Psychological professionals' relationship to mental imagery

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TABLE OF CONTENTS

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ABSTRACT

This thesis explored how psychological professionals relate to mental imagery: how they view and experience using it in their therapeutic and supervisory practices. Applying Bell and his colleagues' (2015) broad definition of the concept enabled the study to incorporate a variety of imagery practices, from direct interventions to involuntary processes. The thesis analysed the application of mental imagery in cognitive behavioural and psychodynamic therapies and provided the first review of systemic and supervisory use of imagery.

Eighteen psychological professionals; six CBT therapists, six clinical psychologists and six non-registered psychologists were interviewed about their experiences of different applications of imagery. The interviews were analysed using thematic analysis (Braun & Clarke, 2022), and after a lengthy process of coding and developing themes, six themes were constructed to answer the research question.

Based on these themes, psychological professionals relate to mental imagery in their clinical practice as one of the many clinical procedures (Theme 1), approach it according to the content of the image (Theme 2) or see it as a practice influencing the therapeutic relationship (Theme 3). Mental imagery was also considered based on how its use affected the psychological professionals' view of themselves (Theme 4), and some participants emphasised their link to creativity and art (Theme 5) and some structural/organisational factors (Theme 6). All these different ways of relating to mental imagery could offer opportunities for psychological professionals to advance their clinical work but could also create difficulties. Unlike previous research, the study noted a high level of apprehension across the spectrum, from fear of not using certain procedures correctly to negative experiences with trauma images. The thesis ended with specific clinical and research recommendations and acknowledged the study's limitations.

Keywords related to the study: mental imagery, attitudes or beliefs or perceptions; therapist or counsellor or psychotherapist or psychologist or

clinician; CBT or systemic or psychodynamic or supervision; trauma images; vicarious traumatisation

1. INTRODUCTION

1.1. Overview of the Research

The following study examines how psychological professionals; clinical psychologists, cognitive behavioural therapists and non-registered psychologists view mental imagery and how their attitude to imagery might influence their clinical and supervision practices of using imagery interventions. Eighteen semi-structured interviews were conducted for this research to explore psychological professionals' relationships to mental imagery. Thematic analysis of the interview data informed our recommendations on supervision and psychology training.

1.2. The Definition of Mental Imagery

Based on Kosslyn et al.'s (2001) research, Bell and his colleagues (2015, p. 592) defined mental imagery (MI) as "a multi-modal, multisensory phenomenon that occurs when perceptual information is accessed from memory or imagination, rather than being directly perceived by the senses".

This definition includes involuntary and voluntary mental processes, waking and nighttime imageries or, in other words, reveries and dreams (Hackmann et al., 2011). Many involuntary mental imageries are described as psychopathological concepts, such as hallucinations and flashbacks (Pearson et al., 2013), but they can also be harmless experiences when images pop into people's minds. Voluntary mental imageries are conscious acts when a person actively evokes or recalls an image (J. Pearson et al., 2015). The multi-modal aspect of mental imagery is most evident in the interplay of imageries from different sense modalities, like at the engagement with music, when auditory and visual

imageries are both activated (Nanay, 2023). Saulsman and his colleagues (2019) define mental imagery as a form of cognition. Many factors such as age (Isaac & Marks, 1994), gender, and exposure to imagery activities could affect the individual's capacity to imagery (Floridou et al., 2022), and some people might experience a generally impoverished visual or multisensory imagery; aphantasia or dysikonesia (Dance et al., 2021).

Both Bell and his colleagues' (2015) definition of mental imagery used by this thesis and Kosslyn and his colleagues' (2001, p. 635) often quoted description of "seeing with the mind's eye and hearing with the mind's ear" agrees that perception of external visual images would not qualify as imagery. Similarly, mental activities are not considered mental imagery if they are purely verbal or abstract (Hackmann et al., 2011). Although the inclusion of nighttime images in the definition of mental imagery is not always emphasised, dreams and images have often been studied alongside each other in psychotherapy and neuropsychology literature (Nikolinakos, 1992).

1.3. The Clinical Use of Mental Imagery

1.3.1. Mental Imagery and Emotions

Although mental imagery techniques have been used for thousands of years (Achterberg, 1985), Hackmann et al. (2011) remarked that academic psychology had struggled to provide research evidence about the long-standing clinical observation that emotions and mental imagery are closely linked; therefore, failed to explain how imagery could be so useful in psychological treatments. The first research evidence came from Holmes and Mathews' (2005) experiment, in which participants reported stronger emotional impact when they were asked to imagine fearful scenarios rather than just listen to a verbal description of them. A year later, Holmes et al. (2006) devised another experiment and proved that imagery impacts positive emotions more than verbal cues. Further experiments (Holmes, Mathews et al., 2008) highlighted that the involvement of images always evokes stronger emotions than if similar

scenarios are described verbally. Holmes and Mathews (2010) attempted to explain why images could have such a powerful effect on emotions and cited three theories: 1. Imagery is similar to perception, and as such, it can evoke emotions more instantly (Kosslyn et al., 2001), 2. As an evolutionary old stimulus, fear is represented in perceptual/imaginal form, not in a relatively new linguistic/verbal form (Öhman & Mineka, 2001); and 3. Imagery is closely linked to autobiographical memory, and it might be an evolutionary preferred form to remember highly emotional experiences (Conway, 2001).

These studies allowed further academic examinations of the connection between mental health problems and imagery. Since then, it has been advocated (Ji et al., 2019) that imagery should be an essential part of psychiatric assessments and treatment planning. Various imagery assessment tools are available to understand the impairments in imagery (Pearson et al., 2013). Negative intrusive imagery is considered an important symptom of many mental health problems, from anxiety presentation to psychosis, while the lack of positive future imagery is understood as a feature of depression (Pearson et al., 2015). The increased academic understanding of mental imagery contributed to the development of contemporary treatment protocols and heavily influenced imagery rescripting interventions (Holmes, Arntz, et al., 2007)

1.3.2. Clinical Applications of Mental Imagery

There is a long history of applying mental imagery in healing practices. Mental imagery techniques were part of Stoic (Robertson, 2010) and Christian (Hadot, 1995) practices to overcome distress. Stoic philosophers were expected to practice meditation exercises such as the '*View from above*', '*The meditation on death*' or '*The Sage and the World*', which were designed to help people aspired to live in the Stoic way, to take a broader perspective of their life. Inspired by Hellenic texts, medieval Christian monks continued these mediation practices while using a Christian framework. The meditations and contemplative imaginations of St. Augustine (354) and Marcus Aurelius (167) could be considered some of the earliest psychological manuscripts in the Western world. In his essay, when examining the history of mental imagery in

psychotherapy, Edwards (2011) also highlighted Christian visualisation exercises alongside Shamanistic traditions and Buddhist practices as a precursor of later imagery healing methods. He concluded that every significant psychotherapeutic modality applied imagery in their treatment methods, and important theorists in the therapy field, from Freud to Jung and Pearls to Lazarus, used imagery in helping their patients.

According to the systemic review of Schwarz and his colleagues (2020), mental imagery techniques have been shown to be effective in supporting not just adults but also children and adolescents. Mental imagery could also be useful in creating adaptations in treatment protocols to aid people with intellectual disabilities (Hewitt et al., 2022).

The subsequent subchapters (1.3.3-1.3.7) present a narrative review of the various clinical applications of mental imagery within the three primary psychotherapeutic models utilized in the United Kingdom: cognitive behavioural therapy (CBT), systemic family therapy, and psychodynamic/psychoanalytic therapy. This review was developed with three primary objectives:

- To address the requests of research participants who sought an accessible summary of mental imagery interventions in psychological practice.
- To provide a theoretical foundation for the studies cited in section 1.4 and facilitate readers' understanding of cognitive behavioural concepts of mental imagery interventions as described by Bell et al. (2015), as well as psychodynamic concepts of reveries and spontaneous mental imagery as articulated by Cartwright et al. (2019) McGown (2014) McVey (2017) and Warrington (2020).
- To develop the first overview of its kind on the clinical applications of mental imagery in systemic and family psychotherapies and clinical supervision practices, areas where such overviews have been previously lacking.

1.3.3. The Use of Mental Imagery in Cognitive Behavioural Therapy (CBT)

The application of mental imagery within cognitive behavioural therapy (CBT) has been significantly influenced by both cognitive and behavioural traditions, associated with theorists such as the behaviourist Arnold Lazarus and the pioneer of cognitive therapy, Aaron Beck. Blackwell (2021) observed that the literature on mental imagery in CBT over the past decade has been extended so much that it may challenge readers to distinguish between the various imagery practices, potentially leading to a perception that researchers are merely "reinventing the wheel" (p. 171). He also noted that practitioners of mental imagery would benefit from recognising the original source of their interventions. In alignment with his advice, the following paragraphs will elaborate on the contributions of the early theorists Lazarus and Emery before addressing the work of contemporary clinicians.

Lazarus' mentor, the behavioural psychologist Wolpe (1958), advocated for increased use of mental imagery in behavioural interventions, such as systemic desensitisation and flooding. Behavioural mental imagery techniques were also used in an attempt to “treat” LGBTQI+ patients[1] (Sheikh & Panagiotou, 1975), an unethical and dark chapter of mental imagery. Multimodal behavioural therapy, the behaviouralist treatment model developed by Lazarus (1977), placed a significant emphasis on the use of mental imagery. As part of the clinical assessment, the Multimodal Life History Inventory (Lazarus & Lazarus, 1991) is administered, which assesses patients “BASIC ID”, an acronym for behaviour, affect, sensation, imagery, cognition, interpersonal relationships and drugs/biology. Imagery remains central to the treatment throughout the course of the therapy, as presented in his case studies (Lazarus, 2006; Lazarus & Abramovitz, 2004); patients were frequently encouraged to practice positive coping images and yoga exercises, and imagery interventions were also

[1] In this thesis, the term ‘patient’ will be used to describe individuals receiving any form of psychological treatment and assessment. Despite efforts in recent decades to introduce alternative labels such as ‘service-user’, ‘client’, and ‘survivor’, these terms have not gained widespread acceptance among both providers (Simmons et al., 2010) and recipients (Dimbylow, 2017) of mental health interventions. Priebe (2021) has argued that 'patient' is an appropriate term as it accurately reflects the individual’s situation of receiving care, and it highlights the necessity for continued funding of public healthcare systems, a significance that the term ‘service user’ and ‘client’ do not convey. Furthermore, 'patient' is a preferred term in psychodynamic and systemic literature.

administered as part of systemic desensitisation. Unlike advocates of collaborative practices in cognitive-behavioural therapy (CBT), such as Dattilio and Hanna (2012), Lazarus often adopts an authoritative expert-like stance. One particular case study (Lazarus, 2006) was formulated around Lazarus's own initial, spontaneous image suggesting the patient's husband might have been unfaithful, with no evidence in the paper that Lazarus reflected on the veracity of this image. Additionally, he advised the patient to boost her confidence by imagining the torture of her husband, a recommendation that could raise ethical concerns.

Aaron Beck started his academic career by researching dreams (Beck, 1971), and he often emphasised the importance of mental images in the development of mental health problems (Beck et al., 1979). It was, however, his co-author, Emery, who gave the first comprehensive list of mental imagery techniques in CBT (Beck et al., 1985). Emery emphasised the role of intrusive images and the metacognitive appraisals of these images in the maintenance of anxiety presentations. He argued that clinicians needed to attend to the patients' intrusive imagery in assessments, and the elaboration of images could lead to cognitive restructuring. He also recognised that intrusive images could be often linked to traumatic childhood memories. Table 1. describes the mental imagery techniques he recommended; although the list may appear somewhat arbitrary, many of the techniques will resurface in later CBT research.

Table 1. Early CBT imagery techniques as recommended by Emery (the table is a summary of a chapter - Beck et al. (1985)

Imagery technique	Description/rationale
Turn-off technique	Teaching patients to switch off fantasising about an anxiety-provoking episode by clapping and distracting themselves. Changing the ending of the image could also turn off the anxiety.
Repetition	Repeating the fantasy/image several times in order to become less realistic or to lose its emotional potency.

Time projection	Imagining what would happen in one-three-five years if the catastrophic outcome happened.
Symbolic images	Using metaphors and adding new symbols to the disturbing image.
Decatastrophysing the image	Imagining the intrusive image past the worst point. Applying the 'So what if…' question works as a less traumatic cognitive flooding to many patients.
Images and thoughts	Using cognitive therapy techniques to manage the cognitive appraisals of the intrusive image.
Facilitating change	Changing the image by imagining the patient watching TV or drawing a picture could shift the intrusive image into a more positive one.
Substituting positive imagery	Imagining positive, relaxing scenes at times of anxiety.
Substituting contrasting imagery	Creating an image with a contrasting outcome of the original intrusive image and practising using this new image when an intrusion happens.
Exaggeration	Imagining passing the worst outcome in an exaggerated way.
Coping models	Imagining to cope like a famous person in a particular field ("What would Bernstein do?" - p. 225).
Imagery to reduce threat	Using humour to soften threatening images, imaging the therapist accompanying the patient in anxiety-provoking situations.
Escaping the worst alternatives	Imagining surviving an alternative scenario worse than the feared scenario.
Future therapy	Imagining what would happen after a successful therapy.
Goal rehearsal	Imagery rehearsing what would happen if the patient faces their anxiety and how they could cope.

Review articles (Blackwell, 2021; Saulsman et al., 2019) and books (Hackmann et al., 2011) on imagery in cognitive-behavioural therapy (CBT) often

emphasised a significant shift in CBT practice marked by the establishment of Ehlers and Clark's (2000) CBT protocol for post-traumatic stress disorder (PTSD) and portrayed this protocol as a turning point bringing imagery from the periphery of CBT practice to become a central method. As evidenced in the previous paragraphs, this description is somewhat misleading: imagery had been prominent in the writings of the founders of cognitive therapy (CT) and behavioural therapy (BT), though it may have received less attention within British CBT circles during the 1990s.

However, the significance of Ehlers and Clark's (2000) protocol lies in its role as the first NICE (2018) recommended CBT guideline that integrated imagery as a core feature of the treatment, thus embedding imagery interventions into future CBT PTSD protocols.

Hackmann's authoritative book (2011) on imagery states that Ehlers and Clark's (2000) PTSD protocol had been an improvement to Foas' (2007) treatment concept of prolonged exposure therapy because it was not just advocating for the use of imagery reliving of the trauma (an often aversive aspect of the treatment as Gaston (2017) observed) but also used imagery to update and rescript the trauma memory and discriminate the past trauma from the present flashback episode. When reading Ehlers and Clark's (2000) detailed article, this distinction is not as apparent as Hackmann would suggest, and the application and importance of imagery in the treatment course is better clarified in later practice guidelines and case studies (Ehlers & Clark, 2008; Ehlers & Wild, 2015). While imaginal reliving was the key aspect of the treatment in the initial theory (Ehlers & Clark, 2000), imaginal restructuring of the intrusive traumatic images and the imagery identification of emotional hotspots became more central in subsequent publications on clinical practice (Ehlers & Clark, 2008). The clinical vignette presented in Ehlers and Wild's (2015, pp. 173–179) paper demonstrates the comprehensive utilisation of mental imagery within the CBT-PTSD model. In the initial sessions, imaginal reliving was employed to identify key cognitions associated with the trauma, facilitating the cognitive restructuring of these memories. These restructured and rescripted cognitions and images were subsequently reintegrated into the intrusive memory image. Towards the

conclusion of the treatment, positive imagery interventions were incorporated to reinforce the reconstructed trauma memory.

Another NICE (2013) guideline recommended diagnostic-specific CBT protocol using imagery is on social phobia (Clark & Wells, 1995). This protocol formulates the problem around the appraisal of the negative self-image and employs imagery techniques such as video feedback and reliving and manipulating distorted images (Hackmann et al., 2000). A group treatment program focusing on imagery-based methods is now available for CBT for social anxiety (McEvoy & Saulsman, 2014).

These early protocols have inspired other diagnosis-specific CBT interventions to integrate mental imagery into their repertoire. Krakow and Zadra's (2006) group program helps patients with chronic nightmares practice positive imagery and rescript the ending of their reoccurring nightmares. In this four-session group treatment, participants could practice positive imagery exercises, employ imagery as a vehicle of change and learn to rescript distressing images. In other diagnostic-specific protocols, Day's research team (2004) highlighted the importance of early intrusive images in the development of agoraphobia, while Morrison (2004) emphasised the imagery from traumatic memories in the development of psychosis and they both advocated for imaginal rescripting, changing the observer in the image and help patients to identify the image as part of a historical trauma rather than an intrusion. Other studies also showed the efficacy of imagery restructuring and a focus on negative self-schemas in treating paranoia (Taylor et al., 2019) and voice hearing (Paulik et al., 2019). Imagery rescripting of the memories related to childhood abuse, body image and negative core beliefs has been used effectively to support patients with eating disorders (Arntz, 2012; Dugué et al., 2019; Tatham, 2011). In their case report, Carey and Wells (2019) successfully treated an extremely suicidal young patient by reconstructing the flash-forward (Holmes, Crane, et al., 2007) suicidal image, de-glamorising the old suicide image and applying guided imagery to help the patient focus on future planning and problem-solving. A mixture of short imagery techniques and mobile applications have been proven useful in supporting patients to cope with self-harm whilst on the waiting list for therapy (Simplicio et al., 2020).

One of the most significant clinical shifts in the use of mental imagery occurred in the treatment of depression. Although research has highlighted the lack of positive imagery (Holmes, Lang, et al., 2008) and the importance of negative intrusive imagery (Patel et al., 2007) in depression, traditional CBT protocols have adhered to Beck's recommendations (Beck et al., 1979) of employing verbal thought records and behavioural activation for treating low mood. Brewin's (2009) and Wheatley's (2007) research team demonstrated that imagery rescripting of negative intrusive images linked to abusive childhood memories could be an effective treatment without the use of other CBT methods. This finding suggests that the rescription of intrusive images and the introduction of compassionate self-images could serve as a stand-alone treatment for depression without the application of any other BT or CT interventions. Wheatley and his colleagues' paper (2007) described the first practical applications of imagery rescripting for depression cases. Therapy sessions were solely used to rescript intrusive trauma memories; following imaginal reliving, various aspects of the trauma narrative were altered and re-imagined. These imaginal rescripting interventions reduced patients' psychosomatic symptoms and increased their moods. They also inspired the patients to explore other negative memories from their childhood, which were similarly rescripted without any direct work on verbal cognition.

Treating depression can also be supported by online training programmes aimed at increasing reward sensitivity (Linke & Wessa, 2017) and positive self-image (Dainer-Best et al., 2018). Behavioural activation treatments can be enhanced by incorporating imagery for future thinking (Hallford et al., 2020), offering a single-session motivational imagery group (Renner et al., 2019) or combining BA with mental imagery (Pellas et al., 2022). Mental imagery has also been integrated into the use of thought records to help identify negative automatic thoughts, gather emotionally charged evidence for and against these thoughts, and create more balanced cognitions (Josefowitz, 2017). It is not surprising that recent advancements in mental imagery methods for treating depression have been compiled into a self-help booklet (Moritz et al., 2018).

As demonstrated in the previous clinical and research examples, the most frequently cited contemporary imagery intervention is imagery rescripting or

ImRs (Arntz, 2012), which is increasingly becoming a transdiagnostic approach, challenging the necessity of other CT or BT methods, such as cognitive restructuring (Voncken et al., 2023). ImRs have been shown as effective in treating PTSD as Eye Movement Desensitisation and Reprocessing (EMDR) Therapy (Boterhoven de Haan et al., 2020), with other efficacy studies also showing promising results for social anxiety and depression (Morina et al., 2017). Arntz (2012) claimed that ImRs could be less aversive than traditional CBT protocols (Ehlers & Clark, 2008; Foa et al., 2007) because reliving the traumatic memory and intrusive image is not necessary and treatment can commence with the consolidation of the restructured image. In ImRs protocols (Arntz, 2011; Arntz & Weertman, 1999), the therapist may initially enter into the restructured image of childhood abuse, but in later sessions, the patient is encouraged to intervene as an adult and eventually observe the reconstructed events as a child. As previously discussed, similarly to Ehlers and Clark's (2008) view on imagery reliving techniques, Arntz initially believed that reliving was an essential part of the treatment but later revised his opinion, deeming reliving unnecessary (Arntz, 2012). ImRs was developed to support patients with personality disorders (Arntz, 2011) and assist them in overcoming intrusive negative memories. During treatment, several negative memories are revisited; sessions often begin with positive, safe place imagery exercises, and by using the “affective bridge technique” (p. 472), patients can evoke a negative childhood image to focus on for intervention. It has been recognised that during the rescripting of negative childhood memories of abuse and maltreatment, the newly created imagery narrative must include not only an intervention to stop the abuse but also to promote images addressing the child's needs for care, support, and play.

The benefits of ImRs are that it moves away from the diagnostic-specific protocol models and, therefore it could maintain a trauma-informed approach (SAMHSA, 2014) and answer the questions of “What happened to you?”(Kezelman & Stavropoulos, 2012) without aligning itself necessarily with the problematic diagnostic term of PTSD (Rosen et al., 2008). However, as an individual therapy focusing on only certain aspects of trauma memories, it risks

overlooking wider contextual aspects of adverse life events (W. R. Ellis & Dietz, 2017).

Authors listed in Table 2. argued that mental imagery techniques are universal clinical tools and should not be confined to diagnostic-specific models or the application of ImRs. They claimed that imagery interventions could be effectively utilised while maintaining an overarching CBT approach and advocated for the transdiagnostic application of these techniques. Table 2. summarises these techniques and their rationale for using them.

Table 2. Transdiagnostic CBT imagery techniques

Author	Imagery technique	Description/rationale
Saulsman et al. (2019)	Thought record	Imagery could be used to elicit cognition, test evidence, and consolidate new, balanced cognitions.
	Behavioural experiments	Imagery is used to specify the patient's predictions by creating a detailed image, making the behavioural experiment more meaningful.
	Enacting behavioural change	Imagining desired behavioural actions and introducing positive images to enhance motivation.
Renner & Holmes (2018)	Cognitive bias modification	"Imagining positive outcomes for ambiguous scenarios" (p. 151)
Hackmann et al. (2011)	Assessment of images	Assessment of the content, the meaning and the metacognitive role of the intrusive image.
	Mini-Formulation	Creating a mini-formulation can highlight the importance of the intrusive image and the metacognitions regarding its significance.

	Transforming images	Imagining the feared scenario passing the point of disaster or rescripting the image to a positive one.
	Emotional bridge technique	Linking traumatic/aversive memory and intrusive image by evoking the disturbing image and identifying past memories where similar emotions were present.

To summarise, CBT therapists' attitudes to imagery have evolved significantly in the last 70 years. Initially, imagery was viewed as a useful technique to be taught to clients for coping (Beck et al., 1985). With the advent of diagnosis-specific protocols, intrusive images were recognised as biased cognitions that contribute to suffering (Clark et al., 1995). More recently, this understanding has shifted to acknowledge that imagery can indicate historical traumas requiring rescripting (Arntz, 2012). This increased awareness of the significance of the content of intrusive negative images, the identification of their roots in traumatic childhood experiences, and the development of techniques such as the "emotional bridge" signify CBT's growing interest in mental imagery, potentially aligning its theoretical focus closer to its historical neo-Freudian roots (Rosner, 2012). It is noteworthy that CBT practitioners interested in mental imagery are advocating to consider the integration of psychodynamic concepts such as transference-countertransference (Cartwright, 2011) and the clinical utilisation of therapists' spontaneous mental images (Cartwright et al., 2019). Should this theoretical shift succeed, the practice of imagery interventions within CBT would undergo a profound transformation, moving away from the Lazarus-like experts "administering" imagery techniques to patients towards a more collaborative and exploratory engagement with co-created memory images, embracing the uncertainty of what might be uncovered.

1.3.4. The Use of Mental Imagery in Systemic and Family Therapy

On the surface, modern systemic therapy practised in the United Kingdom aligns itself with psychological traditions rooted in communication science (Watzlawick et al., 1974) and postmodern social constructionist ideas (McNamee & Gergen, 1992), positioning family communications and language as the central focus of its enquiry. However, in the daily practice of family therapy, postmodernist ideas are not always practical and sometimes even unnecessary (Rivett et al., 2002), which can open up opportunities for non-verbal clinical interventions such as mental imagery.

There is no summary currently available about the clinical use of mental imagery in systemic and family therapies; therefore, this subchapter could be considered as a first attempt to describe the possible use of mental images in this modality. For this reason, the subsequent paragraphs will focus on defining what is and is not considered mental imagery in family therapy rather than providing a comprehensive critique of the interventions used.

There is some caution regarding the use of mental imagery in family therapy literature, highlighting its underutilisation (Ziegler & Black, 2019), its riskiness in using it with children (J. K. Morrison, 1981) and the need to seek additional consent to apply it in therapy (Piercy & Tubbs, 1996). There are systemic case studies where therapists attributed their failure to act promptly on a patient's suicidal ideation to their own dreams (Rycroft, 2004). Despite these concerns, mental imagery as a concept and clinical practice is present in many aspects of systemic and family therapies.

