Cognitive Therapy and the Restructuring of Early Memories Through Guided Imagery

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This article describes the application of a guided imagery psychodrama technique to emotionally charged early memories. Such memories provide access to core schemata about the self and social relationships. Two case studies illustrate how the imagery technique enables the therapist to identify and restructure key cognitions out of which the schemata are constructed. The need for techniques to modify developmentally primitive schemata is discussed. Examples are given of ways to assist the patient in confronting the strong affect that may be aroused and in dealing with cognitions that block the process. Effectiveness is discussed in terms of the contribution of a guided imagery session to the overall process of "learning to learn" that takes place in cognitive psychotherapy.

THE NATURE OF COGNITIVE RESTRUCTURING

The Development of Cognitive Therapy

Cognitive therapy as developed by Beck and his colleagues had recently become widely recognized as an effective treatment for depression, and it is also being developed for the treatment of anxiety disorders, (Beck & Emery, 1985; Beck, Rush, Shaw & Emery, 1979). The therapy takes its name from the centrality of cognition in Beck's formulation of the theory of therapy. Essentially, he argues that people become depressed or anxious because of what they believe about themselves, the world, other people, and the future. These beliefs are often inaccurate, and the work of therapy is to identify the beliefs and systematically reevaluate them through logical analysis and reality testing.

The prominence Beck gives to cognition is in stark contrast to its fate in the two major traditions in therapy from which cognitive therapy derives, namely, the psy-
choanalytic and the behavioral. Early behavior therapy either excluded cognition from its models (Watson's metaphysical behaviorism), allowed it only as a hypothetical construct (methodological behaviorism), or regarded it as a type of behavior but largely ignored it (Skinner's radical behaviorism) (Zettle & Hayes, 1982).

In the Freudian tradition, cognition became the "Cinderella of psychoanalysis" (Arieti, 1985). For Freud's followers, to deal with the cognitive was to take attention from the repressed, irrational unconscious processes of the id. Of Freud's early colleagues, Adler had the most explicitly cognitive formulation, and today he is sometimes called the father of cognitive therapy (Freeman, 1983). But Freudians rejected his approach as too much involved with ego processes, so much so that Arieti (1985) accused them of systematically repressing cognition as ruthlessly as the rest of society repressed sexuality.

Various reformulations of the traditional Freudian position redressed the balance to some extent. Arieti (1985) explicitly based his approach, which he named Cognitive Psychoanalysis on a cognitive developmental model. Transactional analysis, as developed by Berne and his followers, is heavily cognitive, and an important feature is the identification and critical reevaluation of false beliefs or inappropriate rules (Barnes, 1977; James & Jongeward, 1971). Perls's Gestalt therapy did the same but in a less explicit way (see Edwards, 1989). Object relations theory has developed a detailed cognitive model of the infant's developing schemata for representing herself, others, and the relationships between them (Reppen, 1985). Adler and Horney both contributed to the development of the cognitive aspects of therapy and were the major influences on the contemporary leading cognitive theorists Beck and Ellis (Freeman, 1983; Rendon, 1985; Shulman, 1985).

The term cognitive restructuring refers to the alteration of the beliefs, attitudes, and meanings that a person brings to the interpretation of experience. The process can be broken down into the following steps: (1) identification and labeling of emotion; (2) identification of the meaning of the emotion as either an automatic thought, an underlying belief, or a felt meaning; (3) tracing the historical process through which the belief was acquired; (4) testing the belief for rationality (is it logical), accuracy (does it fit the data?) or functionality (does it work for me?); (5) if appropriate, revising the belief; (6) changing behavior to accord with and operationalize the new belief.

