

## Personality Disorder Patients' Perspectives on the Introduction of Imagery Within Schema Therapy: A Qualitative Study of Patients' Experiences

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*A qualitative study was done on patients' perspectives on the first phases of imagery work in the context of schema therapy (ST) for personality disorders. Patients participated in a multi-center randomized controlled study of the effectiveness of ST. Patients' experiences and opinions were collected with semistructured in-depth interviews at the time when they were still in the early phases of treatment. The interviews were analyzed using a thematic analysis. For validation, a so-called member check was completed, in which participants could indicate whether they agreed or could correct the transcripts and the conclusions we drew from their interviews. We concentrated on the first imagery techniques that are used as preparation for imagery rescripting; that is, diagnostic imagery and imagery of a safe place. We compared the experiences reported by the patients with Young, Klosko, and Weishaar's (2003) ST manual. The results show that early imagery techniques in ST are considered a valuable method. However, patients emphasize that more attention should be paid to the emotional impact of this specific technique. They report lacking information, communication, and support during the initial phases of imagery work. Furthermore, patients mention that the duration of the imagery exercises is unpredictable; this creates feelings of uncertainty and fear. These results give essential information for protocol adjustments for the use of early imagery techniques and for the implementation of ST.*

In the last decade an increased interest in the use of imagery rescripting, a technique that can be used in cognitive-behavior therapy, has led to a series of publications about its application (e.g., this issue; Arntz et al., 2007; Arntz & Weertman, 1999; Beck, Emery, & Greenberg, 1985; Brewin et al., 2009; Butler, Fennell, & Hackman, 2010; Grunert et al., 2007; Hackmann, Bennett-Levy, & Holmes, 2011; Holmes, Arntz, & Smucker, 2007; Hunt et al., 2006; Hunt & Fenton, 2007; Kindt, Buck, Arntz, & Soeter, 2007; Layden, Newman, Freeman, & Morse, 2004; Smucker, Dancu, Foa, & Niederee, 1995; Smucker & Niederee, 1995; Stopa, 2009; Wheatley et al., 2007; Wild, Hackmann, & Clark, 2007). Most of the applications are directed at modifying troubling images. Less often the technique is used to process memories of earlier events that are related to the formation of dysfunctional schemas. One specific form of treatment for personality disorders,

schema therapy (ST; Arntz & van Genderen, 2009; Young, Klosko, & Weishaar, 2003), is an example of a therapy that uses the latter type of imagery rescripting extensively. ST was developed by Jeffrey Young and colleagues (Young, 1990, 1999) as an extensive, integrative therapy for patients with chronic personality problems, who had profited insufficiently from traditional cognitive behavior therapy (CBT). The therapy focuses on early maladaptive schemas. These are mental representations assumed to underlie dysfunctional emotional and cognitive patterns that begin early in development and repeat throughout life. ST builds on traditional CBT, but also draws insights from other forms of therapy and schools, and places a greater emphasis on exploring the origins of psychological problems in childhood and adolescence, on emotive techniques, on the patient-therapist relationship, and on dysfunctional coping styles (Young et al., 2003).

Among the range of methods, experiential techniques are central to ST. These techniques have two goals: (a) to elicit emotions associated with early maladaptive schemas in order to increase patients' insights regarding their developmental roots; and (b) to process and correct these emotions and their underlying schemas, partially by "limited reparenting," in which the therapist partially heals the emotions and meets unmet basic needs of the patient from

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*Keywords:* imagery; imagery rescripting; qualitative research; schema therapy; personality disorders

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childhood (Young et al., 2003). Through experiential exercises, patients can switch from intellectually knowing that their schemas are wrong to experiencing that emotionally. Within the cognitive literature it is generally accepted that "hot cognitions" (when the patient experiences strong affect) are easier to change than "cold cognitions" (when the affect of the patient is flat; Young et al.). This makes experiential techniques an important component of ST.

In the early phases of ST, specific imagery exercises are used to prepare the patient for imagery rescripting, in which the image is actively rescripted. The preparation aims at clarifying the important childhood memories related to the problems and maladaptive schemas of the patient, and to help the patient to become used to imagery work. Two major techniques are used in this initial phase: *diagnostic imagery* and *imagery of a safe place* (Arntz, 2011-this issue; Young et al., 2003).