To structure the following paragraphs and aid the reader in navigating the various levels at which psychotherapy can be applied, Burnham's (1999) concept of Approach, Method, and Technique is utilised. This concept suggests that psychological practitioners can engage and relate at different levels when conducting therapy: Approach refers to the theoretical models of therapy and the practitioners' disposition, Methods describe the practice protocols and ways of working, while Technique encompasses the diverse therapeutic tools practitioners employ. Although this concept was previously mentioned in 1.3.3, describing the expansion of imagery rescripting from the Technique level to the

overarching Approach, employing this model to describe systemic and psychodynamic use of mental imagery in 1.3.4 and 1.3.5 allows for the incorporation of ideas not directly prescribing imagery in daily practice, thus enriching the understanding of mental imagery utilised in these therapies.

1.3.4.1. Mental imagery techniques in systemic therapies

Mental imagery as a technique or therapeutic tool could be integrated into the everyday practice of systemic family and couple therapy, as shown in Table 3. Piercy and Tubbs (1996) argued that imagery techniques could easily fit into family and couple therapy practices regardless of the theoretical background of the family therapist. Imagery in couple therapy can be employed when both partners are present in the session (Piercy & Tubbs, 1996) or during individual sessions with each partner, with reflections on the differences and similarities in the content of their images discussed in subsequent joint sessions (J. K. Morrison, 1981).

Unlike in CBT, the majority of imagery techniques in systemic therapy focus on positive images, motivating patients to engage in the therapeutic process and evoking images that highlight exceptions and new possibilities. Some of the techniques listed in Table 3 are traditional family therapy exercises understood as mental imagery, such as the miracle question and the family sculpting, while others were designed to foster new conversations within the family and couple.

Table 3. Imagery techniques in systemic and family therapy

Author	Description of the technique
(J. K. Morrison, 1981)	Using imagery at assessments to enrich the data ("Imagine a childhood scene when you had similar arguments")
	Comparing imagined childhood scenes with more current imagined scenarios with eyes closed. Using roleplays to highlight findings.
(Piercy & Tubbs, 1996)	Miracle questions in solution-focused therapy (Shazer, 2007): helping patients to imagine a positive outcome and refocus attention on solutions to achieve it.
	Exploring alternatives by imagining them: imagining happier times to highlight exceptions (White & Epston, 1990)
	Encouraging the couple to imagine their argument had been videotaped and ask them to edit the footage.

	Imagine two future of the couple's relationship: staying together and separating.
	Imagining the "statue of the relationship" (p. 59)
	Asking the clients to imagine themselves in the therapist's role and encouraging them to come up with solutions
Carr, 2009	The use of visual relaxations and imagery in couple sex therapy
Balmbra & Raimundo, 2021	The use of computerised family sculpting programs

1.3.4.2. Mental imagery methods in systemic therapies

Certain family therapy imagery techniques have become so widely used or have the potential to become widely used that they should not be considered merely as techniques or tools but as comprehensive methods or as ways to work with families (Burnham, 1999). This subchapter provides a more detailed description of four methods: genograms, externalisation, outside witnessing and the concept of the Emotional Map of the Home.

McGoldrick's (2008) concept of representing family relationships using a genogram revolutionised the understanding of multigenerational family dynamics and relationship patterns in family therapy. This visual depiction of the family encourages both therapists and patients to create a mental representation or image of the wider multigenerational patterns influencing problems and coping mechanisms. The genogram also serves as a mental aid for representing the entire family, including those not physically present in the therapy room (Fahri & Berentsen, 2022). In other words, the visual structure of the genogram gradually forms a mental imagery of the patient's family in the mind of the therapist and the patient, which might differ from the patients' initial verbal understanding of their family structure.

In his book, White (2007) suggested that externalising conversations could be strengthened by encouraging patients to create visual representations of the externalised objects. In one of his case studies, he encouraged a child to imagine and draw a picture of his diagnosis of ADHD. Creating a mental and visual image of the faceless diagnostic criteria helped the family to mobilise their creative resources and opened up possibilities in thinking of the family

problems differently (Burnham, 2016). It also placed the verbal discussions of the parent's concerns and medical descriptions of ADHD into an image-based new realm which centred more around the child's concerns rather than the adult problems.

Another important narrative therapy method is outside witnessing (Russel & Carey, 2004; White, 2000, 2005), which, when practised in family therapy settings, is often referred to as reflective teamwork (Andersen, 1987), and when it is applied in community and anthropological intervention called as definitional ceremonies (Myerhoff, 1986). Imagery often plays a central role in these interventions as outside witnesses are often invited to talk about their experiences of how witnessing someone's story moved them emotionally and "transported" them to somewhere new. Images of old memories or future possibilities are shared. A key aspect of this method is that the witness reflects on how the experience of witnessing the story could allow them to make changes in their future, conveying the message that the often marginalised storyteller has important knowledge to share with their wider communities and, hence their life and suffering has a meaning to themselves and others. In definitional ceremonies, these reflective conversations could be presented using creative methods such as video images, live sculptures, plays, and singing/music.

Sallay and her colleagues' (2019) concept of representing the family home on a hand-drawn floor plan or adopting their Emotional Map of the Home toolkit has the potential to inform the image of home life in family therapy practice. When applying this method (Sallay, 2014), family members are asked to draw their own family home floor plan and mark emotionally important places on it, such as the place for insecurity, well-being, tension and suffering. Similarly to genograms, the aim of visually representing the family home is to influence the mental image of the home in the family members' minds and foster a new image of what it means and how it looks to be at home in their family. Sallay described how a family was mobilised (Fahri & Berentsen, 2023) upon recognising the discrepancies between their teenage son's floor plan, marking a range of tension and suffering in places used by the parents for well-being and security. Further conversations helped the family reevaluate their behaviour in their home

to open up new spaces for the teenager and imagine a homelife more inclusive for all family members.

1.3.4.3. Mental imagery approaches in systemic therapies

Some systemic theorists' ideas on mental imagery could influence wider systemic approaches. Roffman (2007) and Teleska and Roffman (2004) theorised that family therapy conversations are, in essence, "hypnotic conversations", where hypnotic trance is not required, but the way the discussions is conducted have hypnotic qualities, placing the whole therapeutic endeavour in the realm of imagery. Onnis and his colleagues' (2004) theory also saw imagery as an overarching framework to understand what is happening in the therapy space. They suggested that metaphors are not just widely used therapy techniques in family therapy, but they are also central to family therapy's thinking about the therapy itself: family therapists look at their patients' problems as a metaphor for the organisation of the whole family and consider psychosomatic symptoms as the problems of the "family body". The elevation of the difficulties onto the family level forces family therapists to use new techniques such as family sculpting (Satir, 1972) and its refined version, Sculptures of Family Time (Onnis et al., 2004), which can create a co-produced image of the family in the past, present and future providing an opportunity to the families to explore family myths and fears.

One of the most detailed systemic theories applying mental imagery is associated with Rober (1999, 2005). In his writing on dialogical family therapy, he emphasised the importance of therapists attending to their own inner conversations to explore the "not-yet-said" and help clients discover new meanings. Rober (2005) described these inner dialogues as negotiations between the self and the role of the therapist, where therapists could contemplate "going public" with some of their inner ideas and images and share them with their patients. Imagery is central to the concept of inner dialogues, and in one of his case studies, Rober (1999, p. 215) described how he experienced a spontaneous image of a white wolf while listening to his patient. Sharing a tale centred around the wolf and facilitating a discussion about the tale helped move the therapy away from a deadlock. When reflecting on the case, Rober acknowledged the patients' initial confusion and the risks of making

the decision to “go public” with the image and argued that psychological professionals need to be cautious when sharing inner dialogues.

1.3.5. The Use of Mental Imagery in Psychodynamic and Psychoanalytic Therapy

As discussed in subchapters 1.3.3 and 1.3.4, mental imagery was less central to the approach of early CBT and systemic therapies; however, this was not the case with psychodynamic therapies. Freud (1901, 1916) characterised psychoanalysis as an epistemological enterprise devoted to exploring the unconscious, which included a range of mental activities such as dreams, errors, forgetfulness, fantasies, and traumatic memories. This description aligns with Bells' (2015) and Kosslyns' (2001) definitions of mental imagery outlined in 1.2. Some scholars, such as Nikolinakos (1992), have even suggested that Kosslyn et al.'s (2006) neurological descriptions were rooted in Freud's (1900) psychotherapeutic insights into dreams.

In his initial attempts to alleviate patients' distress through psychotherapy, Freud employed hypnosis (Freud & Breuer, 1895) and hypnotic suggestions, evoking childhood images. However, due to his limited success with hypnosis, he transitioned to encouraging patients to free associate (Silverstein & Silverstein, 1990). In this new form of talking therapy called psychoanalysis, imagery remained important. Understanding the content of the patient’s dreams through free association, linking early memories to later distress and using emotions presented in sessions to access traumatic childhood scenes were important initial psychoanalytic practices (Hermann, 1933). As discussed above in 1.3.3., these practices parallel contemporary trauma-informed CBT therapies that employ imagery rescripting and the emotional bridge technique. Psychoanalytic theory and practice, however, evolved significantly in the subsequent 120 years, leading to new applications of mental imagery. The following paragraphs will examine two key concepts in the clinical practice of psychoanalysis: image/fantasy and dreams. These concepts have been crucial in the works of some authors (Cartwright et al., 2019; McGown, 2014; McVey, 2017;

Warrington, 2020) discussed in 1.4. and in the understanding of the notion of spontaneous mental imagery.

1.3.5.1. Image/fantasy in psychodynamic therapies

Curtis (2016) noted that Freud was sceptical about the use of mental images in therapy, and some of his Neo-Freudian followers in the USA shared his view by regarding their patients' images as resistance (Sheikh & Panagiotou, 1975). Although some theorists, such as Andresen (1996, p. 307), argued that psychoanalysis is fundamentally "a treatment by imaginative spontaneity" and the set up of the method of the classical free association of lying on a couch facing away from the therapist was developed to enhance imagination (Lothane, 2018), the term "imagery" is seldom used in psychoanalytic literature. Imagery in the concepts of "imago" and "complex" has been central to Jungian psychoanalysis (Vivian, 2022), where symbolic images are therapeutically employed (Sheikh & Panagiotou, 1975) by followers of Jung, like Assagioli (1965), Leuner (1984) and Grof (2010) through interventions such as the holotropic breathing.

Imagery regained prominence in Freudian psychoanalysis with object-relational theorists introducing concepts like "phantasie", "internal representations", and "internal objects" (Vivian, 2022). Since children often process information through imagination rather than verbal memory (Nikolinakos, 1992), child therapists such as Klein and Winnicott extensively engaged with their patients' fantasies.

Central to Klein's theory (Klein, 1932, 1946; H. Segal, 1988), that infants form internal representations from the beginning of their life, with the maternal breast being a primary image representing all good and bad experiences (depending on the baby's sensations of hunger and the mother's availability[2]). As the child grows, these early partial representations will serve as a developmental basis for later internal representations (or, in Kleinein terms, objects), and they could

[2] It is important to Klein's concept to understand that when she writes about objects such as the "mother", she refers to the internal representation or the image of the mother; therefore, any qualities of the mother are imagery and are based on the infant's perception and emotional state rather than the actual behaviour of an actual mother, which would be epistemologically impossible to observe during the therapy of the child or the adult (Sayers, 1984).

be observed in later relationships, including the therapeutic relationship, where the patient projects into or introjects elements from the analyst. Patients projecting infantile unresolved unconscious wishes to the therapeutic relationship is called transference (Laplanche & Pontalis, 1988), while the analyst's response of projecting their feelings back to the patient is described in the concept of countertransference (Heimann, 1950; Winnicott, 1949). In the everyday clinical work of Kleinian psychoanalysis (Hinshelwood, 1994), attending to the transference-countertransference relationship and understanding and containing the patient's disruptive projective images are central. These theories of Klein place psychoanalysis in the realm of imagery: every communication between analyst and patient is understood as projection and introjection, transference and countertransference.

Winnicott (1971) shares many of Klein's insights on projection and transference but believes that internal objects and imagination develop gradually as the infant notices the lack of maternal breast at the time of hunger and begin imagining that sucking their thumbs would decrease the sensation. This early *phantasie* creates the template for later creative and imaginative exercises such as play and art. These exercises are practised in the *transitional space* where new objects can be created. Winnicott argues that therapy, when it works, is happening in such a transitional space where creativity and playfulness are encouraged (Wright, 2012).

It is important to note that interpretations of clinical situations vary among psychoanalytic schools and practitioners. For example, authors from the British Independent School suggest that overuse of transference interpretations can detract from addressing the traumatic content of patients' narratives (Budd, 2012). Budd also commented that vivid imagination and intuitive thinking, often found in mentally unwell patients, typically diminish as they recover. Weisel-Barth and Eldridge (2019) suggested that to achieve successful analytic treatment, a collaboratively created "future vision" of the therapy is necessary, and the therapist's task is to co-join their own vision with their patient's vision.

1.3.5.2. Dreams in psychodynamic therapies

Dreams appeared to be so central to psychoanalysis that the publishing of Freud's (1900) book, the Interpretation of Dreams, marked the birth of psychoanalysis. In this book, Freud proposed that dreams could indicate unconscious or repressed emotions and concerns, which are often encrypted by the dream's manifest content; therefore, the analyst's job is to interpret these dreams to reach the unconscious content. He also suggested that dreams could maintain sleep and help process negative events and heal them. Contemporary authors such as Kohon (2000) argued that instead of focusing on interpreting the dream content, analysts should ask why the act of telling the dream had happened at that given point of the analysis and what the act of telling meant to the patient.

Object relations and dream theory are fundamental to Bion and his followers' clinical thinking. Bion extended Klein's theory by developing the concept of container/contained and describing the process of containing the patients' destructive projections (Bion, 1970). He also contributed to psychoanalytic theory by developing a new psychodynamic language on thinking processes (Bion, 1962). Unlike Freud, Bion believed that real thinking has to come from unconscious emotions, and therefore, the process of analysis is not to "make the unconscious conscious but the conscious unconscious*"* (Ogden, 2017, p. 2). Dreaming is essential in this theory, with Bion suggesting (1992, p. 120) that "the analyst must be able to dream the session".

His contemporary followers elaborated his theory and made drastic changes in psychoanalytic practice. The Post-Bionian Analytic Field Theory (BFT) argues that the dyad of the analyst-patient could be understood as a field rather than the interaction of two individuals (Civitarese, 2022). This idea has a radical consequence on the therapy: the therapeutic relationship becomes the centre of the therapy, and the focus of the therapeutic conversation will be the intersubjective or unconscious content of the here-and-now of the field (Civitarese, 2021). As BFT moves away from differentiating between the You/I in the therapeutic relationship, the technique of transference-countertransference will be employed less frequently (Civitarese, 2017). To observe the unconscious, affect became a key aspect of the formulation. As

narratives are co-created in the field, stories are often understood as dreams (Ferro, 2018) and interpreted as dreams or dreamlike narratives. Although BFT, similarly to Teleska and Roffman's ideas (2004) on systemic hypnotic conversations, elevated the approach of psychodynamic therapy to the metaphorical level of “fields” and understood conversation as dream narratives presented in the fields, on technique, it maintained the centrality of verbal narratives (Lorincz, 2022). A more playful and imaginal application of BFT is described by Gyomlai (2022), who argued that the therapist could imagine narratives in the field theory as plays presented in the here-and-now; hence, the characters of the narratives should be regarded by the analyst as characters of the play.

Ogden, a prominent post-Bionian thinker, developed a psychoanalytic practice centred around mental imagery, elaborating on Freud’s and Bion’s ideas on dreams. Ogden shares Bion’s view that dreaming could lead to psychic growth, and therefore, the analyst should aim to develop a therapeutic relationship where the analyst and the patient can “dream the session together” (Ogden, 2017) to allow new meanings to emerge. Ogden emphasised that dreams could be terrifying, and to help the patient not to wake up, the analyst's role is to contain the emotions: “It takes (at least) two people to dream one’s most disturbing experience” (Ogden, 2010, p. 329). During the process of the analysis, the analyst could also experience reveries, which Ogden recognises as the unconscious construction of the analyst and the patient, which could help them start dreaming again. Ogden argues that analysts could reach “dreaming the session” by “talking simply” to patients and moving beyond the professional constraints of the therapeutic relationship (Ogden, 2002, 2008). Ogden's (2017) clinical case studies offer a practical depiction of how mental imagery could be placed at the forefront of contemporary psychoanalytical practice. In his clinical vignettes, the analysts observed and reflected on their own reveries throughout the session and shared some of the images with his patient, allowing them to develop a discussion understood as “dreaming together”, where emotional themes were verbalised without “waking up” or making them conscious. Similarly to Rober's (1999) ideas of “going public” with the therapist’s inner

conversations (see 1.3.4.3), Ogden also emphasised that sharing his own reveries could pose risk to the therapeutic relationship.

For readers less familiar with psychoanalytic literature, terms like “dreaming together” or “transitional objects” could be alienating. Ogden (1997) himself also acknowledged that the difficulty with psychoanalytic language is that it often reflects on the context of the intersubjective therapeutic space where this language was developed to represent the specificities of the clinical situations while its meaning is often mitigated by the terminology of specific psychoanalytic schools. Andrade (2016) also argued that psychoanalytic language often exceeds its semantic function and moves beyond only representing rationality. If clinicians not aligned with psychodynamic therapy modalities could overcome their initial difficulties with psychoanalytic literature, they could improve their use of mental imagery by considering and reflecting on the process of the therapeutic relationship, inviting conversations about dreams and remaining curious about the images of their own wondering mind.

1.3.6. The Use of Mental Imagery in Clinical Supervision

In their systemic review of supervision, Kühne et al. (2019) noted that active methods such as exercises and role plays were infrequently used; nevertheless, some authors have advocated for incorporating imagery in supervision sessions. Similarly to 1.3.4., this subchapter is the first attempt in supervision literature to develop a summary of mental imagery practices used in supervisions of different therapeutic modalities.

1.3.6.1. Mental imagery in CBT supervision

In a series of articles, Prasko and his colleagues (2020) argued for a more innovative use of CBT supervision spaces. They emphasised that “imagery can help in all significant supervision moments: conceptualisation, relationship, intervention, self-reflection, training and personal development” (p. 37). Imagery could be applied to help the supervisees visualise problematic situations, restructure their memories of the therapeutic relationship with their clients, or evoke resource-based images to strengthen their skills (Prasko, 2020). In a second article, Prasko and his colleagues (2022) suggested that imagery

exercise could help supervisees share their difficulties in the transference-countertransference relationship with their patients by the supervisors encouraging the supervisees to imagine the difficult moments of the therapy sessions from the patient's perspective or prompting the supervisees to rescript their negative images of their therapy sessions based on information they gained in supervision. Imagery exercises can elicit countertransference beliefs of the supervisee, and cognitive restructuring could be used to mitigate these beliefs.

The self-practice/self-reflection workbook by Bennett-Levy et al. (2015), a common self-supervision tool for CBT therapists, also advocates for the use of imagery. Therapists are encouraged to imagine a strength-focused "New Ways of Being", subsequently reinforcing this image through narratives and daily exercises centring around the image. Readers of the workbook are also prompted to use more active techniques such as adding music and body movements to the strength-based image.

1.3.6.2. Mental imagery in systemic supervision

Systemic supervision aims to support the supervisees in becoming reflexive to their own positioning and considering ethical and aesthetic aspects of joining or deconstructing wider system narratives (Partridge, 2010). To achieve these goals, supervisors often use imagery and visual practices to help supervisees expand their choices.

A notable visual method is the cultural genogram (Hardy & Laszloffy, 1995), which is shared between the supervisor and supervisee to foster a culturally reflexive supervision space. Discussions around the cultural genogram could address themes beyond the Social GRRRAAACCEEESSS (Burnham, 2012) and "address issues of social location, legacies of loss, migration, privilege, and oppression" (Hernández, 2008, p. 15). The supervision genogram (Aten et al., 2008) represents another innovative approach, enhancing reflections on past supervision experiences and allowing supervisees to imagine their learning journeys.

Systemic group supervision practices often invite participants to share their images: the Fifth Province method (McCarthy & Minogue, 2019) of group

mediation was designed to create a space where ideas could be transported to new meditative group thinking. Fifth Province theory is often characterised by diamond-shaped diagrams (O'Brien, 2014) where the impressions and thoughts are placed in the middle of the group, and outside of the individual narratives. Another systemic group supervision (Proctor, 1997) applying images is inspired by the outside witnessing methods and invites observers to present their memories and images in the specific "Bells that Ring" phase of the supervision when observers are encouraged to share their personal memories and images relating to the case study presented. The Appreciative Inquiry method, originally designed to conduct discussions to support organisational developments (Cooperrider & Whitney, 2005), is now recommended for application in the National Health Service's (NHS) supervision spaces and team discussions (HEE, 2022a). Appreciative Inquiry centres the conversations around strengths and invites participants as part of the Dream phase to envisage positive future-oriented outcomes (Partridge, 2019). The supervisors' use of appreciative questions could help supervisees identify successful past responses and motivate them to use previously hidden resources.

Rober (2021) advocated that to help therapists master relational reflexivity (Burnham, 2005; Haber, 1990) and reflective capacity in their own inner dialogues of images and ideas; supervisions need to nurture therapists' capacity to reflect on the here-and-now occurrences of therapy.

1.3.6.3. Mental imagery in psychodynamic and psychotherapy supervision

Psychoanalytic theories of supervision came from the recognition that discussions of the therapy sessions were only recollections of the supervisee, and the presentation of this recollection was heavily influenced by the conscious and unconscious layers of the supervisor-supervisee relationship (Yerushalmi, 2021). As detailed above, Ogden described the analytic process using a metaphor of dreaming. In his concept of supervision (Ogden, 2008), he further expanded on this metaphor by describing the supervision's task as to "dream the interplay of the supervisory and the analytic relationships" (p. 35). In his case examples of supervisory interventions, Ogden paid close attention to his own internal images, often informing his comments on his supervisees' clinical

work. His aim was to help his supervisees “dream up” their therapeutic work with their patients.

Limited research has also suggested that other creative, imagery-based methods could be applied in clinical supervision. Moon's (2021) study indicated that even one guided imagery and reimagining supervision session could enhance therapists’ clinical efficacy. Wagner's (2012) article on the use of music and mandala in the supervision of psychotherapists highlighted the therapeutic benefits of creative art-based methods but also described psychological professionals’ ambivalent willingness to take up the supervision offer of an imagery-based method.

1.3.7. Summary of the Clinical Use of Mental Imagery

In the last few subchapters, a brief review has been presented on the application and theoretical understanding of mental imagery in Cognitive Behavioural Therapy (CBT), systemic family therapy, and psychodynamic therapies, adhering to the definition of mental imagery as proposed by Bell and his colleagues' (2015). As part of this definition, voluntary mental processes, such as the administration of specific imagery techniques (Beck et al., 1985; Hackmann et al., 2011), and the utilisation of involuntary mental images were reviewed where therapists make use of their own or their patients' spontaneous mental images (Ogden, 2017; Rober, 1999). As Bells' (2015) definition extends beyond waking images, psychodynamic (Ferro, 2018; Freud, 1900) and CBT (Beck, 1971; Krakow & Zadra, 2006) theories of the clinical use of dreams were examined.

Burnham's (1999) concept of Approach-Method-Technique was employed to illustrate that mental imagery could be more than just a technique when patients are instructed to imagine potential outcomes with their eyes closed, but therapists could influence the mental image of their patients’ home (Sallay et al., 2019) and understanding of their families (McGoldrick, 2008) less directly on a method level. Mental imagery can also be an overarching approach to how therapy is perceived and how the work of the therapists is understood as navigating in hypnotic conversations (Teleska & Roffman, 2004) and in the

realm of the metaphors of families (Onnis et al., 2004) or the analytic field (Civitarese, 2022). Another compelling conceptualisation of therapeutic encounters was provided by Ogden (2017), who argued that therapists should aim to "dream the sessions" with their patients. As noted in 1.3.3, recent theoretical shifts in CBT could have the potential to transform imagery rescripting from a therapeutic technique to become an important method to treat different mental health problems (Arntz, 2011; Wheatley et al., 2007) or even as some scholars advocated (Holmes, Arntz, et al., 2007), making it an overarching theoretical approach to therapy.

Although this theoretical introduction provided the first comprehensive albeit brief summary of the use of mental imagery in systemic family therapy and supervision practices and linked the clinical psychological concept of mental imagery to psychodynamic practices using different theoretical language (Vivian, 2022), decisions had to be made about the limitations of the scope of this review. As this thesis researched psychological practitioners not exclusively using cognitive approaches, sufficient account had to be provided for systemic and psychodynamic understanding of mental imagery. Due to these editorial decisions, contemporaries of early family therapy, like the hypnotherapist Milton H Erickson (1992) and the Gestalt therapist Fritz Perls (1969), were omitted. Similarly, the psychoanalytic subchapter could not provide a detailed account of the use of imagery and dreams in Jungian and post-Jungian analysis (Franz, 1970; Hall, 1984). Most notably, the entire third-wave CBT literature was excluded from this summary as it would require a second volume of this thesis; therefore, Acceptance and Commitment Therapy (Hayes et al., 1999), Mindfulness-based Cognitive Therapy (Z. V. Segal et al., 2002), Compassion Focused Therapy (Gilbert, 2010) and Eye Movement Desensitisation and Reprocessing Therapy (Shapiro, 1995) was left out from this narrative review.

