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Mental imagery in psychoanalysis, psychodynamic and cognitive-behavioral approaches: literature review

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Abstract:

This article provides an overview of the use of images in the psychoanalytic, psychodynamic, cognitive and cognitive-behavioral approach based on existing literature. Imagination, as an intervention technique has been shown to be effective and even superior to other intervention techniques, in different life fields. The majority of clinicians use imaginative techniques to promote relaxation, to reduce stress, to regain control of unwanted behaviors, to increase self-awareness, to plan a lifestyle, to improve health. On the level of therapeutic intervention it is essential to increase the motivation of the subject to work with the images. Imaginative therapies are used by many therapists. There are wide varieties of imaginative therapies that have been thoroughly examined. These approaches can be classified into a series of models based on their theoretical assumptions and pre-established objectives. Those who use images in the context of psychoanalysis and in analytical psychotherapy have modified the method of free association using imaginative instructions as a way to improve discovery and revelation. Behaviorists have used images to extinguish fear-based symptomatic behaviors through desensitization and through the alteration of the cognitive representations that guide these behaviors, as in the case of symbolic modeling by Bandura and covert modeling by Cautela.

Key words: cognitive-behavioral approach, imaginative therapies, mental imagery, psychoanalytic-psychodynamic approach

1. INTRODUCTION

In psychoanalysis and in psychodynamic approaches, the use of images should be understood as the recovery and reinterpretation of images of the past, with the aim of constructing new and useful images for the future. The dream acts as a connector between past, present and future. In the dream, images are the priority. Patients through dreams bring images that constitute the material on which to intervene therapeutically and to obtain the desired transformation. The images are therefore the instrument through which it becomes possible to construct new metaphors that can help the patient to reorganize his own existence more serenely. In our mind we create a series of connections that through the metaphors give life to the images that arise from our imaginary. Usually we tend to neutralize the imaginative activity by reducing it to names that belong to a verbal code with precise and rigid rules. The patient must be accustomed again to the use of images. In dynamic psychotherapy there is a strong presence of direct solicitation to the production of mental images. According to Rorschach, for example, the patient must find in the memory the images corresponding to the figure proposed and subsequently translate them verbally and communicate them. Some studies show that psychoanalytic and psychodynamic techniques that resort to the evocation of sequential images in the patient are able to make the relevant material emerge more quickly, lowering defenses and evoking greater emotionality. There are many techniques developed and used thanks to the contribution of Jung, Desoille, Leuner. It has been demonstrated that the use of imagination can be useful to identify the resistances, the tendencies to avoid, the defense mechanisms, the false beliefs and the myths family. Psychoanalytic and psychodynamic therapies aim to identify defenses and specific episodes of childhood that may have created a system of false beliefs or self-harming behaviors.

Using images can be a way to encourage the patient to develop strategies to examine the conflicts and to make defense and transference aware.

2. THE MENTAL IMAGES IN PSYCHOANALYTIC TREATMENT

Imaginative techniques can facilitate the psychotherapeutic process by stimulating the patient's insight, helping the latter to discover and master affects, improve empathic contact and access counter transfer. What is the influence of imaginative methods in the traditional analytic process? [18]

2.1. Historical background

In his first studies on psychopathology, Freud realized the importance of mental images. His interpretation of imaginary processes was of a psychodynamic type. The intrapsychic function of the imaginary was explored by Freud and Breuer in "Hysteria Studies" (1895). Following hypnotic induction, hysterical patients experienced vivid mnemonic images, sometimes almost hallucinatory in terms of quality. For the authors these images corresponded to childhood traumatic experiences, not sufficiently assimilated in the intrapsychic system. When the patient described and explored the imaginary verbally, its vividness vanished, as if the patient got rid of it by transforming the imaginary into words[18].The authors believed that the dissipation of the image equaled the raising of the symptom. During their work with hysterical patients, the authors (1895) developed the concentration technique, which actually derived from Bernheim, who demonstrated that the memories of events, during the hypnotic trance, which are usually forgotten in the waking state, they can be relived through a pressure of the hand on the forehead. Freud and Breuer used the technique to recover the childhood memories at the origin of hysterical symptoms. They assumed that the

