reflect on Imagery

Ten trainees wanted to develop an increased awareness and an ability to reflect on their imagery experiences. For example, one trainee wrote online that s/he wanted to learn "ways to think about [imagery] reflexively" (P.18). Another trainee said, "I would like a greater awareness of [my imagery] and learn how to include it in my self-reflective practice" (P.23). Another trainee reported wanting to develop their awareness and self-reflection to be able to recognise "how it affects me being in the moment with a client, the impact that it has on me as a therapist and on the relationship" (P.9). Many trainees commented on the benefit of the interview in increasing their awareness and reflection. For example, one trainee said, "Since I heard about this study, my awareness of my own experience has changed. I have

learnt a lot about myself through the questions you have asked. It's been helpful to have a process to derive meaning out of my imagery … and helpful to process" (P.39). Another trainee said, "It has been good to talk, good questions … I would like to learn more about how to explore imagery in a reflective way" (P.8).

Theme Four: Learning How to Manage Imagery

Eight trainees said they wanted to learn how to manage their imagery in therapy. For example, one trainee reported wanting to learn "practical skills to reduce imagery when it impedes therapy and to enhance it when it's useful" (P.3). Most of the trainees in this theme described wanting to learn how to manage difficult vivid intrusive imagery in session and outside sessions. For example, one trainee said, "I would like to learn more about keeping myself safe from vicarious trauma and some of the more negative effects of mental imagery. What to do when mental imagery becomes unhelpful. How to maintain a distance" (P.7). Another trainee said s/he wanted to learn, "how to switch [imagery] off … so I don't get all those visuals staying with me after work … but I feel really uncomfortable about switching off my felt senses and associated feelings because I think I do rely on them a lot. I would like to learn more about how to manage that" (P.39).

Theme Five: Learning How to Use Imagery

Fifteen trainees said they wanted to learn how to use their imagery when working with clients. For example, one trainee asked, "How can imagery be used to enhance my practice?" (P.3). Another trainee said, "I would like to learn more about the ways imagery can be used in therapy, in building formulations, or in framing a piece of therapeutic work" (P.11). Some trainees wanted to learn from other therapists' experiences of using imagery. For example, one trainee said, "I want to hear how other clinicians have interacted with their imagery and used it and worked with it in session" (P.30). Many of the trainees wanted to

learn how to draw meaning from their imagery to develop their work with clients. For example, one trainee said s/he wanted "more guidance on using [imagery] as a tool to analyse and draw meaning from my imagery whilst being with a client, to translate my imagery into meaning, especially to speak to process" (P.38). Some trainees wanted to learn about the appropriateness and helpfulness of sharing their imagery experiences with clients. For example, one trainee said, "Would it be helpful to share some of my experiences with a client? I would like to learn how best to do this" (P.9). Some trainees who described using imagery experiences as a "guide" in therapy, wanted to understand the limits of this. For example, one trainee said, "If for some reason my felt sense is wrong, I feel so tricked and let down because I do trust it so much and I question how my felt sense got that so wrong. I would like to make sense of this" (P.39).

Most of the trainee therapists recognised the importance of therapists' imagery and wanted it to be acknowledged and addressed in therapy training. The trainees also wanted to develop an understanding of therapists' imagery, develop awareness and an ability to reflect on imagery experiences, learn how to manage imagery, and learn how to use imagery to improve their work with clients.

Chapter Five: Discussion

Overview

Previous cognitive, neuropsychological, and clinical research suggests the importance of imagery in therapy. Yet client imagery has been the focus, with little consideration of therapist imagery. The small amount of research (Bell et al., 2015; Cartwright el al., 2019; McGown, 2015) and clinical literature (e.g., Althofer, 1983; Finlay, 2016; Kern, 1978) that relates to therapists' experiences of imagery suggests that therapist imagery has the potential to facilitate and enrich the therapeutic process, although it may also be challenging and disrupt the therapeutic process. It is possible that trainee therapists may experience even greater difficulty with imagery in therapy than experienced therapists, yet there does not appear to be any existing research on trainee therapists' experiences of imagery to date. Thus, in this thesis study, the subject of investigation was trainee therapists' experiences of imagery. This exploratory investigation took a qualitatively driven mixed methods research approach and involved a questionnaire study and an interview study.

This chapter considers the main findings of this thesis study with reference to the research questions and the existing empirical and clinical literature. The clinical and training implications of the research findings, the limitations of this thesis study, and the implications for further research are then discussed. The chapter closes with a summary and the final conclusions of this study.

Trainee Therapists' Experiences of Imagery

Types of Imagery Experienced

In the questionnaire study, the majority of the trainee therapists (83.8%) reported experiencing imagery in their everyday life and when working with clients in therapy. Of

these, most (95.5%) reported experiencing imagery in the visual modality, with more than two-thirds (68.2%) additionally experiencing it in other modalities, including tactile, auditory, olfactory, and felt senses. This finding is consistent with the broad understanding of imagery in the imagery literature, which incorporates all sensory modalities (e.g., Horowitz, 1970; Lacey & Lawson, 2013). This finding also reflects the predominance of the visual domain in the imagery literature, despite the lack of existing evidence that this is the preferred or most proficient modality in individual experience (Lacey & Lawson, 2013; Pearson et al., 2015). In both the questionnaire study and the interview study, the trainees described experiencing literal, symbolic, and metaphoric imagery, which is consistent with two previous studies of therapists' imagery (Cartwright et al., 2019; McGown, 2015).

Frequency and Vividness of Imagery

The questionnaire study found that there was individual variation in the frequency and vividness of the imagery experienced, from vague impressions to vivid photographic imagery. A large group of trainees rated the frequency (37.8%) and vividness (48.7%) of their imagery in everyday life as low (1 or 2 on a 5-point scale). In comparison, in Cartwright et al.'s (2019) study, a smaller group of therapists, approximately one-third, rated their daily experience of imagery (29.3%) and the vividness of the imagery (36.6%) as low (1 or 2 on a 5-point scale). Around one-third of the trainees in this study rated the frequency (32.4%) and vividness (29.7%) of their imagery in everyday life as high (4 or 5 on a 5-point scale). A larger group of therapists in Cartwright et al.'s (2019) study rated their daily experience of imagery (51.2%) and the vividness of the imagery (39.0%) as high (4 or 5 on a 5-point scale). Although the sample sizes of these studies are small, one could speculate that more experienced therapists may pay more attention to their own imagery, have a heightened awareness of their imagery, or may have cultivated their own imagery processes in comparison to trainee therapists, who may focus on other aspects in therapy whilst learning to

work with clients. Perhaps this could also help to explain why the trainees' perceived frequency of imagery was associated with perceived imagery vividness ($\rho = .72$, $p < .01$) and with perceived helpfulness of imagery ($\rho = .67$, $p < .01$).

Factors Influencing Trainee Therapists' Imagery

Some trainees thought that the frequency and vividness of their imagery was influenced by the emotional intensity of their work with clients in therapy and the emotional state of the clients and/or themselves. For example, the trainee who visualised a client's violent assault against another person perceived that her/his own heightened "emotions influenced the vividness" of the imagery (P.38). Some trainees also thought that their heightened emotions at the time enhanced their memory and recall of these imagery experiences. Neuropsychological research suggests that heightened emotional experience enhances memory and recall (e.g., Buchanan, 2007; Holland & Kensinger, 2010).

Some trainees also thought that their imagery was more vivid and more frequent when they perceived that the therapeutic bond was either particularly strong or particularly weak. For example, the trainee who described a particularly strong therapeutic bond with a client with complicated grief after losing her husband described particularly vivid multisensory imagery of the husband's gravesite; like being "in the client's shoes" (P.15). Another trainee thought that her/his poor therapeutic relationship with a client, and the associated stress from this, influenced her/his ongoing intrusive "revolting images" of the client's provocative statements (P.13). Similarly, Jung (1968) described experiencing imagery when there was a loss of rapport between himself and the client.

In this thesis study, trainees did not describe being in a state of reverie when their imagery emerged, which is consistent with one previous research study of therapists' experiences of imagery (McGown, 2015). This is in contrast to much of the existing psychodynamic literature, which posits that a state of reverie is necessary for the emergence

of imagery among other associations (e.g., Birksted-Breen, 2012; Bion, 2013; Ogden, 2001; Reik, 1948).

The Impact of Trainee Therapists' Imagery

The trainee therapists in this thesis study described emotional and bodily responses to their imagery in therapy. The link between imagery and heightened emotion was particularly emphasised by the trainees. This special relationship is established in cognitive and neuropsychological research (e.g., Holmes & Mathews, 2005, 2010) and is also reflected in Cartwright et al.'s (2019) study of therapists' experiences of imagery. Some trainees described their imagery experiences and their emotional reactions influencing their responses in therapy. This is consistent with the empirical evidence that emotions influence behavioural responses (e.g., Baumeister et al., 2007).

Confusion About Imagery

In the questionnaire study, six trainee therapists reported that they did not experience imagery. However, four of these trainees reported elsewhere in the questionnaire, or later in a follow-up interview, that they did experience imagery. This appeared to reflect the trainees' uncertainty about the definition of imagery and uncertainty about whether or not their experiences were imagery. For example, the trainee who initially reported not experiencing imagery because s/he thought it was "something akin to psychotic phenomena, déjà vu, or matakite", later in a follow-up interview described a shift in her/his understanding of imagery and an awareness of experiencing "vague" visual imagery (P.5). The trainees' uncertainty and lack of awareness of their own imagery does not seem to be reflected in previous clinical research. An absence of imagery across all modalities is recognised in the imagery literature (Zeman et al., 2015), however the focus has been on the absence of visual imagery, also

known as aphantasia (Zeman et al., 2015, 2016), which has an estimated prevalence rate of 1.9–2.7 percent (Faw, 2009; Greenberg & Knowlton, 2014).

Most of the trainee therapists in this thesis study described being unaware of their experiences of imagery prior to reflecting on them in the questionnaire or interview, and some struggled to identify or differentiate their experiences of imagery. For example, one trainee who reported in the questionnaire that s/he had not heard of the term "mental imagery", later said in a follow-up interview, "Prior to this conversation I hadn't thought about the concept or recognised my imagery, but visualising and imagining things has always been part of my day-to-day life, it was just unconscious" (P.33). Another likened imagery to other unreflected automatic internal functions such as breathing. S/he said, "I hadn't thought about [my imagery] before. It's just the way I think. I don't think about my imagery, like I don't think about breathing, I just do it" (P.15). The trainees' awareness, perceptions, and conceptualisations of their own experience of imagery changed in the time-lag between the questionnaire and the follow-up interviews, and also over the course of the interviews. Similarly, Bell et al.'s (2015) study of novice therapists' experience and use of imagery also found that their conceptualisation and definition of imagery developed and broadened as the interviews progressed. The novice therapists in Bell et al.'s (2015) study were trained in CBT but many had not reflected on their imagery in any depth prior to the interview, and a number seemed unaware or doubted their own experience of imagery. The study also found that the therapists' own experience of imagery impacted their use of imagery with clients. Many were apprehensive and avoidant of using imagery with clients in therapy.

Lack of Training and Research on Therapist Imagery

The trainees' confusion about imagery and their own experience of imagery may reflect a lack of training. Most (87%) of the trainees reported little or no training in understanding and managing their imagery (rating 1 or 2 on a 5-point scale). This finding is

consistent with two previous studies on therapists' experiences of imagery (Bell et al., 2015; Cartwright et al., 2019), in which the therapists reported minimal training. In Bell et al.'s (2015) study, all the therapists reported some form of imagery avoidance when working with clients in therapy, which some linked to a lack of training on imagery in general and a lack of theoretic clarity that limited their confidence to work with imagery in therapy. McGown's (2015) study of therapists' experiences of imagery also found gaps in training to support a broader understanding and recognition of the value of therapists' imagery, despite the range of training backgrounds that had varying emphases on humanistic and psychodynamic traditions. The lack of training on therapists' imagery may reflect the lack of research on this subject.

This lack of attention given to therapist imagery in clinical training and research, at least in CBT, may reflect the relative lack of attention to the therapeutic relationship within CBT (Gilbert & Leahy, 2007). It may also reflect the consequent lack of consideration of therapists' experiences in the therapeutic relationship that may influence the dynamics of the therapeutic relationship and therapy processes (Kazantzis et al., 2017). Nevertheless, there has been a growing emphasis on the centrality of the therapeutic relationship in the effectiveness of therapeutic work within CBT (Cartwright et al., 2018; Castonguay et al., 2006) and growing acknowledgement that therapist self-awareness and self-reflection is as important in CBT as it is in other therapies (Bennett-Levy et al., 2015; Wills & Sanders, 1997), particularly when working with complex clients where issues often arise in the therapeutic relationship (Beck et al., 2004; Bennett-Levy et al., 2015). Nevertheless, research suggests that formal CBT training tends to be orientated towards learning formulation and technical skills, which overrides interpersonal and self-reflective learning (Bennett-Levy, & Beedie, 2007; Niemi & Tiuraniemi, 2010).

Trainee Therapists' Conceptual Understanding

Conceptualisation of Therapist Imagery as a Form of Cognition

There were common patterns in the way the trainee therapists in this thesis study experienced and conceptualised their imagery. Most of the trainees perceived their imagery as a way of thinking, processing, understanding, and remembering client material. Some thought that their imagery played a role in their intuitive sense of knowing. For example, the trainee whose multisensory imagery elaborated on a client's account of punching someone at a party, interpreted the imagery as "a form of intuition" that enabled the trainee to gain a sense of the client's experience, draw "connections", "understand", and "remember this more easily" (P.35). Another trainee interpreted her/his multisensory imagery of a client's memory of being lost at a fair, as a "way of knowing", which enabled the trainee to "quickly conceptualise and understand" the client's experience (P.39). In McGown's (2015) study, some therapists also understood their imagery as a way of "knowing", which they linked to "intuition" (pp. 132-133). In the interpretive phenomenological analysis (IPA), McGown used her own imagery as "an instrument of knowing", which she perceived as "an alternative model of knowing which goes beyond conscious cognitive-analytical knowing" (McGown, 2015, p. 130).

This conceptualisation of imagery as a form of cognition is consistent with the cognitive and neuroscience research on the function of imagery in learning, information processing, reasoning, and memory (e.g., Kosslyn et al., 1995; Pearson & Kosslyn, 2015). Dual process theories and research, such as Epstein's (1998, 2003) cognitive-experiential self-theory (CEST), suggest that humans operate with two independent but interactive processing systems. CEST refers to these systems as the experiential system and the rational system. According to CEST, the experiential processing system functions automatically and subconsciously, operates through associative connections, encodes and integrates information

in the form of imagery, and facilitates an experiential way of knowing, which gives rise to intuition (Norris & Epstein, 2011). Imagined experience is particularly important in CEST because it operates in a similar manner to real experience, including the way in which it enables learning from experience within the experiential system (Norris & Epstein, 2011). Thus, CEST claims that imagery functions in the experiential information processing system and therefore plays a role in non-verbal cognition. Hence, CEST provides a framework for understanding the trainees' conceptualisation of imagery as a form of cognition.