1.4. Previous Research on Psychological Professionals' Relationship to Mental Imagery

Despite its important role in clinical interventions, Hackmann and his colleagues (2011) noticed that many therapists felt cautious or unprepared when applying imagery. Similarly, Saulsman et al. (2019) reported that therapists often experienced difficulties attuning to an imaginal sensory mode of cognitions. There is a reoccurring narrative in studies on mental imagery that clinicians neglect imagery aspects of the treatment (Gamby & Desposito, 2020). However, similarly, a range of clinical studies presented in the previous subchapters indicated that many therapists had been curious and excited about applying a variety of innovative imagery interventions with their patients or supervisees. A systematic literature review was conducted to substantiate these anecdotal beliefs with empirical evidence.

The literature review was conducted on PsycINFO using the following keywords:

- “mental imagery” AND
- “attitudes or beliefs or perceptions” AND
- “therapist or counsellor or psychotherapist or psychologist or clinician”.

After removing duplicates, 429 articles were found. Only a handful of studies had been written about psychological professionals' relationship with mental imagery, and these studies only focused on specific aspects of mental imagery.

Davis and Brown (2000) surveyed counselling master students using a self-designed questionnaire and concluded that although many students were interested in using mental imagery, they felt unprepared and untrained. Singler's (2016) dissertation examined healthcare professionals' and educators' understanding of mental imagery and its application in public health and psychoneuroimmunology. The varied professional backgrounds of participants limited the study's relevance to psychology and psychotherapy. Reisberg and his colleagues' paper (2003) highlighted that even researchers of mental imagery are not immune to their own predispositions and past experiences of imagery when creating theories on this subject. Bosch and Arntz (2023) interviewed nine ImRs therapists and ten of their patients to explore their beliefs on the change elements of the intervention. Almost all interviewed mentioned

core ImRs techniques such as “caring for the child by the therapist” and the “therapist speaking up” against the perpetrator during imaginal rescripting as important change elements; however, the authors noticed that patients mainly valued relational elements of the therapy while therapist put a bigger emphasis on specific techniques.

Four qualitative studies explored therapists' relationship with their own mental imagery and how it has been understood when experiencing images during the therapy process.

McVey's PhD research (2017), inspired by Bion’s and Ogden’s writing, examined psychological therapists’ attitudes to their own reveries. This highly reflective and poetic research was based on seven in-depth interviews with integrative therapists. Each participant was interviewed twice, and during the second interview, they had an opportunity to reflect on the first conversation and create new meanings. These in-person interviews were videotaped, and a detailed Interpretive Phenomenological Analysis (IPA) was used on the data. McVey and her colleagues' (2020) subsequent paper suggests that “awareness of reverie can extend therapists’ access to ‘secrets and dreams’ …, enabling them to use the predictive moment to connect with clients and begin, together, to understand and transform their experiences” (p. 519).

The other three studies on therapists’ experiences of images focused on experiences of spontaneous mental imagery or SMI. The benefit of the concept of SMI, as opposed to the notion of reverie, inner dialogues or countertransference, is that it is independent of therapeutic modalities while still encompassing experiences related to these concepts.

McGown's (2014) small-scale research was based on interviewing five registered psychotherapists and processing the data using IPA. All therapist interviewed reported having experienced spontaneous mental imageries in their clinical practice. The four themes identified during the data analysis closely corresponded to the three main topics of the interview, inadvertently leading to the development of topic summaries rather than meaningful themes. In her discussion, McGown commented that in line with contemporary psychoanalytic theories, all participants understood their experiences of SMI not just as a

countertransference phenomenon but as an event co-created with their patients. She also noted that even therapists with an affinity to use imagery felt unsure and unprepared when experiencing images spontaneously and recommended that therapy training courses should place a bigger emphasis on these mental episodes.

Cartwright et al. (2019) further developed McGown's exploratory research by recruiting 43 psychologists to complete an online questionnaire containing quantitative and qualitative questions on therapist's experiences of SMI. The questionnaire was a non-standardised, self-developed measure. When provided a definition of SMI, all participants recognised that some of their experiences could be conceptualised as such. Many therapists "appeared to value their imagery and viewed it as clinically meaningful. The majority (85%) rated SMI as helpful, and many (70%) agreed to some extent their SMI symbolised something about the client" (p. 233). Cartwright and her colleagues (2019) made some methodological errors in treating their Likert scale results coming from a non-standardised survey as if they were interval data (Sullivan & Artino, 2013). Regardless, some of their observations listed in their Discussion chapter are worth mentioning. They noted (Cartwright et al., 2019) that no participant with a background in CBT (a profession making up almost half of the sample) could comment on questions on countertransference, and they suggested that subsequent research on SMI should employ a language more independent from different therapeutic modalities.

Cartwright's clinical psychology doctorate student, Warrington (2020), has conducted the most extensive mixed-method study on SMI to date. She recruited 37 trainee psychologists to complete an online questionnaire on SMI, and 15 of her participants were also invited to attend a more in-depth interview to discuss their experiences. Most participants reported previous experiences of SMI, and those who could not recall such mental events in the interview phase recognised that some of their experiences could be understood as mental imagery. It appeared that trainee psychologists were unsure about their imagery experiences and how they could be utilised clinically. However, many were able to bring clinical examples suggesting an intuitive understanding of countertransference phenomenons or seeing their experiences of images as a

symbolic representation of the therapy process. Other trainees had a less psychodynamic understanding of their experiences, and they emphasised the benefits of gaining insight and meaning-making when using their imagery. As many interview questions reflected on training experiences, participants could elaborate on their lack of training in imagery while recognising that even their research discussion with Warrington helped them attend more consciously to their imagery experiences in therapy.

There has been only one study conducted on therapists' attitudes to mental imagery not restricted to the therapists' own imagery experiences or SMIs. Bell and his colleagues (2015) interviewed 12 recently qualified CBT therapists to explore their relationship to using mental imagery in their clinical practice. Some participants found imagery-based techniques enjoyable and exciting, while others talked about feeling overwhelmed and confused when applying imagery interventions. Bells noted that although some apprehension about mental imagery was present in almost all participants, previous personal experiences had a significant mitigating influence on the utilisation of the imagery techniques independent from the therapists' theoretical preference for doing so: participants with positive experiences such as previous practice in meditation felt more confident using imagery, while therapists with a personal history of experiencing upsetting images were more resistant to introduce imagery into their clinical practice. Some participants reported using imagery frequently in their clinical practice, but all acknowledged moments when the application of imagery was avoided. The most frequent reasons for this avoidance were the perceived riskiness of the imagery intervention, the clients' resistance and lack of receptivity to imagery and the therapists' concerns that it would be emotionally taxing on them. Participants also mentioned practical reasons for not using imagery interventions: time constraints, a perceived lack of evidence base, and a lack of a manualised version of imagery methods. It appeared that therapists were more willing to use imagery when they received further training, and many cited completing third-wave CBT courses as helping them to be more confident in employing imagery. Bell also observed that the research interview process helped the participants to widen their understanding of mental imagery. The quality of the participants' reflections on their imagery interventions and their

grasp of the concept of imagery increased as the interview progressed, and many found attending the interview transformative. This observation informed their recommendation to introduce new training opportunities on mental imagery for CBT therapists.

As a precursor to the methodological chapter, the research methods of the studies presented in this subchapter were summarised in Table 4. As highlighted earlier, quantitative research elements used in the studies (Cartwright et al., 2019; Davis & Brown, 2000; Warrington, 2020) were based on non-standardised self-developed questionnaires. Descriptions of the development of these questionnaires did not indicate that scientific guidelines for questionnaire design were followed (Burns et al., 2008; Ranganathan & Caduff, 2023), causing a limitation in the validity of the results.

The majority of the qualitative studies cited in this subchapter applied Interpretative Phenomenological Analysis (IPA) to analyse their data and develop themes; however, more recent studies by Cartwright et al. (2019) and Warrington (2020) utilised thematic analysis (see subchapter 3.1).

Table 4. Methods of previous studies on mental imagery

Research	Participants' background	Participant number	Scope of the study	Qualitative/ Quantitative	Form of measurement	Online/ In-person	Analysis methodology
Davis & Brown (2000)	Master and doctorate counsellor students	57	MI	Mixture of qual-quant	Self-developed questionnaire	n/a	Descriptive analysis – no methodology used
Singler (2016)	Nurses, medics, psychologists, educators	13	MI	Qualitative	Self-developed questionnaire	Via email	"content analysis"
McGown (2014)	Registered psychotherapists	5	SMI	Qualitative	Semi-structured interview	In-person	Interpretative Phenomenological Analysis (IPA)

Bell et al. (2015)	CBT therapists	12	MI	Qualitative	Semi-structured interview	In-person	Interpretative Phenomenological Analysis (IPA)
McVey (2017)	Psychotherapists	7	Reverie	Qualitative	Semi-structured interview	In-person	Interpretative Phenomenological Analysis (IPA)
Cartwright et al. (2019)	Clinical psychologists, CBT therapists, Psychotherapists	43	SMI	Mixture of qual-quant	Self-developed questionnaire	Online	Descriptive statistical analysis, thematic analysis
Warrington (2020)	Trainee counselling psychologists	Phase 1: 37 Phase 2: 15	SMI	Mixture of qual-quant	Phase 1: Self-developed questionnaire Phase 2: Semi-structured interview	Phase 1: Online Phase 2: in-person/Skype	Thematic analysis

2. METHOD

2.1. The Development of the Research Method of this Thesis

Based on the previous studies on psychological professionals' relationship to mental imagery reviewed in 1.4, several methodological decisions were made to enhance the interpretive power of this thesis and prevent issues previous studies faced. To help readers orient themselves in the method chapter, a brief summary of the thesis method is provided here, with a more detailed rationale presented in the subsequent subchapters. At the end of the Method chapter, the

influence of the research's epistemological stance and ethical commitments will be explored.

As quantitative research on the topic of psychological professionals' relationship with mental imagery struggled with validity issues described in 1.4, the examples of more recent papers were followed, and a qualitative, semi-structured interview method was used. The number of participants was increased, and participants were invited from more varied professional backgrounds. In accordance with Cartwrights' (2019) recommendation, a broad, theoretically less-aligned definition of mental imagery from Bells's (2015) study was adopted, and efforts were made to create and use a language non-aligned to one therapeutic modality. Although the majority of previous qualitative studies used IPA, they often failed to provide a rationale for applying such a specific analytic method. As thematic analysis is a more flexible approach, which could be used across a range of epistemologies and is more responsive to processing large datasets (Nowell et al., 2017), it was decided to follow the example of Warrington's (2020) thesis and apply this method for the analysis. (see further rationale for analysis methods in chapter 3.1). Table 5. Describes the methods of this present study and works as an extension of Table 4.

Table 5. Method of this current study

Research	Participants' background	Participant number	Scope of the study	Qualitative/ Quantitative	Form of measurement	Online/ In-person	Analysis methodology
	Clinical psychologists, CBT therapists, non-registered psychologists	18	MI/SMI	Qualitative	Semi-structured interview	Online – MSTeams	Thematic analysis

2.2. Research Question

As it has been shown in the introductory chapters, the concept of mental imagery could be applied in clinical practice in many different ways: it could be a clinical technique the therapist administers to their patients, such as revoking a traumatic image (Foa et al., 2007) or meditating on their future selves with a couple (Piercy & Tubbs, 1996). Mental imagery, however, could also be an important tool clinicians use to understand their own mental processes and hypothesise on the process of their relationship with their patients (Ogden, 2017; Prasko et al., 2022; Rober, 1999). Either way, administered externally to patients or reflected upon the internal processes of the therapists, mental imagery could impact far beyond the immediate clinical technique level and influence the methods and approaches used in therapy. As mental imagery has been overlooked in academic training, supervision spaces have become important platforms to practice and reflect on the clinical use of imagery (Prasko et al., 2020).

Based on this multitude of uses of mental imagery in clinical practice, the following research question was created:

What relationship do psychological professionals have to mental imagery: their views on the role of mental imagery in clinical practice, and their experiences of using and managing mental imagery and their own spontaneous mental imagery in therapy and supervision?

When framing the question, the concept of spontaneous mental imagery was specifically included to highlight the clinical importance of the therapist's internal imagery processes. The inclusion of spontaneous mental imagery allowed this thesis to build on the research results of Cartwright et al. (2019), McGown (2014) and Warrington (2020) and highlight clinical applications used in psychodynamic and systemic practices without aligning the research to specific therapeutic modalities.

When phrasing the research question, specific word choices had to be made. Choosing to research the *relationship* between psychological professionals and

mental imagery had the benefit of allowing the study to reflect on the dynamic interplay between clinicians and clinical concepts. The term "psychological professionals" was chosen in the research question instead of "psychologists" to avoid legal and professional debates about psychology titles (British Psychological Society, 2023) and to acknowledge the professional work of non-registered psychologists in the field of psychology.

Bell and his colleagues' (2015) article researched the “use and *lack of use* of imagery in the clinical practice” of CBT therapists. By adding the word “using and *managing”* to the research question, this thesis aimed to highlight the variety of applications of mental imagery beyond using it or avoiding using it, such as reflecting on the images outside of the therapy space, taking the image to supervision or deciding to revisit the image in a later session.

This research question captured all the objectives of the research:

- To learn more about the attitude of psychological practitioners to mental imagery and how they use mental imagery in their clinical practice

- To synthesise studies on SMI and MI and learn about practitioners' experiences with different mental imagery applications, whether administered externally or reflected upon internally.

- And enrich professional knowledge about supervision’s influence on the clinical use of mental imagery.

2.3. Originality of the Research

As discussed above in 2.1, this thesis intended to synthesise many elements of the previous studies on psychological practitioners' relationship to mental imagery while providing space to explore new original ideas. This study aimed to harmonise the theoretical understanding of mental imagery in clinical practice by combining and building on the findings of Bell and his colleagues' (2015) paper on imagery as an externally administered clinical intervention and Cartwrights' (2019) McGown's (2014) and Warrington's (2020) research on

spontaneous mental imagery as an internal process that therapists could reflect upon. Bell and his colleagues (2015) used a CBT theoretical framework to describe mental imagery, while the SMI studies often cited psychodynamic authors such as Ogden and linked spontaneous mental imagery to psychoanalytic concepts such as countertransference (Cartwright, 2011). Combining the findings of these studies could provide a more unified and extended understanding of the clinical use of mental imagery.

This thesis also exceeded previous studies on psychological professionals' relationship to mental imagery in its methodological scope. The highest number of participants to date were interviewed on this topic, and following Bells' (2015) recommendation, participants with professional backgrounds other than that of CBT therapists were also included. By adding a question specifically on the use of mental imagery in supervision spaces and providing a literature review on supervision (see 1.3.4), the importance of a mental imagery clinical pratice not previously discussed in research was highlighted.

2.4. Ethics

2.4.1. Ethical Approval

Ethical approval was granted by the School of Psychology Ethics Committee at the University of East London (UEL) on the 6th of April, 2023. As part of the application process for ethics approval, a data management plan and a risk assessment were submitted. All participants volunteered to take part in the research as independent professionals and not as employers of specific NHS Trusts; therefore, no NHS ethics approval was required. All participants were approached in their capacity as independent psychological practitioners. The Ethical Approval Letter and the Ethics Application Form can be found in Appendix A and B.

2.4.2. Consent, Confidentiality and Safeguarding

Before attending the interview, all participants were provided with an information sheet (see Appendix C), which explained confidentiality rules and data management of the research. Participants were required to electronically sign a consent form (Appendix D) agreeing that they understood the research's confidentiality and data management procedures. At the start of the interview, topics of confidentiality, data management and consent to participate were revisited again to allow participants to share their concerns or ask questions. It was also explained to participants that they could withdraw consent within three weeks of the interview being completed.

The consent forms, the interview transcribes and the interview videos were all stored in separate password-protected folders on the researcher's UEL drive. The list of pseudonyms was stored separately from other research-related documents in a different password-protected folder on the researcher's UEL drive. Transcribes did not contain any identifiable information; any names were anonymised, and any identifiable information was reducted and replaced. To maintain confidentiality and reduce unnecessary information collection, it was decided not to collect any personal data such as age, gender, or ethnicity as it was irrelevant to the research topic but could risk participants being easily identifiable. The only personal information participants were asked were 1. their professional background, 2. whether they had been in that role longer than six months and 3. their preferred therapeutic modality. At the end of the interview, participants were also asked whether they would like to receive a copy of the completed thesis, and if they responded positively, their personal email addresses were saved on a separate sheet on the researcher's UEL drive, which was discarded upon submission of this thesis.

Previous research on the topic (Bell et al., 2015; Cartwright et al., 2019; Warrington, 2020) did not suggest that participating in an interview about the clinical experiences of using mental imagery would be harmful to participants and, in fact, reported opportunities for personal and professional development. However, recognising that any interaction could create distress, all participants received a Debrief sheet (Appendix E) before the interview detailing necessary

information if they became adversely affected by the interview process. At the start of the interview, participants were also asked how to signal if they wished to terminate the interview.

2.5. Participants

2.5.1. Sample Size

The thesis aimed to interview eighteen psychological professionals: six clinical psychologists, six CBT therapists, and six non-registered psychologists working as assistant psychologists or in similar roles in the NHS. Guest et al. (2006) suggested that a relatively homogenous participant sample would only require twelve interviews to create the majority of available codes for thematic analysis. Ando and his colleagues (2014) also advocated for twelve interviews while noting that the first six transcripts were pivotal enough to create a codebook. Fugard and Potts' (2015) research tool approached the question of participant number differently and argued that to have a sufficient number of participants; researchers need to consider the prevalence of the themes in the population, which could be slightly difficult in underresearched topics like mental imagery. Nevertheless, their tool also suggested that eighteen participants could capture themes with low prevalence. As it was recognised that the different psychological practitioners in the sample might have contrasting levels of clinical experience and training background, Guests' (2006) advice was followed, and the sample size was increased from twelve to eighteen. Six participants from each professional category were recruited to support a more robust code production process.

2.5.2. Sampling Frame

Previous qualitative research on psychological professionals' relationship to aspects of mental imagery was conducted on participants with a background in CBT therapy (Bell et al., 2015), integrative psychotherapy (McGown, 2014;

McVey, 2017) and counselling psychology training (Warrington, 2020). CBT therapists were included in the sample for three reasons: 1. the majority of the interview schedule was based on Bell and his colleagues' (2015) study (see 2.7), 2. CBT therapists working in the Increasing Access to Psychological Therapies (IAPT) services had to follow NICE guidelines (2013, 2018) prescribing imagery interventions and were expected to use diagnostic-specific treatment protocols applying imagery (Clark et al., 1995; Ehlers & Clark, 2000), and 3. Imagery was part of the competency framework (Roth & Pilling, 2007) expected from CBT therapists to adhere to.

As clinical psychologists' attitudes to the use of mental imagery have only been researched via Cartwright and her colleagues' (2019) online survey, it appeared crucial to include this profession. Bell and his colleagues' (2015) study also had a specific recommendation to include clinical psychologists in the future replication of their research.

Non-registered psychologists were added to the research sample because this group is relatively underresearched and underreported in psychology studies, and their skill level and workplace expectations could vary immensely (British Psychological Society, 2007). In this study, professionals are referred to as non-registered psychologists if they have a degree in psychology and work as assistant psychologists, personal well-being practitioners (PWP) or children/educational mental health well-being practitioners (CWP). These latter two categories can achieve professional accreditation to the British Association for Behavioural and Cognitive Psychotherapies but would not be able to practice independently (BABCP, 2023). When evaluating PWPs' use of self-practice/self-reflection workbooks, Thwaites and her colleagues (2015) noted that PWPs often struggle when applying imagery exercises, indicating a need for further research. Including this group of professionals was also personally important to the author of this thesis as his experience of working as an assistant psychologist in the past was that imagery interventions such as meditation exercises were often viewed as inferior to therapy, and interventions were allocated to assistants to facilitate even without any previous training.

2.6. Recruitment

For the recruitment process, personal contacts were used as nominated gatekeepers to approach psychological professionals to participate in the research. Using personal connections instead of approaching professionals of one institution helped gain access to participants working in different parts of the UK. The inclusion criteria for CBT therapists and clinical psychologists was to hold a professional registration, while non-registered psychologists were to be in their clinical role for longer than six months.

Recruitment commenced in June 2023, and the first research interviews were conducted in July 2023. Appendix F shows an example of a recruitment letter detailing the purpose of the research and discussing confidentiality and data management. People agreeing to participate in the research were sent the participant information leaflet, the interview schedule, and the post-interview debrief sheet (Appendix C, G, E). Participants also received their MSTeam link to the online interview. Participants were always informed that they could withdraw their consent from attending the research within three weeks of completion of the interview, but no participant contacted about this. Almost all participants requested to receive a copy of the completed research.

Efforts were made to avoid recruiting too many individuals from the same workplace; therefore, clinical psychologists and non-registered psychologists were recruited from adult, children and older adult services. Due to the nature of the CBT training program, the CBT therapist sample was somewhat more homogenous than the other professional groups, as four CBT therapists worked in a similar inner London service. However, two other CBT therapists were deliberately recruited who completed their therapist training in universities outside of London, one of whom also worked outside of the capital. All twelve CBT therapists and non-registered psychologists were interviewed in July 2023, but the recruitment process significantly slowed down when approaching clinical psychologists. The last interview was completed in January 2024.

Nineteen participants were interviewed for the study because one clinical psychologist had to be excluded after the interview. This participant did not allow the interview to be conducted similarly to the other participants and failed to sign the consent form despite reminder emails. After consulting with the thesis supervisor, it was agreed that this participant should be excluded and not proceed with transcribing the interview. An additional clinical psychologist was recruited to replace them.

Table 6 shows the characteristics of the participants.

Table 6. Characteristics of participants

Participant number	Professional category	Type of workplace	Preferred therapeutic modality
1	Non-registered	Children	Behavioural/ CBT
2	CBT therapist	Adults	CBT
3	CBT therapist	Adults	CBT
4	CBT therapist	Adults	CBT/ACT
5	Non-registered	Adults	CBT
6	Non-registered	Adults	CBT
7	CBT therapist	Adults	CBT/EMDR
8	Non-registered	Adults	CBT
9	Non-registered	Children	Behavioural/CBT/Systemic
10	Non-registered	Older adults	CBT/Systemic
11	CBT therapist	Adults	CBT/psychodynamic
12	CBT therapist	Adults	CBT
13	Clinical psychologist	Children	Systemic/CFT
14	Clinical psychologist	Children	Systemic
15	Clinical psychologist	Adults	Psychodynamic
16	Clinical psychologist	Older adults	Systemic/CBT
17	Clinical psychologist	Adults/Leadership	Systemic
18	Clinical psychologist	Children	Systemic/CBT/ACT/CFT

2.7. Measurement and the Interview Process

An interview schedule was created based on the measures used in previous research to conduct the semi-structured interviews with the participants. Bell and his colleagues' (2015) interview schedule was applied, and two open-ended questions from Cartwright and her colleagues' (2019) study were added to consider therapists' experiences of spontaneous mental imagery. One question on supervision and mental imagery was also created. Using measurements from previous research aimed to increase the validity of this current study (Bowling, 2005). Bells' and Carthwrights' practice was followed, and a definition of mental imagery and spontaneous mental imagery was provided before the questions. The interview schedule can be found in Appendix H.

The interview schedules were emailed to the participant before the interview, and many reported that receiving the schedule before the meeting helped them collect their thoughts about mental imagery. The schedule was followed at each interview, but sometimes additional clarification questions were asked. After the thirteen questions in the interview schedule, a few more questions were often formulated based on the participants' previous answers and the areas of mental imagery they had not covered. The following topics were asked (unless they were mentioned earlier in the interview):

- Previous personal experiences of meditation and mindfulness, experiences of facilitating meditation and mindfulness.
- Previous experiences of:
    - Working with patients' dreams.
    - Working with patients having flashbacks or psychotic experiences.
    - Using CBT imageries such as imagining the "pink elephant".
- If participants struggled with questions on spontaneous mental imagery, the similarities with the concept of transference-countertransference were discussed, and they were encouraged to recall episodes when they had benefitted from that theory.
- Previous experiences of imagery in their personal therapy (if the participant mentioned that they had received personal therapy).
- For systemic therapists:

    - Previous experiences using externalisation, the miracle question, family sculpting and genograms.
- Previous experiences of using art in therapy.

The interviews lasted between 35 minutes and an hour and 20 minutes. The usual interview time was 50 minutes. All interviews were conducted via MS Teams, and they were all recorded. The MS Teams transcription program was running in the background during the whole duration of the interview. Participant consent was sought before recording, and transcription was switched on.