In diagnostic imagery the patient is asked to bring a memory or image of each parent (or other caregiver) during childhood to the mind that is emotionally loaded. In the interview after the exercise the therapist helps the patient to explore the schemas that are expressed in, or associated with, these images (Arntz, 2011-this issue; Young et al., 2003). The images are often of major events that have influenced the formation of maladaptive schemas. Diagnostic imagery often makes clear why some patients experience problems in the present. The therapist helps the patient to understand the connection between the memories of the past and current problems. Diagnostic imagery can start from strong emotions in the present, but the patient is instructed to work with an image from his/her childhood, involving one of the parents (Arntz; Young et al.). The exercise is called *diagnostic*, not because it leads to a classification of the patient's psychopathology, but because it leads to a "diagnosis" of the types of *early* experiences and relationships that played a role in the formation of the maladaptive schemas underlying the patient's problems.

In the safe place imagery in ST, patient and therapist work together to create an image of a place where the patient feels safe. This image can be used later to bring safety in the session whenever needed. It can also be used to start and finish imagery rescripting (Arntz, 2011-this issue; Young et al., 2003). Some patients feel less frightened about doing imagery rescripting if they know that they can switch to the safe image any time that they want.

It is important to realize that imagery work in ST can differ from the use of imagery in other approaches. Imagery work, and especially imagery rescripting, is used in a variety of applications, and in many approaches it is clear from the start what images or memories will be used in therapy (e.g., Arntz et al., 2007; Brewin et al., 2009; Grunert et al., 2007; Holmes et al., 2007; Hunt & Fenton, 2007; Hunt et al., 2006; Kindt et al., 2007; Smucker et al.,

1995; Wheatley et al., 2007; Wild et al., 2007). This type of imagery rescripting is labeled "Type A" by Holmes et al. In such applications, therapists can give relatively straightforward explanations of the aims and procedures of imagery work. By contrast, in ST for personality disorders, the memories or images that are subject of imagery work are usually not known before the technique is applied (they unfold as the imagery work proceeds), and during the course of therapy many memories that the patient did not explicitly link to current problems might be the focus of imagery work. This makes explanation to and preparation of the patient more complicated than in the case of the more straightforward "Type A" imagery rescripting, where a clearly circumscribed image or memory is the topic of therapy. "Type B" imagery rescripting (Holmes et al.) is used to change the meaning of memories of early events in order to promote the change from dysfunctional schematic representations to functional ones (Arntz, 2011-this issue). For personality disorder patients that are not troubled by recurrent images, it might be difficult to understand how processing memories of early experiences by means of imagery rescripting could help them to recover from their personality disorder.

But how do patients actually experience the initial imagery exercises? To answer this question, a qualitative study was conducted within a multicenter randomized controlled trial (RCT) into the (cost-)effectiveness of ST for personality disorders. Previously, Spinhoven et al. (2007) explored patients' perspectives on the therapeutic relationship within an RCT comparing ST and transference-focused psychotherapy (TFP) for borderline personality disorder (BPD) in a quantitative study. Patients rated the therapeutic relationship as more positive in ST than in TFP, and the therapeutic relationship was predictive of outcome. Although this study suggests that ST is valued more by patients than another specialist treatment, there might be room for improvement. This especially holds for specific techniques that are central to ST, but that might initially be experienced by patients as strange or frightening, like imagery work.

The purpose of the present study was to learn from the experiences of patients receiving ST with the early phases of imagery as described in the ST protocol. The early phases of imagery work might strongly influence the patients' attitudes and feelings towards the technique, and might influence crucial factors like hope, motivation, avoidance, fear evoked by the treatment, and the therapist. The structure of this article is as follows. First, the method is presented. Then we focus on the experiences and opinions of patients with various aspects of early imagery. As is typical of qualitative research, we illustrate our summary of the patients' views with quotes of the interviews (Morse & Richards, 2002). A section with limitations of the study is followed by the conclusion, in

which we compare the patients' experiences with the start of imagery with the guidelines given in Young et al.'s (2003) ST manual. From this, suggestions from the patients' perspective for improvement of the introduction of the first imagery exercises in ST follow.

## Method

### Setting

Patients who participated in the present study were enrolled in ST as participants of a multicenter RCT on ST for Cluster-C, paranoid, narcissistic, and histrionic personality disorder. They were recruited from three participating large mental health institutes. The interviews were held at the location where the patient was treated (with two exceptions in which telephone interviews were conducted instead).