The trainees' conceptualisation of imagery as a form of cognition is also reflected in CBT; in CBT, imagery is one of two forms of cognition, the other being verbal thoughts. CBT emphasises the importance of cognitions and the value of examining and transforming these cognitions, including imagery, although this is in relation to the client's experience (Beck et al., 1985; Hackmann et al., 2011). As previously mentioned, there is increasing acknowledgement in the CBT literature of the value of therapists' self-reflection. Research on self-reflection training demonstrates the value of therapists attending to their own cognitive processes, including imagery, by practicing CBT techniques on themselves (Bennett-Levy et al., 2009; Bennett-Levy & Lee, 2014; Bennett-Levy & Thwaites, 2007).

The Facilitative Role of Therapist Imagery as a Form of Cognition

The trainees who conceptualised their imagery as a form of cognition described it as having a facilitative role since it led to insights either into the client, themselves, or into the therapeutic relationship or processes. In almost three-quarters (72.6%) of the imagery reports, trainees described their imagery as producing insights into the client, which impacted how they understood the client, aided their formulation of the client's presenting problems, and informed and guided their work with the client in therapy. For example, the trainee who interpreted her/his imagery of a noose around her/his own neck and feeling a choking sensation during an assessment as a source of insight into the client's undisclosed suicide

intent (P.21). Another trainee working with a client who was struggling to identify his emotions, spontaneously visualised a monkey on the client's back and interpreted this as a symbol of the client's unarticulated agitation and feeling of being weighed down (P.15). The potential for therapist imagery to facilitate the therapeutic process by serving as a source of insight into the client and giving guidance is reflected in two previous studies on therapists' imagery (Cartwright et al., 2019; McGown, 2015). It is also discussed by other psychodynamic therapists (e.g., Levenson, 2003; Shaverien, 2007) and integrative therapists (e.g., Finlay, 2016) in the clinical literature.

In just over one-third (39.7%) of the imagery reports, the trainees described mostly metaphoric or symbolic imagery that led to insights into their own personal experience of the therapeutic relationship or therapy processes. For example, the trainee who visualised her/his supervisor watching during a challenging session, interpreted the imagery as symbolising her/him "feeling anxious and critiqued" at the time (P.13). Cartwright et al.'s (2019) study also described therapists' imagery that represented the therapists' own personal experiences or reactions in therapy, which at times reflected the interpersonal processes in therapy. In their study, some therapists' imagery also contained autobiographical elements. None of the CBT therapists in their study wrote about imagery related to their own personal experiences or reactions, or imagery that reflected the therapeutic relationship. This perspective was only held by therapists who had a training background in psychodynamic or integrative approaches, which the authors suggested may have reflected the greater emphasis in psychodynamic and integrative approaches placed on working with the therapeutic relationship. The authors suggested that the therapeutic approach may influence how therapists attend to or make sense of their imagery. In comparison to Cartwright et al.'s (2019) study, some trainee therapists in this thesis study, who described imagery reflecting their own experience within the therapeutic relationship, reported that their training was CBT

orientated, but was also supplemented with training in other therapy approaches, mainly extensions of CBT and relational models. In some instances, the trainees described their insights into themselves influencing their responses and leading to altered relational dynamics. For example, the trainee who experienced a felt sense of needing to protect her/himself and imagery of her/himself checking that the windows and doors at home were secured, interpreted this imagery as symbolising her/him feeling "vulnerable" in the therapeutic relationship. The trainee reported discussing this imagery experience in supervision in order to manage her responses in the relational dynamics (P.23). This reflects Kern's (1978) account of his imagery expressing his previously unrecognised experience in therapy, which once reflected upon, enabled him to overcome personal issues that were blocking therapeutic progress.

Imagery and Countertransference

Some trainee therapists in this thesis study interpreted their imagery as a countertransference experience. This interpretation is also discussed by psychodynamic therapists (e.g., Althofer, 1983; Kern, 1978; Schaverien, 2007) and researchers (e.g., Cartwright et al., 2019; Samuels, 1985) in the clinical literature. The extent to which trainees had received training on countertransference was not clarified in this thesis study. However, all the trainees who described their imagery providing a source of insight either into themselves, the therapeutic relationship, or therapeutic processes reported that they had received training on countertransference. One could speculate that training on countertransference may have influenced the trainees' considerations of their imagery as possibly reflecting something about them and their own contribution to the therapeutic relationship. In Cartwright et al.'s (2019) study, no CBT therapists wrote about imagery that they thought reflected countertransference, which the authors thought may have reflected the

greater emphasis placed on countertransference in psychodynamic and integrative approaches.

The trainees' interpretations and value of their imagery as a potential source of information about the client or about the trainees themselves, reflects how some therapists in the clinical literature have described understanding and making use of countertransference (e.g., Diamond, 2014; Kern, 1978). Interpreting and making use of therapist imagery as a source of insight into the client's experience or dynamics may reflect the notion of objective countertransference, and interpreting and making use of therapist imagery as a source of insight into the therapist's experience or issues may reflect the notion of subjective countertransference (Cartwright, 2011; Winnicott, 1949).

Some trainees described their imagery as providing a source of information on both the client and the therapist, and also the therapeutic relationship or therapeutic processes. For example, the trainee who had an autobiographical memory image of a fishhook embedded in her/his partner's skin, interpreted the image as a metaphor for the difficult dynamics in a therapeutic relationship, the client's "fear of abandonment", and her own previously unrecognised "trapped" feeling, as though the client was "under [her/his] skin"; this insight influenced how the trainee managed the therapeutic relationship (P.13). This corresponds to some psychodynamic therapists' understanding of imagery as reflecting and revealing the experiences of both the client and therapist, and transference and countertransference (e.g., Althofer, 1983; Jacobs, 1983; Kern, 1978). It may also reflect some psychodynamic therapists' (e.g., Cwik, 2017; Ogden, 2004) understanding of imagery as a co-construction, which is unconsciously jointly created by the therapist and the client within the dynamics of their therapeutic relationship. In this view, imagery not only reflects both the therapist and client, but also reflects what is going on between them, and is a manifestation of the transference and countertransference (Cwik, 2011; Ogden, 2004; Shaverien, 2007).

Some trainees reported that their insights into themselves, the client, and their dynamics influenced their work with clients. This reflects some psychodynamic therapists' (e.g., Cwik, 2017; Ogden, 2004; Shaverien, 2007) view of imagery as a vehicle for the therapist's symbolic function, whereby the therapist can access and express previously unrecognised, unsymbolised, and unarticulated aspects, which then, once recognised, can alter the relatedness of the therapist and the client and facilitate the client's transformation. Although the client's experience and progress in therapy was not investigated in this thesis study, some trainees' insights appeared to facilitate how they managed the therapeutic relationship and therapeutic processes.

Conceptualisation of Imagery as an Element of Empathy

In just over half (56.2%) of the imagery reports, the trainees perceived that their imagery played an important role in facilitating empathy or a greater sense of connection with the client. The trainees perceived that this influenced their responses in therapy and in some cases improved the therapeutic relationship. For example, the trainee working in a forensic setting whose imagery of an inmate's childhood abuse elicited "empathy" and enabled a sense of connection with the inmate, which had previously been a struggle for the trainee given the nature of the client's crimes, including murder (P.23). The clinical literature (e.g., Arizmendi, 2011; Berger, 1987; Reiser, 1999) and empirical research (e.g., Cartwright et al., 2019) on therapists' imagery has established a link between therapists' imagery and empathy. Psychotherapists (e.g., Arizmendi, 2011; Kohut, 1984) have suggested that therapists' imagery can facilitate both the cognitive and affective components of empathy, whereby the therapist can identify and understand the client's perspective and affective state and also experience this affective state.

Some trainee therapists in this thesis study described their imagery containing autobiographical elements that enhanced the trainees' sense of identification and connection

with the client. For example, the trainee whose imagery involved autobiographical memories of an experience of relationship breakdown and separation similar to what the client described (P.23). Another trainee imagined her/his child self in her/his own childhood home experiencing the client's description of a traumatic home invasion (P.25). In both cases, the trainees described a greater sense of empathy and connection with the clients, which influenced the trainees' responses. This is consistent with neuropsychological research, which demonstrates that the generation of imagery can draw on autobiographical memories that can reinstate the associated emotions (Schacter et al., 2007). Research studies (e.g., Bluck et al., 2013; Meconi et al., 2019) provide neuropsychological evidence that autobiographical memories and associated emotions play an important role when inferring others' inner states in the development of empathy. These studies (e.g., Bluck et al., 2013; Meconi et al., 2019) demonstrate that the reactivation of autobiographical memories of personal experiences of pain is associated with higher self-reported empathy for others in pain. Although the causal relationship between autobiographical memory and empathy has not been established, this thesis study supports previous findings suggesting that therapists' autobiographical memories may be retrieved in the service of empathy.

In this thesis study, the trainee therapists' experiences of imagery that were associated with empathy were evoked by the clients' narrative-based descriptions of difficult experiences. This is consistent with CEST, which suggests that narratives particularly engage and influence the experiential information processing system, which is imagistic, emotionally driven, highly involved in the generation of empathy, and tends to dominate the rational system unless reflected on (Epstein & Epstein, 2016; Norris & Epstein, 2011). This suggests the potential potency of clients' narratives to elicit imagery in the mind of some therapists, which can contribute to the therapists' empathy.

Empathy-Based Stress and Vicarious Trauma

Some trainees described their empathetic engagement and literal imagery of their clients' descriptions of distressing or traumatic experiences negatively impacting them emotionally, physically, and cognitively, which was difficult to manage. Bell et al. (2015) also found that some novice therapists experienced overwhelming and upsetting vivid imagery. Although their study did not provide information about the context and content of the imagery, the therapists perceived that their negative experiences of imagery influenced their caution and avoidance of imagery-based work with clients in therapy. The negative cognitive impact of imagery on experienced therapists is reflected in McGown's (2015) study, in which some therapists described experiences of imagery that were confusing and disorientating.

Many of the trainee therapists in this thesis study who described negative imagery experiences were working with clients' traumatic experiences at the time and some understood their imagery experiences as "vicarious trauma". For example, the trainee who experienced intrusive and distressing vivid imagery of a client's physical and sexual abuse in the session and afterwards, made sense of this experience as "vicarious trauma" (P.15). This reflects previous research studies (e.g., Arnold et al., 2005; Steel & Downing, 1998; Wilson & Thomas, 2004) that investigated the effects of trauma work on therapists and showed that most participants reported intrusive imagery of their clients' trauma narratives, as well as negative emotional responses. Therapists' intrusive imagery is considered to be one symptom of secondary traumatic stress and vicarious trauma, although there is no research on the role that imagery plays. However, some therapists (e.g., McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995) have suggested that the generation of trauma-related imagery when listening to their clients' descriptions of traumatic experiences is a key component of the development of trauma-related symptoms and vicarious trauma. Previous experimental research (e.g.,

Krans et al., 2010) demonstrates that when listening to verbal descriptions of traumatic experiences, visualising these descriptions is associated with more intense negative emotional reactions and persistent intrusive imagery.

Some trainees reported that some imagery experiences evoked negative emotions that undermined their sense of connection with the client and/or led to responses, which they thought disrupted the therapeutic relationship or therapeutic processes. For example, the trainee who visualised a client's violent crimes described a loss of empathy and subsequent withdrawal from the client in that session, which the trainee thought negatively impacted the therapeutic relationship (P.8). Another trainee's imagery of a client's vomit led to the trainee over-identifying with the client's fear of vomiting, which made the trainee's process of challenging the client's beliefs more difficult (P.24). Consistent with these reported experiences, Wilson & Thomas (2004) suggested that the imagery content of trauma narratives can lead to therapists experiencing emotional reactions, empathic strain, and countertransference responses, such as withdrawal from or over-identification with the client. However, the trainee therapists in this study did not understand the negative impact of their difficult imagery experiences as reflecting countertransference. As discussed earlier, some therapists (e.g., Kern, 1978; Ross & Kapp, 1962) in the psychodynamic literature who have described the potential for their imagery to disrupt empathy and therapeutic processes, understood their imagery as a reflection of their countertransference.

The challenges of the difficult imagery experiences described by the trainees may reflect the increased vulnerability of trainee therapists compared to more experienced therapists (Neumann & Gamble, 1995). Previous clinical studies (e.g., Adam & Riggs, 2008; Chrestman, 1999; Jenkins & Baird, 2002) that used self-report measures found that trainee therapists and less experienced therapists experienced greater difficulties with higher levels of trauma symptomology and overwhelming distress compared to more experienced

therapists. A small number of trainees in this thesis study disclosed personal traumatic experiences, which reflects previous research that used self-report measures and demonstrated that therapists who have experienced traumatic experiences themselves may be more vulnerable to developing trauma-specific symptoms (e.g., Jenkins & Baird, 2002; Pearlman & MacIan, 1995) and more vulnerable to experiencing difficult countertransference reactions (e.g., Pearlman & MacIan, 1995), particularly trainee therapists (e.g., Adams & Riggs, 2008).

Challenges With Trainee Therapists' Interpretations

The trainee therapists in this thesis study identified different ways in which they interpreted their imagery. Some trainees interpreted their imagery as a source of information about the client. However, there may be possible alternative interpretations. For example, the trainee who visualised a “noose around” her/his own neck and experienced a “choking” and “panic response”, thought that the imagery reflected the client’s undisclosed suicide intent (P.21). Yet the trainee’s imagery may have represented something about the trainee, such that s/he felt choked by the situation.

Some trainees interpreted their imagery as a source of information about their own experience within the therapeutic relationship or the therapeutic relationship or processes. However, there may be possible alternative interpretations. For example, the trainee who visualised preparing dinner during a session in which a client was going over the same information repeatedly, interpreted the imagery as a countertransference response that provided a source of information about her/himself and reflected her/his lack of presence with the client, so s/he responded by refocusing and taking more control of the session (P.11). Yet the trainee’s imagery experience may have also provided a source of information about the client and reflected how others might also respond to the client. Some therapists (e.g.,

Cooper, 2008; Diamond, 2014) in the psychodynamic literature, in discussing the link between countertransference and imagery, warn of the dangers of therapists' misinterpretation and misuse of their own mental experiences, including imagery, as a source of information about the client or themselves; thus, they emphasise that a judicious process is required to filter and consider these experiences over time.

There may also be alternative interpretations in some cases where trainees' interpreted their imagery as facilitating empathy development. For example, the trainee working in a forensic setting who visualised an inmate's childhood abuse story thought that the imagery enabled her/him to identify with the inmate as a vulnerable child and develop empathy for the inmate when this had been a struggle previously. However, the trainee's "protective mummy reaction" may be interpreted as a countertransference reaction that may have involved a shift from empathy to over-identification with the inmate, which can lead to blurred boundaries, difficulties maintaining therapeutic distance, inaccurate conceptualisation of client presenting problems, and ineffective therapeutic interventions (Gelso & Hayes, 2007). In another case, a trainee visualised a wolf that s/he experienced as threatening and "scary". S/he interpreted this imagery as symbolising the client feeling "under threat" from depression and anxiety, and "hopeless and helpless", which the trainee thought helped her/him to understand the client and develop empathy (P.25). Yet the imagery may also have reflected the trainee feeling threatened by the client's anxiety and depression and her/his own capability to help.

These examples demonstrate the complexity and potential challenges associated with how therapists conceptualise, interpret, and make use of their imagery when working with clients in therapy, which suggests the importance of a cautious approach and self-reflection, and the importance of training and supervision.