2.8. Transcription and Data Management

All interviews were transcribed to a text file. MS Team has an embedded transcription function but operates with several errors and struggles to understand different accents. Therefore, every transcription had to be checked and corrected manually, taking up as much as 3-7 hours for each interview. As part of the transcription process, identifiable information was anonymised, and names of people, places and institutions were changed to a more generic description (e.g., the name of the participants' workplace was changed to a generic description such as “a psychological service in London”). Usually, transcripts were as long as 25-40 pages. As reading so many pages of interviews for thematic analysis could not just be a daunting task, but it would risk that non-textual information might get lost, the video recordings of the interviews were kept for the first stages of the thematic analysis process. All transcriptions were stored in a password-protected UEL One Drive folder.

2.9. Epistemology and Relational Ethics

2.9.1. Epistemology

Epistemological considerations of research projects, such as enquiries about the “nature of the knowledge, the conditions under which it is most likely to be

achieved, and the capacities possessed by humans which make them potential knowers" (Amundson, 1985, p. 128) are essential parts of psychological enquiries (Tomlinson, 2023).

Three aspects of the research made epistemological considerations of this present thesis complex: 1. the participants had different preferred therapeutic modalities rooted in different epistemological understandings; 2. the broad understanding of the mental imagery concept used in this thesis, which included spontaneous and externally ignited mental imagery, was based on cognitive and psychodynamic theoretical models employing different understandings of where knowledge came from, and finally, 3. the recent epistemological shift in thematic analysis prompted a reconsideration of the initial ideas introduced in the thesis proposal.

As Amundson (1985) noted, research projects should ascribe themselves to similar epistemological understandings their participants use. As Table 6 shows, participants of this thesis used CBT, systemic and psychodynamic therapeutic models to understand their patients' lives. According to Harper (2011), CBT is more on the spectrum of being critical realists assuming that their data was a reflection of an external reality even if it is not a mirror image of it, while psychodynamic and especially modern narrative systemic therapies (Rivett et al., 2002) are more comfortable using a social constructionist epistemological stance emphasising the socially co-constructed nature of knowledge production. To avoid the "bitter and endless acrimony" (Borges Florsheim & Simão, 2021, p. 161) that epistemological misunderstandings between different psychological practitioners could create, the research proposal advocated for a stricter critical realist position in thematic analysis. This approach aimed to ensure that the more data-driven knowledge presented by CBT-affiliated participants would not be treated as socially constructed during the process of thematic analysis.

However, the proposal did not consider fully that qualitative research and thematic analysis of healthcare narratives had become increasingly complex in the last few years (Sundler et al., 2019), resulting in an aspiration to epistemological and methodological purity. For instance, Finlay argued (2021, p. 106) that good quality thematic analysis should not "clump together" different

epistemological commitments. While Braun and Clarke's (2006) groundbreaking article on thematic analysis published fifteen years ago emphasised that thematic analysis could be used in both realist and constructivist paradigms, their recent book (Braun & Clarke, 2022) advocated for a more socially constructionist understanding of the data and called their method reflexive thematic analysis.

As Braun and Clarke's (2022) thematic analysis model evolved to be more socially constructionist research, an epistemological and methodological gap had been opened to researchers more interested in qualitative studies using a critical realist position. Two recent articles have been published (Fryer, 2022; Wiltshire & Ronkainen, 2021), advocating specific amendments in the thematic analysis methodology to better fit a critical realist position. The two articles used slightly different understandings of critical realism and differed in the preferred methodological amendments, which Fryer (2022) acknowledged might bring unnecessary complications to the research.

Fryer's (2022) and Wiltshire and Ronkainen's (2021) models have never been used on a full dataset; therefore, this thesis resisted the contemporary urge for epistemological purity and followed one of Harper's (2011) students, Timberlake's (2015) research and maintained the proposal's original intention for a critical realist epistemological position to social constructionist analyses. The social constructionist analysis could enable the use of the most advanced thematic analysis methodology (Braun & Clarke, 2022), while the critical realist position can help consider data as a reflection of external reality and create themes to make practical recommendations and interventions in this external reality (Fryer, 2022). Using the categorisation of Braun and Clarke (2022), this thesis' orientation to data could be described as inductive or data-driven, while the analysis focuses on latent meanings to include psychodynamic and systemic therapeutic knowledge.

2.9.2. Relational Ethics

King et al. (2021) observed that epistemology gained primacy in psychological research over any other considerations, and they advocated that researchers

should explore the ethical aspects of their study at least in a similar depth. They also highlighted that ethical discussions could have implications for the relationship between the researcher and participants and could reduce the power imbalance inherent to research. The following paragraphs will detail some ethical considerations before concluding the Method chapter with personal reflections.

Some of the ethical applications described by Guillemin and Gillam (2004) as “procedural ethics” and “ethics in practice” have been discussed in chapter 2.4, where methodological manifestations of these concepts in the form of consent forms and debrief sheets were examined. This section specifies aspects of the research defined as *relational ethics* by Ellis (2007). Relational ethics is close to ethics of care and, as such, considers how research could act in a “humane, nonexploitative way while being mindful of our role as a researcher” (p. 5) and all the power imbalances this role brings. Relational ethics can affect every part of the research, from data collection to discussion; however, in the coming paragraphs, three aspects will be highlighted to show how relational ethics influenced this thesis: the participant-researcher relationship, the methodology and the overarching aim of the research.

Sampson (2003) advocated for researchers to take an unconditional kindness position when researching other humans and wondered about the effect this could have on the participant-researcher relationship. He explained the benefits of using a caretaking role metaphor when interacting with participants as opposed to a market metaphor and wrote that participation in research should not be just “getting a good deal out” (p. 160) for taking part but being adequately cared for. He also recommended creating dialogues with the participants where they could move away from discussing mastery and instead feel appreciated. These pieces of advice were central to the conduct of interview discussions, aiming to create an atmosphere where participants could feel appreciated. Additionally, dropping the one participant uncomfortable with the interview process served as an act of safeguarding them.

Because the concept of epistemological violence is central to epistemology and relational ethics, these two seemingly different topics are discussed in the same

subchapter. As detailed above, epistemology is also about “the capacity possessed by humans, which makes them potential knowers” (Amundson, 1985, p. 128). Researchers, therefore, have an ethical responsibility to increase participants' capacity to know and reduce the epistemological gaps between researchers and participants (Kaulino & Matus, 2021). It was crucial in designing the method of this thesis to reduce epistemological violence; sending participants the interview schedule in advance and providing definitions of the concepts the interview questions were referring to were all designed to increase the epistemological capacity of the participants with different professional and training backgrounds. Epistemological violence could also occur in the discussion of research projects when some participants might be misrepresented, and their different epistemological positions would not be considered in context. Therefore, this topic will be revisited in section 4.1.2.

Creating research where ethical considerations play a central role (P. King et al., 2021) was a key factor in choosing to follow Bell and his colleagues' (2015) paper and study psychological professionals’ relationship to mental imagery, as Inspiration was drawn from their observation that the administration of the research interviews was experienced as professionally and personally helpful to most of their research participants and the interview encouraged the participants to be more creative in their clinical practice. One could argue that this observation indicated that their research was based on a caretaking rather than a market metaphor (Sampson, 2003).

2.10. Reflection 1.: My Relationship to Mental Imagery and the Interview Process

I first learnt about psychological imagery interventions on the first day of my undergraduate course as I signed up for a rather unusual three-day introductory experiential workshop facilitated by the then most-well-known clinical psychologist in Hungary. The workshop, titled “Psychofitness” (Bagdy, 1996), contained multiple meditation and mental imagery exercises. I had less

exposure to mental imagery in my later academic career; however, I could still attend some seminars on altered mental states and the 8-week Mindfulness group, and I was also exposed to some psychodynamic ideas on mental imagery during my 2.5-year-long personal analysis.

Engaging with my thesis and administering all the interviews encouraged me to rethink my relationship with mental imagery; they helped me to identify the theoretical gaps in my knowledge and influenced my clinical and supervisory practices. In my last few placements, I worked with families applying a systemic approach to therapy; therefore, it felt embarrassing not being able to draw to particular systemic theories on imagery. Recognising my initial lack of knowledge, I added a specific subchapter on systemic therapy and mental imagery (1.3.4). I also started actively looking for opportunities to re-introduce imagery to my clinical work: encouraging families to imagine alternative solutions and facilitating roleplays of these imagined scenarios became a regular technique for me. Similarly, I started attending to my own spontaneous mental images about the different family members I was seeing and reflecting on the contrasting images they had evoked in me to inform my understanding of their family dynamic and their communication of emotions.

Interviewing so many psychological professionals was a real privilege, as we psychologists rarely have long and detailed conversations about the clinical techniques we use outside of supervision spaces, and I could have 18 of these conversations. It was also reassuring and heart-warming to see how professional and well-trained all the participants were, and I often imagined that I would be glad to be their patient as they eloquently and thoughtfully talked about the clinical problems they had faced.

3. ANALYSIS AND RESULTS

3.1. Analysis Methodology

Most of the qualitative studies on psychological professionals' relationship to mental imagery cited in subchapter 1.4 applied Interpretative Phenomenological Analysis (IPA) to analyse their data and develop themes. As noted earlier, the decision to use IPA over other qualitative research methods was not always fully justified in some studies; for instance, Bell and his colleagues (2015) did not provide a comprehensive explanation for choosing IPA in their research. IPA is concerned with providing "a detailed description and interpretation of accounts of particular experiences or phenomena as told by an individual" (Howitt & Cramer, 2016, p. 454), and it is aimed at making sense of experiences and understanding. IPA was created (Smith, 1996) to capture descriptions of complex experiences affecting the self and influencing the environment. It has traditionally been used to analyse experiences like pain, illness or health (Smith & Osborn, 2007). IPA, therefore, could be a useful research method in studies concerned with therapists' subjective experiences of their reveries (McVey, 2017). However, applying IPA to explore psychological professionals' relationship to an entire clinical concept, such as mental imagery as opposed to subjective experiences (Bell et al., 2015), could be less fitting and could lead to overcomplications of the research.

Since the publication of Braun and Clarke's article in 2006, thematic analysis (TA) has become a popular qualitative analytic method, and as literature on TA has grown in recent years, academic criticisms that thematic analysis was *not serious enough* for doctorate-level research have reduced (Braun & Clarke, 2014). Thematic analysis is "a method for developing, analysing and interpreting patterns across a qualitative dataset, which involves systemic processes of data coding to develop themes" (Braun & Clarke, 2022, p. 4). The process of the analysis is described in six phases, making it accessible to researchers new to qualitative methods (Braun & Clarke, 2006). These phases have been reworked and re-named in the authors' recent book (Braun & Clarke, 2022): 1. Familiarising yourself with the dataset. 2. Coding, 3. Generating initial themes, 4. Developing and reviewing themes, 5. Refining, defining and naming themes, 6. Writing up.

As the research question explored professionals' relationship to psychological concepts and practices, thematic analysis concerned with the experiences, perspectives, and meanings of the participants (Braun & Clarke, 2022) appeared to be an appropriate analytic method. Further advantages of TA over other qualitative methods were its theoretical flexibility and ability to handle large datasets (Nowell et al., 2017). Unlike more rigorous methods, TA does not require more than one coder for reliability, which is beneficial for writing an individual thesis. Thematic analysis has a rich history of being used in research exploring therapists' experiences, whether the practitioner is aligned with cognitive behavioural (Børtveit et al., 2023), psychodynamic (Jones et al., 2020) or systemic (Frediani & Rober, 2016) therapies. The differing therapeutic modalities bring different epistemological standpoints, and thematic analysis was described as a qualitative method able to harmonise these differences well (Maguire & Delahunt, 2017). As has been discussed in 2.9.1, recent developments in thematic analysis literature and the creation of reflexive TA (Braun & Clarke, 2022) questioned the epistemological flexibility of the method and moved thematic analysis closer to social constructionism. Table 7 summarises the benefits and disadvantages of using thematic analysis for this thesis.

Table 7. The rationale for using TA

Advantages of using Thematic analysis for this thesis
Similarly to this thesis' research question, thematic analysis is concerned with participants' experiences, perspectives, and meanings.
TA is theoretically flexible.
TA is able to handle large datasets.
TA could be completed by an individual researcher.
TA has been used to research therapists' experiences applying different therapeutic modalities.
TA has historically used to be seen as an epistemologically flexible method.
Disadvantages of using Thematic analysis for this thesis
Recent developments in TA literature advocated for epistemological coherence.

This research shares the belief that it is crucial to remain open to listening to and processing psychological ideas with differing philosophical/theoretical/epistemological standpoints; therefore, it was decided to maintain the epistemological position described in 2.9.1, and data was approached with critical realist epistemological position and processed in the social constructionist analyses method of thematic analysis.

Social constructionist reflexive thematic analysis views the analytic process as storytelling (Nadar, 2014) and embraces the idea that TA is “not a neutral activity but a values-based, situated practice” (Braun & Clarke, 2022, p. 22). To maintain reflexive thematic analysis’ position as a scientific qualitative method, Finlay (2021) emphasised that researchers need to apply rigour (a systemic and robust engagement across the entire dataset), relevance (the practical applicability of the results), resonance (the creation of themes which are emotionally relatable to the readers) and reflexivity. When describing reflexivity, she argued that the researchers need to show self-awareness, openness, and ethical sensibility (Finlay, 2016) and highlighted the importance of a research practice championing by routinely reflecting on assumptions, expectations, choices and actions (Finlay & Gough, 2008).

3.1.1. Reflection 2.: Reflective Journaling and Familiarising with the Dataset

I started familiarising myself with the data during the long transcription process. This was also the time when I started making reflective journal notes. As I was revisiting my journal, I noticed how anxious I was about the coming coding phase and how desperately I wanted to spot some underlying themes so early on in the analytic process.

My first impression of the data was how participants with different professional backgrounds described their relationship to mental imagery: while CBT therapists appeared to be very confident in delivering imagery interventions, non-registered psychological practitioners and clinical psychologists were less sure in their abilities and at the same time more critical of administering imagery techniques. However, when describing experiences of one’s own spontaneous mental imagery, CBT therapists - in line with Cartwrights' (2019) observation –

became less confident, and the majority of them could not recall experiences of SMIs. The only CBT therapist, Participant 11, who shared their experience of making therapeutic use of their own SMI, had had extensive psychodynamic teaching during their undergraduate course. Experiences of spontaneous mental imagery appeared to be more defining for non-registered psychological practitioners, while clinical psychologists' approaches to SMI were strongly influenced by their therapeutic allegiances. Although this initial observation appeared interesting, and I often shared it as preliminary results when people asked me about my thesis; I was aware that this reflection might not be backed by data and would fail rigorous analysis. I was also mindful that the professional background was the only variable I collected; therefore, it was easy to make comparisons between the only subgroups I could form. I also wondered if I collected demographic information such as ethnicity and religious background, would that prompt me to make different comparisons?

3.2. Coding

After significant time was spent familiarising the dataset, coding started in February 2024. As suggested by Braun and Clarke (2022), data was only tagged with a code label if it was related to the research question. As the research question (see 2.2.) covered a broad range of experiences of mental imagery, a large amount of data was coded. Instead of using a codebook (N. King, 2012), open coding was applied, where codes were developed and modified throughout the coding process (Maguire & Delahunt, 2017). No line-by-line coding was employed.

Microsoft Excel was used to aid the coding process (Bree & Gallagher, 2016). While re-reading the interview transcripts and listening to the recordings of the interviews, every piece of data related to the research question was marked with a highlighter pen on the hard copy of the transcript, and the code labels were recorded in an Excel file. Alongside the code label, the page number of the transcript to which the code label referred was noted. Code labels used in

more than one interview were written in a blue font, and labels reoccurring in the same interview but nowhere else were distinguished with a green font.

The coding process started by coding the interviews of the first two psychological practitioners from each professional group (Participants 1,5, 2, 3, 13,14). This coding order was chosen to avoid coding the interviews based solely on participant numbers, as clinical psychologists were interviewed last, which could risk failing to introduce codes specific to their group early in the coding process. As mentioned in 2.5.1, research also indicated that coding the first six interviews – depending on how similar or dissimilar the sample is - could be crucial for developing code labels (Ando et al., 2014; Guest et al., 2006). After some deliberation, code labels were written in first person as third-person descriptions were often confusing (e.g., "I did not feel confident sharing my patient's images with my supervisor" instead of "therapist's concern about supervisors' reaction to patient's images" a statement where it would be unclear who the participant was).

Table 8 shows an example of the codes produced from the interview with Participant 11.

Table 8. Coding of the interview with Participant 11

Interview transcript extract	Code labels
INTERVIEWER 22:34 **What thoughts or emotions do you experience when using or discussing imagery in clinical practice?** **PARTICIPANT11 22:48** Yeah. Um, it has changed over time. Initially, I felt awkward and embarrassed and like lost in what to say. I think when we have a good rapport and we are introduce imagery, I actually really enjoy it. And I enjoy sort of using this sort of second language between the client and me where we are like communicating on a different level and.	Initially, I used to feel awkward and embarrassed when using imagery. I like the use of imagery. Imagery as an opportunity to communicate with clients differently.

INTERVIEWER 22:55 Hmm. **PARTICIPANT11 23:17** But then also yeah, I think I feel confident to use imagery in certain situations and then when I don't have a script, then I feel kind of lost. I know that there's a nagging thought in my head I should probably use imagery here, but I'm not always sure.	I am not so confident in my ability to deliver imagery without scripts.

Altogether, 786 codes were created, 383 unique codes only appeared once in the dataset, and 403 code labels were used on more than one occasion (see Table 9). Interviews from Participants 7, 15, 17 and 18 had the highest share of unique codes, which might be linked to their unique training and work experiences: Participant 7 was the only professional using EMDR therapy, while Participant 15 was the only psychodynamic practitioner in the sample, Participant 17 had a leadership position, therefore used imagery not in a therapeutic but in a clinical leadership context and Participant 18 had the longest career with various experiences of imagery interventions.

Table 9. Code development in each interview.

Participant number	Professional category	Number of codes	Number of unique codes	Number of reoccurring codes (blue)	Number of reoccurring codes (green)
1	Non-registered	66	34	21	11
2	CBT therapist	50	18	25	7
3	CBT therapist	41	13	28	0
4	CBT therapist	54	23	23	6
5	Non-registered	52	14	28	12
6	Non-registered	29	12	17	0
7	CBT therapist	52	30	14	8
8	Non-registered	45	18	23	4
9	Non-registered	33	18	11	4

10	Non-registered	38	17	21	0
11	CBT therapist	46	24	16	6
12	CBT therapist	35	17	18	0
13	Clinical psychologist	47	17	20	10
14	Clinical psychologist	38	12	24	2
15	Clinical psychologist	34	24	10	0
16	Clinical psychologist	44	30	12	2
17	Clinical psychologist	39	29	6	4
18	Clinical psychologist	43	33	10	0
TOTAL		**786**	**383**	**325**	**78**

Although 786 code labels could seem high, creating only 30-40 codes from interviews 50 minutes long each could only be possible when data not linked to the research question is not coded. This thesis aimed to follow Braun and Clarke's (2022) recommendation to create code label lists that would capture the meaning and the richness of the interviews by reading the codes alone. This aspiration of making the code label list a good representation of the dataset influenced the decision of when to stop coding. Although by the end of the coding and re-coding of the 18 interviews, many code labels became similar, code labels capturing slightly different experiences were not merged to prevent codes from losing meaning-making capacity in the later phases of theme development where codes play a crucial initial role. Leaving code labels closer to the original dataset was also more in line with the research's critical realist epistemological position on data. Table 10 gives an example of code labels which were kept separate, although they all captured aspects of the topic of imagery and emotions.

Table 10. Code labels on imagery and emotion.

Code labels
Imagery could have a big emotional impact on the therapists.
My images helped me to understand my patients' emotional states.
Imagery helps assess the patient's emotions.
Imagery helps make the session emotionally more meaningful.
I feel that with imagery work, I can achieve changes in emotions more effectively.

Images could be powerful communication tools to express emotions.

3.2.1. Reflection 3: Coding

In their book, Braun and Clarke (2022) dedicated a whole subchapter to managing anxiety during the process of thematic analysis. During the eight years of my academic career, I have never been so overwhelmed by any academic work as I felt from seeing the large volume of codes I produced. I found it reassuring that not all the codes would be needed for theme development, so making a "mistake in coding" would not "ruin" my thesis (Braun & Clarke, 2022).

I also found solace in the metaphor of thematic analysis I created for myself to comprehend the research process. As I was thinking about the epistemological aspects of coding and theme development, I recognised how close the process is to the typical therapy sessions I would deliver: what my patients tell me in the session is initially processed as the verbal representation of a more-or-less valid perception of reality, similarly to a critical realist coding, but my interpretations and the aim of my psychological interventions would be designed to help the patients to recognise underlying patterns and question the grip of reality on their thinking helping them to create a new understanding of their life, similarly to social constructionist theme development in qualitative research. This metaphor of thematic analysis as therapy helped me gain confidence that, eventually, I will be able to process the hundreds of codes and develop meaningful themes as I have helped patients in the past when they approached me with complex problems.

3.3. Generating, Developing and Reviewing Themes

After a weeks-long process of familiarisation with the dataset and coding, sufficient knowledge of the codes was attained to start generating and developing themes. As mentioned above in 1.4., themes developed in previous studies on professionals' relationship to mental imagery using qualitative

analytic research methods (Bell et al., 2015; McGown, 2014) often resembled the research questions. These so-called topic summaries (Braun & Clarke, 2013) failed to explain why certain professionals might be apprehensive about using imagery in their clinical practice, and they also could not reveal why others might feel joy when introducing imagery in their work. To avoid similar pitfalls in the analysis, a set of guiding rules was established for theme development (see Table 11).

Table 11. Rules for developing themes

Rules for developing themes
1. Themes should be more than topic summaries (Braun & Clarke, 2022) and should not just cover particular answers to certain questions (Braun & Clarke, 2013).
2. Themes should not be divided based on the participant's professional groups or therapeutic allegiances. There shouldn't be a CBT- or a clinical psychologist-only theme.
3. Themes should welcome contradicting codes, and it would be good to avoid creating Good practice – Bad practice themes.
4. Should aim to create as few subthemes as possible.

Using these rules proved extremely helpful when decisions had to be made about interpreting certain codes and understanding how these codes could be used to construct themes. These rules were also utilised to implement the ethical and epistemological ideas described in 2.9. Making a theme specific to one participant group or creating themes representing only bad therapeutic practices could risk inflicting epistemological violence in the analysis and interpretation against the specific participant group (Kaulino & Matus, 2021). The benefit of having a defined aspiration for themes incorporating data from various professional groups and theoretical allegiances is that it could push the analysis to move away from semantic theme development and pursue the creation of inductive, latent themes, mindful of their socially constructive epistemological nature.

Table 12. describes the initial themes generated from the first readings of the codebooks. Although these themes were later dropped in the development

phase, they were useful in organising the codes and structuring thought processes. The first set of initial themes was discarded because the three themes acted almost as topic summaries of the questions on mental imagery, spontaneous mental imagery and supervision. As Theme 2 (*Imagery as opportunity or disaster*) incorporated all codes about unsafe imagery practices, it risked portraying SMI and non-CBT imagery practices as unsafe or harmful. In the second set of initial themes, a deliberate decision was made to generate more themes to bring new perspectives. Theme 1 and 2. in this second set were defined as opposites of each other: while Theme 1 (*Process-based understanding of imagery*) – a redevelopment of Theme 1 from the first set (*Imagery as craft*) included all third-wave CBT elements of imagery, Theme 2 (*Content-based understanding of imagery*) provided a space for the understanding of images from trauma-focused CBT (Ehlers & Clark, 2008) and systemic and psychodynamic therapy and served as an improved version of the previous Theme 2 (*Imagery as opportunity or disaster*). Themes 3-6 were not extremely well-defined and contained many similar codes.

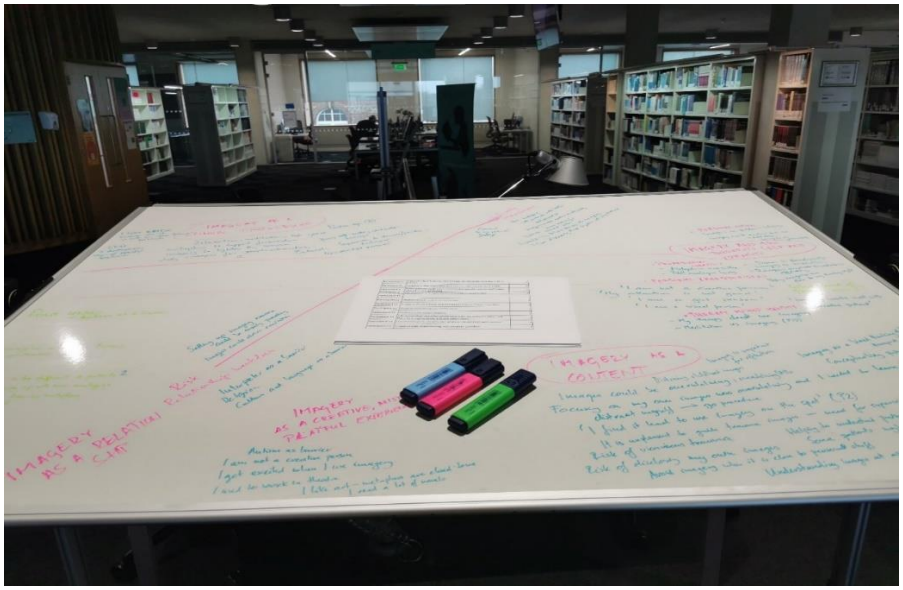
Table 12 Initially generated themes

First set of initial themes		Second set of initial themes	
Themes	**Characteristics**	**Themes**	**Characteristics**
1. Imagery as craft	Imagery interventions as calming and relaxing techniques	**1. Process-based understanding of imagery**	Images, when aligned with values, are useful, but otherwise, they are a distraction.
		2. Content-based understanding of imagery	Imagery could be informative or, dangerous and uncontaining. Trauma images and risk of vicarious trauma.
2. Imagery as opportunity or disaster	Negative experiences of imagery, risk stories, wishes to develop and understand patients better – systemic and	**3. Imagery as seen by others and reflected back on the professionals.**	Imagery as unscientific, imagery and biased thinking

	psychodynamic practices ideas about "gut feelings".	**4. Imagery as an opportunity to make treatment more creative**	Enthusiastic comments about creativity
3. Imagery as a reflection of therapy	Concerns about imagery being pseudoscientific, discussions about supervision and training opportunities.	**5. Perceived lack of ability in visual imagery and difficulties in receiving meditation**	"I am not a creative person", "I dislike/am not good at meditation".
		6. Patients' images making an overwhelming impact on therapists	Codes about being a passive recipient of images, needing to go to therapy and worrying about vicarious trauma.