### Ethics

The approval for the larger RCT including our qualitative study was obtained by the medical ethical committee of Maastricht University. Informed consent for the interviews with patients was included in the agreement to participate in the nationwide study that patients signed. In the larger trial confidentiality was regulated. In our study, names and other characteristics of the patients were deleted. Their transcripts were not shared with their therapists and after the study the transcripts and tapes were destroyed. The researcher/first author had no therapeutic relationship with the respondents and she was not aware of their diagnosis to prevent bias. The patients received an announcement letter with an explanation of the study and an invitation to participate. The letter announced that they would be called 1 week later to answer any questions and, if willing to participate, to make an appointment for a semistructured interview. In concert with the patient, a time was chosen that met the wishes of the patient to keep the burden as low as possible.

### Data Collection

Data collection was done through semistructured interviews with patients. Prior to the interviews with patients, interviews with members of different patient councils were held. In consultation with them, a list of topics was identified that should be addressed in the interviews with the participating patients. The main topics included: information about the interview, information received concerning ST before the therapy started, motives for participation in the therapy and research, expectations of therapy, experiences with this form and other forms of therapy, the treatment, opinion on the effectiveness of this treatment, any statements regarding efficiency of the treatment, contact with the therapist, and tips and opinions. Next, three pilot interviews with patients from different

personality clusters were held to test the validity of the topic list. These interviews indicated that the same topic list could be used for each personality disorder cluster.

The style of the interview was such that the respondent directed and structured the conversation during the interview, the interviewer followed the respondent and checked afterwards whether all topics, from the predetermined topic list, were discussed (Kvale, 1996). Listening and probing were essential. Care was taken to prevent common pitfalls, including outside interruptions, stage fright, awkward questions, jumping from one subject to the other, and the temptation to counsel respondents (Britten, 1995).

In a separate study, patients will also be interviewed about their experiences with diagnostic imagery and imagery of a safe place at the end or after their treatment. One of the aims of this step is to determine whether the experience with imagery work changes over the course of treatment. The current article reports on the experiences of patients at the beginning of their treatment.

After consent, the interviews were recorded on an MP3 player and later typed out verbatim. At the beginning of the interview it was stressed that nothing the patient said during the interview would be reported to the therapist. The anonymity was stressed. The interviews had no fixed duration, and they stopped when no new information was brought forward. The interviews varied in length from 45 to 90 minutes. Nine interviews were held by the first author, one by the last author. After the interview, a book token was given or sent as a sign of appreciation for participation.

### Sampling

Usually only a relatively small group of respondents is studied in qualitative research. This allows a thorough understanding of the meaning endowed to the experiences by the interviewees. In qualitative research the logic of sampling is purposeful. The respondents are not randomly selected, but instead the selection is guided by a criterion. In our study, the selection criterion was maximum variation in order to get as many aspects of the phenomenon as possible (Kuper, Lingard, & Levinson, 2008; Meadows & Morse, 2001). The investigators aimed to map the widest possible range of meanings and experiences. The criterion of maximum variation was applied in this study by interviewing respondents from different institutions, with different therapists. There was neither random sampling nor prospective stratification by certain characteristics of the participating patients, with one exception: we also wanted to include patients who dropped out of treatment. However, after sampling, the characteristics of the participating patients were inventoried.

Initially, 18 patients from three participating centers were asked to participate. Of these, 12 agreed and were interviewed. Two of them said they had not had any

diagnostic imagery or imagery of a safe place at that point. They were excluded from the present analysis. Variations in gender, marital status, education level, and (un)employment were all represented in the sample, similar to the study's total sample. Age varied between 22 and 54 years. As in the study's total sample, most interviewed patients were diagnosed with a Cluster-C PD ( $n=8$ ). There was 1 paranoid and 1 narcissistic patient. At the time of the interviews the respondents had received on average five sessions ST. The majority of respondents had received at least one other previous treatment. See Table 1 for a detailed overview of the characteristics of the participants.

**Analysis**

All the recorded interviews were fully transcribed. For the analysis of the transcripts we followed an inductive approach in order to be as open as possible to the experience of the patients. Moreover, as this patient group's perspective on ST has not been systematically studied before, we could not rely on a priori topics for analysis. The analysis focused on the content of the interview transcripts, as opposed to the linguistic or narrative form (Lieblich, Tuval-Mashiach, & Zilber, 1998). The analysis aimed to identify recurring themes in the interviews. The first author started with close reading of the transcript of each interview. Labels were given to the text fragments of each interview. In the literature, this is called open coding. Next, the first author focused on the complete set of interviews. All the labels of the open coding process were compared and redefined and clustered into main themes and subthemes. This is known as axial coding.