patients knew the genetic roots of their disease but the associations that could lead to this material were blocked by the fact that they did not want to remember. Concentration technique was designed to overcome resistances by stimulating visual images. It was a trick to temporarily overcome an ego ready for defense. Once the image was retrieved, Freud encouraged patients to verbally explore its meaning. He instructed them to focus on the image until even the last detail had been clarified. If the patients said they saw nothing, they thought it was impossible. They insisted on the fact that the patients refused the image either because they thought it irrelevant, or because they were afraid to describe it. He insisted that he could repeat the procedure every time the patients wanted it, and that they would always see the same image. But this method presented various complications. The image that sometimes appeared was an intermediary link in a chain of associations leading to pathogenic material, an image of mediation that indicated the way to the source of the hysterical symptoms. Other times it did not seem connected to the subject of discussion in analysis. Freud interpreted these results as evidence of an intelligence out of the awareness that organizes the psychic material and has a fixed plan for his return to consciousness. Patients sometimes refused the image, or in their descriptions deformed it, rearranged it and filtered it. For Freud this indicated a defense process, a mental strategy to "turn a strong idea into a weak one, (to) deprive it of its affection" (Breuer and Freud, 1985, p.280).

2.2. The abandonment of imaginative techniques

Freud abandoned the technique of concentration before 1900 and without a really clear reason. For Kris (1950) this marked an intermediate stage in Freudian history, the important passage from the hypnotic method to that of free associations. This happened due to a displacement of attention from the visual processes to the verbal ones. The method of free

associations was first performed with closed eyes (a residue of the hypnotic method), then Freud suppressed the visual elements of free associations in favor of verbal processes. Visual elements in free associations did not mean a complete abandonment of mental images. The transition from hypnosis to free associations, accompanied by the conversion to verbal processes, underlined the passage of psychoanalysis in a direction that excluded the emphasis on mental images. Analysis of the transfer became the main therapeutic objective. The mental images were considered a resistance, a distraction from the systematic rational exploration of the patient's transfer. A wide historical perspective helps in the explanation of this passage. As Holt (1964) observed in his historical analysis, academic psychology in the early 1900s started to abandon structuralism and the emphasis on mental events. With Watson's behaviorism, the study of images was deemed to be unproductive, impractical, and not empirical.[11]

2.3. The updated interest in imaginative techniques

The interest in mental images has been reawakened thanks to Penfield's work on brain stimulation, memory research in cognitive psychology and the irony of fate, the creation of the systematic desensitization technique, one of the best known of the behaviorist theory. A similar change was also found in psychoanalysis. Ferenczi (1950) proposed the procedure of forced fantasy, a procedure similar to the method of concentration. Other analysts began to study how spontaneous images intruded into the patient's free verbal associations. Green (1959) emphasized the communicative function of imaginative fantasies, while Sullivan (1956) seemed to ignore the imaginary in favor of the analysis of interpersonal interactions.

European psychology had welcomed the images with open arms. The expansion of the psychodynamic movement in Europe included a flourishing of imaginative theories as

demonstrated by the work of Jung, Desoille, Assagioli, and others. The first articles in the United States reflected this European style but it is only from 1960 onwards that imaginative theories have taken root, especially in the works of Ahsen (1968-1977), Leuner (1969-1977) and Desoille (1965). What followed was an explosion of interest for the mental images and imaginative techniques. Many of these theories and techniques fall into the category of psychodynamic therapies, rather than the mainstream of psychoanalytic thought. A universally accepted premise concerning imaginative techniques saw images as a special language of consciousness, a link between conscious and unconscious realms. The structure of the images was conceptualized as a condensation of ideas and emotions. Therapists supported the fact that through work with images they could evade defenses and gain a more direct access to unconscious affective and creative processes.