Generating these initial themes in phase 3 proved helpful in preparing for phase 4 of the thematic analysis, the Systematic development of themes. A hard copy of the codebook was reviewed code by code, and a large lecture hall whiteboard was utilised to painstakingly redesign all themes (see Table 13). The whiteboard facilitated easy redrawing of themes if they became irrelevant or overly inclusive. After a full day standing in front of a whiteboard, a satisfactory version of the themes was constructed. The following days were spent reviewing these themes to ensure relevance and rigorous application when compared against the codebook and the original dataset. During this review process, an Excel file of the codebook was used, and as suggested in Bree and Gallagher's (2016) paper, all codes were highlighted with the colours of the different themes. Frequent revisits to the original interview transcripts were made to verify the thematic belonging of certain codes. Codes not categorised into themes represented data on topics not so closely linked to the research question: 1. participants' attempts to define mental imagery, 2. expressing their wish to have more training and supervision on imagery and 3. emphasising their gratitude for taking part in the research. At the end of the review phase, some transcripts were re-read and compared against the themes to ensure the constructed meanings aligned with those conveyed in the interviews.

Table 13. Code development process



3.4. Results (Refining, Defining and Naming Themes)

Table 14. summarises the themes which were constructed during the theme development process. These themes describe how participants related to mental imagery or viewed imagery when they talked about MI and SMI in their interviews. As Table 14 shows, six main themes were identified based on the 18 interviews and the 786 codes coded from the transcripts. Participants sometimes talked about mental imagery (and spontaneous mental imagery) as a clinical procedure (Theme 1), but at other times, they viewed the content of the image as its central feature (Theme 2). Subthemes of Theme 1 and 2 were designed to highlight the different narratives participants used when discussing imagery as a procedure and as a content. Mental imagery was also considered in connection with the therapeutic relationship (Theme 3) and how this therapeutic relationship and the application of imagery could influence each other. As participants discussed their therapeutic practices in their interviews, they often reflected on how imagery affected themselves as people (Theme 4). The subthemes in Theme 4 helped to distinguish between the different sides of the participants' selves: views about professional identities, allegiances to therapeutic modalities, and perceived inherited characteristics could all be

impacted when psychological practitioners used imagery. Theme 5 accommodated ideas about the perceived link between creativity and imagery and its consequences of the professionals' relationship to imagery, while Theme 6 was constructed to present views about wider systemic limitations and opportunities of imagery use.

Table 14. Themes

Theme number	Theme names	Subtheme names	Characteristics
1	**How? - Imagery as a clinical procedure**		Participants viewed imagery as a specific clinical procedure or technique.
1.1		**"Imagery is a powerful clinical tool."**	Previous experiences with imagery procedures
1.2		**Needs for developing clinical processes**	How imagery interventions could be more effective: training, supervision, guidelines.
2	**What? - Imagery as a content**		Participants approached imagery based on the content of the image.
2.1		**Experiences with image content**	Previous experiences of working with image content: trauma images, SMIs
2.2		**Views on image content**	Participants' overall view of working with image content
3	**With whom? - Imagery as a relationship**		Participants were concerned about how imagery use affected the therapeutic relationship.
4	**Who am I? - Imagery and the therapist's self and identity**		What would imagery use say about the participant:
4.1		**Personal characteristics**	- as a person
4.2		**Professional identity**	- as a psychological practitioner

4.3		**Therapy method identity**	- As someone aligned with certain therapeutic modalities
4.4		**Personal concerns in therapy skills**	- As someone with a set of anxieties
4.5		**Personal coping**	- As someone with a set of coping strategies
5	**Imagery as a creative/ artistic experience**		- Imagery was perceived as creative.
6	**Where? - wider Systemic/workplace aspects of imagery**		- Discussions about contextual factors influencing imagery use

All six themes fulfil the rules I described in Table 11 and follow the recommendations of thematic analysis literature (Braun & Clarke, 2022; Finlay, 2021). None of the themes could be considered as a topic summary, and none of them could be linked to one particular question. All themes use ideas from the three main professional participant groups, and none of the themes would be aligned to one therapeutic modality. Theme 1-3 all include codes relating to cognitive behavioural, systemic and psychodynamic ideas. All themes incorporated discussions about different risks and judgments, ensuring that moral decisions were not linked to only one particular theme. All themes were constructed inductively based on the code list and the transcripts, and the created themes explored hidden, latent meanings. In the following pages, I will describe the six themes. I will also present some data extracts in Tables 15-28 to show how these themes were discussed during the interview process.

3.4.1. Theme 1 – How? - Imagery as a Clinical Procedure

This theme was constructed from discussions when psychological professionals viewed imagery as a specific therapeutic procedure; they related to imagery as an intervention or technique and explained their use of imagery in their clinical practice because it was based on evidence or was prescribed by a therapeutic protocol or NICE guideline. Some of the interventions understood as clinical procedures were meditative exercises, compassionate images and yoga exercises, but the prescriptive use of the solution-focused miracle question

(Shazer, 2007), the Gestalt technique of chair-work (Perls, 1969) or a process-based understanding of dream analysis (Kohon, 2000) could also be categorised as a more procedural understanding of imagery. The anxieties professionals described in this theme were also related to procedures: lack of guidelines, therapists' difficulties in setting up imagery exercises, patients' increased rumination due to imagery techniques and people's dislike of mediation. Therapists' spontaneous mental imageries were viewed as a distraction to the treatment process, and participants often advocated for using other therapeutic procedures, such as soothing and grounding techniques, to manage SMIs. In this theme, many professionals described their relationship to mental imagery as comforting and relaxing and viewed the application of imagery as necessary. Teaching has often been highlighted as a way to gain more procedural knowledge, but supervision was also mentioned as a place where interventions could be practiced. Some participants described positive experiences of receiving imagery interventions in their personal therapy. Table 15 present some data extracts related to this theme.

Table 15 – Interview examples for Theme 1 - How?

Participant number	Data extract
Participant 18	So one thing it depends on is also if you are in control of that experience. So, if you are leading that bit of the imagery discussion experience or whatever, so you because you are in control, you can kind of choose how and what to do…
Participant 7	Why do I use it or not use it? So I think, you know the majority of the time, as I mentioned before, I would be forced to use it as an intervention. OK as a protocol because the patients' symptoms require it. […] Um so forced is a big word. I'd had maybe not using the word force, but you get what I mean.
Participant 7	So I guess you know in terms of the meanings that I derive from [SMI] and what I might feel is going on, yes it could be a patient's avoidance or distraction, it could be a therapist not being fully engaged in this in the session.
Participant 5	In the clinical practise, at the beginning, it was very uncomfortable [to facilitate meditation]. Because I had to develop the skills of […] you know, get used to it, so At the beginning was ohh, close your eyes and then I need like a couple of seconds

	to think of what I have to say and was like an uncomfortable silence and things like that. But the more I was practising it. […] I actually realised that if I do it with them, it's easier for them. [...] From practice. It became better. It's a very positive experience, I think, for both of us in the session.
Participant 11	I think if I have like a tool like if I already know a script, then I'm going to stick to it. And. Um, say like the safe place exercise. So I'm going to mainly stick to the script, but also kind of include my own way of doing things, but if I don't have a sort of script for it, I'm less likely to use it because I don't. I didn't have like further training in using imagery, so I don't want to do any harm.
Participant 15	I'm a little bit cautious about dreams. Um because sometimes. Um, the reason why I didn't get into like the content of the dream is because I had the impression that there was maybe the need of, um, exploring what was behind that request first without dismissing the need of having to explore the content necessarily, but having to kind of ascertain, you know, the reason for presenting it first.

Recognising that Theme 1 – How? and Theme 2 – What? at 3.4.2 might appear too complex, two subthemes each were created to highlight specific aspects of the themes. The purpose of these subthemes was to help the readers explore Themes 1 and 2 in more detail.

3.4.1.1. Subtheme 1 – "Imagery is a powerful clinical tool."

The subtheme was named after a code that captured interactions where participants expressed their strong belief that using imagery interventions is extremely effective. Under this subtheme, parts of the interviews were collected in which participants discussed their clinical practices of using imagery procedures or shared their experiences of previous personal therapies where imagery or meditation was used. As highlighted above, participants often used several imagery-based clinical procedures such as imagery rescripting for PTSD, third-wave CBT techniques, safe space meditation exercises, or images aimed to strengthen psychoeducational interventions. When participants wondered about the impact of these interventions on their patients, imagery was always portrayed as powerful. Many participants also disclosed personal experiences using imagery as part of meditative practices, and some shared their positive memories of receiving imagery interventions in their personal therapy.

Table 16 – Interview examples for Theme 1.1

Participant number	Data extract
Participant 3	I think [patients] find it really quite powerful , and you know, when I think about it, I suppose like the, the majority of the kind of intensive imagery work that I've done has been with PTSD. And often that first imaginal reliving where you're kind of engaging with the memory that way for the first time is really kind of a powerful. A powerful thing for them. It's offer them, so much more so than they expect, I think. And […] when we get to the end of it, they and […] reviewing the sessions, they will say. "I was so scared of doing that and it felt so hard, but that was the best thing that we did and that was the thing that made the most difference".
Participant 4	find it helpful for people to talk about examples using imagery. So it's useful for my understanding, but also from a patient point of view, I think in providing a little bit of insight and psychoeducation on the power of images and actually just how powerful our imagination is. Pretty much always a part of my sort of psychoeducation in the formulation stage.
Participant 10	So having a therapist sit down with me and talk with me how to combat those [images], how to follow those through and things was really important and like reflecting right now. I think that would be something that if the right client sort of came along. It's something that I would want to use.

3.4.1.2. Subtheme 2 – Needs for developing clinical processes

As emphasised earlier, discussions about mental imagery, when viewed as a clinical procedure, were often inspirational and criticism was mainly directed towards the lack of guidelines or training opportunities. This subtheme was developed from discussions with participants where they wondered how they could be more effective in delivering imagery procedures: supervision was mentioned as the place where imagery could be practised alongside formal training opportunities and workplace events. The benefits of experiential learning were often highlighted, and the need for continued practising these procedures was appreciated. When viewing imagery as a procedure, participants often commented that their clinical difficulties - such as setting up the meditation exercise or finding interventions tiring - could be improved by more practice or extra training/supervision. Participants also remarked that they had managed disruptive SMIs by using further procedures such as grounding techniques.

Table 17 – Interview examples for Theme 1.2

Participant number	Data extract
Participant 7	Sometimes it's hard to tell when, for a patient, but for myself, you know, I will then bring myself back to the room, you know, look at the time. Make basically just do something that that will allow me to feel present in the room because, you know, I don't want to. I don't need to be thinking about these things. […] If that is occurring with the patient, again, it will be just some present focus techniques and grounding techniques just to bring them back.
Participant 8	I would be very interested to have training on it. I've never worked with imagery in a kind of in a protocolised way […] I've never thought of it as something that I could use as a tool in a more manualised […] way that's more organised and structured. So I think that would be really interesting if there was training I could do or ideas from greater minds that I could use.
Participant 12	So we did role play where it was more so for guided relaxation. It wasn't like mindfulness. It wasn't anything to do with trauma. It was role play of Okay let's go through this. And I want you to be the client now, and I'll be the therapist and vice versa. So we took turns. And I think that was one of my first ever experiences of mental imagery in like a clinical setting with another professional. And I found that it really worked for me. And that's when I think it influenced my practice because I thought , ohh , this really worked for me. Let me use it in my next session.

3.4.2. Theme 2 – What? - Imagery as a Content

Theme 2 – What? was created to contain all communications where the content of the image was at the forefront. Content was frequently described by participants when considering trauma work or the content of the therapists' spontaneous mental imagery. Similarly, assessing patients' images, including mental images of self-harm and suicide, and collaboratively creating future-oriented images of positive therapy outcomes could be categorised as practices where the content of the image is central. Working with mental images within a systemic reflective team or psychodynamic practices of focusing on the therapist's somato-images all highlight an interest in the content of mental imagery. Several participants shared stories of being affected by the content of the images their patients shared with them, and many decided to take personal therapy after such experiences. It is no wonder that many participants also talked about their concerns about becoming the recipient of vicarious traumatisation and described making adjustments in their clinical practices to guard themselves against it. However, working with the content of the images can also be rewarding and could provide opportunities to create new narratives

or change the course of the treatment by gaining a new understanding of the patient's life.

Table 18 – Interview examples for Theme 2 – What?

Participant number	Data extract
Participant 4	But yeah, I suppose that then the only difficulty with [picturing what the patient says] is that I think sometimes those images can linger on my mind afterwards. Particularly working with trauma clients, I found that to be the case, not too sort of a really distressing level, but definitely something that kind of, you know, comes home with the job.
Participant 11	the images of person changing, if that makes sense, like when someone talks and you suddenly see like a child in front of you, but you don't actually see the child in front of you. […] yeah. Like when they respond, sort of from this child place. And then you kind of see them as very different to how they had looked just before.
Participant 12	So she [the patient] was trying to explain in detail what had happened to her. And you know how she was feeling. […] I can't lie. I was having flashbacks of similar situations that I was in. Not only that, but even you know, scenarios in movies that I'd watched and it was out of the blue, very random […] it took me back to […] something that I had experienced.
Participant 16	So I think in a trauma setting, I mean the images and the memories we were accessing were just so traumatic […] So first of all, it's very difficult for you to be receiving as a therapist and hearing the horrors that certain people have been through. […] More kind of the anxiety of I gotta take this information in that the person is gonna share with me and then do something helpful with it without letting me overwhelm me. And in some of the settings I worked with are things that I wish I had never heard, and I couldn't unhear to be honest.
Participant 17	Like I remember when we did, when a colleague of mine left the team I worked in. And [head of service] came and did an appreciation like a what do we call it? An appreciative inquiry! Sort of session. where [head of service] interviewed this worker, and then we all were the reflective team and then we did, I guess, yeah outside of witnessing and then we […] gave off these images and I just feel like it's so it hits another level that words don't, just talking doesn't always hit. And so it's just something that like because then if you describe the image, you are noticing that person can then feel it too, and start to imagine it as well.

Similar to Theme 1-How?, two subthemes were developed to highlight certain aspects of understanding mental imagery by focusing on the content features of the images.

3.4.2.1. Subtheme 1 – Experiences with image content

Many participants talked about their experiences of attending to the content of mental images when using trauma-focused interventions or managing their own spontaneous mental images in their clinical work or supervision. The purpose of collecting these correspondences under this subtheme was to show how different the quality of these communications was from the discussions about working with images as clinical procedures (see 3.4.1.1). Although many innovative clinical practices were shared by participants, such as attending images at staff consultations, imagery rescripting at trauma therapies, psychoanalytic interpretations of dreams, or when writing narrative therapy letters, it was also notable that the clinical work was perceived as much harder and riskier. Participants often disclosed episodes from their clinical practice where their patients or themselves were triggered by attending traumatic mental images, and many found this aspect of their work overwhelming. Unlike in 3.4.1.2, participants did not believe that their difficulties could be improved by increased training and the supportive aspects of supervision and personal therapy were highlighted as platforms where psychological practitioners could turn to when struggling with distressing images.

Table 19 – Interview examples for Theme 2.1

Participant number	Data extract
Participant 2	Other times I do have a more visceral reaction that I would obviously not show in front of the clients. For instance, if we're going into PTSD work and they're talking about the peak of their traumatic incidents, and I can imagine what's going on and it's not pleasant thing to kind of watch, it's not pleasant thing to be present with. […] It's like a feeling in the pit of your stomach.
Participant 7	I might be caught up with the content of the trauma. […] Do I take them into that, that memory or not? And you know, are they gonna find it pleasant or not? You know, trying to protect them from, from reliving that.[…] That's

	sometimes made me avoid going in there, especially in my early days as a therapist and that that's when I. Yeah, I remember cases clearly. […] it has a lot to do with the content, personal experience as well. If I'm very mindful that what someone is about to imagine or tell me has been relating to my life. I may not want to use imagery.
Participant 9	In terms of […] imagery to help understand or formulate, I guess I imagine you know for example with the genograms it's just a helpful tool which you don't need to have to write it down. But sometimes I think once they have worked with the family and starting to map how the generations and the potential influences that have led us to now, I feel like I almost retained that, you know what, I internalised it in a way and I kind of think about those complete, I can kind of see that is as a component whilst trying to understand the interactions.

3.4.2.2. Subtheme 2 –Views on image content

Participants' ambivalent clinical and supervision experiences of attending to the content of mental images were in line with their views of working with images. Although some participants acknowledged that an increased focus on mental images could be helpful in assessments and images could be useful for reflecting and thickening patients' stories, the overwhelming opinion shared by the majority of the participants was that images could be “risky”, “biased”, “triggering” and “unhelpful”. Participants' concerns about becoming a subject of vicarious traumatisation were one of the often-held beliefs under this subtheme.

Table 20 – Interview examples for Theme 2.2

Participant number	Data extract
Participant 16	I don't think [images] necessarily have more or less values than other input that we receive, but they just become part of that input and I think maybe because they are, they can impact us so strongly because they're multisensory. We also need to be a bit more careful with them. You know, like that just because something impacts personally doesn't mean that that's not necessarily the direction we're going to be taking on therapy.
Participant 17	I guess I definitely think it's important because part of the narrative theory really suggests that it can help people like really thicken their stories of preferred ways of being. […] And it's so part of the work to remind people that were just always like always moving through time […] if you project yourself backwards and think of a time in the past and you know, use your imagery to really connect with that time in the past, you might remember times that were better and actually how that like would help someone connect with themselves .
Participant 18	So there is that sense of yeah, the image is being connected with the feeling-sense that you have about someone or who they relate to you. Whatever is relevant to them. A little bit spooky, actually.

3.4.3. Theme 3 – With whom? - Imagery as a Relationship

Theme 3 – With whom? was formed to accommodate correspondences describing imagery as an agent for the therapeutic relationship; imagery helps increase communication between therapists and patients and supports them to create or reflect together. The relational aspect of imagery could be at the centre of therapeutic interventions not just in systemic but also in collaborative exercises of CBT and psychodynamic practices. Spontaneous mental imageries were regarded as part of this theme when they were used for relationship building between the therapist (Participant 17) and the team they were giving consultation to. This theme also included risk scenarios resulting in a relationship breakdown.

Table 21 – Interview examples for Theme 3 – With whom?

Participant number	Data extract
Participant 2	I think [imagery] can be very, very helpful, [...] I mean, I also find it easier to communicate to clients in this way […]. So it's easy to bridge that gap in communication by using imagery. […] Yeah, I think it's helpful in the connecting with the clients. […] bridging any language barriers or comprehension barriers.
Participant 4	Yeah, it tends to be very apparent when a patient I'm working with shares that same experience, cause I feel I can gain a lot deeper understanding when people have quite detailed sort of pictures. […]There's kind of a shared understanding.
Participant 8	So when you use imagery to explain these things, I feel like sometimes it's a lot easier for people to understand what they're doing and what's happening.
Participant 14	I think it would be easy to use [imagery] with clients that I've got a better therapeutic relationship than with others.
Participant 15	[what is important is] what we are doing with the vision. I feel that is something that has to be, as I was saying before, co-created; it is not something that would necessarily be my decision to make. […] it helps it to almost like create a sort of language that you kind of go back to from time to time.
Participant 17	I guess cause it's really stuck with me, and I found it really useful as a metaphor or as an image to be thinking of. And then like it's more like how it

	helped me think about the dilemma I have at work? […]But how do I then offer something that's different but still like still useful? […] So I guess it's like it's how I then change my work with the frontline staff based on this consultation with that imagery.

3.4.4. Theme 4 – Who am I? - Imagery and the Therapist's Self and Identity

In Themes 1-3, participants' view of the concept of mental imagery influenced how they related to applying it in their clinical practice. Theme 4 – Who am I?, however, was constructed from communications concerned with how the participants and their view of themselves were affected by using imagery. As the participants were psychological practitioners, it is expected that they would be able to reflect on different aspects of themselves and therefore, dividing this theme into five subthemes appeared to be practical to highlight the different ways participants related to their professional and personal selves or their perceived inherited characteristics.

3.4.4.1. Subtheme 1 - Personal characteristics

This subtheme was constructed from statements participants made about their perceived ability to apply imagery in their lives. This ability was often portrayed as a permanent, inherited characteristic of the person and was communicated in matter-of-fact statements. Under this subtheme, many participants shared that they were "visual thinkers" or were "very good at thinking in pictures". Participants 1, 11, 15 and 16 viewed themselves as lacking the ability to engage with imagery and meditation and talked about their "short attention span", which somewhat influenced (at least initially) their use of imagery practices.

Table 22 – Interview examples for Theme 4.1

Participant number	Data extract
Participant 1	And I think for me, what I find difficult, so I don't, I don't dislike it, but I find difficult is my attention is all over the place and understand meditation is precisely the attempt to bring that in the present moment and to, you know, to

	deal with your attention. But I've never really completely successfully been able to focus on like this. […] You know, I think, yeah, I can't consistently stay in an image or picture something without completely different popping up or me completely losing track of what we're doing. And I think that has made it harder. My attention is pretty poor. My concentration is pretty poor.
Participant 18	it's the way I work, and it is the way I think; everything needs to be visual as well, as you know said, if that makes sense. The words need to become visual for me to remember things for me, to make sense for me, to be me.

3.4.4.2. Subtheme 2 - Professional identity

Using imagery activated some of the beliefs the participants held about being a psychological professional. In this subtheme, the participants shared their concerns that imagery use might badly reflect on them as psychologists or on the profession as an evidence-based practice. Worries that imagery and dreamwork were pseudoscientific or quasi-religious were widely shared.

Table 23 – Interview examples for Theme 4.2

Participant number	Data extract
Participant 14	the use of imagery, I think, for some people, can feel a bit out there, a bit wowo. […]Do you know what I mean? […] like maybe not based as much in science.
Participant 17	[my colleagues] think, like 'Oh God, psychologists just love thinking!' You know, […] in a bit of a like a derogatory way because they just want action, and they want me to go in and just diagnose people or whatever. And so I'm just like[…] if I then asked them to also do some imagery, should be like ohh No now really??. You like you were gone so far out!

3.4.4.3. Subtheme 3 - Therapy method identity

Discussion about imagery practices also encouraged some participants to consider how imagery could be used in their preferred therapeutic modalities and activated their beliefs related to therapeutic modality group identities. Views like "I am not sure imagery rescripting is as effective" or "I don't use much

imagery because I use systemic therapies" were typical within this subtheme. Comparing imagery to other practices was also common.

Table 24 – Interview examples for Theme 4.3

Participant number	Data extract
Participant 13	So there's that piece of my own personal bias in terms of what works, maybe that perception with a lot of the therapeutic modalities that breath work and body work comes first, and then [imagery maybe later].

3.4.4.4. Subtheme 4 - Personal concerns in therapy skills

The use of imagery, as with any other therapeutic technique, could activate psychological professionals' long-standing concerns about their ability to conduct therapy or relate to patients. These anxieties might influence how they view the imagery interventions themselves.

Table 25 – Interview examples for Theme 4.4

Participant number	Data extract
Participant 2	If I'm trying to do [imagery] on the spot for instance, then I might start to feel a little bit lost and confused and a little bit just uncertain, feeling like I'm letting my patient down on some level or feeling like I'm not as experienced as I would like to be or as the level of expertise would like. But most times, it tends to go okay.

3.4.4.5. Subtheme 5 - Personal coping

In this last subtheme, beliefs were collected where participants reflected on their relationship with imagery based on how effective it was in helping them cope with their personal struggles.

Table 26 – Interview examples for Theme 4.5

Participant number	Data extract

Participant 7	that's really been my personal experience of using imagery in my life really. My, you know, problem orientation when I'm thinking about a problem. I'm imagining the different ways I can solve it.