**Quality Procedures**

To assess the validity of our study, we used the checklist published in Kuper et al. (2008). The "rock bottom" of

the internal validity in qualitative research is considered the "member check" as this procedure helps to eliminate bias (Lincoln & Guba, 1985; Meadows & Morse, 2001). In our study each patient received the transcript and the analysis of their transcript by the researchers. Patients were asked whether they recognized the analysis, and whether it expressed carefully what they had wanted to express. All respondents agreed with the verbatim text and the analysis. In qualitative research the process of data collection and analysis ends when "saturation" is reached (Meadows & Morse). This is the point where no information is added and replication of data occurs. The point of saturation cannot be predicted in advance and is dependent on the scope of the study, the quality of the interviews, and the appropriateness of participant selection. In this study, saturation was reached after nine interviews. During the study process, the researcher/first author regularly met with an independent expert of qualitative methods to discuss methodological decisions, which is known as peer debriefing. For example, the sampling procedure was subject of their conversation as well as the role of the researcher, overidentification with the respondents, and the proper balance between distance and engagement. Considering the external validity this study enables readers to assess the potential transferability of its results to other therapeutic settings by presenting a description of the studied context and meanings expressed by participants.

**Results**

The analysis resulted in five main themes and several subthemes, which will be discussed below. For an overview see Table 2.

*Introduction of Diagnostic Imagery*

"As if you go all together to an innocent tea party and then suddenly someone says, come we now undress." This

Table 1  
Overview of Characteristics of the Interviewed Participants

Participant	1	2	3	4	5	6	7	8	9	10
Age	45	45	38	24	22	42	?	54	39	?
Gender	M	F	M	M	F	M	F	M	F	F
Education	4	1	4	2	2	3	?	3	2	6
(un)employment	c	c	c	c	a	c	c	c	c	b
Marital Status	married living together	single	married living together	single	living together	married living together	?	married living together	married living together	single
Diagnosis	A	P	A	A	A	A	A	N	A	A
Previous Treatment(s)	No	Yes	Yes	No	Yes	Yes	?	Yes	Yes	Yes

1=Graduate/professional, 2=College graduate, 3=Some college, 4=High school graduate, 6=grades 7–11  
 a=housewife, b=student, c=employed, d=disability, e=welfare  
 A=avoidant personality disorder, P=paranoid personality disorder, N=narcissistic personality disorder  
 ?=missing



Table 2  
Overview of Themes Derived From the Interviews

Main themes	Subthemes
Introduction of diagnostic interviewing	Understanding introduction Preparation
Diagnostic interviewing	Selecting a past event Visualization of an event
Time perception during diagnostic interviewing	Time limit Concentration
Imagery of a safe place	Relaxation Concentration
Costs and benefits	Burden of imagery Added value of the therapy

statement reflects a patient's reaction to a first diagnostic imagery exercise. The patient explained that he experienced the exercise as "sudden and [was] quite unprepared."

The patients were at the beginning of their treatment and indicated in the interviews that they underwent imagery exercises without initially understanding the explanation fully, and that they were anxious about what they probably would further undergo in treatment. A this patient expressed, "In the explanation of imagery I got a warning that you can first start feeling worse, in the hope that it goes better then. Some would feel better, but others not. Then I thought, 'I better don't do it because I'm probably going to feel worse.'"

Most interviewees indicated that they had not yet acquired insight into their schemas through diagnostic imagery at the time of the interviews. Some had gained some insight, but missed the explanation of the purpose of the exercise and how it would practically be carried out. Others mentioned that they had done just a few imagery exercises.

#### *Diagnostic Imagery*

One of the skills that the patient is expected to have is selecting a past event. From the interviews, different experiences emerge about selecting an event for imagery. Some patients indicate that so many images pass by that it is very difficult in the beginning of treatment to choose which situation suits a diagnostic imagery exercise. For example: "All kinds of events flash through your mind. Then you have to pick out one, I had troubles with that."

Patients with many images/situations that popped up reported that it helped when the therapist indicated explicitly and clearly that it made no difference which situation was selected. When multiple imagery exercises have been done, most interviewees indicate that they understand why it does not matter what situation you choose—but in the beginning of treatment this is difficult to grasp. One patient said that it would have helped to organize the ages of 0 to 10 in groups of 2 years: "Take a

confusing situation for you in the age of 4 to 6 years and then another time a confusing situation in the age of 6 to 8 years."

Patients must also have the skill to visualize. In some cases the difficulties with visualizing are specific for certain contents. For instance, as one of the above excerpts showed, one patient had specific difficulty with imagining positive situations. Some patients state that they have trouble visualizing because they are aware of the presence of the therapist. Others indicate that they are able to go to a feeling from childhood, but that it is difficult to get an image. Others indicate that they can evoke an image and a feeling, but that they find it difficult to imagine what the other would say. And even if they can imagine it, it is often difficult to say this out loud. One patient puts it as follows: "A conversation with someone in your head, what would that person say? Well, no idea." Patients indicated that they did not have any suggestions for this problem.