Trainee Therapists Desired to Learn More About Therapist Imagery

Most (69.2%) of the trainee therapists in this thesis study wanted to learn more about therapist imagery. Some described wanting acknowledgement, normalisation, and validation of therapists experiencing imagery, and they expressed the need for learning about therapists' subjective experiences more generally in their training. Some suggested that the absence of this had contributed to their discomfort in discussing their imagery experiences. Some described wanting to develop an understanding of therapist imagery on a conceptual level. For example, one trainee thought that "a model or framework to think about imagery, based on the literature" would be helpful (P.8). Some described wanting to develop increased awareness of their imagery in therapy. Some trainees described valuing the process of self-reflection that they experienced as part of the process of taking part in the study and wanted to learn more about how to reflect on their imagery. For example, one trainee said, "It has been good to talk, good questions … I would like to learn more about how to explore imagery in a reflective way" (P.8). Some trainees described wanting to learn how to manage their imagery in session and afterwards. For example, one trainee reported wanting to learn "practical skills to reduce imagery when it impedes therapy and to enhance it when it's useful" (P.3). Previous research suggests that therapists may benefit from learning strategies to manage intrusive imagery (e.g., Dean & Barnett, 2011). Some trainees described wanting to learn how they could make use of their imagery when working with clients. For example, one trainee said, "I would like to learn more about the ways imagery can be utilised in therapy, in building formulations, or in framing a piece of therapeutic work" (P.11). To this end, some thought they would benefit from learning from other therapists how they could use imagery.

Clinical and Training Implications

The results of this study suggest that the trainees' conceptualisations and interpretations of their imagery generally influenced their understanding of the client, their own experience, and aspects of the therapeutic relationship. The results of this study also suggest that the trainees' conceptualisations and interpretations of their imagery influenced their responses in therapy. Yet, for most of the trainees, the influence of their imagery was unrecognised prior to their reflection as part of the process of participating in the study. This suggests the importance of therapists' awareness of their own imagery, if experienced, and its potential impact on their work with clients in therapy. In general, the trainee therapists conveyed that the questionnaire and interviews facilitated a helpful process of reflection regarding their imagery, which appeared to generate increased awareness and insight. This suggests that trainee therapists may benefit from a guided reflection process in their training or supervision.

The majority of the trainee therapists in this thesis study, once they had reflected on their imagery, valued their imagery and perceived it to be beneficial in their work with clients in therapy. However, most of the trainees wanted to learn more about therapist imagery and how it can be conceptualised and used in therapy. This suggests that trainee therapists may benefit from learning the ways in which therapist imagery can be conceptualised and used in therapy. However, the different ways that therapist imagery can be conceptualised, interpreted, and used presents challenges and is suggestive of its complexity. This has implications for supervision, as it can facilitate discussion regarding trainees' imagery experiences and interpretations.

Some trainees who described difficult and traumatic imagery experiences reported a desire to learn practical skills and techniques to manage and reduce their intrusive imagery. This has implications for training, particularly given trainees are likely to be more vulnerable

to difficult intrusive imagery and previous research on working with trauma and preventing vicarious trauma suggests the benefit of therapists learning and using coping skills, including the management of intrusive imagery (Dean & Barnett, 2011).

Limitations of This Study

There are a number of limitations to this study. Firstly, although the participant sample size was appropriate for qualitative analysis, it was relatively small for quantitative analysis. Although exploratory quantitative analysis was possible, including the correlations between imagery variables such as perceived frequency, vividness, helpfulness, difficulty, training and supervision, and demographic variables, a larger sample size would enable further analysis of the relationships and a better understanding of the factors that influence imagery experience and the effects of imagery.

A second limitation is the potential for self-selection bias. The trainee therapists who chose to participate in this study may have been characterised by having a greater interest in imagery compared to those who did not respond. Furthermore, the sample of trainee therapists who chose to participate in the study were largely of European descent and within predominantly CBT focused clinical psychology training programmes. Therefore, the results may not accurately represent all trainee therapists across therapy disciplines and approaches and across all cultural perspectives. For example, other therapy training programmes such as psychoanalytic psychotherapy or counselling training may have a greater focus on therapist imagery and focus on particular conceptualisations and uses of therapist imagery in therapy, and different cultural backgrounds may influence trainees' awareness, experience, and understanding of their imagery. Different cultural conceptualisations and terminologies may have been a barrier to participation. Several factors contribute to mitigating concern over the sample size and self-selection bias. There was diversity within the sample with respect to

demographics and reported level of experience of imagery, and there were also notable similarities in the trainees' reported experiences, as identified in the themes.

A third limitation is the use of trainees' self-report, which may have been influenced by the limits of memory. The trainees' recollections of their imagery experiences may have been distorted due to the passage of time. It is also possible that the trainees' reports represented exceptional instances and awareness rather than what is typical. While the trainees' developed their awareness and understanding of their imagery through their participation in the study, most said that they had not attended to their imagery prior to the study.

A fourth limitation is the degree of subjectivity in the research given my own role as the researcher and an instrument of data collection and analysis of data. While the research process was regularly reviewed by my primary supervisor to ensure trustworthiness and rigour, and my own personal experiences and conceptualisations and potential biases were discussed in supervision, another researcher may have had a different influence on the interview dynamics and the trainees' self-disclosures, and thus, elicited different details from the trainees in the interviews. A different researcher may have identified somewhat different themes or provided different emphases using the same data set. Despite these potential limitations, this study is a useful exploratory study given there is no empirical research on trainee therapists' experiences of imagery to date.

Further Research

It may be useful to investigate the conditions and/or factors that might enhance therapists' imagery and enable therapists to pay attention to their imagery, or, conversely, the conditions and/or factors that might block therapists' experiencing imagery, such as: therapist characteristics including cognitive style and therapy approaches and models used; the clients'

presenting problems, diagnoses, and progress; dynamics of the therapeutic relationship; and the nature of the therapeutic situation. Gaining deeper understanding of the factors that facilitate and reduce the occurrence of imagery could be useful for trainee therapists in managing both the benefits and challenges associated with imagery. Further research exploring the ways in which therapists manage their imagery and particularly how experienced therapists manage traumatic imagery could be beneficial. Also, exploring the ways in which therapists make use of their imagery in their work with clients, such as specific techniques, and how this impacts therapy processes and outcomes could be beneficial. It would also be helpful to explore the impact of therapists' cultural differences in how they understand and use their imagery. Given the limitations of relying on delayed recollections, further research could benefit from making use of the collection of data from participants' daily or weekly diary entries, notes, and reflections on their experiences of imagery when working with clients in therapy.

Summary of Findings and Conclusions

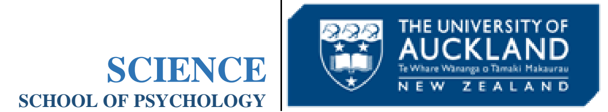
This thesis study demonstrates the importance of considering trainee therapists' experiences of imagery when working with clients in therapy. Most of the trainee therapists who participated in this study experienced imagery. Their imagery was primarily visual and often also involved other sensory modalities that took literal, metaphoric, and symbolic forms. The trainees were often impacted emotionally, physically, and cognitively by their imagery, which influenced their work with clients in therapy. Most trainees valued their imagery and understood it as a way of processing client material, gaining insight into the client, or developing empathy. Some also understood their imagery as a way of gaining insight into themselves or the therapeutic relationship or processes. Some understood their imagery as an experience of countertransference. The various possible interpretations suggest

the complexity and potential challenges. Furthermore, although some trainee therapists experienced difficulties with distressing and disruptive imagery, most reported little or no training to help them understand or manage their imagery, which they thought they would benefit from. Overall, the findings of this thesis study suggest that trainees may benefit from training and supervision to help them understand imagery, reflect on and interpret their imagery experiences, and learn how to manage problematic imagery. This exploratory study took a qualitatively driven mixed method approach and contributes to the existing body of research on imagery in therapy by identifying patterns in the way trainee therapists have experienced and conceptualised their imagery in therapy and the potential benefits and challenges, which has clinical and training implications. Further research could investigate how therapists enhance and manage their imagery, how experienced therapists manage traumatic imagery, how therapists make use of their imagery in therapy, and how this impacts therapy processes and outcomes.

Appendices

Appendix A: Advertisement

Appendix B: Participant Information Sheet



School of Psychology
Tamaki Innovation Campus
261 Morrin Road, St Johns
Private Bag 92019
Auckland 1142, New Zealand
T +64 9 373 7599
W psych.auckland.ac.nz
E psych@auckland.ac.nz

PARTICIPANT INFORMATION SHEET

Investigating Trainee Therapists' Experiences of Imagery in Therapy

Tēnā Koe

Ngā mihi nui ki a koe e panuitia tēnei pānui. Ko Ngāti Toa Rangitira tōku iwi. Ko Danielle Hay tōku ingoa.

My name is Danielle Hay. I am of both Māori and Pākehā descent and my whānau are from central North Island. I am conducting this research as part of a Doctorate in Clinical Psychology under the supervision of Dr Claire Cartwright and Dr Margaret Dudley from the School of Psychology at the University of Auckland.

Mental imagery is experienced by people in everyday life although not everybody reports experiencing it. Mental imagery may be visual and involve seeing pictures in the mind's eye, or it may involve others senses such as sound, smell and physical sensations. Some people describe having a 'felt sense'.

There is a vast literature on clients' experiences of imagery and the use of imagery in therapy, yet little is known about therapists' experiences of imagery. Some therapists experience mental imagery as part of their everyday life and also when working with clients. However, not much is known about how this effects therapists or trainee therapists. This study aims to understand trainee therapists' experience of mental imagery when working therapeutically with clients, the ways in which they understand and manage these experiences, and how this is influenced by cultural identity.

Who will benefit from this study?

This study will be useful for the training of psychologists and therapists. Participants who take part may also find it interesting and can request a summary report of the findings.

You're invited to participate in this study

You are invited to participate in this study if you are a trainee therapist (psychology, psychotherapy, counselling) enrolled in a post-graduate training programme in Aotearoa New Zealand and you have completed at least two work practicums. You are invited to take part in this study whether you experience mental imagery or not as we want to understand the range of experiences that trainee therapists have. Taking part in this study is entirely voluntary and you will not be disadvantaged in any way if you decide not to participate.

What does the study involve?

In taking part in this study you will complete an online anonymous questionnaire that includes open-ended questions about your own experiences and will take approximately 20 minutes depending on the depth of your answers. Your consent to take part in the study will be indicated by your completion of the questionnaire. You can also volunteer to take part in a follow-up interview, which will take approximately 30 minutes. The interview can be in a location of your choice or via telephone or skype. During the interview you will be asked to talk in some more depth about your experiences of mental imagery.

Compensation

After completing the online questionnaire you can enter the prize draw to win one of four $100 supermarket vouchers. If you also participate in an interview you will receive a $40 supermarket voucher.

What will happen to the information you share?

The information you provide will be kept confidential. As the questionnaire is anonymous, your identity will be unknown and therefore protected. If you choose to enter the prize draw or participate in an interview you will need to provide your email address in the questionnaire.

The interviews will be audio recorded and transcribed by a professional transcriber who will sign a confidentiality agreement. You may ask for the recorder to be turned off at any time, or choose not to answer a particular question, without needing to provide a reason. Your name will not be used on the recording and your identity will be protected. Each recording will be assigned a number and the identity of the numbers will be stored in a separate location so that individual recordings cannot be identified. The data from the questionnaire, audio recordings, and transcripts will be stored in a password-protected University of Auckland computer. All data will be kept for ten years and then destroyed.

You have the right to withdraw from the interview at any time. You can request to have your transcript sent to you for review. You may modify your transcript or withdraw any data provided from the interview up to two weeks from the date of receiving your transcript. Withdrawal of anonymous data from the questionnaire is not possible.

The results from this study will be submitted in a doctoral thesis and may be published in New Zealand and in international research journals. Publications will not contain any identifiable information. If you take part in the study, you can request a summary report of the findings by emailing me and this will be sent to the email address you provide.

Are there any risks involved?

We do not foresee any risks from the online questionnaire. Participants who take part in an interview will talk about their experiences of working therapeutically. Should an issue arise during the interview, I can discuss with my supervisors who are registered clinical psychologists and will be able to advise on the best action to take, for example to provide assistance with a referral to an external support person. This is considered very unlikely but important to note.

Where can you get more information about this study?

Should you have any queries or concerns about any aspect of this research feel free to contact me. Or, alternatively, you may contact my supervisors, the Head of School, or the Chair of the Ethics Committee at The University of Auckland. Contact details are provided below.

Contact details

Researcher

Danielle Hay
School of Psychology, University of Auckland
Email: dhay068@aucklanduni.ac.nz

Supervisors

Dr Claire Cartwright
School of Psychology, University of Auckland
Email: c.cartwright@auckland.ac.nz
Phone: (09) 923 6269

Dr Margaret Dudley
Te Rarawa, Te Aupōuri, Ngāti Kahu ki Whangaroa
School of Psychology, University of Auckland
Email: m.dudley@auckland.ac.nz
Phone: (09) 923 6869

Head of Department

Prof William Hayward
School of Psychology
University of Auckland
Email: w.hayward@auckland.ac.nz
Phone: (09) 373 7599 extn. 88516

For any ethical concerns:

The Chair, The University of Auckland Human Participants Ethics Committee,
Private Bag 92019, Auckland 1142.
Email: ro-ethics@auckland.ac.nz
Phone: 09 373-7599 extn. 83711.

Approved by the University of Auckland Human Participants Ethics Committee on 31 October 2016 for three years. Reference Number 017626.

Appendix C: Questionnaire

The questionnaire was placed on Qualtrics, which automatically added the University of Auckland logo.

The questionnaire opened to the participant information sheet, which the participants were asked to read before proceeding to the questions.

Demographics

1. What is your age?
2. What is your gender?
3. What ethnicity/ies do you identify with?
4. What training programme are you in? (Clinical Psychology, Counselling Psychology, Psychotherapy, Other)
5. What is your professional training programmes' qualification structure? (Master's programme, Doctorate programme, PhD programme, Other)
6. What year of your professional training programme are you in? (1, 2, 3, Other)
7. How many semesters have you been working with clients?
8. Please estimate how many clients you have worked with.
9. Please estimate how many sessions you have observed others working with clients.
10. Please rank the top four therapeutic approaches you have received training in, from 1 (most training) to 4 (least training). (Cognitive behavioural therapy and related approaches, Psychodynamic or psychoanalytic, Humanistic approaches, Acceptance and commitment therapy, Dialectic behavioural therapy, Other)

Introduction to Mental Imagery

Some people experience mental imagery. Mental imagery can be visual and involve seeing pictures in the mind's eye, or it can involve sounds, smells, tastes or physical sensations. Some people also describe having a 'felt sense'.

We are interested in the mental imagery – images, sounds, smells, tastes, physical sensations, felt senses – that trainee therapists experience, particularly in therapy.

Not everybody experiences mental imagery. If you don't experience mental imagery, we're still interested in your experience. We want to understand the experiences of those who have mental imagery and those who don't.