3.4.5. Theme 5 - Imagery as a Creative/Artistic Experience

Theme 5 was organised around the idea that imagery was related to creativity and art. This belief often activated baseless judgements that patient with neurodiversity might find it harder to benefit from imagery interventions as their creativity was somewhat impaired. Other participants emphasised that imagery interventions could be very effective with patients with artistic backgrounds, while a few wondered about their own artistic aspirations and how that could influence their use of imagery.

Theme 5 was developed from *Theme 4 – Who am I?* as its core ideas about being creative could be understood as statements from the other end of a spectrum about being “bad at imagery” or “wishes to have a more scientific practice”. However, it was recognised that beliefs about creativity could influence ideas away from the participants' selves and activate stereotypes about patients’ characteristics (e.g., artist patients or patients with learning disabilities); therefore, it was decided to collect these statements into this separate theme.

Table 27 – Interview examples for Theme 5

Participant number	Data extract
Participant 9	I mentioned I guess I've tried to read a lot, and I think that inevitably evokes imagery. And so I think [...] Some really like nice writing or music can kind of evoke or summarise […] in a way that just talking about it doesn't. If something's quite poetic, you know, sometimes it has quite some beauty to it, if that makes sense. Sometimes, you don't fill the gaps, and the things leave space for you to imagine. […] That can sort of influence how you listen to the stories of the patients.

Participant 13	He [the patient] worked in the creative arts if I am not wrong, so he was so creative that was a real strength for him and [the imagery intervention] just clicked immediately, and it was amazing the difference.

3.4.6. Theme 6 – Where? - Wider Systemic/Organisational Aspects of Imagery Use

Comments about systemic/organisational barriers to the use of imagery in clinical practice were collected together to construct this theme. Many participants highlighted time limitation, especially in IAPT services, as a major factor for not using imagery interventions as frequently as they wished. Others mentioned that the changing ways of delivering therapy had affected the use of imagery, while some highlighted therapists' high caseload as a reason for not engaging with more original clinical practices. Participant 10 talked about their experiences as an assistant psychologist and how their role was viewed concerning imagery interventions.

Table 28 – Interview examples for Theme 6 – Where?

Participant number	Data extract
Participant 3	It is tricky when you are doing [imagery interventions] remotely, I think.
Participant 4	with respect to people that were trained some time ago, I'm not sure how much importance was put on kind of working with imagery. But yeah, we had a whole lecture on it, so it was definitely seen as a priority and something that was important.
Participant 6	As a PWP you have again quite short sessions, and you don't have a lot of them either, so I tend to feel like I really want to like do one thing really well with a patient and kind of really make sure that they completely understand it rather than look at many different things and relaxation and mindfulness, and that kind of stuff is something that I think can be so so useful. But I wanna bring it in once it feels like we kind of covered the other basic stuff. And often, it means that we don't really have time, or I don't have time to go through that with the patient.
Participant 10	I think in the context of me, as like an assistant psychologist that really wants to kind of push on with my career. When you hear someone wants you to do a

	piece of mindfulness or you've been assigned a piece of like relaxation and all mindfulness work, it kind of almost feels like a bit dull at the same time because even though, you know, it's helpful, it doesn't feel like you're really getting into, like, nitty gritty psychology. And I think that's because of the way it's presented as something the assistants do, you know? […]. It's not in the same league as something like um. Like a piece of narrative work.
Participant 11	I think we haven't talked about countertransference and transference at all during my CBT trainings. […] when it comes to reflecting on yourself in CBT because you have SP/SR, but that's kind of encouraged that you do that based on a book in your own free time. It's not like you have this sort of reflective practice built in your actual therapy practice.

3.5. Summary of the Results/Analysis Chapter

After familiarising with the transcriptions, all 18 interviews were coded using a critical realist approach to data, keeping the codes close to the original text and mirroring CBT therapists' approach to therapeutic information. Through several phases of theme development, and maintaining a reflective, curious attitude and a social constructionist position—similar to the theoretical approaches of the participants using systemic and psychodynamic modalities—six themes were constructed to answer the thesis research question.

These themes tell six different stories of how psychological professionals view, use and manage mental imagery in their clinical (and supervisory) practices. In some cases, imagery is viewed as a lesser-known but interesting clinical procedure that could be applied as a technique at certain moments of the therapy, and it is also prescribed in some protocols. Clinical procedures can be taught. In other cases, the content of the imagery could come so much at the forefront of the encounter that it could influence the course of the therapy, and when the content is traumatic and revisited, it can cause pain not just to patients but to the therapist. Through supervision, personal therapy, and reflection, even difficult content can be processed, which can often be transformative. In some cases, professionals viewed imagery as an aspect of the therapeutic relationship, and it was interpreted in a relational framework as collaboration, a deterioration of the relationship, or an opportunity to amend that relationship.

Theme 4 – Who am I? talked about how the use of imagery could be interpreted as a reflection of some aspects of the professionals themselves: linking the use of imagery to personal characteristics and professional or personal identity elements can easily define one's attitude to imagery and can encourage or discourage professionals from using specific imagery practices. The idea that imagery is intrinsically creative can motivate some professionals looking to use their artistic skills in their therapeutic practices but could also scare others off from exploring imagery in their clinical work. The perceived link between creativity and imagery could also limit to whom professionals introduce imagery interventions. Theme 6 – Where? discussed some structural limitations psychological professionals face when trying to maintain good quality treatments: organisational time restrictions, insufficient training and supervision and power imbalance amongst different professionals.

4. DISCUSSIONS, RECOMMENDATIONS, LIMITATIONS OF THE RESEARCH AND CONCLUSION

4.1. Discussions

The six themes constructed during the process of thematic analysis have the capacity to answer the research question on psychological professionals' relationship to mental imagery; their views and experiences of using and managing mental imagery in their clinical and supervisory practice in depth. Unlike previous qualitative studies (Bell et al., 2015; McGown, 2014; Warrington, 2020), these themes could tell stories not just about professionals' different views of mental imagery but also explain why some professionals did not like to work with images and how they could be supported to become more confident in their clinical practices with mental imagery. Although professionals'

positive experiences with mental imagery will be considered in this Discussion chapter, a bigger emphasis will be put on how the six themes can explore clinicians' problems with mental imagery and how these problems could be mitigated within the frameworks of the specific themes.

When reading articles on the clinical applications of mental imagery, one can easily have the impression that there is a "growing interest in the use" of imagery (Holmes, Arntz, et al., 2007, p. 297), and this "interest in application is quickly increasing" (Arntz, 2012, p. 189). Although in the same articles, the reader could notice some comments indicating that psychological professionals could be apprehensive about using imagery[3], this apprehension has never been elaborated, and there has been no recognition that "holding" the patient's negative images "in mind" could be a more "emotionally charged experience" (Holmes, Arntz, et al., 2007, p. 299) for therapists as well. Previous research on psychological professionals' relationship to mental imagery (Bell et al., 2015; McGown, 2014) acknowledged the apprehension psychological professionals experienced when using mental imagery. However, these qualitative studies failed to develop rigorous and relevant themes to explain the underlying reasons for this apprehension and settled with less meaningful topic summaries instead. The negative experiences Bell et al. (2015) and McGown (2014) listed in their Discussions were very similar to the experiences participants reported in their interviews for this thesis: feeling unprepared, scared from vicarious traumatisation and worried about being perceived as pseudoscientific.

To highlight how widespread the apprehension and dislike of mental imagery was in this current sample of participants who volunteered to participate in research on mental imagery, Table 29 collected some of the negative experiences they mentioned in their interviews.

Table 29. Negative experiences with mental images

Participants sharing these views	Negative views and experiences

[3] "Therapists tended to prefer ImRs above IE [imagery exposure] as they felt less helpless listening to the trauma relivings and experienced less distress with ImRs" (Arntz, 2012, p. 193).

Participants 1, 11, 15 and 16	*"I am not imaginative", "I can't attend to my images".*
Participants 5, 8 and 12	Reported experiencing disturbing spontaneous mental images during therapy, which made them seek therapy for themselves.
Participant 9	Reported feeling guilty for attending to their spontaneous mental images.
Participants 13, 14 and 16	Talked about previous workplaces where they worried about vicarious traumatisation.
Participants 2 and 4	Reported finding it hard to work with trauma images.
Participant 18	Shared that they had made deliberate career choices to avoid working with severe trauma cases.

Experiences like the ones reported by Participants 5, 8 and 12, forcing professionals seeking therapy, highlight that studies researching mental imagery have an ethical responsibility to consider the negative consequences of using mental imagery. Research should not assume that all professionals want to use imagery and don't have any negative preconceptions about the clinical applications of mental images. Talking openly in research studies about professionals' apprehensions, fears and misbeliefs about the clinical use of images can be the first step in reducing therapists' burnout, treatment breakdowns and the administration of insufficient psychological interventions.

Before discussing each theme in detail and exploring the opportunities they could provide to enrich the understanding of the clinical application of mental imagery, it is worth revisiting how some of the theoretical decisions of the Introductory chapter enabled the development of these themes. This thesis employed an expanded definition of the clinical use of mental imagery by incorporating spontaneous imagery and voluntary imagery interventions. It also harmonised the understanding of the use of SMI and MI in different therapeutic modalities, such as CBT, systemic and psychodynamic therapies, and considered supervision practices, developing the most detailed and versatile description of the clinical use of imagery in psychological literature today.

Burnham's (1999) concepts of Approach-Method-Technique provided a framework to explain how seemingly different therapeutic encounters could still be understood as imagery use. Many participants commented that they had not found a comprehensive text on how to use imagery in their practice. The writing of the Introduction chapter was a response to these requests and, in a manner of research ethical caretaking (Sampson, 2003), an attempt to thank them for their participation. The detailed description of the different imagery use in the Introduction chapter was also indispensable in the construction of the analytic themes. Without understanding how CBT practices changed from early cognitive and behaviouralist techniques to contemporary imagery rescripting or appreciating the differences between Ogden's and Rober's attitudes to imagery, the final themes would struggle to represent various theoretical modalities and tell meaningful stories about professionals' apprehension, risks and positive practices.

4.1.1 Discussion of the Results

Theme 1 – *How? – Imagery as clinical procedures* can integrate many therapeutic experiences from different therapeutic modalities, from process-based psychodynamic dream interpretation to meditative and imagery interventions (Beck et al., 1985; Hackmann et al., 2011; Kohon, 2000; Piercy & Tubbs, 1996). Problems with imagery under the framework of this theme were understood as either the professional had not gained enough knowledge in delivering the imagery interventions or they were hindered by something from completing the intervention properly. To overcome these difficulties, psychological practitioners could employ the following measures: they can practice imagery interventions more often to manage initial hardship (1), they can attend experiential learning spaces (2), especially supervision spaces where imagery could be role-played (Milne & Reiser, 2017) and they could engage with other clinical procedures like grounding exercises and goal setting (3). The most often recommended way (Bell et al., 2015; Davis & Brown, 2000) to overcome problems with imagery procedures was by attending further

training (4). Teachings on mental imagery, whether in High-Intensity therapy training, third-wave CBT courses or special modules in Psychology Master's programmes, could be invaluable in acquiring the necessary skills to facilitate mental imagery procedures. Practising meditation could also be experienced as part of the systemic Fifth Province supervision spaces (McCarthy & Minogue, 2019).

This theme would suggest that if the professional was well-trained and delivered the imagery procedure as prescribed, therapists and patients should not face many challenges. If they did, for example, they experienced highly disturbing traumatic images, they could employ further clinical procedures like breathing and grounding techniques or short-term distractions. Although Participant 3 and 4 talked enthusiastically about their experiences of lectures on imagery during their Postgraduate High-Intensity Therapy training, imagery interventions are only mentioned in the national curriculum for CBT therapy as part of certain diagnostic-specific treatment protocols (HEE, 2022b), indicating that there is still a significant variety in the quality of imagery teachings in therapy training. The doctorate training in clinical psychology at the University of East London, where this thesis has been submitted, has no lectures on imagery.

Even the limited data extracts shared in this thesis constructing *Theme 2 - What?- Images as content* could highlight (see Table 18) that clinical procedures and more training could not always be the answer to managing distressing images. Theme 2 – What? would suggest that professionals struggling with their negative spontaneous images or their patients' trauma images had found imagery difficult not because they had not used enough distraction techniques but because the content of the image was so personal that it became hard to move on. As the source of the distress for these professionals was the content of the image, it appears that it could be beneficial to create supervision spaces where the psychological professionals could attend to these distressing content elements. As highlighted in Subtheme 2.1, professionals believed that their struggles with the content of the images could only be addressed in reflective and supervisory conversations, and there was no suggestion of improving their practices through individual learning or training courses, which were often put forward as a desired outcome in Subtheme 1.2.

Supervisory conversations about what evoked the distressing image in the therapy and to whom the image belongs could be implemented using various theoretical models. Psychodynamic theoretical frameworks of transference-countertransference (Kernberg, 2010) and field theory (Ferro, 2021) are only one way of conducting these supervisions. Alternative supervisory discussions could be managed using systemic (Rober, 2021) or CBT approaches. Although recent articles argued for the use of transference-countertransference in CBT supervision spaces (Cartwright, 2011; Prasko et al., 2022), practitioners finding the theoretical framework too far off from their usual practice could implement more traditional CBT supervision frameworks still allowing space to discuss the supervisee's distress (Newman, 2010; Padesky, 1996). Even the self-reflective SP/SR workbook (Bennett-Levy et al., 2015) encourages therapists to consider the content of their images in relation to their own mental activities. With access to efficient supervision, psychological professionals could use the content of mental images presented in therapy sessions to inform their formulations of the case and transform treatment plans. Similar to McVey's study on reverie (2020), participants who shared experiences of successful clinical use of the content of mental images reported an improved understanding of their cases and an enhanced connection with their patients.

Theme 3 – With whom? – Imagery as a relationship told a different story about managing images, and it highlighted that therapists have more opportunities to handle images than to attend to the content or the clinical procedure. Imagery could be used with a relational intent, and relationships could be used to contain or process distressing images. Psychological professionals can weigh the benefits of using imagery interventions based on their judgment of whether it serves the therapeutic relationship or not. It often appeared that participants used imagery because of its relational benefits: it helped their emotional communication with their patients, and they felt that it enabled them to form a closer therapeutic relationship. These relational benefits could prevail when skills appear to be doubted, and anxieties about possible negative contents are high.

Participants sharing their difficulties with traumatic images and imagery procedures often concluded that they maintained using imagery as they felt that

it helped the therapeutic relationship. The relational benefits of imagery could be mobilised in appreciative inquiries (Cooperrider & Whitney, 2005), team consultations and supervision spaces where the meeting facilitator could encourage the group or team to create images together and use these to support team dynamics and help the groups move forward. The use of images in agency-based systemic supervision could aid cohesion within work teams and support the understanding of the organisational context (Partridge, 2010).

Themes 4 – Who am I? - Imagery and the Therapist's Self and Identity highlighted several beliefs which could affect the clinical use of imagery: concerns that psychological professionals could be inherently bad/good at imagery (Theme 4.1), that imagery use would affect how they were viewed as psychologist/scientist-practitioners (Theme 4.2), whether their preferred therapeutic modalities appeared to be assigned with imagery (Theme 4.3) and their previous personal concerns (4.4) and coping methods (4.5) included any imagery elements.

Narratives about having some deficits in imagery were presented differently in the interviews. Some participants (Participants 1 and 16) complained of having "*terrible attention"*, making it hard to focus on meditations and maintain mental images for long. Others (Participants 11 and 15) reported struggling with poor capacity to imagine things and cited low hypnotisability skills. Ideas about low hypnotisability (Elkins, 2021) and imagery deficit could be linked to participants' aphantasia (Dance et al., 2021) but could also be a response to the interview: participants often reported that they were unsure about their skill level in imagery and concerned that they might give insufficient answers to the questions. Similar to Bells' (2015) findings, participants characterising themselves as "bad" at imagining did not show evidence of poor practices when describing their clinical practice in imagery. On the contrary, Participant 11 used innovative practices of creating personalised meditation tape recordings for their patients, highlighting that relational aspects of the therapy (e.g., patients' appreciation) could help practitioners overcome their professional difficulties. Similarly, participants who considered themselves particularly "good" at imagery were not necessarily able to translate this trait into clinical skills, and some

(Participants 2, 8, 18) reported that being a “visual person” might have been a risk factor when treating patients’ trauma images.

Ideas related to Subtheme 4.2 on professional identities as psychological practitioners and 4.3 as therapists of certain modalities appeared to be more flexible than the beliefs creating Subtheme 4.1. Participants often reflected that they had initial fears that imagery practices would be perceived as unscientific by the patients, but the positive reception from patients helped them overcome these fears. Similarly, participants who were unsure about the clinical use of imagery in their preferred therapeutic modality often reflected that the experience of participating in the interview helped them realise that their modality had a rich imagery practice they might not have tapped into. As mentioned earlier, academic training could support the dissemination of efficacy studies on imagery interventions and reduce concerns about their perceived unscientific nature. Similarly, one of the aims of the extended introduction chapter was to tackle beliefs that imagery would only be a CBT intervention and emphasise that it could be used in psychodynamic and systemic practices. It also intended to show that even within traditional CBT, there were many avenues to apply imagery, and it should not be limited to the therapy of PTSD. Concerns that psychological practices would be experienced as unscientific are not specific to imagery interventions, and it could be argued that they are more of a reflection of modern psychology’s obsession with science, clinical psychology’s unhelpful desires to compete with medicine, and evidence-based medicine influence on reinterpreting the meaning of treatment evidence and efficacy (Bruun, 2023). Participants expressing their fears of being seen as pseudoscientific, therefore, could be understood in this wider context.

Subthemes 4.4 *Personal Concerns in Therapy Skills* and 4.5 *Personal Coping* showed how the use of clinical practices such as imagery could activate professionals' already existing fears about their competencies or inspire them to apply these practices in their lives. The relatively few codes under these subthemes were insufficient to support Bell and his colleagues' (2015) conclusion that positive personal experiences with imagery could increase the clinical use of imagery.

By creating Theme 5, this research attempted to highlight that linking imagery practices to creativity and art could often hinder the clinical use of imagery rather than help it: psychological professionals considering themselves non-artistic might feel unskilled in using imagery sufficiently. Ideas about creativity and the artistic nature of imagery interventions also encourage harmful stereotypes and could lead to the exclusion of marginalised patients with neurodiversity, learning disability or non-middle-class, non-artistic backgrounds from receiving evidence-based imagery interventions. The interviews did not support the idea that there would be any benefits in promoting the link between creativity and imagery: Participants 6 and 9, who considered themselves to have artistic interests, reported struggling to transform these artistic skills into clinical applications. Creativity, imagination and artistry are often used interchangeably in everyday language and earlier in the thesis, studies were cited advocating for more artistic psychological interventions (Moon, 2020; Wagner, 2012); however, the creation of this theme prompted a revisit of the use of words and increased awareness about employing adjectives like "*creative*".

Theme 6 Where? - Wider Systemic/Organisational Aspects of Imagery Use described several structural issues, from time limitation to training gaps and professional role perceptions to cultural aspects of imagery. As the majority of the CBT therapist participants and several non-registered participants worked in IAPT services, many of the structural problems cited within this theme have been described in the literature critical with IAPT services (Dalal, 2018; Scott, 2018). Time limitation was mentioned by every CBT therapist and PWPs working in IAPT services as a major factor for not using imagery interventions. However, these concerns were not shared by clinical psychologists working in other services or the sole CBT therapist from the sample working in private practice.

The privatised IAPT services were created to promote an individualistic New Labour ideology propagated by Lord Layard (2006) and David Clark. In these services, therapy session numbers have been reduced to increase the financial efficacy of the local IAPT companies, making therapists struggle to complete treatment plans with imagery interventions, like Clark's own PTSD protocol,

properly. The reduction in session numbers has been discussed in IAPT's official promotional articles (Clark, 2018) as an “increase in efficacy”. However, pressures on therapists to complete treatment in a few sessions is often contrary to the CBT protocols (Beck et al., 1979; Fennell, 1997) the therapists meant to follow, and it might influence CBT’s declining recovery rate (McInnes, 2023) and contributes to CBT therapists growing discomfort with their work at IAPT services (Bruun, 2023). As it is unlikely that the commissioning of IAPT services would significantly change in the future (Labour, 2023) and service targets might continue promoting short-term interventions, it is up to the psychological professionals in managerial positions how these targets are enforced and whether efficient treatments with imagery interventions are promoted.

Other concerns collected in this theme could also be eased by organisational changes and amendments in team dynamics: access to weekly individual clinical supervision and further group supervision practices could help clinicians reflect on their difficulties with traumatic images and consider transference-countertransference aspects of their work. Expectations of the assistant psychologist’s role are widely different from services (Ramsden et al., 2022), and organisations often fail to recognise that the role was originally developed to provide work experiences to prospective trainee clinical psychologists (Snell et al., 2022); therefore the role should have a strong developmental focus (Woodruff & Wang, 2005) where learning about imagery and meditative practices and attending appropriate training opportunities could be one of the priorities.

4.1.2 Reflection 4.: Discussion of the Interview and the Analysis Process

Participating in the interviews and facilitating conversations on mental imagery had an impact on my participants and my own understanding of the topic. Similarly to previous research findings (Bell et al., 2015; Cartwright et al., 2019; Warrington, 2020), almost all participants talked about their appreciation of attending the interview and how it provided a space to think about aspects of their clinical practice. They often reported that going through the interview

process helped them gain a deeper understanding of their use of mental imagery and that they enjoyed spending time exploring their clinical work differently from a regular supervision or training session. Participants also frequently expressed their hope that attending the interview could positively impact their clinical practice and reflected that they were pleasantly surprised about the richness of their own clinical practice.

Facilitating the interviews and discussing mental imagery with the participants affected my relationship with the subject and encouraged me to think more widely about the clinical applications of imagery. Although this thesis was not a participatory research project (ICPHR, 2013), co-learning between participants and myself was evident throughout the interview process. As mentioned above, I included many imagery interventions in the Introduction chapter in response to my conversations with my participants. I am also indebted to Participants 14 and 17 for their literature recommendations about Peter Rober and Appreciative Inquiry.

As discussing my own and my participants' relationship to the interview and analysis process, it could be useful to revisit ideas of relational ethics and assess whether the thesis managed to avoid committing any epistemological violence during the analysis and interpretation process. Inspired by Kaulino and Matus's (2021) paper, the six themes and their discussions were conducted with an attempt to refrain from using any essentialist arguments (e.g., “this is what CBT therapists/APs do”). When choosing transcript extracts, I was mindful of not presenting any participants in a negative context. Even when I was critical of my participants’ opinions on neurodiversity (See Theme 5), I deliberately did not list transcript extracts from any particular participants as I did not want to make the impression of arguing with their views.

4.2. Recommendations

4.2.1. Clinical Recommendations

Psychological professionals' relationship to mental imagery could be improved by increasing access to training opportunities, shifting the focus of supervision discussions and enhancing an awareness of the language used around imagery.

1. Training appeared to be pivotal to overcoming anxieties around the administration of clinical procedures; therefore, courses on third-wave CBT, meditation, and imagery techniques could help professionals become more confident in applying these interventions. However, curriculum guidelines (HEE, 2022b) should emphasise the transdiagnostic features of imagery applications instead of only suggesting imagery interventions as part of certain specific protocols. Many participants using CBT emphasised that they would have welcomed more training on the specific procedures of imagery rescripting (Arntz, 2012), as CBT training courses slightly overlooked this approach. Teachings on meditation, imagery, and relaxation techniques in Psychology Master's programmes could help provide a specific skill set to prospective assistant psychologists and define assistant psychology roles. Similarly, imagery procedures should be part of the doctorate in clinical psychology programs to better reflect the role's responsibilities of delivering and supervising imagery interventions. More training opportunities could challenge professionals' beliefs about imagery's unscientific nature and highlight its applicability in therapeutic modalities other than CBT.

2. Individual and group supervision spaces could be beneficial for psychological professionals to practice imagery skills, but they could also offer a reflective space to consider the content of distressing images regardless of whether they came from the patients or the professionals themselves. Services failing to provide sufficient and supporting supervision provisions could risk professionals being subject to vicarious traumatisation or could deter professionals from using imagery interventions. Supervisors

need to be aware of addressing the content of distressing images and not approach imagery interventions exclusively as clinical procedures. Systemic and psychodynamic supervision spaces could highlight the relational aspects of imagery interventions and provide opportunities to consider transference-countertransference in clinical practice.

3. To support the use of effective imagery interventions in clinical practice, professionals and researchers need to consider the language used around imagery: linking imagery in creative and artistic practices could lead to discrimination against patients from certain marginalised groups. No research indicates that imagery would only be beneficial for neurotypical and creative patients. Unhelpful connections between imagery and creativity could not just scare off prospective patients but could deter professionals from facilitating imagery interventions. Professionals considering themselves as “bad” at imagery and creative/artistic activities could be put off from using imagery due to their supposed link to art while anecdotal evidence so far would not support that these professionals would not be able to apply imagery successfully.

4.2.2. Research Recommendations

Future research could explore the relevance of the themes, investigate clinical mental imagery use from the patient’s perspective and use the theoretical foundations of the thesis to build bridges towards other professions using imagery.