2.4. Imaginative techniques in psychoanalysis: Theoretical and practical problems

Using images in psychoanalysis raises a series of theoretical and technical questions regarding therapeutic change, such as the level of directivity of various imaginative techniques and the application of these methods taking into account individual differences in imaginative capacity. Given the adherence of traditional psychoanalytic theory to the principle of neutrality, a non-directive analyst, the imaginative techniques used can be evaluated according to their level of directivity.[17]

At the lowest level of directivity are the methods that focus on spontaneously verified images in the therapeutic session. The underlying premise of this is that spontaneous images, like dreams, reveal a fruitful path of unconscious dynamics. For example, some analysts (Kanzer, 1958; Lewin1955; Warren 1961) have worked with images that intruded into the free verbal associations of patient without being activated by the analyst. Since the imaginary is an

internal experience that is sometimes overlooked by the patient or weakened by verbalizations, the analyst must be sensitive to signals that indicate the occurrence of images, for example periods of silence or interrupted verbalizations, often accompanied by a movement of the eyes upwards and a shift towards metaphorical language. To make the image appear, the analyst may need to ask if patients have experienced an image or seen something in their mind. A relaxed body posture and light sensory deprivation created by the use of the analytic bed increases the probability of occurrence of spontaneous images (Singer, 1974).

At a higher level of directivity the analyst can deliberately or specifically instruct the patient to generate associations using images. A particular problem or conflict can serve as a starting point for imaginative associations. These associations can be used to deepen a previously achieved compression or, similar to Freud's concentration technique and Kepecs' work (1954) with intrapsychic barriers, can be applied to bypass the defenses that block the patient at some point of the analytical process. The analyst's metaphors and interpretations can provoke imaginative associations. Obviously, there are many degrees of directness that consist of stimulating and guiding imaginative associations on the part of the analyst. Leuner (1969, 1977) used ten standard scenes as clues, each of which is designed to touch a distinct psychodynamic topic, such as climbing a mountain to reveal conflicts over success and failure. Other analysts have used special methods to increase imaginative associations, such as inducing hypnologic states through relaxation and breathing techniques. Imagining instructions, such as the concentration method, can simply suggest to produce a single imaginative scene or, as in free verbal associations, encourage the patient to produce a continuous stream of visual ideas, usually with eyes closed. Patients can be instructed to generate free imaginative associations without a specific starting signal. Although this

approach appears less direct because of the lack of an explicit suggestion, the method often requires strategies to keep the patient in the imaginative mode. Because imaginative experiences are the main goal, the role of the therapist is to encourage patients, gently but firmly, to continue the imagination. Reyher (1963,1977,1978) emphasized that the therapist remains absolutely silent during the patient's images, with the exception of occasional observations intended to increase the imagination and clarify to patients what they are experiencing, or when the associations of patient appear to be non-productive, helping them to concentrate their images on a dynamically significant area. He argued that even if the images could be vague, futile or lacking in affection, the continuous search of visual flow led to extremely vivid fantasies dominated by primary processes. These images could trigger the release of repressed material with intense abreactions and regressive behaviors, therapist allowed these reactions to follow their course without interfering and providing reassurance.

At a high level of directivity we find the structured imaginative exercises that are intended to correct rather than uncover simple intrapsychic dynamics. Referring to a decidedly psychoanalytic perspective Silverman (1987) proposed the image as an aid in working with unconscious conflicts. He suggested that patients with the help of the analyst can create an imaginative scenario that arouses emotions and refers to a critical psychodynamic problem discovered during treatment. These techniques must be evaluated in the context of the fundamental principles of psychoanalytic therapy, including the analysis of defenses and resistances, and transference and counter-transference. If imaginative techniques are used as an addition to traditional psychoanalytic methods, the analyst must evaluate their suitability based on the characteristics of the patient. One cannot think that these techniques have an effect that is the same for everyone. The level of psychopathology, the formation of symptoms, the structure of

the character can be significant variables, as is the ability to imagine.

In general, the literature suggests that imaginative techniques are more applicable to the therapy with neurotic patients where the primary objective is to break through the defenses. But because objects and self-representations are effectively included in the holistic structure of the image diagnostic and therapeutic work with images can be productive for patients with impaired object relations. The empathic contact powerfully established by imaginative interpretations and the concordant imaginative experiences between the analyst and the patient can facilitate the creation of a symbolic bond and a containment environment to reconstitute defects in ego functions and sense of self. When they come empathically guided by the therapist, the imaginative interpretations and the structured exercises that immerse the patient in a powerful affective state, can provide a vehicle for experimenting and internalizing the therapist's ego functions, and in particular the ability to tolerate and master the repressed affects.