Step 3, in which the historical process through which the belief is acquired is examined, is often not employed in short-term treatments. It has been widely used in transactional analysis (Barnes, 1977; Erskine & Zalcman, 1979; James & Jongeward, 1971) and has been recommended by recent writers on cognitive therapy (Beck & Emery, 1985, pp. 296–298; Guidano & Liotti, 1983; Young, 1984). For example, in the context of beliefs that create dependency, Emery (1982) writes:

Discover where your beliefs come from. . . . By going back and seeing where you adopted your beliefs you can often make them clearer to you . . . . Many of your beliefs are passed down for generations. We traced one patient's fear of going broke back three generations to immigrants from Russian who were very poor. (pp. 186–187).
Although this analysis applies to much therapeutic work in many traditions, the detailed steps have been made particularly explicit by Beck and his collaborators. It is illustrated in Beck’s method of analyzing dysfunctional thoughts, which was originally developed for the treatment of depression (Beck et al., 1979) but is now widely used in the treatment of anxiety disorders (Beck & Emery, 1985).

Some Treatment Issues in Cognitive Therapy

The standard explication of cognitive therapy uses this procedure as a paradigm, presenting it as a set of verbal techniques for the identification and correction of dysfunctional beliefs. Behavioral methods are employed in this context first as a means of identifying dysfunctional cognitions in real-life situations, second as a test of their accuracy, and third as a means of challenging and changing those that are dysfunctional. The use of imagery techniques is less widely known and recognized as part of this approach. However, Beck (1970; Beck & Emery, 1985) himself places a great deal of emphasis on work with imagery, and Freeman (1981) discusses the use of dreams in cognitive therapy. I have argued elsewhere (Edwards, in press) that the type of psychodrama methods used by Perls (1976)—either as live drama (as in empty chair work or enactment of dream figures) or in imagery—embody the same process of cognitive restructuring that is made explicit in cognitive therapy.

Cognitive therapy is sometimes criticized for being limited to addressing easily accessible, conscious attitudes and thoughts and the products of cognitive mechanisms that are developmentally relatively advanced. According to this view, it cannot modify the products of primitive, developmentally earlier systems. Although it is true that, in the early stages of cognitive therapy, work does focus on relatively accessible automatic thoughts and conscious beliefs; as therapy proceeds, the patient learns to exercise greater self-awareness, and thoughts and underlying assumptions that he or she was not previously aware of come into focus.

The short-term treatment model, which Young (1984) calls technical cognitive therapy, is a focused educative process in which reality-testing skills for relatively accessible cognitions are learned and practiced together with problem-solving techniques. Longer-term therapy follows a more flexible program based on the same theoretical framework but using a broader range of therapeutic skills and techniques. This approach, which Young calls conceptual cognitive therapy can be used to identify and modify the more primitive cognitive schemata. In Italy, Guidano and Liotti’s (1983) “structural cognitive therapy” is very similar.

Beck (1985) himself is explicit about the importance of restructuring developmentally primitive schemata. He argues that while cognitive therapy differs from psychoanalysis in technique, it has a similar theoretical framework. In both types of therapy, immature and primitive beliefs and assumptions (primary process) are reexamined and restructured through the medium of mature, rational (secondary process) thinking. It is not enough to evaluate rationally the cognitions of the
primitive levels. When this is done, a rational perspective is gained in the mature thinking systems, but the distortions remains firmly coded in the primitive systems and do not lose their ability to control behavior. The analysts recognized that the primitive levels had to be directly activated in the therapy if these distortions were to be removed and that this often involved the patient’s experiencing a great deal of emotion. Beck takes the same view. For example, he writes about the treatment of agoraphobia:

It is crucial that the patient experience anxiety in order to ensure that the primitive cognitive levels have been activated (since these levels are directly connected to the affects). The repeated, direct, on-the-spot recognition that the danger signals do not lead to catastrophe . . . enhance [s] the responsivity of the primitive level to more realistic inputs from above. (p. 342)

THERAPEUTIC WORK WITH EARLY MEMORIES

Early Memories as Structures of Cognitions

For Freud, the repression of early emotionally charged memories provided the basis for his traumatic theory of neurosis. He supposed that severely traumatic childhood incidents, such as sexual molestation or the viewing of sexual activity or violence, were stored in memory, but the memory was repressed. In adulthood, events might occur that had a theme similar to that contained in the repressed memory and would threaten to reactivate it. Neurotic behavior would then arise as a result of the complex cognitive and behavioral avoidance the individual would engage in to keep the memory repressed.