#### *Time Perception of Diagnostic Imagery*

"It is much more frightening if you don't know how long the exercise will last."

Various interviews showed that at the beginning of treatment it was tense to entrust oneself to the first imagery exercise. Patients reported: "You feel vulnerable," "You need to put aside all your defenses," "You do something unknown and in all kinds of ways an appeal is done to you." The interviews revealed that tension increases if there is no time limit given to the length of the imagery. "That uncertainty about how long it will last ... that is not what I'm waiting for."

During the treatment, when experience is gained in imagery, the fear of it declines, its usefulness is experienced, and almost all interviewees indicated that a fixed time for such an exercise would be dysfunctional.

Another time-related problem is lack of sustained concentration. Several interviews revealed that patients are frequently unable to concentrate on the exercise, but did not tell their therapist:

"So I closed my eyes, am totally into it. And at a certain point I desire to come back, you have been emerged so long and sometimes it becomes a little 'too much'. Then I just quit, I don't say that, but... Then I am actually out of it. It is just a bit too lengthy. Then I just don't want anymore for that moment."

The feeling of "not wanting anymore" that can emerge during imagery is perceived by the patients as very annoying.

*Safe Place Imagery*

"You need to go to a safe place in your head, well that is already impossible for me if it must be positive. If it is negative I don't get it out of my head, but something positive, I really don't get it into my head. I also feel I'm talking bullshit because I really find it difficult and don't see it for my eyes."

In contrast to the above quotation, the interviews suggest that most patients like to imagine a safe place. For example, "a safe place is nice because you feel very comfortable and you know that you always come back to that feeling, no matter what happens during the exercise." A safe place imagery helps patients outside of the therapy situation.

That a good (sustained) concentration capacity is required for therapy has already been mentioned (understanding the explanation, remain in the imagery exercise). This also holds for imagining a safe place. From the interviews, it is clear that the vast majority of patients suffer from concentration problems early in treatment. As one patient puts it: "Anyway my concentration is poor."

*Costs and Benefits From a Patient Perspective*

When asked how the burden of imagery was experienced, it is striking that most patients find imagery tiring, hard, confrontational, emotional, stressful, and energy-consuming.

"For me it requires much more energy. Much more than just sitting and talking."

Despite this experience, almost all found that imagery has a very high added value in therapy. Here are some quotes to illustrate:

"It actually works so well because you really realize how it really should go."

"It really breaks through my way of thinking."

"I come easier in touch with my feelings. I also notice that I can do more then."

"It has shown to me very clearly what is going on with me. What exactly I do wrong and what I have to learn."

Patients indicate that the added value of diagnostic imagery lies in learning to recognize schemas in situations; getting more grip on and better placing their emotions; clearer and better understanding of their problems.

When patients compared ST with previous treatments, ST stood out favorably. One patient, who had already undergone many treatments in which he had mainly talked about his past, found that the diagnostic imagery

exercises touched the core of his problems for the first time in his treatment history. Other patients were similarly positive about ST in comparison to other treatment modalities.

*Limitations of the Study*

This study was based on a small sample of severely personality disordered participants at the beginning of their ST. It is still unknown how diagnostic imagery and imagery of a safe place in the later stages of ST will be experienced by such a sample of complicated patients. Although our results might inform therapists conducting other therapies in which imagery is used, care should be taken to generalize findings, as the therapy model might be quite different, creating a different context for the patient. Care should also be taken to generalize our findings to other patient populations. It might be the case that the specific profile of our patients relates to their comments. The participants in the present study were severely personality disordered patients, most of whom had experienced earlier, unsuccessful treatment. Of particular importance is that the majority of patients were highly anxious, avoidant, and/or distrusting, personality traits that might be directly related to their problems with engaging in a highly emotional and relatively unpredictable and uncontrollable technique of imagery. The qualitative interviews suggested that patients' problems in the early stages of ST were especially related to imagery, not to other methods and techniques. However, the fact that we interviewed the patients at the start of treatment might have been related to that, as the patients had not yet experienced other ST techniques that might also have been confronting. As mentioned above, another study focuses on PD patients' opinions at the end of ST. This study will reveal how imagery work in ST for PDs is experienced at the end of treatment, and how the imagery techniques compare to the other techniques in ST. Nevertheless, the responses from the patients in this study represent a challenge to therapists to find ways to respond and to adjust diagnostic imagery and imagery of a safe place to meet the needs and limitations of this type of patient at that moment in treatment.