3. A CONCEPTUAL MODEL

This model is proposed to understand the role of mental images in psychodynamic processes and the problems concerning their use as a therapeutic technique. The primary objective is the conceptualization of the image in terms of interaction between primary and secondary processes. Other models, such as that of Horovitz (1967, 1968, 1970, 1972a, 1972b) and Singer (1966, 1971a, 1971b, 1974) are consistent with this model. A strong point of this conceptual framework is its rooting in the rich psychoanalytic literature concerning the functions mental and its congruity with theories and research in cognitive, clinical and physiological psychology. The theory of primary and secondary processes was born with Freud (1895.1900, 1911) and subsequently it was modified and expanded (Holt 1967,

Rapaport 1950,1951). According to Freud the primary process is unconscious and operates in accordance with the principle of pleasure. Its purpose is the release of tension through the manipulation of large amounts of psychic energy. The primary process can be conceptualized as a mental function responsible for the regulation of unconscious desires, needs and affects. In the secondary process ideas and experiences are correlated regardless of their relationship with subjective desires and affective states. The principle of reality supplants the principle of pleasure. Thinking becomes logical, practical and realistic. Ideas are more limited and differentiated. The psychoanalytic theory of primary and secondary processes, considered the two fundamental modalities of mental functioning, corresponds to theories of cognitive psychology, in particular to the double code theory of Paivio (1971) which describes mental images and verbal processes such as the two cognitive systems fundamental for the coding of experience and for information processing. Considering that the primary process is more easily expressed in the form of images, the secondary process is more easily expressed in language. The image is often unrealistic, symbolic and charged with affection, reflecting the influence of primary formal and content processes. Verbal processes involve more abstract coding and communication of more effective ideas that reflect the conceptual qualities of secondary processes. The verbal system manipulates the representations in a linear sequence. The imaginative system involves holistic constructions of information that describe the relations between objects (Horowitz, 1972), thus making it a more effective system in expressing the functions of primary processes in the organization of the self and of object representations and in creating reality subjective of one's identity. The correspondence of the primary and secondary process to images and verbal processes is supported by a research on cerebral hemispherical lateralization (Galen, 1974). The left hemisphere, which contains the centers of speech and language, tends to be more

analytical and logical, more oriented towards problem-solving through the linear manipulation of abstractions and therefore more rooted in the secondary process. The right hemisphere works more as a Gestalt, non-linear principle. Information is processed by multiple convergent factors and is represented under the non-verbal, sensory form of mental images - it is the seat of primary processes. Of course it would be too simple to identify images with primary processes and verbal responses with secondary processes. The image can serve secondary processes as in problem-solving, and primary processes can appear in language, as in poetry. Hilgard (1962) and Rapaport (1957) suggest that primary and secondary processes are best conceptualized as ideal models that do not exist in pure form. The imaginary is strongly influenced by the primary process but is structured and modified in some way by the logical requests of the secondary process. These ideas are consistent with the cognitive research that makes the imaginative process appear as the product of the interaction between "molecular" processes that they are endowed with irreducible sensory and affective qualities, and "molar" processes involving image processing and evaluation mechanisms at a more conscious level (Anderson, 1978; Kosslyn and Swartz, 1977; Strosahl and Ascough, 1981). The prosperous application of imaginative techniques in psychoanalytic treatment can be conceptualized as a regression to the service of the ego, also known as adaptive regression (Kriss, 1952). Imagining relieves what Kris calls the inspiration phase of this regression in which the barriers that restrain the unconscious ideation are withdrawn, causing the emergence of the affects, symbols and fantasies of the primary processes. However this ego regression is not in itself sufficient. During the processing phase the barriers to unconscious ideas are restored. The reality principle is reintegrated to subject the primary processes to the rational control, evaluation and synthesis of secondary processes, a task carried out with the help of verbal descriptions and elaborations. In this way the