1. The relevance of the themes developed in this thesis could be examined further in future studies on the supervision of mental imagery interventions. The hypothesis shared in 4.1 suggests that supervisors should consider the type of mental imagery (procedural, content or relationship) presented to them when offering support to their supervisees. As imagery practices categorised under different themes could require different supervisory

approaches, supervisors working in services using mental imagery could be interviewed about the applicability and relevance of these different themes.

2. *Theme 3 - With whom?* highlighted the relational impact of imagery interventions between patients and therapists. This could be further explored by focusing on patients' rather than professionals' relationship to different mental imagery interventions. Similar to Bosch and Arntz's (2023) study of interviewing therapists and patients about the usefulness of ImRs, patients could be surveyed about their experiences and views of imagery interventions. Learning more about patients' views of imagery interventions could allow research to interrogate the validity of therapists' concerns that imagery could be viewed as pseudoscientific by prospective patients or, as Participant 14 (see at Table 23) commented, as a "wowo".

3. This thesis tried to harmonise the language of mental imagery within different psychological therapeutic and supervision approaches; however, imagery interventions are widely used in other alternative therapeutic interventions such as yoga instruction (Gimbel, 1998), reiki meditation (Buyukbayram & Citlik Saritas, 2021), sport psychology and coaching (Munroe-Chandler et al., 2022) and art therapies (Haeyen & Staal, 2021). As training pathways and professional socialisations of psychological professionals are widely different from those of these aforementioned therapeutic practitioners, studies using the framework of mental imagery could help to gain more understanding between these professions.

4.3. Limitation

This thesis employed a broad definition of mental imagery and considered the clinical applications of imagery by interviewing a variety of psychological professionals using different therapeutic modalities. Agreeing with Vasileiou et

al. (2018) that the perceived inadequacy of sample size has been unjustly used as an argument for the limitations of many qualitative studies and given that this thesis interviewed the highest number of participants in any study researching psychological professionals' relationship to mental imagery, it could be confidently stated that participant number would not limit the validity of the analysis.

As noted in 1.2., the definition employed by this thesis did not consider psychological interventions using external visual images or perception. Studies advocating for the therapeutic application of pictures were not included in this thesis (MacLennan et al., 2024; Wilson et al., 2018) as they did not possess a comprehensive theory to explain how the perception of external images could be transformed into an internal mental representation. When interventions using visual aids were considered, in the form of genograms or the emotional map of the home, it was explained in what forms these interventions could be viewed as mental imagery procedures (see 1.3.4.2). Although nighttime images are not always regarded as part of the mental imagery literature, the omission of dreams would risk restricting this thesis's capacity to interrogate the psychodynamic use of images; therefore, efforts were made for participants to reflect on their dreams even if the interview schedule did not have a specific question on nighttime images (see 2.7). Decisions about the use of an inclusive definition of mental imagery allowed this study to develop themes relevant (Finlay, 2021) to a wide variety of psychological professionals and able to resonate with therapists aligning themselves to different modalities and hence not limit itself to become a replication of Bell's (2015) cognitive study or Cartwright's (2019)' research on SMI.

As mentioned earlier, due to space limitations, it was impossible to give a detailed description of the clinical use of imagery in third-wave CBT approaches and Jungian psychoanalysis. The interview questions were similarly not modified to capture the application of imagery in these approaches, and professionals familiar with these therapies were not specifically recruited for the research. It is also crucial to recognise that this research was conducted within a British context, which might differ from places where psychological professionals are less frequently employed and trained by the public healthcare

system. Job roles, training pathways, and even the theoretical underpinnings of different therapeutic modalities could be dissimilar to the context of this thesis.

4.4 Conclusion

This thesis explored psychological professionals' relationship to mental imagery. Bell and his colleagues' (2015) adopted definition of mental imagery was chosen for the research as it employed a broad understanding of the concept, allowing the study to explore voluntary imagery interventions and involuntary phenomena such as dreams and spontaneous mental images. After a detailed examination of how imagery has been employed in cognitive behavioural, systemic family and psychodynamic therapies and related supervisory practices, the limited literature on psychological professionals' attitudes to mental imagery and spontaneous mental imagery was reviewed, and research capable of synthesising the literature on spontaneous and voluntary mental imagery interventions and imagery's use in supervision were designed. Eighteen professionals (six CBT therapists, six clinical psychologists, and six non-registered psychologists) were recruited and interviewed about their experiences with different clinical applications of imagery. The interviews were analysed using thematic analysis (Braun & Clarke, 2022), and after a lengthy process of coding and developing themes, six themes were constructed to answer the research question. Based on these themes, psychological professionals relate to mental imagery in their clinical practice as one of the many clinical procedures (Theme 1), approach it according to the content of the image (Theme 2) or see it as a practice influencing the therapeutic relationship (Theme 3). Mental imagery was also considered based on how its use affected the psychological professionals' view of themselves (Theme 4), and some participants emphasised their link to creativity and art (Theme 5) and some structural/organisational factors (Theme 6). All these different ways of relating to mental imagery could offer opportunities for psychological professionals to advance their clinical work but could also create difficulties. Unlike previous research, a high level of apprehension was noted across the spectrum, from

fear of not using certain procedures correctly to negative experiences with trauma images. Some professionals had to seek therapy because of their clinical experiences with mental imagery. The thesis closed with specific clinical and research recommendations and acknowledged the limitations of psychological research conducted in a British psychology context.

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6. APPENDICES

Appendix A. Ethical Approval Letter

School of Psychology Ethics Committee

NOTICE OF ETHICS REVIEW DECISION LETTER

For research involving human participants

BSc/MSc/MA/Professional Doctorates in Clinical, Counselling and Educational Psychology

Reviewer: Please complete sections in **blue** | **Student:** Please complete/read sections in **orange**

Details	
Reviewer:	Please type your full name **Andrea Giraldez-Hayes**
Supervisor:	Please type supervisor's full name **Mary Spiller**
Student:	Please type student's full name **Andras Tringli**
Course:	Please type course name **Prof Doc Clinical**
Title of proposed study:	**Psychological professionals' relationship to mental imagery**

Checklist (Optional)			
	YES	**NO**	**N/A**

Concerns regarding study aims (e.g., ethically/morally questionable, unsuitable topic area for level of study, etc.)	☐	☐	☐
Detailed account of participants, including inclusion and exclusion criteria	☐	☐	☐
Concerns regarding participants/target sample	☐	☐	☐
Detailed account of recruitment strategy	☐	☐	☐
Concerns regarding recruitment strategy	☐	☐	☐
All relevant study materials attached (e.g., freely available questionnaires, interview schedules, tests, etc.)	☐	☐	☐
Study materials (e.g., questionnaires, tests, etc.) are appropriate for target sample	☐	☐	☐
Clear and detailed outline of data collection	☐	☐	☐
Data collection appropriate for target sample	☐	☐	☐
If deception being used, rationale provided, and appropriate steps followed to communicate study aims at a later point	☐	☐	☐
If data collection is not anonymous, appropriate steps taken at later stages to ensure participant anonymity (e.g., data analysis, dissemination, etc.) – anonymisation, pseudonymisation	☐	☐	☐
Concerns regarding data storage (e.g., location, type of data, etc.)	☐	☐	☐
Concerns regarding data sharing (e.g., who will have access and how)	☐	☐	☐
Concerns regarding data retention (e.g., unspecified length of time, unclear why data will be retained/who will have access/where stored)	☐	☐	☐
If required, General Risk Assessment form attached	☐	☐	☐
Any physical/psychological risks/burdens to participants have been sufficiently considered and appropriate attempts will be made to minimise	☐	☐	☐
Any physical/psychological risks to the researcher have been sufficiently considered and appropriate attempts will be made to minimise	☐	☐	☐
If required, Country-Specific Risk Assessment form attached	☐	☐	☐
If required, a DBS or equivalent certificate number/information provided	☐	☐	☐
If required, permissions from recruiting organisations attached (e.g., school, charity organisation, etc.)	☐	☐	☐
All relevant information included in the participant information sheet (PIS)	☐	☐	☐
Information in the PIS is study specific	☐	☐	☐
Language used in the PIS is appropriate for the target audience	☐	☐	☐
All issues specific to the study are covered in the consent form	☐	☐	☐
Language used in the consent form is appropriate for the target audience	☐	☐	☐
All necessary information included in the participant debrief sheet	☐	☐	☐

Language used in the debrief sheet is appropriate for the target audience	☐	☐	☐
Study advertisement included	☐	☐	☐
Content of study advertisement is appropriate (e.g., researcher's personal contact details are not shared, appropriate language/visual material used, etc.)	☐	☐	☐

Decision options	
APPROVED	Ethics approval for the above-named research study has been granted from the date of approval (see end of this notice), to the date it is submitted for assessment.
APPROVED - BUT MINOR AMENDMENTS ARE REQUIRED BEFORE THE RESEARCH COMMENCES	In this circumstance, the student must confirm with their supervisor that all minor amendments have been made **before** the research commences. Students are to do this by filling in the confirmation box at the end of this form once all amendments have been attended to and emailing a copy of this decision notice to the supervisor. The supervisor will then forward the student's confirmation to the School for its records. **Minor amendments guidance:** typically involve clarifying/amending information presented to participants (e.g., in the PIS, instructions), further detailing of how data will be securely handled/stored, and/or ensuring consistency in information presented across materials.
NOT APPROVED - MAJOR AMENDMENTS AND RE-SUBMISSION REQUIRED	In this circumstance, a revised ethics application **must** be submitted and approved **before** any research takes place. The revised application will be reviewed by the same reviewer. If in doubt, students should ask their supervisor for support in revising their ethics application. **Major amendments guidance:** typically insufficient information has been provided, insufficient consideration given to several key aspects, there are serious concerns regarding any aspect of the project, and/or serious concerns in the candidate's ability to ethically, safely and sensitively execute the study.

Decision on the above-named proposed research study	
Please indicate the decision:	**APPROVED**

Minor amendments

Please clearly detail the amendments the student is required to make

Major amendments
Please clearly detail the amendments the student is required to make

Assessment of risk to researcher		
Has an adequate risk assessment been offered in the application form?	**YES** ☒	**NO** ☐
	If no, please request resubmission with an **adequate risk assessment.**	
If the proposed research could expose the researcher to any kind of emotional, physical or health and safety hazard, please rate the degree of risk:		
HIGH	Please **do not approve a high-risk** application. Travel to countries/provinces/areas deemed to be high risk should not be permitted and an application not be approved on this basis. If unsure, please refer to the Chair of Ethics.	☐
MEDIUM	Approve but include appropriate recommendations in the below box.	☒

LOW	Approve and if necessary, include any recommendations in the below box.	☐
Reviewer recommendations in relation to risk (if any):	Please insert any recommendations	

Reviewer's signature	
Reviewer: (Typed name to act as signature)	**Andrea Giraldez-Hayes**
Date:	**06/04/2023**
This reviewer has assessed the ethics application for the named research study on behalf of the School of Psychology Ethics Committee	

Appendix B - Ethics Application Form

UNIVERSITY OF EAST LONDON

School of Psychology

APPLICATION FOR RESEARCH ETHICS APPROVAL

FOR RESEARCH INVOLVING HUMAN PARTICIPANTS

(Updated October 2021)

FOR BSc RESEARCH;

MSc/MA RESEARCH;

PROFESSIONAL DOCTORATE RESEARCH IN CLINICAL, COUNSELLING & EDUCATIONAL PSYCHOLOGY

Section 1 – Guidance on Completing the Application Form (please read carefully)	
1.1	Before completing this application, please familiarise yourself with: British Psychological Society's Code of Ethics and Conduct UEL's Code of Practice for Research Ethics UEL's Research Data Management Policy UEL's Data Backup Policy
1.2	Email your supervisor the completed application and all attachments as ONE WORD DOCUMENT. Your supervisor will look over your application and provide feedback.
1.3	When your application demonstrates a sound ethical protocol, your supervisor will submit it for review.
1.4	Your supervisor will let you know the outcome of your application. Recruitment and data collection must NOT commence until your ethics application has been approved, along with other approvals that may be necessary (see section 7).
1.5	Research in the NHS:

	If your research involves patients or service users of the NHS, their relatives or carers, as well as those in receipt of services provided under contract to the NHS, you will need to apply for HRA approval/NHS permission (through IRAS). You DO NOT need to apply to the School of Psychology for ethical clearance. Useful websites: https://www.myresearchproject.org.uk/Signin.aspx https://www.hra.nhs.uk/approvals-amendments/what-approvals-do-i-need/hra-approval/ If recruitment involves NHS staff via the NHS, an application will need to be submitted to the HRA in order to obtain R&D approval. This is in addition to separate approval via the R&D department of the NHS Trust involved in the research. UEL ethical approval will also be required. HRA/R&D approval is not required for research when NHS employees are not recruited directly through NHS lines of communication (UEL ethical approval is required). This means that NHS staff can participate in research without HRA approval when a student recruits via their own social/professional networks or through a professional body such as the BPS, for example. The School strongly discourages BSc and MSc/MA students from designing research that requires HRA approval for research involving the NHS, as this can be a very demanding and lengthy process.
1.6	If you require Disclosure Barring Service (DBS) clearance (see section 6), please request a DBS clearance form from the Hub, complete it fully, and return it to applicantchecks@uel.ac.uk. Once the form has been approved, you will be registered with GBG Online Disclosures and a registration email will be sent to you. Guidance for completing the online form is provided on the GBG website: https://fadv.onlinedisclosures.co.uk/Authentication/Login You may also find the following website to be a useful resource: https://www.gov.uk/government/organisations/disclosure-and-barring-service
1.7	Checklist, the following attachments should be included if appropriate: Study advertisement Participant Information Sheet (PIS) Participant Consent Form Participant Debrief Sheet Risk Assessment Form/Country-Specific Risk Assessment Form (see section 5) Permission from an external organisation (see section 7) Original and/or pre-existing questionnaire(s) and test(s) you intend to use Interview guide for qualitative studies Visual material(s) you intend showing participants

Section 2 – Your Details		
2.1	Your name:	Andras Tringli
2.2	Your supervisor's name:	Dr Mary Jane Spiller
2.3	Name(s) of additional UEL supervisors:	Dr Trishna Patel
		3rd supervisor (if applicable)
2.4	Title of your programme:	Professional Doctorate in Clinical Psychology
2.5	UEL assignment submission date:	Initial submission date
		Re-sit date (if applicable)

Section 3 – Project Details		
Please give as much detail as necessary for a reviewer to be able to fully understand the nature and purpose of your research.		
3.1	Study title: Please note - If your study requires registration, the title inserted here must be the same as that on PhD Manager	Psychological professionals' relationship to mental imagery
3.2	Summary of study background and aims (using lay language):	Mental imagery is defined as "a multi-modal, multisensory phenomenon that occurs when perceptual information is accessed from memory or imagination, rather than being directly perceived by the senses" (Bell et al., 2015). Mental imagery is closely linked to emotional reactions and autobiographical memory. Mental imagery techniques have been practised in psychotherapy since the beginning of the profession. Despite all the evidence about the efficacy of mental imagery in clinical practices, many psychological practitioners feel uneasy and unprepared to use it in their interventions. Only a few studies have been conducted about psychological professionals' relationship with mental imagery, and these studies only focused on specific aspects of mental imagery. My research will synthesise the findings of these previous studies and examine how psychological practitioners relate to mental imagery, how they use it in their clinical practice or supervision, and

		how they understand when they experience spontaneous mental imagery when delivering treatment. This most extensive study on this topic will be based on eighteen interviews conducted with clinical psychologists, cognitive behavioural therapists, and non-registered psychologists (assistant psychologists and psychological well-being practitioners). The data will be processed using thematic analysis and a critical realist epistemological approach.
3.3	Research question(s):	What relationship do psychological professionals have to mental imagery: their views on the role of mental imagery in clinical practice and their experiences of using it and managing their own spontaneous mental imagery in therapy and supervision?
3.4	Research design:	Participants will be interviewed using a semi-structured interview schedule based on the literature. All participants will be interviewed online via MS Teams. The interview discussions will be transcribed into Word files using the MS Teams transcription plug-in. The researcher will also check and correct the quality of the transcriptions. The transcriptions will be analysed using thematic analysis to identify themes about psychological professionals' relationship to mental imagery.
3.5	Participants: Include all relevant information including inclusion and exclusion criteria	The proposed study will include the interview of eighteen psychological professionals. I am aiming to interview six clinical psychologists, six CBT therapists and six assistant psychologists/PWPs. Guest et al. (2006) suggested that a relatively homogenous participant sample would only require twelve interviews to create the majority of available codes for thematic analysis. As I recognised that the different psychological practitioners in my sample might have different levels of clinical experience, I followed Guests' (2006) advice and increased the sample size slightly. The research literature has influenced my decision on participant groups: interviewing

		clinical psychologists about their relationship to mental imagery was a specific recommendation of Bells' (2015) study. Including CBT therapists in the sample is a recognition that they are professionally required to use mental imagery in their practices. The need to add non-registered psychological practitioners to the sample was highlighted in Thwaites and her colleagues' (2015) paper, reporting the struggles of Psychological wellbeing practitioners with using mental imagery. The inclusion criteria for CBT therapists and clinical psychologists is to hold a professional registration: for CBT therapists; this would be a registration to BABCP (British Association for Behavioural and Cognitive Psychotherapies), while for clinical psychologists, a registration to HCPC (Health and Care Professions Council). Non-qualified psychology graduates can take part in the study if they have worked as an assistant psychologist (AP) for longer than six months or graduated as a Wellbeing professional (PWP, CWP, EMHP) or as a Clinical associate psychologist (CAP). As Wellbeing professionals and CAP training courses require students to attend clinical placements to qualify, they would have sufficient clinical experience post-qualification to participate in the research. The mandatory accreditation process of all Wellbeing Professionals is currently undergoing within the BABCP, but as it is a recent development, it would not be inclusion criteria for Wellbeing professionals.
3.6	Recruitment strategy: Provide as much detail as possible and include a backup plan if relevant	For the recruitment process, I aim to use my personal contacts to act as nominated gatekeepers and approach other professionals to participate in the research. Using personal connections can help gain access to participants working in different parts of the UK. If the proposed recruitment method proved to be unsuccessful, slightly different professional groups

		could be selected as an alternative. Instead of clinical psychologists, third-year, while instead of APs/PWPs, first-year trainee clinical psychologists from the University of East London (UEL) could be approached as participants. I can also recruit trainee CBT therapists from other North London universities instead of qualified therapists. It has also been discussed that another alternative recruitment process could be to restrict the number of participants and only interview participants from two professions instead of the planned three (clinical psychologists, CBT therapists and APs/Wellbeing practitioners)
3.7	Measures, materials or equipment: Provide detailed information, e.g., for measures, include scoring instructions, psychometric properties, if freely available, permissions required, etc.	I will use the interview schedule presented in Appendix A for the semi-structured interviews. Based on Bells' (2015) research and considering the additional time required by the extra three questions about SMI and supervision, I estimate that each interview would last approx. 35-50 minutes. The interviews will be conducted online using Microsoft Teams. This program can transcribe video conversations into texts, which can serve as the base of the interview script. For the process of the thematic analysis, I will follow the steps identified by Braun and Clarke (2006, 2021) and Maguire and Delahunt (2017).
3.8	Data collection: Provide information on how data will be collected from the point of consent to debrief	After consented, participants will take part in a semi-structured interview. The interview will be conducted online via MSTeams. Consent will be gathered in the form of electronically signed consent forms (pdf) that will be password protected. Consent will also be gained verbally at the start of the interview process. The interview will be recorded through MSTeams and a transcription of the interview will be used as the data for the research. The transcribes will be reviewed and corrected by the researcher where needed and will be stored as a word document. Based on Bells' (2015) research and considering the additional time required by the extra three

		questions about SMI and supervision, I estimate that each interview would last approx. 35-50 minutes.	
3.9	Will you be engaging in deception?	YES ☐	NO ☒
	If yes, what will participants be told about the nature of the research, and how/when will you inform them about its real nature?	If you selected yes, please provide more information here	
3.10	Will participants be reimbursed?	YES ☐	NO ☒
	If yes, please detail why it is necessary.	If you selected yes, please provide more information here	
	How much will you offer? Please note - This must be in the form of vouchers, not cash.	Please state the value of vouchers	
3.11	Data analysis:	The transcribed scripts of the interviews will be analysed using thematic analysis. "Thematic analysis is a method for identifying, analysing, and reporting patterns (themes) within data (Braun and Clarke, 2006, p. 6). For the process of the thematic analysis, I will follow the steps identified by Braun and Clarke (2006, 2021) and Maguire and Delahunt (2017).	

Section 4 – Confidentiality, Security and Data Retention			
It is vital that data are handled carefully, particularly the details about participants. For information in this area, please see the UEL guidance on data protection, and also the UK government guide to data protection regulations. If a Research Data Management Plan (RDMP) has been completed and reviewed, information from this document can be inserted here.			
4.1	Will the participants be anonymised at source?	YES ☒	NO ☐
		Confidentiality of the data will be ensured at the transcription stage, where the data will be pseudonymised by changing names to pseudonyms, and other identifying information,	

		such as geographical location, will be replaced with a meaningful descriptive which typifies the location (e.g. 'Harrow' to 'North London'). Transcription will be undertaken only by the researcher to protect the confidentiality of the participant. Steps taken when anonymising data after the 3-week period will include clearly labelling replacements to be anonymised using [brackets]. If there is an increased risk of harm or disclosure, then statements will be redacted. Information regarding the sharing of the anonymous transcript with the research supervisor and information regarding the dissemination of the research data in the form of a thesis will be outlined in the participant information sheet and consent form. Each audio file will be named under the participant's pseudonym. The list of pseudonyms will be stored on a different, password-protected Word document. Pseudonymised transcripts of the interview will be stored in a password-protected word file separate from the identifiable interview recording data. (see above)The completed consent form documents (pdf) will be stored in a separate place away from the identifiable data, in a separate password-protected file in the researcher's UEL OneDrive.	
4.2	Are participants' responses anonymised or are an anonymised sample?	YES x	NO x
	If yes, please provide details of how data will be anonymised (e.g., all identifying information will be removed during transcription, pseudonyms used, etc.).	See my answer at 4.1	
4.3	How will you ensure participant details will be kept confidential?	Between 12 and 18, 35 to 50 minutes recordings will be generated and stored. The interviews will be conducted online using my UEL Microsoft Teams. This program can transcribe video conversations into texts, which can serve as the base of the interview script. The interviews will be only transcribed by the researcher. Following the transcription process, the original video recordings	

		will be deleted. All identifiable characteristics will be anonymised or removed from the transcribed interview scripts. Only the participants' professional role and their length of employment will be recorded as personal information. The interview scripts will be stored on my UEL Onedrive. Each interview transcript will be saved under a pseudonym. The list of pseudonyms will be stored separately on a password-protected Word file on my UEL OneDrive so participants can be reidentified if they wish to withdraw within the 3-week deadline. Before the interviews, participants will be informed that only a few people (supervisor and examiner) will have access to the transcribed scripts. Participant consent forms will also be created (pdf) which will contain personal data (names). Consent forms will be saved in a password-protected folder on the researcher's UEL OneDrive. Before the interviews, email addresses will be collected to arrange interviews via the researcher's UEL email address.
4.4	How will data be securely stored and backed up during the research? Please include details of how you will manage access, sharing and security	Recordings of interviews will initially be stored in a password-protected folder on the researcher's One Drive. The laptop used by the researcher for the research project will be his personal computer which is non-networked and password-protected. The password is only known by the researcher. Each audio file will be named under the participant's pseudonym. The list of pseudonyms will be stored on a different, password-protected Word document. Pseudonymised transcripts of the interview will be stored in a password-protected word file separate from the identifiable interview recording data. (see above)The completed consent form documents (pdf) will be stored in a separate place away from the identifiable data, in a separate password-protected file in the researcher's UEL OneDrive. Backup savings of the thesis documents will be stored on the

		researcher's UEL Microsoft account linked to his OneDrive.
4.5	Who will have access to the data and in what form? (e.g., raw data, anonymised data)	The transcripts and data might be shared with the research supervisor and ethics bodies if serious ethical concerns would arise. After the writing of the thesis, the transcripts and the data will not be shared via the UEL data repository since the information gathered may be too sensitive even if anonymised. Extracts from the anonymised transcript will be written up into a thesis which will be deposited and shared via the UEL's Research Repository. Identifiable data will not be included in these extracts. There is no intention or need to share the identifiable data (the original MSTeams video recordings) with anyone.
4.6	Which data are of long-term value and will be retained? (e.g., anonymised interview transcripts, anonymised databases)	The MS Teams video recordings of the interviews will be destroyed once they are no longer needed for data analysis and transcription. Anonymised transcripts and analysis data will be retained for up to 3 years, stored on the supervisor's UEL OneDrive, as the researcher may wish to submit the research for publication. Consent forms may also be preserved for one year to ensure that participants' consent can be explicitly checked at further dissemination and review or the publication stage. A thesis will be written up using extracts of transcripts, and this thesis will be stored in the research open-access repository (the consent form will inform participants that extract of the anonymised transcripts could be placed in the main text of the thesis and might be made publicly available).
4.7	What is the long-term retention plan for this data?	The MS Teams recordings will be destroyed once they are no longer needed after data analysis. The thesis will be stored and deposited in the research open-access repository (as outlined in the UEL Research Data Management Policy). Anonymised data (e.g. transcripts) and metadata (e.g. consent forms, analysis data) will be moved and deleted from the researcher's UEL OneDrive by Oct 2024

		as the researcher will no longer have access to these UEL storage facilities as their course will have finished. These data files will be sent to the research supervisor, who will store them on her UEL OneDrive for up to 3 years. Anonymised data and metadata will be stored on the research supervisor's UEL OneDrive for up to 3 years, as this data may be required if the thesis is to be reviewed for publication. Identifiable data, e.g. consent forms, will be stored separately from anonymised data (e.g. transcripts) and, again, will be password protected and be stored in encrypted files for up to 3 years. If the research supervisor leaves the university during this period, UEL procedures will be followed to appoint a person responsible for the safe storage of the data. After three years, all the consent forms, anonymised data and all metadata will be deleted. Participants will be informed that consent forms and anonymised data will be kept by the research supervisor for up to 3 years. During the research process, the researcher and, after thesis completion and marking, the research supervisor, Dr Mary Spiller, will be responsible for managing the data.	
4.8	Will anonymised data be made available for use in future research by other researchers?	YES ☐	NO ☒
	If yes, have participants been informed of this?	YES ☐	NO ☒
4.9	Will personal contact details be retained to contact participants in the future for other research studies?	YES ☐	NO ☒
	If yes, have participants been informed of this?	YES ☐	NO ☒