This study was completed by a researcher with a background in clinical psychology. This enabled her to probe into the matters that influence the patient-therapist relationship, emotions and feelings and details about the techniques. We are well aware of the fact that this particular training might also have colored the interviews and the analyses.

**Conclusion and Recommendations**

The patients in this study experienced the first imagery exercises in ST—diagnostic imagery and imagery of a safe place—as an invasive but effective method. In this respect, the purpose of diagnostic imagery as described in the

manual (to determine the relationship between schemas in the present and childhood events and relationships; Young et al., 2003) corresponds to the perception of its effectiveness by the patients.

Based on the data obtained from patients' semistructured interviews, a number of ways emerge in which this method can be changed to better meet patients' expectations and needs. Table 3 shows the main patient recommendations derived from the semistructured interviews. We discuss the main issues and compare them with the advice in Young et al.'s (2003) ST manual.

First, the patient should be seen as an equal and full partner in treatment. It is important to emphasize this, because a risk exists that the opinions of patients are seen as arising merely from their pathology, so that their comments, criticisms, and questions are seen as resistance (e.g., schema avoidance). For example, not being able to—or being resistant to—visualize is interpreted as schema-avoidance in the manual (Young et al., 2003). According to the manual, methods to deal with schema-avoidance are as follows: educate the patient about the reasons for working with imagery; explore the pros and cons of such an exercise; begin with reassuring images and gradually introduce material that evokes more fear; conduct a dialogue with the avoiding side of the patient (schema mode work); use affect-regulating techniques (e.g., concentration or relaxation exercises); prescribe psychotropic medication. This interpretation does not leave room for alternate reasons for a patient's inability to visualize. We suggest that therapists learn to see their patients more as full conversation partners from whom they can learn. At the same time, therapists should stay alert to symptoms that may be linked to their pathology.

Agreement between therapist and patient on which reactions belong to what is essential for a successful start with imagery exercises. Needless to say, this is a highly complicated task with severe PD patients.

The following statement is given by Young et al. (2003, p. 111) about the introduction and preparation for imagery in assessment: "We generally present a brief rationale to patients for doing the imagery assessment work. Most patients do not require more." However, patients in this study indicated that the information provided at the beginning of the therapy was not well understood. They generally perceived that communication about the explanation, the experience, the skills needed, and the timing of imagery exercises was not collaborative. This creates the possibility that patients disengage because they are not heard or taken seriously. The therapist also misses the opportunity to assess whether the patient is receptive to imagery and whether the patient needs specific tools to participate in imagery. In short, introduction and evaluation should be done regularly and in an open dialogue.

About the degree of support during imagery work, the manual states:

When doing imagery work with patients, one guiding principle is to give the least amount of instruction necessary for the patients to produce a workable image. We want the images that patients produce to be totally their own. The therapist avoids making suggestions and gives as few prompts as possible. The aim is to capture as accurately as possible the patient's experience, rather than inserting the therapist's own ideas or hypotheses.

Table 3  
Suggestions From Patients for Start With Imagery

Session prior to the first session with imagery	<ul style="list-style-type: none"> <li>• Prepare the patient for the next meeting.</li> <li>• Give a concrete explanation of what the imagery exercise implies.</li> <li>• Inform them that there are different approaches: from more structured to less structured, explorative experiential techniques. Explain this in concrete.</li> <li>• Give the explanation printed in a ring binder.</li> <li>• Take into account any concentration problems of the patient.</li> <li>• Verify that the explanation is understood, whether there are any questions, and how the patient views the imagery exercise.</li> </ul>
During the session in which imagery is done	<ul style="list-style-type: none"> <li>• Agree for the first imagery on a fixed time. Repeat this if needed.</li> <li>• Use a kitchen timer.</li> <li>• Give clear instructions for choosing a memory or situation for imagery.</li> <li>• Inform patients explicitly that it doesn't matter what situation they choose.</li> <li>• If there are many situations from different ages, tell the patient to choose a situation from a specific age, instead of a situation before a certain age.</li> <li>• If the patient fails to come to visualization, investigate whether there is (schema) avoidance or whether there are other factors that play a role, including factors that are not related to the pathology of the patient.</li> </ul>

The goal is to elicit core images—those connected with such primary emotions as fear, rage, shame, and grief—that are linked to the patient's early maladaptive schemas. (Young et al., 2003, p. 112)

Despite this theoretical idea, patients said that the degree of support with imagery exercises should be tailored to the needs and wishes of the patient. We suggest that the adaptation of the technique should be individually tailored as each patient undergoes his or her own learning process, even within the first imagery exercises.