material of primary processes can be significantly assimilated. Strosahl and Ascough (1981) established that the union of verbal operations and imaginative is essential for therapeutic efficacy. Although some therapists emphasize the imaginative experience and underestimate the importance of its verbalization, all imaginative procedures, implicitly or explicitly, give meaning to the experience through the secondary process. In many contemporary imaginative methods the patient must necessarily filter the images through the verbal system. Many factors can increase or hinder the process of harmonization of primary and secondary processes in adaptive regression. Individual differences in imaginative capacity can be seen as personality variables that prevent, facilitate or exaggerate this regression. Flexible defenses, interpersonal trust, openness to new experiences can improve adaptive regression, while rigid defenses and fear of losing control are discouraging (Schafer, 1958). In the psychotherapeutic context, the therapist's role is to overcome difficulties by structuring and regulating adaptive regression.

4. THE MENTAL IMAGERY IN COGNITIVE-BEHAVIORAL APPROACH

Today, greater emphasis is placed on environmental influences and cognitive processes that are inserted in the stimulus response sequence and variables that contribute to producing and modifying behavioral responses are taken into consideration. Among these variables, mental images are also included. cognitive-behavioral approach the use of mental images begins with the use of systematic desensitization (Bandura, 1969; Wolpe and Lazarus, 1966), a technique developed to reduce anxiety and fear by means of guided exposure to anxiogenic stimuli and phobigeni. After experimental evidences have shown the effectiveness of imaginative exposure to anxiety stimuli. With this technique

also covert events (not directly observable) have become part of the psychotherapeutic setting.

The covert conditioning techniques (In Di Nuovo, 1999) are based on:

-Hypogeneity hypothesis: the overt and covert events obey the same laws;

- Interaction hypothesis: overt and covert events influence each other;

- Automaticity hypothesis: conditioning occurs when two events occur in temporal contiguity (Mahoney, 1974).

The above hypotheses summarize how it is necessary to have the transition from behaviorism to cognitivism. Openness to the cognitive model is reflected in the self-education training characterized by the identification and modification of the irrational conditions, self-assertions and self-assessments of the patient.

Cognitive therapy and cognitive behavioral therapy emerge from two separate theoretical traditions, but over time they have begun to have many characteristics in common. Cognitive therapy originates as a top down approach, an approach where thoughts influence feelings and behaviors. Cognitive behavioral therapy derives from behavioral therapy. It can be considered a bottom up approach where the situational stimuli, the responses, including the thoughts, and the consequences that they entail are in the foreground. One of the characteristics in common is the incorporation of imaginative techniques in the treatment of affective disorders. Cognitive CT therapy was originally developed to treat depression (Beck, Shaw and Emery, 1979), and later it was also extended to the treatment of anxiety disorders (Clark 1986). It is based on the assumption that it is the interpretation of an event, rather than the event itself that determines the emotional state of the individual. It focuses on malfunction, inaccurate or extreme thoughts, on patterns that influence

automatic thoughts and on attributional styles that predispose the individual to interpret situations in such a way that give rise to stressful and painful experiences. Specific thoughts are associated with particular types of emotional responses. Depression with its sadness and guilt involves malfunction thoughts of loss or having acted wrongly. Anxiety is associated with dangerous thoughts and anger at thoughts about the behavior of others being offensive. Cognitive therapy is among the most direct therapies. The therapist assumes a role of authority in instructing, analyzing, prescribing and guiding the patient in his process of change. Patients are asked to evaluate the validity of their reaction patterns related to thoughts and emotions.

There are three stages for treating an emotional disorder:

1) patients are taught to identify malfunction thoughts associated with a dominant negative emotional state;
2) therapist and patient evaluate together the validity of thoughts, and
3) more adaptive thoughts are identified and used to replace malfunction thoughts.

CBT cognitive-behavioral therapy originates from two models: cognitive and behavioral. The principle of cognitive theory is based on the assumption that a stimulus does not automatically generate a behavior but that between a stimulus and a behavior there is a cognitive interpretation of the identifiable stimulus as an automatic thought and based on a network of assumptions and convictions. Aim of cognitive therapy is the transformation of maladaptive beliefs into adaptive beliefs. The introduction of this principle within behavioral techniques has given rise to a remarkable strengthening of therapeutic strategies.