Section 5 – Risk Assessment

If you have serious concerns about the safety of a participant, or others, during the course of your research please speak with your supervisor as soon as possible. If there is any unexpected occurrence while you are collecting your data (e.g., a participant or the researcher injures themselves), please report this to your supervisor as soon as possible.			
5.1	Are there any potential physical or psychological risks to participants related to taking part? (e.g., potential adverse effects, pain, discomfort, emotional distress, intrusion, etc.)	YES ☒	NO ☐
	If yes, what are these, and how will they be minimised?	It is not expected that the interview would cause any physical harm to me as the interview would be conducted online. Although it is not expected that the questions listed in the interview schedule below would cause any psychological harm to the participants working as psychological professionals, I recognise that talking about experiences of supervision and previous cases could evoke strong emotions and traumatic memories. To avoid participant distress and reduce performance anxiety, participants can receive the interview schedule before the interview, alongside the Consent form and Participant Information sheet. Receiving the interview schedule before the interview could also help participants make more informed decisions about whether they wish to participate. Participants will also be informed that they can take breaks at any time during the interview or skip any questions they do not wish to answer. In case of emotional discomfort during the study, contact details for a list of supporting agencies will be provided on the debrief sheet.	
5.2	Are there any potential physical or psychological risks to you as a researcher?	YES ☐	NO ☒
	If yes, what are these, and how will they be minimised?	It is not expected that the interview would cause any physical harm to me as the interview would be conducted online. It is also not expected that the interview would cause any psychological harm to me, but as it was acknowledged at 5.1, there is a	

		small possibility that hearing other professionals' answers about their practice could evoke strong emotions or traumatic memories in me. I have started arranging personal therapy, which would be hoped to start before the recruitment process, to help me cope with the emotional load of managing my education/thesis and my clinical placements.		
5.3	If you answered yes to either 5.1 and/or 5.2, you will need to complete and include a General Risk Assessment (GRA) form (signed by your supervisor). Please confirm that you have attached a GRA form as an appendix:	YES ☒		
5.4	If necessary, have appropriate support services been identified in material provided to participants?	YES ☒	NO ☐	N/A ☐
5.5	Does the research take place outside the UEL campus?	YES ☒	NO ☐	
	If yes, where?	The data collection/ interview process would take place online via my UEL MS Teams.		
5.6	Does the research take place outside the UK?	YES ☐	NO ☒	
	If yes, where?	Please state the country and other relevant details		
	If yes, in addition to the General Risk Assessment form, a Country-Specific Risk Assessment form must also be completed and included (available in the Ethics folder in the Psychology Noticeboard). Please confirm a Country-Specific Risk Assessment form has been attached as an appendix. Please note - A Country-Specific Risk Assessment form is not needed if the research is online only (e.g., Qualtrics survey), regardless of the location of the researcher or the participants.	YES ☐		

5.7	Additional guidance: For assistance in completing the risk assessment, please use the AIG Travel Guard website to ascertain risk levels. Click on 'sign in' and then 'register here' using policy # 0015865161. Please also consult the Foreign Office travel advice website for further guidance. For on campus students, once the ethics application has been approved by a reviewer, all risk assessments for research abroad must then be signed by the Director of Impact and Innovation, Professor Ian Tucker (who may escalate it up to the Vice Chancellor). For distance learning students conducting research abroad in the country where they currently reside, a risk assessment must also be carried out. To minimise risk, it is recommended that such students only conduct data collection online. If the project is deemed low risk, then it is not necessary for the risk assessment to be signed by the Director of Impact and Innovation. However, if not deemed low risk, it must be signed by the Director of Impact and Innovation (or potentially the Vice Chancellor). Undergraduate and M-level students are not explicitly prohibited from conducting research abroad. However, it is discouraged because of the inexperience of the students and the time constraints they have to complete their degree.

Section 6 – Disclosure and Barring Service (DBS) Clearance			
6.1	Does your research involve working with children (aged 16 or under) or vulnerable adults (*see below for definition)? If yes, you will require Disclosure Barring Service (DBS) or equivalent (for those residing in countries outside of the UK) clearance to conduct the research project	YES ☐	NO ☒
	* You are required to have DBS or equivalent clearance if your participant group involves: (1) Children and young people who are 16 years of age or under, or (2) 'Vulnerable' people aged 16 and over with particular psychiatric diagnoses, cognitive difficulties, receiving domestic care, in nursing homes, in palliative care, living in institutions or sheltered accommodation, or involved in the criminal justice system, for example. Vulnerable people are understood to be persons who are not necessarily able to freely consent to participating in your research, or who may find it difficult to withhold consent. If in doubt about the extent of the vulnerability of your intended participant group, speak with your supervisor. Methods that maximise the understanding and ability of vulnerable people to give consent should be used whenever possible.		

6.2	Do you have DBS or equivalent (for those residing in countries outside of the UK) clearance to conduct the research project?	YES ☒	NO ☐
6.3	Is your DBS or equivalent (for those residing in countries outside of the UK) clearance valid for the duration of the research project?	YES ☒	NO ☐
6.4	If you have current DBS clearance, please provide your DBS certificate number:	001632651715	
	If residing outside of the UK, please detail the type of clearance and/or provide certificate number.	Please provide details of the type of clearance, including any identification information such as a certificate number	
6.5	Additional guidance: If participants are aged 16 or under, you will need two separate information sheets, consent forms, and debrief forms (one for the participant, and one for their parent/guardian). For younger participants, their information sheets, consent form, and debrief form need to be written in age-appropriate language.		

Section 7 – Other Permissions			
7.1	Does the research involve other organisations (e.g., a school, charity, workplace, local authority, care home, etc.)?	YES ☐	NO ☒
	If yes, please provide their details.	Please provide details of organisation	
	If yes, written permission is needed from such organisations (i.e., if they are helping you with recruitment and/or data collection, if you are collecting data on their premises, or if you are using any material owned by the institution/organisation). Please confirm that you have attached written permission as an appendix.	YES ☐	
7.2	Additional guidance: Before the research commences, once your ethics application has been approved, please ensure that you provide the organisation with a copy of the final, approved ethics application		

	or approval letter. Please then prepare a version of the consent form for the organisation themselves to sign. You can adapt it by replacing words such as 'my' or 'I' with 'our organisation' or with the title of the organisation. This organisational consent form must be signed before the research can commence. If the organisation has their own ethics committee and review process, a SREC application and approval is still required. Ethics approval from SREC can be gained before approval from another research ethics committee is obtained. However, recruitment and data collection are NOT to commence until your research has been approved by the School and other ethics committee/s.

Section 8 – Declarations		
8.1	Declaration by student. I confirm that I have discussed the ethics and feasibility of this research proposal with my supervisor:	YES ☒
8.2	Student's name: (Typed name acts as a signature)	Andras Tringli
8.3	Student's number:	2195633
8.4	Date:	01/04/2023
Supervisor's declaration of support is given upon their electronic submission of the application		

Student checklist for appendices – *for student use only*

Documents attached to ethics application	YES	N/A
Study advertisement	☒	☐
Participant Information Sheet (PIS)	☒	☐
Consent Form	☒	☐
Participant Debrief Sheet	☒	☐
Risk Assessment Form	☒	☐
Country-Specific Risk Assessment Form	☐	☒
Permission(s) from an external organisation(s)	☐	☒
Pre-existing questionnaires that will be administered	☐	☒
Researcher developed questionnaires/questions that will be administered	☐	☒

Pre-existing tests that will be administered	☐	☒
Researcher developed tests that will be administered	☐	☒
Interview guide for qualitative studies	☒	☐
Any other visual material(s) that will be administered	☐	☒
All suggested text in RED has been removed from the appendices	☒	☐
All guidance boxes have been removed from the appendices	☒	☐

Appendix C - Participant Information Sheet

PARTICIPANT INFORMATION SHEET

Psychological professionals' relationship to mental imagery

Contact person: Andras Tringli

Email: u...@uel.ac.uk

You are invited to participate in a research study. Before you decide whether to take part or not, please carefully read through the following information, which outlines what your participation would involve. Feel free to talk with others about the study (e.g., friends, family, etc.) before making your decision. If anything is unclear or you have any questions, please do not hesitate to contact me at the above email.

Who am I?

My name is Andras Tringli. I am a postgraduate student in the School of Psychology at the University of East London (UEL) and am studying for a Doctorate in Clinical Psychology. As part of my studies, I am conducting the research in which you are invited to participate.

What is the purpose of the research?

I am researching psychological professionals' (such as clinical psychologists, CBT therapists, psychological well-being practitioners and assistant psychologists) relationship to mental imagery. The research is interested in how mental imagery is conceptualised and understood by these professionals and how mental imagery is used in clinical and supervision practices.

Why have You been invited to take part?

To address the study aims, I am inviting clinical psychologists, accredited CBT therapists, psychological well-being practitioners and assistant psychologists to take part in my research. If you are a Clinical psychologist or a CBT therapist with a professional registration (such as HCPC or BABCP) or a qualified Wellbeing Practitioner (PWP/CW/EMHP) or Clinical Associate in Psychology or you have been working as an assistant psychologist for over six months, you are eligible to take part in the study.

It is entirely up to you whether you take part or not; participation is voluntary.

What will You be asked to do if You agree to take part?

If you agree to take part, you will be asked to complete a semi-structured interview about your relationship to mental imagery. The interview could have thirteen questions, and based on previous research, it could last 35-50 minutes. The interview will be conducted via Microsoft Teams. As the content of our discussion will serve as the basis of my research data, it is necessary to record the conversation to transcribe everything correctly.

You can see the interview schedule in the attached document.

Can You change your mind?

Yes, you can change your mind at any time and withdraw without explanation, disadvantage or consequence. If you would like to withdraw from the interview, you can do so by ending the interview conversation or requesting the ending of the conversation from the interviewer. If you withdraw, your data will not be used as part of the research.

Separately, you can also request to withdraw your data from being used even after you have taken part in the study, provided that this request is made within three weeks of the data being collected (after which point the data analysis will begin, and withdrawal will not be possible).

Are there any disadvantages to taking part?

During the interview, you might wish to talk about your clinical practice and recall some specific clinical cases or supervisions you experienced. Although this is not specifically required, some

people might find it difficult to share aspects of their clinical practice. Information about supporting agencies will be made available to you by the start of the interview.

How will the information you provide be kept secure and confidential?

The video interview will be recorded and transcribed into a text file. After the transcription, the video file will be deleted. All identifiable information will be anonymised during the transcription: all names and geographic locations you might have mentioned in the interview will be changed or anonymised.

Transcribes will be stored in a password-protected folder connected to my university account. In the first three weeks after the interview, you have the right to request to be withdrawn from the study, therefore for these three weeks windows, I will keep a list to link your interview data back to you, but this list will be destroyed immediately after the three weeks window.

I will be the only person with access to the full transcribes, although I might need to share aspects of them with my thesis supervisor and the external examiner. Only anonymised segments of the transcribe will be available in the text of the thesis. Full transcribes will not be part of the thesis nor be listed in the thesis's appendixes. Transcribes will not be publically available in full, although a few sentences might be placed in the main text of the thesis and its subsequent publications.

After the thesis submission, anonymised research data will be securely stored by the thesis supervisor, Dr Mary Jane Spiller for a maximum of 3 years, after which all data will be deleted.

For the purposes of data protection, the University of East London is the Data Controller for the personal information processed as part of this research project. The University processes this information under the 'public task' condition contained in the General Data Protection Regulation (GDPR). Where the University processes particularly sensitive data (known as 'special category data' in the GDPR), it does so because the processing is necessary for archiving purposes in the public interest, scientific and historical research purposes or statistical purposes. The University will ensure that the personal data it processes is held securely and processed in accordance with the GDPR and the Data Protection Act 2018. For more information about how

the University processes personal data, please see www.uel.ac.uk/about/about-uel/governance/information-assurance/data-protection

What will happen to the results of the research?

The research will be written up as a thesis and submitted for assessment. The thesis will be publicly available on UEL's Online Repository. Findings will also be disseminated to a range of audiences (e.g., academics, clinicians, the public, etc.) through journal articles, conference presentations, talks, magazine articles, and blogs. In all material produced, your identity will remain anonymous in that it will not be possible to identify you personally, and personally-identifying information will be removed.

You can request to receive a summary of the research findings once the study has been completed, for which relevant contact details will need to be provided; these contact details will be saved in a separate password-protected document until the submission of the thesis. Contact details will be deleted after the emails with the research findings are sent out.

Who has reviewed the research?

My research has been approved by the School of Psychology Ethics Committee. This means that the Committee's evaluation of this ethics application has been guided by the standards of research ethics set by the British Psychological Society.

Who can I contact if I have any questions/concerns?

If you would like further information about my research or have any questions or concerns, please do not hesitate to contact me.

Andras Tringli trainee clinical psychologist – u...@uel.ac.uk

If you have any questions or concerns about how the research has been conducted, please contact my research supervisor Dr Mary Jane Spiller. School of Psychology, University of East London, Water Lane, London E15 4LZ,

Email: …

or

Chair of School Ethics Committee: …, School of Psychology, University of East London, Water Lane, London E15 4LZ.

(Email: …)

Thank you for taking the time to read this information sheet

Appendix D - Consent Form Template

CONSENT TO PARTICIPATE IN A RESEARCH STUDY

Psychological professionals' relationship to mental imagery

Contact person: Andras Tringli

Email: u…@uel.ac.uk

	Please initial
I confirm that I have read the participant information sheet dated XX/XX/XXXX (version X) for the above study and that I have been given a copy to keep.	
I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	
I understand that my participation in the study is voluntary and that I may withdraw at any time, without explanation or disadvantage.	
I understand that if I withdraw during the study, my data will not be used.	
I understand that I have 3 weeks from the date of the interview to withdraw my data from the study.	
I understand that the interview will be recorded using MSTeams.	
I understand that my personal information and data, including video recordings from the research will be securely stored and remain confidential. Only the research team will have access to this information, to which I give my permission.	
It has been explained to me what will happen to the data once the research has been completed.	
I understand that short, anonymised quotes from my interview may be used in material such as conference presentations, reports, articles in academic journals resulting from the study and that these will not personally identify me.	

I would like to receive a summary of the research findings once the study has been completed and am willing to provide contact details for this to be sent to.	
I agree to take part in the above study.	

Participant's Name (BLOCK CAPITALS)

……
……

Participant's Signature

……
……

Researcher's Name (BLOCK CAPITALS)

……
……

Researcher's Signature

……
……

Date

……..……
……

Appendix E - Participant Debrief Sheet

PARTICIPANT DEBRIEF SHEET

Psychological professionals' relationship to mental imagery

Thank you for participating in my research study on Psychological professionals' relationship to mental imagery. This document offers information that may be relevant in light of you having now taken part.

How will my data be managed?

The University of East London is the Data Controller for the personal information processed as part of this research project. The University will ensure that the personal data it processes is held securely and processed in accordance with the GDPR and the Data Protection Act 2018. More detailed information is available in the Participant Information Sheet, which you received when you agreed to take part in the research.

What will happen to the results of the research?

The research will be written up as a thesis and submitted for assessment. The thesis will be publicly available on UEL's online repository. Findings will also be disseminated to a range of audiences (e.g., academics, clinicians, the public, etc.) through journal articles, conference presentations, talks, magazine articles and blogs. In all material produced, your identity will remain anonymous in that it will not be possible to identify you personally, and all identifying information will either be removed or replaced.

You can request to receive a summary of the research findings once the study has been completed, for which relevant contact details will need to be provided; these contact details will be saved in a separate password-protected document until the submission of the thesis. Contact details will be deleted after the emails with the research findings are sent out.

All other anonymised research data will be securely stored by Dr Mary Jane Spiller for a maximum of 3 years, following which all data will be deleted.

What if I had been adversely affected by taking part?

It is not anticipated that you will have been adversely affected by taking part in the research, and all reasonable steps have been taken to minimise distress or harm of any kind. Nevertheless, it is possible that your participation – or its after-effects – may have been challenging, distressing or uncomfortable in some way. If you have been affected in any of those ways, you may find the following resources/services helpful in relation to obtaining information and support:

NHS staff support hubs: https://www.england.nhs.uk/supporting-our-nhs-people/

Your local NHS talking therapy service: https://www.england.nhs.uk/supporting-our-nhs-people/

Samaritans charity: https://www.samaritans.org/

Whom can I contact if I have any questions/concerns?

If you would like further information about my research or have any questions or concerns, please do not hesitate to contact me.

Andras Tringli trainee clinical psychologist – u...@uel.ac.uk

If you have any questions or concerns about how the research has been conducted, please contact my research supervisor Dr Mary Jane Spiller. School of Psychology, University of East London, Water Lane, London E15 4LZ,

Email: ...@uel.ac.uk

or

Chair of School Ethics Committee: Dr Trishna Patel, School of Psychology, University of East London, Water Lane, London E15 4LZ.

(Email: … @uel.ac.uk)

Thank you for taking part in my study

Appendix F - Template/Example Email to Psychological Professionals

Dear …

I am a second-year trainee clinical psychologist at the University of East London.

I was given your contact details by my former colleague, who recommended that you might be able to participate in my research project. I believe [my colleague] had already explained a bit about my research project, but to summarise it, I am researching psychological professionals' relationship to mental imagery, how it has been used in their psychological interventions, and their relationship with their patients or in supervision spaces. I have attached the Participant information sheet to this email, where you can find more information about the research.

I am approaching you to ask whether it would be possible for you to take part in the research project and spare 50 minutes to have an interview with me online about your relationship to mental imagery. The interview would be on MS Teams. The interview will be recorded so I can transcribe our conversation into text files, but the video recording will be deleted after the transcription. All the information you share in the interview will be anonymised (more information about data protection is also in the attached information sheet). You would not be asked to do anything else in the research other than the one-off interview.

If you think you would be able to participate in the research, we can arrange a date and time which is suitable for you to attend the online interview.

Thank you for considering your participation

Kind regards

Appendix G - Interview Schedule Handed to Participants before the Interview

Interview schedule.

Thank you for accepting to take part in my research! As you might have read in the participant information sheet, my research explores psychological professionals' relationship to mental imagery. To learn more about your relationship to mental imagery, I would conduct a research interview which could last for 35-50 minutes. Some people find it helpful to know what sort of questions they would be asked during the research interview; therefore, I created this document below.

The research interview aims to ask you a few questions about mental imagery and spontaneous mental imagery. The research interview is semi-structured; therefore, I might ask the questions below in a different order or by using slightly different wordings.

Before the research interview, I will discuss the following topics with you:

- Discussion on consent and confidentiality.

- Discussion on how you could signal distress.

- Recording your professional role: as I am interviewing different professionals, it is useful to know what professional role you are working in (clinical psychologists / CBT therapists / non-registered psychologists such as AP or PWP), your preferred therapeutic methods, if you have any, and the number of years you have been in that role.

The first few questions are specifically asking about mental imagery. One of the definitions of the concept of mental imagery is the following: *"Mental imagery is a multi-modal, multisensory phenomenon that occurs when perceptual information is accessed from memory or imagination, rather than being directly perceived by the senses. This definition includes involuntary and voluntary mental processes, waking and nighttime imageries."*

1. Concept—How would you define imagery?

2. Use—How do you use imagery in your practice? When do you use imagery?

3. Rationale—Why do you use, or not use, imagery in your practice?

4. Importance—What are your views about the importance of imagery in clinical practice/CBT?

5. Criteria—What affects your decision whether to use, or not use, imagery?

6. Development—What factors have influenced your views and use of imagery? What would help you develop your practice?

7. View of others—How do you think clients experience imagery work? How do you think other clinicians view imagery in clinical practice/CBT?

8. Personal response—What thoughts or emotions do you experience when using or discussing imagery in clinical practice/CBT?

9. Avoidance/barriers—If you have avoided using imagery, what might have affected your choice? Does anything prevent you from using imagery?

10. Personal experience—What is your own experience of imagery? Has this affected your practice and if so, how?

The next two questions are specifically asking about spontaneous mental imagery. One of the definitions of the concept of spontaneous mental imagery is the following: *"Spontaneous mental imagery (SMI) is 'seeing with the mind's eye' or 'hearing with the mind's ear' is experienced as coming out of the blue. It may be visual and/or involve other sensory modalities, including physical sensations, sound or smell. For some, it may be mainly kinesthetic. Spontaneous mental imagery could be experienced in therapy settings by the patient or by the therapist."*

11. Experience of spontaneous mental imagery in therapy - describe the type of spontaneous mental imagery you experienced (for example, mainly visual, mainly kinaesthetic etc.), describe what was happening in therapy, your spontaneous mental imagery, your response to the spontaneous mental imagery

12. Therapeutic meaning of spontaneous mental imagery - the meaning/therapeutic conceptualisation of the spontaneous mental imagery experience for you and how the spontaneous mental imagery influenced you, if at all

Finally, I have a question about your experiences with supervision and mental imagery and spontaneous mental imagery.

13. Supervision and mental imagery / spontaneous mental imagery – have you had supervision (either as a supervisee or a supervisor) where mental imagery / spontaneous mental imagery was discussed, where mental imagery was applied, or spontaneous mental imagery was experienced?

Appendix H - Interview schedule

Interview schedule.

Asking them to Take Part in the Research

The interview will be semi-structured; therefore, the following schedule will only be used as a prompt.

Introductions and Engagement

- Discussion on consent and confidentiality.

- Discussion on how the participants could signal their distress if they found any questions emotionally difficult.

- Recording the participant's professional role (clinical psychologist/ CBT therapist / non-registered psychologist such as AP or PWP), their preferred therapeutic methods, if they had any, and the number of years they have been in that professional role.

The interview schedule based on Bell et al.'s (2015, p. 593) study:

Before the questions are asked, the following definition of mental imagery will be presented to the participant:

"Mental imagery is a multi-modal, multisensory phenomenon that occurs when perceptual information is accessed from memory or imagination, rather than being directly perceived by the senses. This definition includes involuntary and voluntary mental processes, waking and nighttime imageries."

1. Concept—How would you define imagery?

2. Use—How do you use imagery in your practice? When do you use imagery?

3. Rationale—Why do you use, or not use, imagery in your practice?

4. Importance—What are your views about the importance of imagery in clinical practice/CBT?

5. Criteria—What affects your decision whether to use, or not use, imagery?

6. Development—What factors have influenced your views and use of imagery? What would help you develop your practice?

7. View of others—How do you think clients experience imagery work? How do you think other clinicians view imagery in clinical practice/CBT?

8. Personal response—What thoughts or emotions do you experience when using or discussing imagery in clinical practice/CBT?

9. Avoidance/barriers—If you have avoided using imagery, what might have affected your choice? Does anything prevent you from using imagery?

10. Personal experience—What is your own experience of imagery? Has this affected your practice and if so, how?

The two questions about Spontaneous Mental Imagery (SMI) based on Cartwright et al.'s (2019, p. 229) study:

Before the questions are asked, a definition of SMI will be presented to the participants.

"Spontaneous mental imagery (SMI) is 'seeing with the mind's eye' or 'hearing with the mind's ear' is experienced as coming out of the blue. It may be visual and/or involve other sensory modalities, including physical sensations, sound or smell. For some, it may be mainly kinesthetic. Spontaneous mental imagery could be experienced in therapy settings by the patient or by the therapist."

11. Experience of SMI in therapy - describe the type of SMI you experienced (for example, mainly visual, mainly kinaesthetic etc.), describe what was happening in therapy, your SMI, your response to the SMI

12. Therapeutic meaning of SMI - the meaning/therapeutic conceptualisation of the SMI experience for you and how the SMI influenced you, if at all

The additional question on supervision:

13. Supervision and MI/SMI – have you had supervision (either as a supervisee or a supervisor) where MI/SMI was discussed, where MI was applied, or SMI was experienced?