Questions

Please indicate your experience of mental imagery on the 5 point scales below:

11. I experience mental imagery in everyday life (1-5 point scale)
12. My mental imagery is strong/vivid (1-5 point scale)
13. Do you experience mental imagery or something that fits with this? (No/Yes)

If participant answered "No" to Question 13:

14. If you don't have mental imagery yourself, have you heard the terms mental imagery or visualisation before? What do you think they mean?
15. What has been your experience when you've been asked to visualise or imagine something? What was that like for you?
16. What other internal experiences have you experienced when working with clients that might be more like a felt sense? Please describe below.

If participant answered “Yes” to Question 13:

17. Please briefly describe, in the space below, the type of mental imagery that is most common for you (for example, mainly visual but with some sound; mainly kinaesthetic; and so on).

Some therapists report experiencing mental imagery when working therapeutically with clients. In the questions below, you will find rating scales and open-ended questions about your experience of mental imagery in therapy sessions.

18. Please write about an experience of mental imagery when working therapeutically with a client. Write as much as you would like, the box will expand. Please describe:
    - What happened in therapy
    - How you felt and responded (either inside yourself or in therapy)
    - Any positive or negative effects of your imagery
    - How you understood or interpreted this experience
19. Would you be willing to write about a second experience of mental imagery when working therapeutically with a client? If so, write as much as you would like, the box will expand. Please describe:
    - What happened in therapy
    - How you felt and responded (either inside yourself or in therapy)
    - Any positive or negative effects of your imagery
    - How you understood or interpreted this experience
20. Please rate your agreement with the following statements about mental imagery in therapy situations
    - Overall my mental imagery is helpful (1-5 point scale)
    - Overall my mental imagery is problematic (1-5 point scale)
    - I talk about my experiences of mental imagery in clinical supervision or with colleagues or classmates (1-5 point scale)
    - I have had training in understanding and managing mental imagery (1-5 point scale)
21. Please write about any other experiences or ideas you have about mental imagery that you haven’t been able to express above.

Final questions for all participants:

22. Reflecting on what you’ve written, does your cultural identity influence how you experience, understand or interpret mental imagery? If so, how?
23. What would you like to learn in regard to therapists’ mental imagery when working therapeutically with clients?

End of questionnaire

Thank you very much for taking the time to participate in this study.

If you would like to go into the prize draw to win one of four $100 supermarket vouchers please provide your email address.

Are you willing to take part in a follow-up interview (which can be at a location of your choice or via skype)? If yes, please provide your email address if you haven’t already done so above.

If you would like to receive a summary report of the findings, please email Danielle Hay at dhay068@aucklanduni.ac.nz and you will be sent a summary report of the findings when available.

Please click the arrow button below to submit your responses.

Appendix D: Consent Form

School of Psychology
Tamaki Innovation Campus
261 Morrin Road, St Johns
Private Bag 92019
Auckland 1142, New Zealand
T +64 9 373 7599
W psych.auckland.ac.nz
E psych@auckland.ac.nz

CONSENT FORM

Investigating Trainee Therapists' Experiences of Imagery in Therapy

Interview study

THIS FORM WILL BE HELD FOR A PERIOD OF 10 YEARS

Researchers: Danielle Hay, Dr Claire Cartwright and Dr Margaret Dudley

I have read the Participant Information Sheet and I have understood the nature of the research. I have had the opportunity to ask questions and have them answered to my satisfaction.

- I agree to be interviewed as part of this research and I understand it will take approximately 30 minutes of my time.
- I understand that my participation is voluntary and that I am free to withdraw at any time without giving a reason.
- I understand that I can request to have my transcript sent to me for review and that I may review and modify my transcript or withdraw any data provided from the interview up to two weeks from the date of receiving my transcript. I understand that withdrawal of anonymous data from the questionnaire is not possible.
- I agree to be audio recorded.
- I understand that I may ask for the recorder to be turned off at any time, or choose not to answer a particular question, without needing to provide a reason.
- I understand that a third party who has signed a confidentiality agreement will transcribe the audio recordings.
- I understand that all data provided by me will be treated confidentially and that my anonymity will be protected.
- I understand that data will be stored in a secure location at the University of Auckland by Danielle Hay.
- I understand that data will be kept for ten years, after which time any data will be destroyed.
- I understand that the results from this study will be submitted in a doctoral thesis and may be published in New Zealand and in international research journals.
- I wish / do not wish to receive the summary of findings, which can be emailed to me at this email address:

Name: ____

Signature: ____ Date:_____________

Approved by the University of Auckland Human Participants Ethics Committee on 31st October 2016 for three years. Reference Number 017626.

Appendix E: Interview Schedule

Preamble

Thank you for taking the time to talk to me and share more about your experiences of mental imagery. Throughout the interview, I'll ask you to speak generally about your experiences of mental imagery, and I'll also ask you about specific examples to help me get a clearer picture of your experiences. If there is anything you would prefer not to talk about that is fine. This interview will be recorded but you may ask for the recorder to be turned off at any time.

I am hoping that this study will provide a better understanding of trainee therapists' experiences of imagery and be helpful for the future training of therapists.

Thank you very much for agreeing to be part of this research. Do you have any questions?

Explore their experience of mental imagery and their understanding of it

- Are you comfortable with your understanding of what I mean by mental imagery? Is it clear to you what imagery is?

- Can you talk to me about your experience of imagery in your life in general?
    - Form it takes / vividness (refer to questionnaire)
    - How long have you experienced imagery for across your life?
    - When do you first remember experiencing imagery?
    - Can you describe an early experience or type of experience you had?
    - Did you ever talk to anyone about your experiences?
    - Has your experience of imagery changed?
    - Has your understanding of imagery changed?
    - When do you remember first hearing the term mental imagery or other terms you understand to refer to imagery?
    - Did you experience any difficulties with your imagery across your life? (refer to questionnaire)

Explore their experience of mental imagery in their training and when working therapeutically with clients

- I'm keen to hear about your experience of mental imagery throughout the training programme. You said in the questionnaire you've seen about # clients. It's understandable you might not have paid attention to your imagery, but when you started working with clients, what was it like for you in terms of your imagery?

- Would you be comfortable telling me about a time you experienced a neutral or even positive experience of mental imagery when you were working with a client?
    - What was happening in the session with the client?
    - What did you experience (the imagery, physical sensations, emotions)?
    - What were you thinking at the time?
    - How did you respond (manage or use the imagery)?
    - Did your imagery influence you or your work with your client?
    - Looking back now, what do you think was happening? What did the imagery mean?

- Would you be comfortable telling me about a time you experienced a more challenging experience of mental imagery when you were working with a client?
    - What was happening in the session with the client?
    - What did you experience (the imagery, physical sensations, emotions)?
    - What were you thinking at the time?
    - How did you respond (manage or use the imagery)?
    - Did your imagery influence you or your work with your client?
    - Looking back now, what do you think was happening? What did the imagery mean?

- Would you like to talk about another time? Either helpful or difficult to help me understand?

- Has the nature of your experience of imagery when working therapeutically with clients and your understanding changed across your training?
- Are there any circumstances in which imagery might be more or less likely to occur for you?
- How important is imagery in your life and work?
- How does your cultural identity influence your experience and understanding of imagery?

Learning in their training programme

- What have you learnt about imagery in your training programme?
- What would you like to learn?

Explore any other ideas

- Is there anything else that you would like to talk about regarding imagery?

End of interview process

Thank you for your time and for sharing your experiences and thoughts about this topic. Before we finish, is there anything else you'd like to say about what we have talked about today? Would you be willing to give me any feedback on your experience in this interview?

Appendix F: Transcriber Confidentiality Agreement

School of Psychology
Tamaki Innovation Campus
261 Morrin Road, St Johns
Private Bag 92019
Auckland 1142, New Zealand
T +64 9 373 7599
W psych.auckland.ac.nz
E psych@auckland.ac.nz

TRANSCRIBER CONFIDENTIALITY AGREEMENT

Investigating Trainee Therapists' Experience of Imagery in Therapy

Researcher: Danielle Hay

Primary Supervisor: Dr Claire Cartwright

Secondary Supervisor: Dr Margaret Dudley

Transcriber:

I agree to transcribe the audio-recordings for the above research project. I understand that the information contained within them is confidential and must not be disclosed to, or discussed with, anyone other than the researcher and her supervisors.

Name: ____

Signature: ____ Date:_____________

Approved by the University of Auckland Human Participants Ethics Committee on 31st October 2016 for three years. Reference Number 017626.

Appendix G: Ethics Approval

Office of the Vice-Chancellor
Finance, Ethics and Compliance

The University of Auckland
Private Bag 92019
Auckland, New Zealand

Level 10, 49 Symonds Street
Telephone: 64 9 373 7599
Extension: 87830 / 83761
Facsimile: 64 9 373 7432

UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS ETHICS COMMITTEE (UAHPEC)

31-Oct-2016

MEMORANDUM TO:

Dr Patricia Cartwright
Psychology

Re: Application for Ethics Approval (Our Ref. 017626): Approved

The Committee considered your application for ethics approval for your project entitled **Investigating trainee therapists' experience of imagery in therapy** .

We are pleased to inform you that ethics approval is granted for a period of three years.

The expiry date for this approval is 31-Oct-2019.

If the project changes significantly, you are required to submit a new application to UAHPEC for further consideration.

If you have obtained funding other than from UniServices, send a copy of this approval letter to the Research Office, at ro-awards@auckland.ac.nz. For UniServices contracts, send a copy of the approval letter to the Contract Manager, UniServices.

In order that an up-to-date record can be maintained, you are requested to notify UAHPEC once your project is completed.

The Chair and the members of UAHPEC would be happy to discuss general matters relating to ethics approvals. If you wish to do so, please contact the UAHPEC Ethics Administrators at ro-ethics@auckland.ac.nz in the first instance.

Please quote reference number: **017626** on all communication with the UAHPEC regarding this application.

UAHPEC Administrators

University of Auckland Human Participants Ethics Committee

c.c. Head of Department / School, Psychology
Dr Margaret Dudley
Ms Danielle Hay

Additional information:

1. Do not forget to fill in the 'approval wording' on the Participant Information Sheets and Consent Forms, giving the dates of approval and the reference number, before you send them out to your participants.

2. Should you need to make any changes to the project,please complete the online proposed changes and include any revised documentation.

3. At the end of three years, or if the project is completed before the expiry, please advise UAHPEC of its completion.

4. Should you require an extension, please complete the online Amendment Request form associated with this approval number giving full details along with revised documentation. An extension can be granted for up to three years, after which a new application must be submitted.

5. Please note that UAHPEC may from time to time conduct audits of approved projects to ensure that the research has been carried out according to the approval that was given.

References

Achterberg, J. (1985). *Imagery in healing: Shamanism and modern medicine*. Shambhala Publications.

Adams, S., & Riggs, S. (2008). An exploratory study of vicarious trauma among therapist trainees. *Training and Education in Professional Psychology, 2*(1), 26-34. https://doi.org/10.1037/1931-3918.2.1.26

Ahsen, A. (1968). *Basic concepts in eidetic psychotherapy*. Brandon House.

Ahsen, A. (1974). Anna O. – Patient or therapist? An eidetic view. In V. Franks & V. Burtle (Eds.), *Women in therapy* (pp. 263-283). Bruner/Mazel.

Ahsen, A. (1984). ISM: The triple code model for imagery and psychophysiology. *Journal of Mental Imagery*, *8*(4), 15-42.

Ahsen, A. (1995). Self-report questionnaires: New directions for imagery research. *Journal of Mental Imagery*, *19*, 107-123.

Althofer, B. (1983). Uses of sensory images in the therapeutic interaction. *Psychoanalytic Review, 70*(1), 47-55.

Anchin, J., & Singer, J. (2016). A dual process perspective on the value of theory in psychotherapeutic decision making. In J. Magnavita, *Clinical decision making in mental health practice* (pp. 61-103). American Psychological Association.

Aristotle. (1984a). On memory (J. Beare, Trans.). In J. Barnes (Ed.). *The complete works of Aristotle: Vol. 1. The revised Oxford translation* (pp. 714-720). Princeton University Press. (Original work written between 335-323 B.C.E.).

Aristotle. (1984b). On the soul (J. Smith, Trans.). In J. Barnes (Ed.). *The complete works of Aristotle: Vol. 1. The revised Oxford translation* (pp. 641-692). Princeton University Press. (Original work written between 335-323 B.C.E.).

Arizmendi, T. (2011). Linking mechanisms: Emotional contagion, empathy, and imagery. *Psychoanalytic Psychology*, *28*(3), 405-419. https://doi.org/10.1037/a0024176

Arnold, D., Calhoun, L., Tedeschi, R., & Cann, A. (2005). Vicarious posttraumatic growth in psychotherapy. *Journal of Humanistic Psychology, 45*(2), 239-263. https://doi.org/10.1177/0022167805274729

Arntz, A. (2012). Imagery rescripting as a therapeutic technique: Review of clinical trials, basic studies, and research agenda. *Journal of Experimental Psychopathology, 3*(2), 189-208. ttps://doi.org/10.5127/jep.024211

Assagioli, R. (1965). *Psychosynthesis: A manual of principles and techniques*. Turnstone.

Bartlett, F. (1927). The relevance of visual imagery to the process of thinking. *British Journal of Psychology*, *18*(1), 23-29.

Bartlett, F. (1958). *Thinking: An experimental and social study*. Basic Books.

Baumeister, R., & Vohs, K., & DeWall, C., & Zhang, L. (2007). How emotion shapes behavior: Feedback, anticipation, and reflection, rather than direct causation. *Personality and Social Psychology Review*, *11*(2), 167-203. https://doi.org/10.1177/1088868307301033.

Beck, A. (1970). Role of fantasies in psychotherapy and psychopathology. *Journal of Nervous and Mental Diseases, 150*(1), 3-7. https://doi.org/10.1097/00005053-197001000-00002

Beck, A. (1976). *Cognitive therapy and the emotional disorders*. New American Library.

Beck, A., Emery, G., & Greenberg, R. (1985). *Anxiety disorders and phobias: A cognitive perspective*. Guilford Press.

Beck, A., Freeman, A., & Davis, D. (2004). *Cognitive therapy of personality disorders* (2nd ed.). Guilford Press.

Beevers, C. (2005). Cognitive vulnerability to depression: A dual process model. *Clinical Psychology Review, 25*(7), 975-1002. https://doi.org/10.1016/j.cpr.2005.03.003

Bell, T., Machie, L., & Bennett-Levy, J. (2015). 'Venturing towards the dark side': The use of imagery interventions by recently qualified cognitive-behavioural therapists. *Clinical Psychology and Psychotherapy, 22*(6), 591-603. https://doi.org/10.1002/cpp.1920

Bennett-Levy, J., & Beedie, A. (2007). The ups and downs of cognitive therapy training: What happens to trainees' perception of their competence during a cognitive therapy training course? *Behavioural and Cognitive Psychotherapy, 35*(1), 61-75. https://doi.org/10.1017/S1352465806003110

Bennett-Levy, J., & Lee, N. (2014). Self-practice and self-reflection in cognitive behaviour therapy training: What factors influence trainees' engagement and experience of benefit? *Behavioural and Cognitive Psychotherapy*, *42*(1), 48-64. https://doi.org/10.1017/S1352465812000781

Bennett-Levy, J., & Thwaites, R. (2007). Self and self-reflection in the therapeutic relationship. In P. Gilbert & R. Leahy. (Eds.). *The therapeutic relationship in the cognitive behavioral psychotherapies* (pp. 255-281). Routledge.