Two schemes called ABC Behavioral and ABC Cognitive give an idea of the integration of the two models:

1) Behavioral ABC: the three components of behavior

A = Antecedent; the stimulus

B = Behavior;

C = Consequence; that is, reinforcements

Behavior analysis consists of a detailed evaluation of the antecedents and the consequences of a disturbing behavior. Changing the antecedents and the consequences involves a change in behavior.

2) Cognitive ABC:

A = Antecedent;

B = Belief

C = Emotional and behavioral consequences.

This model places at the center of its interest the cognitive component that stands between an antecedent (event) and the emotional and behavioral consequences.

Cognitive analysis consists in the detailed evaluation of automatic thoughts, assumptions and beliefs that are interposed between an event and the disturbed emotional and behavioral consequences. The modification of the deep convictions generates a modification of the assumptions and therefore of the automatic thoughts, with consequent change of behavior and emotions.

The use of images in cognitive therapy is evident in the identification of the schematic components that contribute to the formation of unsuitable thoughts or to the production of exaggerated thought processes. The unsatisfactory processes of thought as a selective attention to failures, an enlargement of negative consequences and a minimization of positive consequences, and arbitrary inferences on personal responsibility can be explored through imaginative situations involving anxiety or reactions to trauma. Active imagination and fantasy production can serve as a first source for identifying maladaptive cognitions and the respective emotional components that accompany them. A vivid imagination can

illustrate to the patient and the therapist the sequence of thoughts and feelings that are central to emotional dysfunction. The imaginative techniques used in cognitive-behavioral treatments make use of imaginative exposure as an alternative to the difficulties encountered in real exposure. Two are the fundamental premises underlying the use of imaginative exposure. In the first the imaginative situations indicate responses provoked by fear, so the active imagination translates into an approximation of the avoidant response. In the second, the imagined situation provokes a fear response of a lesser degree compared to the real experience, therefore it is more easily managed with alternative adaptive responses.[6] A third most evident reason concerning the use of imaginative procedures is their effectiveness. In cognitive and behavioral techniques, mental images perform some common functions (Di Nuovo, 1999):

- they are able to bring out both positive and negative emotional states. The elicited reactions are considered equivalent to those experienced in vivo, because unlike the verbal mode of approach to reality, the image is able to provide a simultaneous representation of the same using the processes inherent in the perceptive mode of data analysis and succeeding in awakening greater emotional contents than the verbal modality (Sheikh and Panaotou, 1975);
- They act as test actions aimed at the active learning of new responses and the consolidation of previously learned skills;
- Transform some aspects of external or internal reality;
- They facilitate the identification and analysis of emotional states, contents and cognitive processes.

So in cognitive-behavioral therapy, mental images are used to identify and modify the distorted and irrational beliefs of the subject that activate maladaptive emotions by changing the assessment of the danger of the anxiety stimulus or by

changing the evaluation of their coping abilities. use of images is representative of the daily and personal experience of the subject.[7]

CONCLUSIONS

Imaginative techniques have been incorporated into psychoanalytic, psychodynamic and cognitive-behavioral approaches as additional methods of therapy.

In psychoanalytic and psychodynamic therapies, imaginative instructions are used to improve discovery and revelations. The use of these instructions is intended as the recovery and reinterpretation of images of the past, with the aim of constructing new and useful images for the future. A tool through which it is possible to construct new metaphors that can help the patient to reorganize his own existence in a more serene way, to help them in the transformation of memories and difficult thoughts into treatable segments.

In cognitive-behavioral therapies the images help to identify the schematic components that contribute to the formation of non-adaptive thoughts or to the production of exaggerated thought processes. In general these techniques make use of the imaginative exposure procedure as an alternative to the difficulties encountered in real exposure. These images are able to provoke positive or negative emotional states, to transform some aspects of internal and external reality, to facilitate the identification and analysis of emotional states, contents and cognitive processes, to identify and modify the distorted and irrational beliefs of the subjects through a change in the danger of the anxiety stimulus or through a change in the evaluation of their coping skills.[5]

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