This suggestion also applies to time division during the imagery exercise. According to the manual,

It is best to plan to devote almost the whole therapy hour to the first imagery assessment session with a patient. We generally allow about five minutes to representing the rationale and answering any questions; do imagery work about 25 minutes; then take about 20 minutes more to process with the patient what happened during the imagery session. Later imagery assessment may only require the first half of a session. (Young et al., 2003, p. 111)

The handbook does not address exactly how the division of time during imagery sessions should be handled in the course of therapy. The patients indicate that the need for a fixed duration, clear structure, and clarity is greater at the beginning of treatment than later. Furthermore, because patients experience a lack of fixed time for the imagery exercise in the beginning of the therapy, it seems that it should be the therapist who determines whether and when the exercise stops, rather than that this is a joint decision. That the duration of the exercise varies from therapist to therapist and from patient to patient is understandable given personal differences, but the lack of clarity about the length of the exercise in the patients' experience is striking.

The patients' experience of imagery of a safe place fits with the ST manual, in which the importance of creating a safe place is specified:

Starting with a safe-place image is a simple, nonthreatening way to introduce imagery work. Starting this way also provides the patient with a chance to practice doing imagery before getting into more significant, emotionally laden material. At the end of an imagery session, returning to the safe place gives patients a refuge when the imagery material has left them upset. (Young et al., 2003, p. 113)

Since the patients' interviews clearly revealed what they needed for the diagnostic imagery, the current ST protocol should be refined. This is one of the reasons that

the experiences and opinions of patients should have a prominent place in the implementation of ST for personality disorders.

To further explore and verify the perspectives of patients receiving ST, more studies are needed. These should also investigate shifts in time in opinions and experiences, as treatment might have an effect on how treatment techniques are perceived. In PD patients it is interesting to observe whether experiences and evaluations change with reduction of personality pathology, and how they experience imagery rescripting. Subsequently, the perspectives of patients can become the subject of a dialogue with therapists to achieve understanding and enriched insights (Abma, 2005; Abma & Broerse, 2010; Abma, Molewijk, & Widdershoven, 2009). The results from the RCT and the qualitative data can be compared in a meeting of experts and representatives of patients. Any discrepancies between the quantitative and qualitative data can stimulate a research and learning process, and lead to a better understanding of ST and create opportunities for improvement. The experiences of patients, the opinions of the experts, and the results of the mutual learning process should ideally be included in the implementation of ST.

## References

- Abma, T. A. (2005). Responsive evaluation: Its meaning and special contribution to health promotion. *Evaluation and Program Planning, 28*, 279–289.
- Abma, T. A., & Broerse, J. (2010). Patient participation as dialogue: setting research agendas. *Health Expectations, 13*, 160–173.
- Abma, T. A., Molewijk, B., & Widdershoven, G. A. M. (2009). Good care in ongoing dialogues. Responsive evaluation and moral deliberation. *Health Care Analysis, 17*, 217–235.
- Arntz, A. (2011). Imagery rescripting for personality disorders. *Cognitive and Behavioral Practice, 18*, 466–481 (this issue).
- Arntz, A., Tiesema, M., & Kindt, M. (2007). Treatment of PTSD: A comparison of imaginal exposure with and without imagery rescripting. *Journal of Behaviour Therapy and Experimental Psychiatry, 38*, 345–370.
- Arntz, A., & van Genderen, H. (2009). *Schema therapy for borderline personality disorder*. Chichester: Wiley-Blackwell.
- Arntz, A., & Weertman, A. (1999). Treatment of childhood memories: theory and practice. *Behaviour Research and Therapy, 37*, 715–740.
- Beck, A. T., Emery, G., & Greenberg, R. L. (1985). *Anxiety disorders and phobias: A cognitive perspective*. New York: Basic Books.
- Brewin, C. R., Wheatley, J., Patel, T., Fearon, P., Hackmann, A., Wells, A., Fisher, P., & Myers, S. (2009). Imagery rescripting as a brief stand-alone treatment for depressed patients with intrusive memories. *Behaviour Research and Therapy, 47*, 569–576.
- Britten, N. (1995). Qualitative research: Qualitative interviews in medical research. *British Medical Journal, 311*, 251–253.
- Butler, G., Fennell, M. J. V., & Hackman, A. (2010). *Cognitive-behavioral therapy for anxiety disorders*. New York: Guilford Press.
- Grunert, B. K., Weis, J. M., Smucker, M., & Christianson, H. F. (2007). Imagery rescripting after failed prolonged exposure for post-traumatic stress disorder following industrial injury. *Journal of Behavior Therapy and Experimental Psychiatry, 38*, 317–328.
- Hackmann, A., Bennett-Levy, J., & Holmes, E. (2011). *Oxford guide to imagery in cognitive therapy*. Oxford: Oxford University Press.
- Holmes, E. A., Arntz, A., & Smucker, M. R. (2007). Imagery rescripting in cognitive behaviour therapy: Images, treatment techniques and