Bennett-Levy, J., Thwaites, R., Chaddock, A., & Davis, M. (2009). Reflective practice in cognitive behavioural therapy: The engine of lifelong learning. In J. Stedmon & R. Dallos (Eds.). *Reflective practice in psychotherapy and counselling* (pp. 115-135). Open University Press.

Bennett-Levy, J., Thwaites, R., Haarhoff, B., & Perry, H., (2015). *Experiencing CBT from the inside out: A self-practice/self-reflection workbook for therapists*. Guilford Press.

Berger, D. (1987). *Clinical empathy*. Jason Aronson.

Bergmann, J., Genç, E., Kohler, A., Singer, W., & Pearson, J. (2014). Neural anatomy of primary visual cortex limits visual working memory. *Cerebral Cortex, 26*(1), 43-50. https://doi.org/10.1093/cercor/bhu168

Betts, G. (1909). *The distribution and functions of mental imagery*. Columbia University.

Bion, W. (1962). *Learning from experience*. Jason Aronson.

Bion, W. (2013). The psycho-analytic study of thinking. *The Psychoanalytic Quarterly, 82*(2), 301-310. https://doi.org/10.1002/j.2167-4086.2013.00030.x

Birksted-Breen, D. (2012). Taking time: The tempo of psychoanalysis. *The International Journal of Psychoanalysis*, *93*(4), 819-835. https://doi.org/10.1111/j.1745-8315.2012.00597.x

Blackwell, S. (2019). Mental imagery: From basic research to clinical practice. *Journal of Psychotherapy Integration*, *29*(3), 235-247. https://doi.org/10.1037/int0000108

Bloch, D. (2007). *Aristotle on memory and recollection: Text, translation, interpretation, and reception in western scholasticism*. Brill.

Bluck, S., Baron, J., Ainsworth, S., Gesselman, A., & Gold, K. (2013). Eliciting empathy for adults in chronic pain through autobiographical memory sharing. *Applied Cognitive Psychology, 27*(1), 81-90. https://doi.org/10.1002/acp.2875

Bradley, R., Greene, J., Russ, E., Dutra, L., & Westen, D. (2005). A multidimensional meta-analysis of psychotherapy for PTSD. *American Journal of Psychiatry, 162*(2), 214-227. https://doi.org/10.1176/appi.ajp.162.2.214

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77-101. https://doi.org/10.1191/1478088706qp063oa

Braun, V., & Clarke, V. (2013). *Successful qualitative research: A practical guide for beginners*. Sage Publications.

Brogaard, B., & Gatzia, D. (2017). Unconscious imagination and the mental imagery debate. *Frontiers in Psychology, 8*(799), 1-14. https://doi.org/10.3389/fpsyg.2017.00799

Brownell, P. (2016). Contemporary Gestalt therapy. In D. Cain, K. Keenan & S. Rubin (Eds.), *Humanistic psychotherapies: Handbook of research and practice* (2nd ed., pp. 219-250). American Psychological Association.

Bryman, A. (2006a). Integrating quantitative and qualitative research: How is it done? *Qualitative Research, 6*(1), 97-113. https://doi.org/10.1177/1468794106058877

Bryman, A. (2006b). Paradigm peace and the implications for quality. *International Journal of Social Research Methodology, 9*(2), 111-126. https://doi.org/10.1080/13645570600595280

Bucci, W. (2002). The referential process, consciousness, and the sense of self. *Psychoanalytic Inquiry, 22*(5), 766-793. https://doi.org/10.1080/07351692209349017

Buchanan, T. (2007). Retrieval of emotional memories. *Psychological Bulletin, 133*(5), 761-779. https://doi.org/10.1037/0033-2909.133.5.761

Burnett Heyes, S., Pictet, A., Mitchell, H., Raeder, S., Lau, J., Holmes, E., & Blackwell, S. (2017). Mental imagery-based training to modify mood and cognitive bias in adolescents: Effects of valence and perspective. *Cognitive Therapy and Research, 41*, 73-88. https://doi.org/10.1007/s10608-016-9795-8

Butler, A., Rice, H., Wooldridge, C., & Rubin, D. (2016). Visual imagery in autobiographical memory: The role of repeated retrieval in shifting perspective. *Consciousness and Cognition, 42*, 237-253. https://doi.org/10.1016/j.concog.2016.03.018

Cabeza, R., & St Jacques, P. (2007). Functional neuroimaging of autobiographical memory. *Trends in Cognitive Sciences, 11*(5), 219-227. https://doi.org/10.1016/j.tics.2007.02.005

Cain, D., Keenan, K., & Rubin, S. (2016). *Humanistic psychotherapies: Handbook of research and practice* (2nd ed.). American Psychological Association.

Carifio, J., & Perla, R. (2008). Resolving the 50-year debate around using and misusing Likert scales. *Medical Education, 42*(12), 1150-1152. https://doi.org/10.1111/j.1365-2923.2008.03172.x

Cartwright, C. (2011). Transference, countertransference, and reflective practice in cognitive therapy. *Clinical Psychologist, 15*(3), 112-120. https://doi.org/10.1111/j.1742-9552.2011.00030.x

Cartwright, C., Cowie, S., Bavin, L., & Bennett-Levy, J. (2019). Therapists' experiences of spontaneous mental imagery in therapy. *Clinical Psychologist, 23*(3), 225-236. https://doi.org/10.1111/cp.12181

Cartwright, C., Barber, C., Cowie, S., & Thompson, N. (2018). A trans-theoretical training designed to promote understanding and management of countertransference for trainee therapists. *Psychotherapy Research, 28*(4), 517-532. http://doi.org/10.1080/10503307.2016.1252071

Carvalho, S., Martins, C., Almeida, H., & Silva, F. (2017). The evolution of cognitive behavioural therapy – The third generation and its effectiveness. *European Psychiatry, 41*(S1), s773-s774. https://doi.org/10.1016/j.eurpsy.2017.01.146

Castonguay, L., Constantino, M., & Grosse Holtforth, M. (2006). The working alliance: Where are we and where should we go? *Psychotherapy: Theory, Research, Practice Training*, *43*(3), 271-279. https://doi.org/10.1037/0033-3204.43.3.271

Cautela, J. (1966). Treatment of compulsive behavior by covert sensitization. *Psychological Record, 16,* 33-41. https://doi.org/10.1007/BF03393640

Cautela, J. (1967). Covert sensitization. *Psychological Reports, 20*(2), 459-468. https://doi.org/10.2466/pr0.1967.20.2.459

Cautela, J. (1971). Covert extinction. *Behavior Therapy, 2*(2), 192-200. https://doi.org/10.1016/S0005-7894(71)80005-9

Chrestman, K. (1999). Secondary exposure to trauma and self-reported distress among therapists. In B. Stamm (Ed.), *Secondary traumatic stress: Self-care issues for clinicians, researchers, and educators* (pp. 29-36). Sidran Press.

Church, J. (2008). The hidden image: A defense of unconscious imagining and its importance. *American Imago, 65*(3), 379-404. https://doi.org/ 10.1353/aim.0.0024

Cohen, J. (1992). Statistical power analysis. *Current Directions in Psychological Science, 1*(3), 98-101. https://doi.org/10.1111/1467-8721.ep10768783

Conway, M. (2001). Sensory-perceptual episodic memory and its context: Autobiographical memory. *Philosophical Transactions: Biological Sciences, 456*(1413), 1375-1384. https://doi.org/10.1098/rstb.2001.0940

Conway, M., & Pleydell-Pearce, C. (2000). The construction of autobiographical memories in the self-memory system. *Psychological Review, 107*(2), 261-288. https://doi.org/10.1037/0033-295X.107.2.261

Cooper, S. (2008). Privacy, reverie, and the analyst's ethical imagination. *The Psychoanalytic Quarterly, 77*(4), 1045-1073. https://doi.org/10.1002/j.2167-4086.2008.tb00375.x

Corbin, H. (1972). Mundus imaginalis, or the imaginary and the imaginal. *Spring: An Annual of Archetypal Psychology and Jungian Thought*, 1-19.

Costa, V., Lang, P., Sabatinelli, D., Versace, F., & Bradley, M. (2010). Emotional imagery: Assessing pleasure and arousal in the brain's reward circuitry. *Human Brain Mapping, 31*(9), 1446-1457. https://doi.org/10.1002/hbm.20948

Crampton, M. (1969). The use of mental imagery in psychosynthesis. *Journal of Humanistic Psychology, 9*(2), 139-153. https://doi.org/10.1177/002216786900900204

Creswell, J. (2012). *Qualitative inquiry and research design: Choosing among five approaches*. Sage Publications.

Creswell, J., & Plano Clark, V. (2011). *Designing and conducting mixed methods research* (2nd ed.). Sage Publications.

Crisanti, U. (2019). What is the advantage of integrating dual process theories and compassion focused therapy? Is the merger a suitable framework to gain insight on thinking performances in psychotherapy? *Journal of Evidence-Based Psychotherapies, 19*(1), 27-47. https://doi.org/10.24193/jebp.2019.1.2

Cui, X., Jeterb, C., Yangc, D., Montaguec, P., & Eaglemanb, D. (2007). Vividness of mental imagery: Individual variability can be measured objectively. *Vision Research, 47*(4), 474-478. https://doi.org/10.1016/j.visres.2006.11.013

Cumming, J., & Eaves, D. (2018). The nature, measurement, and development of imagery ability. *Imagination, Cognition and Personality, 37*(4), 375-393. https://doi.org/10.1177/0276236617752439

Cumming, J., & Ramsey, R. (2009). Imagery interventions in sport. In S. Mellalieu & S. Hanton (Eds.), *Advances in applied sport psychology: A review* (pp. 5-36). Routledge.

Curwen, B., Palmer, S., & Ruddell, P. (2000). *Brief cognitive behaviour therapy*. Sage Publications.

Cwik, A. (2011). Associate dreaming: Reverie and active imagination. *The Journal of Analytical Psychology, 56*(1), 1-13. https://doi.org/10.1111/j.1468-5922.2010.01887.x.

Cwik, A. (2017). What is a Jungian analyst dreaming when myth comes to mind? Thirdness as an aspect of the anima media natura. *Journal of Analytical Psychology, 62*(1), 107-129. https://doi.org/10.1111/1468-5922.12284

Davis, M. (1983). Measuring individual differences in empathy: Evidence for a multidimensional approach. *Journal of Personality and Social Psychology, 44*(1), 113-126. https://doi.org/10.1037/0022-3514.44.1.113

de Borst, A., & de Gelder, B. (2017). fMRI-based multivariate pattern analyses reveal imagery modality and imagery content specific representations in primary somatosensory, motor and auditory cortices. *Cerebal Cortex, 27*(8), 3994-4000. https://doi.org/10.1093/cercor/bhw211

de Vito, S., & Bartolomeo, P. (2015). Refusing to imagine? On the possibility of psychogenic aphantasia. *Cortex, 74*, 334-335. http://doi.org/10.1016/j.cortex.2015.06.013

Dean, C., & Barnett, G. (2011). The personal impact of delivering a one-to-one treatment programme with high-risk sexual offenders: Therapists' experiences. *Journal of Sexual Aggression, 17*(3), 304-319. https://doi.org/10.1080/13552600.2010.506577

Decety, J., & Grèzes, J. (2006). The power of simulation: Imagining one's own and other's behavior. *Brain Research, 1079*(1), 4-14. https://doi.org/10.1016/j.brainres.2005.12.115

Decety, J., & Jackson, P. (2004). The functional architecture of human empathy. *Behavioral and Cognitive Neuroscience Reviews, 3*(2), 71-100. https://doi.org/10.1177/1534582304267187

Dekeyser, M., Elliot, R., & Leijssn, M. (2009) Empathy in psychotherapy: Dialogue and embodied understanding. In J. Decety & W. Ickes (Eds.), *The social neuroscience of empathy* (pp. 114-124). MIT Press.

Desoille, R. (1961). *lheorie et pratique du reve eveille dirige* [The theory and practice of directed dreaming]. Mont Blanc.

Desoille, R. (1965). *The directed daydream*. Psychosynthesis Research Foundation.

Diamond, M. (2014). Analytic mind use and interpsychic communication: Driving force in analytic technique, pathway to unconscious. *The Psychoanalytic Quarterly, 83*(3), 525-563. https://doi.org/10.1002/j.2167-4086.2014.00106.x

Dietrich, B. (2016). C.G. Jung – Champion of the imagination. In L. Davenport (Ed.), *Transformative imagery: Cultivating the imagination for healing, change, and growth* (pp. 122-135). Jessica Kingsley Publishers.

Dijkstra, N., Zeidman, P., Ondobaka, S., van Gerven, M., & Friston, K. (2017). Distinct top-down and bottom-up brain connectivity during visual perception and imagery. *Scientific Reports, 7*(1), 5677. https://doi.org/10.1038/s41598-017-05888-8

Dorahy, M., Peck, R., & Huntjens, R. (2016). The impact of dissociation on perceptual priming and intrusions after listening to auditory narratives. *Journal of Trauma & Dissociation, 17*(4), 410-425. https://doi.org/10.1080/15299732.2015.1134746

Dörnyei, Z. (2020). *Vision, mental imagery and the Christian life*. Routledge.

Drimalla, H., Landwehr, N., Hess, U., & Dziobek, I. (2019). From face to face: The contribution of facial mimicry to cognitive and emotional empathy. *Cognition and Emotion, 33*(8), 1672-1686. https://doi.org/10.1080/02699931.2019.1596068

Dutton, M., & Rubinstein, F. (1995). Working with people with PTSD: Research implications. In C. Figley (Ed.), *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized* (pp. 82-100). Brunner-Mazel.

Edelson, M. (1993). Telling and enacting stories in psychoanalysis and psychotherapy: Implications for teaching psychotherapy. *The Psychoanalytic Study of the Child, 48*(1), 293-325. https://doi.org/10.1080/00797308.1993.11822389

Edwards, D. (2011). From ancient shamanic healing to twenty-first century psychotherapy: The central role of imagery methods in effecting psychological change. In A.

Hackmann, J. Bennett-Levy & E. Holmes (Eds.), *Oxford guide to imagery in cognitive therapy* (pp. xxxiii-xlii). Oxford University Press.

Ehlers, A., Hackmann, A., Steil, R., Clohessy, S., Wenninger, K., & Winter, H. (2002). The nature of intrusive memories after trauma: The warning signal hypothesis. *Behaviour Research and Therapy, 40*(9), 1021-1028. https://doi.org/10.1016/S0005-7967(01)00077-8

Elliott, R., Bohart, A., Watson, J., & Greenberg, L. (2011). Empathy. In J. Norcross (Ed.), *Psychotherapy relationships that work* (2nd ed., pp. 132-152). Oxford University Press.

Epstein, S. (1973). The self-concept revisited or a theory of a theory. *American Psychologist, 28*(5), 404-416. https://doi.org/10.1037/h0034679

Epstein, S. (1994). Integration of the cognitive and psychodynamic unconscious. *American Psychologist, 49*(8), 709-724. https://doi.org/10.1037/0003-066X.49.8.709

Epstein, S. (1998). Cognitive-experiential self-theory. In Barone, D., Hersen, M., & van Hasselt, V. (Eds.). *Advanced personality* (pp. 211-238). Springer.

Epstein, S. (2003). Cognitive-experiential self-theory of personality. In T. Millon & M. Lerner (Eds.), *Comprehensive handbook of psychology* (Vol. 5, pp. 159-184). John Wiley & Sons.

Epstein, S. (2010). Demystifying Intuition: What it is, what it does, and how it does it. *Psychological Inquiry, 21*(4), 295-312. https://doi.org/10.1080/1047840X.2010.523875

Epstein, S. (2014). *Cognitive-experiential theory: An integrative theory of personality*. Oxford University Press.

Epstein, S., & Epstein, M. (2016). An integrative theory of psychotherapy: Research and practice. *Journal of Psychotherapy Integration, 26*(2), 116-128. https://doi.org/10.1037/int0000032

Epstein, S., Lipson, A., Holstein, C., & Huh, E. (1992). Irrational reactions to negative outcomes: Evidence for two conceptual systems. *Journal of Personality and Social Psychology, 62*(2), 328-339. https://doi.org/10.1037/0022-3514.62.2.328

Epstein, S., & Pacini, R. (1999). Some basic issues regarding dual-process theories from the perspective of cognitive-experiential self-theory. In S. Chaiken & Y. Trope (Eds.), *Dual-process theories in social psychology* (pp. 462-482). Guilford Press.

Epstein, S., & Pacini, R. (2001). The influence of visualization on intuitive and analytical information processing. *Imagination, Cognition and Personality, 20*(3), 195-216. https://doi.org/10.2190/g4vg-akqp-2q91-jqhp

Evans, J. (2009). How many dual-process theories do we need? One, two, or many? In J. Evans & K. Frankish (Eds.), *In two minds: Dual processes and beyond* (pp. 33-54). Oxford University Press.

Evans, J., & Coventry, K. (2006). A dual-process approach to behavioral addiction: The case of gambling. In R. Wiers & A. Stacy (Eds.), *Handbook of implicit cognition and addiction* (pp. 29-44). Sage Publications.

Evans, J., & Frankish, K. (2009). The duality of mind: An historical perspective. In J. Evans & K. Frankish (Eds.), *In two minds: Dual processes and beyond* (pp. 1-32). Oxford University Press.

Evans, J., & Over, D. (1996). *Rationality and reasoning.* Psychology Press.

Faw, B. (2009). Conflicting intuitions may be based on differing abilities: Evidence from mental imaging research. *Journal of Consciousness Studies, 16*(4), 45-68.

Fidaleo, R., Proano, T., & Friedberg, R. (1999). Using imagery techniques to treat PTSD symptoms in bereaved individuals. *Journal of Contemporary Psychotherapy, 29*(2), 115-126. https://doi.org/10.1023/A:1021904731317

Figley, C. (1995). Compassion fatigue: Toward a new understanding of the costs of caring. In B. Stamm (Ed.), *Secondary traumatic stress: Self-care issues for clinicians, researchers, and educators* (pp. 3-28). Sidran Press.

Finke, R. (1980). Levels of equivalence in imagery and perception. *Psychological Review, 87*(2), 113-132. https://doi.org/10.1037/0033-295X.87.2.113

Finlay, L. (2015). Sensing and making sense: Embodying metaphor in relational-centered psychotherapy. *The Humanistic Psychologist, 43*(4), 338-353. https://doi.org/10.1080/08873267.2014.993070

Finlay, L. (2016). *Relational integrative psychotherapy: Engaging process and theory in practice*. John Wiley & Sons.

Foa, E., Hembree, E., & Rothbaum, B. (2007). *Prolonged exposure therapy for PTSD: Emotional processing of traumatic experiences therapist guide*. Oxford University Press.

Freeman, A. (1981). Dreams and images in cognitive therapy. In G. Emery, S. Hollon & R. Bedrosian (Eds.), *New directions in cognitive therapy: A case book*. Guilford Press.

Fretigny, R., & Virel, A. (1968). *L'imageri mentale* [Mental imagery]. Mont Blanc.

Freud, S. (1910). The origin and development of psychanalysis. *American Journal of Psychology, 21*(2), 181-218. https://doi.org/10.2307/1413001

Freud, S. (1955). The psychotherapy of hysteria (J. Strachey & A. Freud, Trans.). In S. Freud & J. Breuer (Eds.), *Studies on Hysteria* (Vol. 2, pp. 253-305). The Hogarth Press and the Institute of Psycho-Analysis. (Original work published 1893).

Freud, S. (1976). *The interpretation of dreams* (J. Strachey, Trans.). Penguin Books. (Original work published 1899).

Gaddy, M., & Ingram, R. (2014). A meta-analytic review of mood-congruent implicit memory in depressed mood. *Clinical Psychology Review, 34*(5), 402-416. https://doi.org/10.1016/j.cpr.2014.06.001

Galton, R. (1869). *Hereditary genius*. MacMillian.

Galton, F. (1880). Statistics of mental imagery. *Mind, 5*(19), 301-318.

Galton, R. (1883). *Inquiries into human faculty and its development*. Macmillan.

Ganis, G., Thompson, W., & Kosslyn, S. (2004). Brain areas underlying visual mental imagery and visual perception: an fMRI study. *Cognitive Brain Research, 20*(2), 226-241. https://doi.org/10.1016/j.cogbrainres.2004.02.012

Gardner, R. (1989). *Self inquiry.* Taylor & Francis.

Gawronski, B., & Creighton, L. (2013). Dual process theories. In D. Carlson (Ed.), *The Oxford handbook of social cognition* (pp. 282-312). Oxford University Press.

Gelso, C., & Hayes, J. (2007). *Countertransference and the therapist's inner experience: Perils and possibilities.* Lawrence Erlbaum.

Gendlin, E. (1978). *Focusing: How to open up your deeper feelings and intuition*. Everest House.

Gendlin, E. (1996). *Focusing-oriented psychotherapy.* Guilford Press.

Gilbert, P. (2000). Social mentalities: Internal 'social' conflict and the role of inner warmth and compassion in cognitive therapy. In P. Gilbert and K. Bailey (Eds.). *Genes on the couch: Explorations in evolutionary psychotherapy* (pp. 118-150). Brunner-Routledge.

Gilbert, P. (2009). Introducing compassion-focused therapy. *Advances in psychiatric treatment, 15*(3), 199-208. https://doi.org/10.1192/apt.bp.107.005264

Gilbert, P. (2010). *Compassion-focused therapy: Distinctive features*. Routledge.

Gilbert, P. (2014). The origins and nature of compassion focused therapy. *British Journal of Clinical Psychology, 53*(1), 6-41. https://doi.org/10.1111/bjc.12043

Gilbert, P., & Leahy, R. (Eds.). (2007). *The therapeutic relationship in the cognitive behavioral psychotherapies*. Routledge.

Gordon, R. (1972). A very private world. In P. Sheehan (Ed.), *The function and nature of imagery* (pp. 63-80). Academic Press.

Goyal, N., Wice, M., Kinsbourne, M., & Castano, E. (2017). A picture is worth a thousand words: The influence of visuospatial and verbal cognitive styles on empathy and willingness to help. *Social Psychology, 48*(6), 372-379. https://doi.org/10.1027/1864-9335/a000318

Greenberg, D., & Knowlton, B. (2014). The role of visual imagery in autobiographical memory. *Memory and Cognition, 42*(6), 922-934. https://doi.org/10.3758/s13421-014-0402-5

Greene, J., Caracelli, V., & Graham, W. (1989). Toward a conceptual framework for mixed-method evaluation designs. *Educational Evaluation and Policy Analysis, 11*(3), 255-274. https://doi.org/10.2307/1163620

Grotstein, J. (1981). *Splitting and projective identification*. Aronson

Grotstein, J. (2007). *A beam of intense darkness Wilfred Bion's legacy to psychoanalysis*. Karnac.

Hackmann, A. (1998). Working with images in clinical psychology. *Comprehensive Clinical Psychology, 6*(14), 301-318. https://doi.org/10.1016/B0080-4270(73)00196-6

Hackmann, A., Bennett-Levy, J., & Holmes, E. (2011). *Oxford guide to imagery in cognitive therapy*. Oxford University Press.

Hall, E., Hall, C., Stradling, P., & Young, D. (2006). *Guided imagery: Creative interventions in counselling and psychotherapy*. Sage Publications.

Hannay, A. (2014). *Mental images: A defence.* Routledge. (Original work published 1971).

Hatfield, E., Rapson, R., & Le, Y. (2009). Emotional contagion and empathy. In J. Decety & W. Ickes (Eds.), *The social neuroscience of empathy* (pp. 19-30). MIT Press.

Hayes, S. (2004). Acceptance and commitment therapy, relational frame theory, and the third wave of behavioural and cognitive therapies. *Behavior Therapy, 35*(4), 639-665. https://doi.org/10.1016/j.beth.2016.11.006

Herbert, J., & Forman, E. (2011). The evolution of cognitive behavior therapy: The rise of psychological acceptance and mindfulness. In J. Herbert & E. Forman (Eds.). *Acceptance and mindfulness in cognitive behaviour therapy: Understanding and applying the new therapies* (pp. 3-25). John Wiley & Sons.

Hergenhahn, B., & Henley, T. (2013). *An introduction to the history of psychology* (7th ed.). Cengage Learning.

Herholz, S., Halpern, A., & Zatorre, R. (2012). Neuronal correlates of perception, imagery, and memory for familiar tunes. *Journal of Cognitive Neuroscience, 24*(6), 1382-1398. https://doi.org/10.1162/jocn_a_00216

Herman, J. (1997). *Trauma and recovery*. Basic Books.

Hersen, M., & Rosqvist, J. (Eds.). (2005). *Encyclopedia of behavior modification and cognitive behavior therapy*. Sage Publications.

Hesse-Biber, S. (2010). *Mixed methods research: Merging theory with practice*. The Guilford Press.

Hesse-Biber, S. (2018). Towards an understanding of a qualitatively driven mixed methods data collection and analysis: Moving toward a theoretically centred mixed methods

praxis. In U. Flick (Ed.), *The SAGE handbook of qualitative data collection* (pp. 545-563). Sage Publications.

Hogan, R. (1966). Implosive therapy in the short term treatment of psychotics. *Psychotherapy: Theory Research and Practice, 3*(1), 25-32. https://doi.org/10.1037/h0087905

Hogan, R., & Kirchner, J. (1968). Implosive, eclectic, verbal and bibliotherapy in the treatment of fears of snakes. *Behaviour Research and Therapy, 6*(2), 167-171. https://doi.org/10.1016/0005-7967(68)90003-X

Holland, A., & Kensinger, E. (2010). Emotion and autobiographical memory. *Physics of Life Reviews, 7*(1), 88-131. https://doi.org/10.1016/j.plrev.2010.01.006

Holmes, E., Arntz, A., & Smucker, M. (2007). Imagery rescripting in cognitive behaviour therapy: Images, treatment techniques and outcomes. *Journal of Behavior Therapy and Experimental Psychiatry, 38*(4), 297-305. https://doi.org/10.1016/j.jbtep.2007.10.007

Holmes, E., Coughtrey, A., & Connor, A. (2008a) Looking at or through rose-tinted glasses? Imagery perspective and positive mood. *Emotion, 8*(6), 875-879. https://doi.org/10.1037/a0013617

Holmes, E., & Mathews, A. (2005). Mental imagery and emotion: A special relationship? *Emotion, 5*(4), 489-497. https://doi.org/10.1037/1528-3542.5.4.489

Holmes, E., & Mathews, A. (2010). Mental imagery in emotion and emotional disorders. *Clinical Psychology Review, 30*(3), 349-362. https://doi.org/10.1016/j.cpr.2010.01.001

Holmes, E., Mathews, A., Mackintosh, B., & Dalgleish, T. (2008b). The causal effect of mental imagery on emotion assessed using picture-word cues. *Emotion, 8*(3), 395-409. https://doi.org/10.1037/1528-3542.8.3.395

Holt, R. (1964). Imagery: Return of the ostracized. *American Psychologist, 19*(4), 254-264. https://doi.org/10.1037/h0046316

Horowitz, M. (1970). *Image formation and cognition*. Century Crofts.

Hover-Kramer, D., & Shames, K. (1997). *Energetic approaches to emotional healing*. Delmar.

Image. (2014) In *Collins English dictionary* (12th ed.). Collins.

Imagery. (2014) In *Collins English dictionary* (12th ed.). Collins.

Ivey, A., D'Andrea, M., Ivey, M., & Simek-Morgan, L. (2012). Adlerian and Jungian counselling and therapy. In A. Ivey, M. D'Andrea, M. Ivey & L. Simek-Morgan (Eds.), *Theories of counseling and psychotherapy: A multicultural perspective* (7th ed., pp. 217-258). Sage Publications.

Jackson, P., Brunet, E., Meltzoff, A., & Decety, J. (2006). Empathy examined through the neural mechanisms involved in imagining how I feel versus how you feel pain. *Neuropsychologia, 44*(5), 752-761. https://doi.org/10.1016/j.neuropsychologia.2005.07.015

Jacobs, T. (1983). The analyst and the patient's object world: Notes on an aspect of countertransference. *Journal of the American Psychoanalytic Association, 31*(3), 619-642. https://doi.org/10.1177/000306518303100303

Jenkins, S., & Baird, S. (2002). Secondary traumatic stress and vicarious trauma: A validation study. *Journal of Traumatic Stress, 15*, 423-432. https://doi.org/10.1023/A:1020193526843

Ji, J., Heyes, S., MacLeod, C., & Holmes, E. (2016). Emotional mental imagery as simulation of reality: Fear and beyond. *Behavior Therapy, 47*(5), 702-719. https://doi.org/10.1016/j.beth.2015.11.004

Jung, C. (1959). *The collected works of C. G. Jung: Vol. 9. Aion: Researches into the phenomenology of the self* (G. Adler & R. Hull, Trans.). Princeton University Press.

Jung, C. (1960). On psychic energy (R. Hull, Trans.). In H. Read, M. Fordham, G. Adler & W. McGuire (Eds.), *The collected works of C. G. Jung: Vol. 8. The structure and dynamics of the psyche* (pp. 3-66). Princeton University Press.

Jung, C. (1961). *Memories, dreams, reflection* (R. Winston & C. Winston, Tans.). Random House.

Jung, C. (1968). *Analytical psychology: Its theory and practice (The Tavistock lectures)*. Vintage. (Original work published 1935).

Jurchiș, R., & Opre, A. (2018). A dual process approach to current issues from cognitive behavior therapies: An integrative perspective. *International Journal of Cognitive Therapy, 11*(4), 374-409. https://doi.org/10.1007/s41811-018-0023-z

Kazantzis, N., Dattilio, F., & Dobson, K. (2017). *The therapeutic relationship in cognitive-behavioral therapy: A clinician's guide*. Guilford Press.

Kearney, R. (2003). *The wake of imagination: Toward a postmodern culture*. Routledge.