- outcomes. *Journal of Behavior Therapy and Experimental Psychiatry*, 38, 297–305.
- Hunt, M., Bylsma, L., Brock, J., Fenton, M., Goldberg, A., Miller, R., & Urgelles, J. (2006). The role of imagery in the maintenance and treatment of snake fear. *Journal of Behavior Therapy and Experimental Psychiatry*, 37, 283–298.
- Hunt, M., & Fenton, M. (2007). Imagery rescripting versus in vivo exposure in the treatment of snake fear. *Journal of Behavior Therapy and Experimental Psychiatry*, 38, 329–344.
- Kindt, M., Buck, N., Arntz, A., & Soeter, M. (2007). Perceptual and conceptual processing as predictors of treatment outcome in PTSD. *Journal of Behavior Therapy and Experimental Psychiatry*, 38, 491–506.
- Kuper, A., Lingard, L., & Levinson, W. (2008). Critically appraising qualitative research. *British Medical Journal*, 337, 1035.
- Kvale, S. (1996). *InterViews: An introduction to qualitative research interviewing*. Thousand Oaks, CA: Sage.
- Layden, M. A., Newman, C. F., Freeman, A., & Morse, S. B. (2004). *Cognitive therapy of borderline personality disorder*. Boston: Allyn and Bacon.
- Lieblich, A., Tuval-Mashiach, R., & Zilber, T. (1998). *Narrative research: Reading, analysis and interpretation*. Thousand Oaks, CA: Sage.
- Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. Beverly Hills: Sage.
- Meadows, L. M., & Morse, J. M. (2001). Constructing evidence within the qualitative project. In J. M. Morse, J. M. Swanson, & A. J. Kuzel (Eds.), *The nature of qualitative evidence* (pp. 187–200). Thousand Oaks, CA: Sage.
- Morse, M. M., & Richards, L. (2002). *Read me first for a user's guide to qualitative methods*. Thousand Oaks, CA: Sage.
- Smucker, M. R., Dancu, C., Foa, E. B., & Niederee, J. L. (1995). Imagery rescripting: A new treatment for survivors of childhood sexual abuse suffering from posttraumatic stress. *Journal of Cognitive Psychotherapy*, 9, 3–17.
- Smucker, M. R., & Niederee, J. (1995). Treating incest-related PTSD and pathogenic schemas through imaginal exposure and rescripting. *Cognitive and Behavioral Practice*, 2, 63–93.
- Spinhoven, P., Giesen-Bloo, J., van Dyck, R., Kooiman, K., & Arntz, A. (2007). The therapeutic alliance in schema-focused therapy and transference-focused psychotherapy for borderline personality disorder. *Journal of Consulting and Clinical Psychology*, 75, 104–115.
- Stopa, L. (2009). *Imagery and the threatened self: Perspectives on mental imagery and the self in cognitive therapy*. London: Routledge.
- Wheatley, J., Brewin, C. R., Patel, T., Hackmann, A., Wells, A., Fisher, P., & Myers, S. (2007). "I'll believe it when I can see it": Imagery rescripting of intrusive sensory memories in depression. *Journal of Behavior Therapy and Experimental Psychiatry*, 38, 371–385.
- Wild, J., Hackmann, A., & Clark, D. M. (2007). When the present visits the past: Updating traumatic memories in social phobia. *Journal of Behavior Therapy and Experimental Psychiatry*, 38, 386–401.
- Young, J. E. (1990). *Cognitive therapy for personality disorders*. Sarasota, FL: Professional Resources Press.
- Young, J. E. (1999). *Cognitive therapy for personality disorders: A schema-focused approach*, Rev. ed. Sarasota, FL: Professional Resources Press.
- Young, J. E., Klosko, J. S., & Weishaar, M. E. (2003). *Schema therapy: A practitioner's guide*. New York: Guilford.

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