Keogh, R., & Pearson, J. (2017). The blind mind: No sensory visual imagery in aphantasia. *Cortex, 105*, 53-60. https://doi.org/10.1016/j.cortex.2017.10.012

Kern, J. (1978). Countertransference and spontaneous screens: An analyst studies his own visual images. *Journal of American Psychoanalytic Association, 26*(1), 21-47. https://doi.org/10.1177/000306517802600102

Kim, S., Kim, J., Kim, J., Jeong, B., Choi, E., Jeong, Y., Kim, J., Ku, J., & Ki, S. (2007). The neural mechanism of imagining facial affective expression. *Brain Research, 1145*, 128-137. https://doi.org/10.1016/j.brainres.2006.12.048

Kohut, H. (1959). Introspection, empathy, and psychoanalysis: An examination of the relationship between mode of observation and theory. *Journal of the American*

Psychoanalytic Association, 7(3), 459-483. https://doi.org/10.1177/000306515900700304

Kohut, H. (1984). *How does analysis cure*? University of Chicago Press.

Kosslyn, S., Ganis, G., & Thompson, W. (2001). Neural foundations of imagery. *Nature Reviews Neuroscience, 2*(9), 634-642. https://doi.org/10.1038/35090055

Kosslyn, S., & Thompson, W. (2003). When is early visual cortex activated during visual mental imagery? *Psychological Bulletin, 129*(5), 723−746. https://doi.org/10.1037/0033-2909.129.5.723

Kosslyn, S., Thompson, W., & Ganis, G. (2006). *The case for mental imagery*. Oxford University Press.

Kosslyn, S., Thompson, W., Kim, I., & Alpert, N. (1995). Topographical representations of mental images in primary-cortex. *Nature, 378*(6556), 496-498. https://doi.org/10.1038/378496a0

Kosslyn, S., Thompson, W., Shephard, J., Ganis, G., Bell, D., Donovitch, J., Wittenberg, L., & Alpert, N. (2004). Brain rCBF and performance in visual imagery tasks: Common and distinct processes. *European Journal of Cognitive Psychology, 16*, 696-716. https://doi.org/10.1080/09541440340000475

Krans, J., Näring, G., Holmes, E., & Becker, E. (2010). "I see what you're saying": Intrusive images from listening to a traumatic verbal report. *Journal of Anxiety Disorders, 24*(1), 134-140. https://doi.org/10.1016/j.janxdis.2009.09.009

Krycka, K., & Ikemi, A. (2016). Focusing-orientated/experiential psychotherapy. In D. Cain, K. Keenan & S. Rubin (Eds.), *Humanistic psychotherapy: Handbook of research and practice* (2nd ed., pp. 251-282). American Psychological Association.

Kugler, P. (2008). Psychic imaging: A bridge between subject and object. In P. Young-Eisendrath & T. Dawson (Eds.), *The Cambridge Companion to Jung* (2nd ed., pp. 77-94). Cambridge University Press.

Lacey, S., & Lawson, R. (2013). Introduction. In S. Lacey & R. Lawson (Eds.), *Multisensory imagery* (pp. 1-8). Springer.

Lachman, G. (2010). *Jung the mystic: The esoteric dimensions of Carl Jung's life and teachings.* Penguin Group.

Lakoff, G., & Johnson, M. (1980). *Metaphors we live by*. University of Chicago Press.

Lang, P. (1979). A bio-informational theory of emotional imagery. *Psychophysiology, 16*(6), 495-512. https://doi.org/10.1111/j.1469-8986.1979.tb01511.x

Lang, P., Greenwald, M., Bradley, M., & Hamm, A. (1993). Looking at pictures: Affective, facial, visceral, and behavioral reactions. *Psychophysiology, 30*(3), 261-273. https://doi.org/10.1111/j.1469-8986.1993.tb03352.x

Lang, P., & McTeague, L. (2009). The anxiety disorder spectrum: Fear imagery, physiological reactivity, and differential diagnosis. *Anxiety, Stress & Coping, 22*(1), 5-25. https://doi.org/10.1080/10615800802478247

Lang, P., & Bradley, M. (2010). Emotion and the motivational brain. *Biological Psychology, 84*(3), 437-450. https://doi.org/10.1016/j.biopsycho.2009.10.007

Lazarus, A. (1989). *The practice of multimodel therapy: Systematic, comprehensive and effective psychotherapy*. Johns Hopkins University Press.

LeDoux, J. (2000). Emotion circuits in the brain. *Annual Review of Neuroscience, 23*(1), 155-184. https://doi.org/10.1146/annurev.neuro.23.1.155

Leuner, H. (1977). Guided affective imagery: An account of its development. *Journal of Mental Imagery, 1*(1), 73-92.

Leuner, H. (1978). Basic principles and therapeutic efficacy of guided affective imagery. In J. Singer & K. Pope (Eds.), *The power of human imagination: New methods in psychotherapy* (pp. 123-166). Plenum.

Levenson, E. (2003). On seeing what is said: Visual aids to the psychoanalytic process. *Contemporary Psychoanalysis, 39*(2), 233-249. https://doi.org/10.1080/00107530.2003.10745819

Levis, D., & Carrera, R. (1967). Effects of ten hours of implosive therapy in the treatment of outpatients: A preliminary report. *Journal of Abnormal Psychology, 72*(6), 504-508. https://doi.org/10.1037/h0020112

Lincoln, Y., & Guba, E. (1985). Establishing trustworthiness. In Y. Lincoln & E. Guba (Eds.), *Naturalistic inquiry* (pp. 289-330). Sage Publications.

Long, M., & Quevillon, R. (2009). Imagery rescripting in the treatment of posttraumatic stress disorder. *Journal of Cognitive Psychotherapy: Theory Research and Practice*, *23*(1), 67-76. http://doi.org/10.1891/0889-8391.23.1.67

MacKisack, M., Aldworth, S., Macpherson, F., Onians, J., Winlove, C., & Zeman, A. (2016). On picturing a candle: The prehistory of imagery science. *Frontiers in Psychology, 7*, 515. http://doi.org/10.3389/fpsyg.2016.00515

Mandler, G. (2007). *A history of modern experimental psychology: From James and Wundt to cognitive science*. MIT Press.

Marks, D. (1999). Consciousness, mental imagery, and action. *British Journal of Psychiatry, 90*(4), 567-585. https://doi.org/10.1348/000712699161639

Martin, R., & Young, J. (2010). Schema therapy. In K. Dobson (Ed.). *Handbook of cognitive-behavioural therapies* (3rd ed., pp. 317-436). The Guilford Press

Martinson, K. (1999). *Mental imaging as a psychotherapeutic tool*. [Doctoral dissertation, University of Durham]. Durham e-Theses. http://etheses.dur.ac.uk/4595/

Mason, J. (2006). Mixing methods in a qualitatively driven way. *Qualitative Research, 6*(1), 9-25. https://doi.org/10.1177/1468794106058866

Mathews, A., Ridgeway, V., & Holmes, E. (2013). Feels like the real thing: Imagery is both more realistic and emotional than verbal thought. *Cognition & Emotion, 27*(2), 217-229. https://doi.org/10.1080/02699931.2012.698252

Maxwell, J., & Mittapalli, K. (2016). Realism as a stance for mixed methods research. In A. Tashakkori & C. Teddlie (Eds.), *SAGE handbook of mixed methods in social and behavioral research* (pp. 145-167). Sage Publications.

McAvinue, L., & Robertson, I. (2007). Measuring visual imagery ability: A review. *Imagination, Cognition and Personality, 26*(3), 191-211. https://doi.org/10.2190/3515-8169-24J8-7157

McCann, I., & Pearlman, L. (1990). Vicarious traumatization: A framework for understanding the psychological effects of working with victims. *Journal of Traumatic Stress, 3*(1), 131-149. https://doi.org/10.1002/jts.2490030110

McGown, L. (2015). A qualitative study of the therapist's spontaneous mental imagery and its impact on therapeutic process. *Counselling and Psychotherapy Research, 15*(2), 128-136. https://doi.org/10.1002/capr.12006

McTeague, L., Lang, P., Laplante, M., Cuthbert, B., Strauss, C., & Bradley, M. (2009). Fearful imagery in social phobia: generalization, comorbidity, and physiological reactivity. *Biological Psychiatry, 65*(5), 374-382. https://doi.org/10.1016/j.biopsych.2008.09.023

Meconi, F., Linde-Domingo, J., Ferreira, C., Michelmann, S., Staresina, B., Apperly, I., & Hanslmayr, S. (2019). *Autobiographical memory reactivation in empathy.* BioRxiv. https://doi.org/10.1101/715276

Miller, G., Levin, D., Kozak, M., Cook, E., McLean, A., & Lang, P. (1987). Individual differences in imagery and the psychophysiology of emotion. *Cognition and Emotion, 1*(4), 367-390. https://doi.org/10.1080/02699938708408058

Milner, P., & Palmer, S. (2003). *Integrative stress counselling: A humanistic, problem-focused approach*. Sage Publications.

Moleski, M., Ishii, M., & Sheikh, A. (2019). Imagery techniques in psychosynthesis. In A. Sheikh (Ed.), Handbook of therapeutic imagery techniques (pp. 269-282). Routledge.

Morina, N., Lancee, J., & Arntz, A. (2017). Imagery rescripting as a clinical intervention for aversive memories: A meta-analysis. *Journal of Behavior Therapy and Experimental Psychiatry, 55*, 6-15. https://doi.org/10.1016/j.jbtep.2016.11.003

Morse, J. (2015). Critical analysis of strategies for determining rigor in qualitative inquiry. *Qualitative Health Research, 25*(9), 1212-1222. https://doi.org/10.1177/1049732315588501

Morse, J., & Cheek, J. (2014). Making room for qualitatively-driven mixed-method research. *Qualitative Health Research, 24*(1), 3-5. https://doi.org/10.1177/1049732313513656

Morse, J., & Niehaus, L. (2009). *Mixed-method designs: Principles and procedures*. Left Coast Press.

Much, N., & Sheikh, A. (2019). The Oneirotherapies. In A. Sheikh (Ed.), *Handbook of therapeutic imagery techniques* (pp. 123-144). Routledge.

Neumann, D., & Gamble, S. (1995). Issues in the professional development of psychotherapists: Countertransference and vicarious traumatization in the new trauma therapist. *Psychotherapy: Theory, Research, Practice, Training, 32*(2), 341-347. https://doi.org/10.1037/0033-3204.32.2.341

Ngata, R. (2014). *Understanding matakite: A kaupapa māori study on the impact of matakite/intuitive experiences on wellbeing*. [Doctoral thesis, Massey University],

Massey University Theses and Dissertations. https://mro.massey.ac.nz/handle/10179/8299

Niemi, P., & Tiuraniemi, J. (2010). Cognitive therapy trainees' self-reflections on their professional learning. *Behavioural and Cognitive Psychotherapy, 38*(3), 225-274. https://doi.org/10.1017/S1352465809990609

Nigro, G., & Neisser, U. (1983). Point of view in personal memories. *Cognitive Psychology, 15*(4), 467-482. https://doi.org/10.1016/0010-0285(83)90016-6

Noll, R. (1985). Mental imagery cultivation as a cultural phenomenon: The role of visions in shamanism. *Current Anthropology, 26*(4), 443-461. https://doi.org/10.1086/203305

Norman, G. (2010). Likert scales, levels of measurement and the laws in statistics. *Advances in Health Sciences Education, 15*(5), 625-633. https://doi.org/10.1007/s10459-010-9222-y

Norris, P., & Epstein, S. (2011). An experiential thinking style: Its facets and relations with objective and subjective criterion measures. *Journal of Personality, 79*(5), 1043-1080. https://doi.org/10.1111/j.1467-6494.2011.00718.x

O'Cathain, A. (2016). Assessing the quality of mixed methods research: Toward a comprehensive framework. In A. Tashakkori & C. Teddlie (Eds.), *SAGE handbook of mixed methods in social and behavioral research* (pp. 531-556). Sage Publications.

Ogden, T. (1979). On projective identification. *International Journal of Psycho-Analysis*, *60*, 357-373.

Ogden, T. (1994). The analytical third: Working with intersubjective clinical facts. *The International Journal of Psycho-Analysis, 75*(1), 3-20.

Ogden, T. (1997). *Reverie and interpretation: Sensing something human.* Jason Aronson.

Ogden, T. (2001). *Conversations at the frontier of dreaming*. Jason Aronson.

Ogden, T. (2004). The analytic third: Implications for psychoanalytic theory and technique. *Psychoanalytic Quarterly, 73*(1), 167-195. https://doi.org/10.1002/j.2167-4086.2004.tb00156.x

Ogden, T. (2008). *Rediscovering psychoanalysis: Thinking and dreaming, learning and forgetting*. Routledge.

Öhman, A., & Mineka, S. (2001). Fears, phobias, and preparedness: Toward an evolved module of fear and fear learning. *Psychological Review, 108*(3), 483-522. https://doi.org/10.1037/0033-295X.108.3.483

Palmer, S., & Neenan, M. (1998). Double imagery procedure. *Rational Emotive Behaviour Therapist, 6*(2), 89-92.

Pearlman, L., & MacIan, P. (1995). Vicarious traumatization: An empirical study of the effects of trauma work on trauma therapists. *Professional Psychology: Research and Practice, 26*(6), 558-565. https://doi.org/10.1037/0735-7028.26.6.558

Pearlman, L., & Saakvitne, K. (1995). *Trauma and the therapist: Countertransference and vicarious traumatization in psychotherapy with incest survivors*. Norton & Co.

Pearson, J. (2014). New directions in mental-imagery research: The binocular-rivalry technique and decoding fMRI patterns. *Current Directions in Psychological Science, 23*(3), 178-183. https://doi.org/10.1177/0963721414532287

Pearson, J., & Kosslyn, S. (2015). The heterogeneity of mental representation: Ending the imagery debate. *Proceedings of the National Academy of Sciences of the United States of America, 112*(33), 10089-10092. https://doi.org/10.1073/pnas.1504933112

Pearson, J., & Westbrook, F. (2015). Phantom perception: Voluntary and involuntary nonretinal vision. *Trends in Cognitive Sciences, 19*(5), 278-284. https://doi.org/10.1016/j.tics.2015.03.004

Pearson, N., Naselaris, T., Holmes, E., & Kosslyn, S. (2015). Mental imagery: Functional mechanisms and clinical applications. *Trends in Cognitive Sciences, 19*(10), 590-602. https://doi.org/10.1016/j.tics.2015.08.003

Perls, F. (1969). *Ego, hunger and aggression: A revision of Freud's theory and method*. Gestalt Journal Press. (Original work published 1947).

Perti, M., & Hevey, D. (2010). Exploratory data analysis. In N. Salkind (Ed.), *Encyclopedia of research design* (pp. 456-458). Sage Publications.

Pfeifer, J., & Dapretto, M. (2009). Mirror, mirror, in my mind: Empathy, interpersonal competence and the mirror neuron system. In J. Decety & W. Ickes (Eds.), *The social neuroscience of empathy* (pp. 183-198). MIT Press.

Phillips, I. (2014). Lack of imagination: Individual differences in mental imagery and the significance of consciousness. In M. Sprevak & J. Kallestrup (Eds.), *New waves in philosophy of mind* (pp. 278-300). Palgrave Macmillan.

Plato. (1888). *The republic of Plato* (B. Jowett, Trans.). Oxford University Press. (Original work written 360 B.C.E.).

Plato. (1892). *The Dialogues of Plato* (B. Jowett, Trans.). Oxford University Press. (Original work written 360 B.C.E.).

Prochazkova, E., & Kret, M. (2017). Connecting minds and sharing emotions through mimicry: A neurocognitive model of emotional contagion. *Neuroscience & Biobehavioral Reviews, 80*, 99-114. https://doi.org/10.1016/j.neubiorev.2017.05.013

Rachman, S. (2015). The evolution of behaviour therapy and cognitive behaviour therapy. *Behaviour Research and Therapy, 64*, 1-8. https:/doi.org/10.1016/j.brat.2014.10.006

Reik, T. (1948). *Listening with the third ear*. Farrar, Straus and Giroux.

Reiser, M. (1999). Memory, empathy, and interactive dimensions of psychoanalytic process. *Journal of the American Psychoanalytic Association, 47*(2), 485-501. https://doi.org/10.1177/00030651990470021701

Richardson, A. (1969). *Mental imagery.* Springer.

Richardson, A. (2018). *Individual differences in imaging: Their measurement, origins, and consequences*. Routledge.

Robinson, S. (2005). *Tohunga – The revival: Ancient knowledge for the modern era*. Reed Publishing.

Roeckelein, J. (2004). *Imagery in psychology: A reference guide*. Praeger Publishers.

Ronen, T. (2011). *The positive power of imagery harnessing client imagination in CBT and related therapies*. John Wiley & Sons.

Ross, W., & Kapp, F. (1962). A Technique for self-analysis of countertransference: Use of the psychoanalyst's visual images in response to patient's dreams. *Journal of the American Psychoanalytic Association, 10*(4), 643-657. https://doi.org/10.1177/000306516201000401

Royal, T. (Ed.). (2003). *The woven universe selected writing of Rev. Māori Marsden*. Estate of Rev. Māori Marsden.

Rubin, D., Boals, A., & Bernsten, D. (2008). Memory in posttraumatic stress disorder: Properties of voluntary and involuntary, traumatic and non-traumatic autobiographical memories in people with and without PTSD symptoms. *Journal of Experimental Psychology: General, 137*(4), 591-614. https://doi.org/10.1037/a0013165

Sabatinelli, D., Lang, P., Bradley, M., & Flaisch, T. (2006). The neural basis of narrative imagery: Emotion and action. *Progress in Brain Research, 156*, 93-103. https://doi.org/10.1016/S0079-6123(06)56005-4

Sabin-Farrell, R., & Turpin, G. (2003) Vicarious traumatization: Implications for the mental health of health workers? *Clinical Psychology Review, 23*(3), 449-480. https://doi.org/10.1016/S0272-7358(03)00030-8

Samuels, A. (1985). Countertransference, the 'mundus imaginalis' and a research project. *Journal of Analytical Psychology, 30*(1), 47-71. https://doi.org/10.1111/j.1465-5922.1985.00047.x

Samuels, M., & Samuels, N. (1975). *Seeing with the mind's eye: The history, techniques, and uses of visualization*. Random House.

Saulsman, L., Ji, J., & McEvoy, P. (2019). The essential role of mental imagery in cognitive behaviour therapy: What is old is new again. *Australian Psychologist, 54*(4), 237-244. https://doi.org/10.1111/ap.12406

Schacter, D., Addis, D., & Buckner, R. (2007). Remembering the past to imagine the future: The prospective brain. *Nature Reviews: Neuroscience, 8*(9), 657-661. https://doi.org/10.1038/nrn2213

Schaefer, R., Desain, P., & Farquhar, J. (2013). Shared processing of perception and imagery of music in decomposed EEG. *NeuroImage, 70*, 317-326. https://doi.org/10.1016/j.neuroimage.2012.12.064

Schmidt, T., & Blankenburg, F. (2019). The somatotopy of mental tactile imagery. *Frontiers in Human Neuroscience, 13*, 1-10. https://doi.org/10.3389/fnhum.2019.00010

Scholefield, S., Cooke, C., Van Vliet, P., & Heneghan, N. (2015). The effectiveness of mental imagery for improving strength in an asymptomatic population. *Physical Therapy Reviews, 20*(2), 86-97. https://doi.org/10.1179/1743288X15Y.0000000013

Schust-Briat, G. (1996). "Fertile eyes": Considerations on visual phenomena in the analyst's mind at work. *Psychoanalytic Inquiry, 16*(3), 376-389. https://doi.org/10.1080/07351699609534089

Seidler, G., & Wagner, F. (2006). Comparing the efficacy of EMDR and trauma-focused cognitive-behavioral therapy in the treatment of PTSD: A meta-analytic study. *Psychological Medicine, 36*(11), 1515-1522. https://doi.org/10.1017/S0033291706007963

Shamay-Tsoory, S., Aharon-Peretz, J., & Perry, D. (2009). Two systems for empathy: A double dissociation between emotional and cognitive empathy in inferior frontal gyrus versus ventromedial prefrontal lesions. *Brain, 132*(3), 617-627. https://doi.org/10.1093/brain/awn279

Sharot, T., Delgado, M., & Phelps, E. (2004). How emotion enhances the feeling of remembering. *Nature Neuroscience, 7*(12), 1376-1380. https://doi.org/10.1038/nn1353

Shaverien, J. (2007). Countertransference as active imagination: Imaginative experiences of the analyst. *Journal of Analytic Psychology, 52*(4), 413-431. https://doi.org/10.1111/j.1468-5922.2007.00674.x

Sheikh, A. (2003). *Healing images: The role of imagination in health.* Baywood Publishing.

Sheikh, A. (2019). Eidetic psychotherapy techniques. In A. Sheikh (Ed.), *Handbook of therapeutic imagery techniques* (pp. 145-154). Routledge.

Sheikh, A., & Jordan, C. (1983). Clinical uses of mental imagery. In A. Sheikh (Ed.), *Imagery: Current theory, research, and application* (pp. 391-435). John Wiley & Sons.

Sheikh, A., & Panagiotou, N. (1975). Use of mental imagery in psychotherapy: A critical review. *Perceptual and Motor Skills, 41*(2), 555-585. https://doi.org/10.2466/pms.1975.41.2.555

Sheskin, D. (2004). *Handbook of parametric and nonparametric statistical procedures* (3rd ed.). Chapman & Hall.

Simos, G. (2002). *Cognitive behaviour therapy*. Taylor & Francis.

Singer, J. (2006). *Imagery in psychotherapy* (1st ed.). American Psychological Association.

Sloman, S. (1996). The empirical case for two systems of reasoning. *Psychological Bulletin, 119*(1), 3-22. https://doi.org/10.1037/0033-2909.119.1.3

Smith, D., Wright, C., Allsopp, A., & Westhead, H. (2007). It's all in the mind: PETTLEP-based imagery and sports performance. *Journal of Applied Sport Psychology, 19*(1), 80-92. https://doi.org/10.1080/10413200600944132

Smith, M., & Glass, G. (1977). Meta-analysis of psychotherapy outcome studies. *American Psychologist, 32*(9), 752-760. https://doi.org/10.1037/0003-066X.32.9.752

Smucker, M., & Dancu, C. (2005). *Cognitive-behavioural treatment for adult survivors of childhood trauma: Imagery rescripting and reprocessing*. Rowman & Littlefield.

Smucker, M., Dancu, C., Foa, E., & Niederee, J. (1995). Imagery rescripting: A new treatment for survivors of childhood sexual abuse suffering from post-traumatic stress. *Journal of Cognitive Psychotherapy, 9*(1), 3-17. https://doi.org/10.1891/0889-8391.9.1.3

Smucker, M., Dancu, C., Foa, E., & Niederee, J. (2002). Imagery rescripting: A new treatment for survivors of childhood sexual abuse suffering from post-traumatic stress. In R. Leahy & E. Dowd (Eds.), *Clinical advances in cognitive psychotherapy: Theory and application* (pp. 294-310). Springer Publishing.

Speckens, A., Hackmann, A., Ehlers, A., & Cuthbert, B. (2007). Intrusive images and memories of earlier adverse events in patients with obsessive compulsive disorder. *Journal of Behavior Therapy and Experimental Psychiatry, 38*(4), 411-422. https://doi.org/10.1016/j.jbtep.2007.09.004

Stampfl, T., & Levis, D. (1967). Essentials of implosive therapy: A learning theory based psychodynamic behavioural therapy. *Journal of Abnormal Psychology, 72*(6), 496-503. https://doi.org/10.1037/h0025238

Stanovich, K. (1999). *Who is rational? Studies of individual differences in reasoning*. Psychology Press.

Steed, L., & Downing, R. (1998). A phenomenological study of vicarious traumatisation amongst psychologists and professional counsellors working in the field of sexual abuse/assault. *Australasian Journal of Disaster and Trauma Studies, 2*(2).

Stott, R., Mansell, W., Salkovskis, P., Lavender, A., & Cartwright-Hatton, S. (2010). *Oxford guide to metaphors in CBT: Building cognitive bridges*. Oxford University Press.

Suler, J. (1989). Mental imagery in psychoanalytic treatment. *Psychoanalytic Psychology, 6*(3), 343-366.

Sullivan, G., & Artino, A. (2013). Analyzing and interpreting data from Likert-type scales. *Journal of Graduate Medical Education, 5*(4), 541-542. https://doi.org/10.4300/JGME-5-4-18

Talarico, J., LaBar, K., & Rubin, D. (2004). Emotional intensity predicts autobiographical memory experience. *Memory and Cognition, 32*(7), 1118-1132. https://doi.org/10.3758/bf03196886

Tashakkori, A., & Creswell, J. (2007). Exploring the nature of research questions in mixed methods research. *Journal of Mixed Methods Research, 1*(3), 207-211. https://doi.org/10.1177/1558689807302814

Tashakkori, A., & Teddie, C. (2008). Quality of inferences in mixed methods research: Calling for an integrative framework. In M. Bergman (Ed.), *Advances in mixed methods research: Theories and applications* (pp. 101-119). Sage Publications.

Teyber, E., & Holmes McClure, F. (2010). *Interpersonal process in therapy: An integrative model* (6th ed.). Cengage Learning.

Thomas, V. (2016). *Using mental imagery in counselling and psychotherapy: A guide to more inclusive theory and practice.* Routledge.

Tiggemann, M., & Kemps, E. (2005). The phenomenology of food cravings: The role of mental imagery. *Appetite, 45*(3), 305-313. https://doi.org/10.1016/j.appet.2005.06.004

Titchener, E. (1909). *Lectures on the experimental psychology of the thought-processes*. Macmillan.

Tolley, E., Ulin, P., Mack, N., Robinson, E., & Succop, S. (2016). *Qualitative methods in public health: A field guide for applied research*. John Wiley & Sons.

Tulving, E. (1984). Précis of elements of episodic memory. *Behavioral and Brain Sciences, 7*(2), 223-238. https://doi.org/10.1017/S0140525X0004440X

Turgoose, D., & Maddox, L. (2017). Factors of compassion fatigue in mental health professionals: A narrative review. *Traumatology, 23*(2), 172-185. http://dx.doi.org/10.1037/trm0000116

van Den Hout, M., & Engelhard, I. (2012). How does EMDR work? *Journal of Experimental Psychopathology, 3*(5), 724-738. https://doi.org/10.5127/jep.028212

van Den Hout, M., Rijkeboer, M., Engelhard, I., Klugkist, I., Hornsveld, H., Toffolo, M., & Cath, D. (2012). Tones inferior to eye movements in the EMDR treatment of PTSD. *Behaviour Research and Therapy, 50*(5), 275-279. https://doi.org/10.1016/j.brat.2012.02.001

Vella, N., & Moulds, M. (2014). The impact of shifting vantage perspective when recalling and imagining positive events. *Memory, 22*(3), 256-264. https://doi.org/10.1080/09658211.2013.778292

Vrana, S., Cuthbert, B., & Lang, P. (1986). Fear imagery and text-processing. *Psychophysiology, 23*(3), 247-253. https://doi.org/10.1111/j.1469-8986.1986.tb00626.x

Vrana, S., & Lang, P. (1990). Fear imagery and the startle-probe reflex. *Journal of Abnormal Psychology, 99*(2), 189-197. https://doi.org/10.1037/0021-843X.99.2.189

Wakefield, C., Smith, D., Moran, A., & Holmes, P. (2013). Functional equivalence or behavioural matching? A critical reflection on 15 years of research using the PETTLEP model of motor imagery. *International Review of Sport and Exercise Psychology, 6*(1), 105-121. https://doi.org/10.1080/1750984x.2012.724437

Wallace-Hadrill, S., & Kamboj, S. (2016). The impact of perspective change as a cognitive reappraisal strategy on affect: A systematic review. *Frontiers in Psychology, 7*, 304-324. https://doi.org/10.3389/fpsyg.2016.01715

Watkins, D., & Gioia, D. (2015). *Mixed methods research*. Oxford University Press.

Watson, J. (1913). Psychology as the behaviorist views it. *Psychological Review, 20*(2), 156-177. https://doi.org/10.1037/h0074428

Watson, J., Goldman, R., & Greenberg, L. (2011). Humanistic and experiential theories of psychotherapy. In J. Norcross, G. VandenBos & D. Freedheim. (Eds.). *History of psychotherapy: Continuity and change* (2nd ed., pp. 141-172). American Psychological Association.

White, A. (1990). *The language of imagination*. Blackwell.

Wicken, M., Keogh, R., & Pearson, J. (2019). *The critical role of mental imagery in human emotion: Insights from aphantasia.* BioRxiv. https://doi.org/10.1101/726844

Wilkins, W. (1971). Desensitization: Social and cognitive factors underlying the effectiveness of Wolpe's procedure. *Psychological Bulletin, 76*(5), 311-317. https://doi.org/10.1037/h0031722

Williams, A., & Moulds, M. (2008). Manipulating recall vantage perspective of intrusive memories in dysphoria. *Memory, 16*(7), 742-750. https://doi.org/10.1080/09658210802290453

Wills, F., & Sanders, D. (1997). *Cognitive therapy: Transforming the image*. Sage Publications.

Wilson, J., & Lindy, J. (1994). *Countertransference in the treatment of PTSD*. Guilford Press.

Wilson, J., and Thomas, R. (2004). *Empathy in the treatment of trauma and PTSD*. Taylor & Francis.

Winnicott, D. (1945). Primitive emotional development. *The International Journal of Psychoanalysis, 26*, 137-143.

Winnicott, D. (1949). Hate in the countertransference. *The International Journal of Psychoanalysis, 30*, 69-75.

Wolpe, J. (1958). *Psychotherapy by reciprocal inhibition*. Stanford University.

Young, J., Klosko, J., & Weishaar, M. (2003). *Schema therapy: A practitioner's guide.* Guilford Press.

Zamuner, E., Oxner, M., & Hayward, W. (2017). Visual perception and visual mental imagery of emotional faces generate similar expression aftereffects. *Consciousness and Cognition, 48*, 171-179. https://doi.org/10.1016/j.concog.2016.11.010

Zeman, A., Dewar, M., & Sala, S. (2015). Lives without imagery: Congenital aphantasia. *Cortex, 73*, 378-380. https://doi.org/10.1016/j.cortex.2015.05.019

Zeman, A., Dewar, M., & Sala, S. (2016). Reflections on aphantasia. *Cortex, 74*, 336-337. https://doi.org/10.1016/j.cortex.2015.08.015

Zinbarg, R., Craske, M., & Barlow, D. (2006). *Mastery of your anxiety and worry (MAW): Therapist guide*. Oxford University Press.