Two factors led Freud away from work with early traumatic memories. First, he came to believe that memories of apparently traumatic events that seemed to have contributed to neurosis were usually mere fantasies, a conclusion that has recently been vigorously questioned (Malcolm 1986). Second, he recognized that recovery and analysis of a past trauma was not in itself curative unless patients had the capacity to use these discoveries intelligently as a basis for changing themselves in the present.

Bowlby (1985) has been among those who have criticized psychoanalytic therapy for steering away from work with early traumatic memories. He points out that it is during early childhood that an individual’s developing cognitive schemata are especially open to the influence of powerful events. When these are negative, the representations of the world, self and relationships that develop are distorted or pathological. The recovery of an early memory can play an important role in allowing these distorted schemata to be identified and sets the stage for their restructuring.

Traumatic early memories are still frequently encountered in contemporary clinical practice. Bowlby (1985) reviews several case studies in which the source of pathology lay in traumatic incidents such as witnessing a parental suicide or being
sexually abused. The child had usually been told implicitly or explicitly by adults that the event did not occur. He shows how recovery of the memory served as a vehicle for accessing distorted cognitive schemata and allowing them to be restructured.

Relationship Between the Memory and the Associated Affect

A memory is a complex cognitive structure that combines sensory information about specific events and behaviors with interpretations of those events and the emotions associated with the interpretations. The traumatic incident mobilizes beliefs that generate emotion so intense as to be perceived as overwhelming. This will be illustrated by the types of emotions and cognitions aroused in a young girl who is sexually molested by her father. The different emotions that might be felt, together with the meaning structure out of which each emotion arises, are summarized in Table 1. Of course, defenses against the different emotions might take various forms. The whole complex may be repressed, but even when it is recovered, certain components may be more accessible at first. For example, the anger may be less accessible than the helplessness or guilt.

Because of the intensity of the experience, the whole cognitive-emotional complex becomes repressed. As a result, the emotions are avoided, the cognitive aspect cannot be reality tested, and the basic belief structure remains intact. But it is re-evoked in everyday situations that have something in common with the original incident(s).

Early Memories That Represent Fundamental Social Schemata

Bowlby (1985) describes how dysfunctional core beliefs about the self, others, and relationships can develop within the early relationship with mother, father, or siblings, not as a result of specific traumatic episodes but in response to numerous more or less subtle responses. From these the child learns about power or dependency in relationships in the family. Patients raised in relationships with dominating or dependent caretakers (for example, where the adult controlled the child through threatening to abandon her or sought to meet her own dependency needs through the child) are particularly at risk.

Schemata developed in these early relationships are applied to other relationships in later life. A case example (Beck, 1970) illustrates this process: A man, on a picnic with his fiancée and his best friend, imagined his fiancée and friend looking at each other in a loving way, signaling to each other, arranging a secret meeting later, and making love. He felt rejected and jealous. In the therapy session he recalled how as a child he was always competing with his brother, who generally seemed to get more attention than he did and took from him things he valued. Out of this had developed a schema about relationships that included expectations such as “In a competition I always lose,” “things I value will be taken away from me,” “I’m powerless to prevent things being taken away.” Without the patient’s being aware
<table>
<thead>
<tr>
<th>Emotion</th>
<th>Cognition</th>
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<tbody>
<tr>
<td>Anger</td>
<td>“He has broken a rule that fathers should not take advantage of or hurt or harm children.”</td>
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<td></td>
<td>“He has failed to respect what I feel and who I am.”</td>
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<tr>
<td>Helplessness</td>
<td>“There is nothing I can do to prevent myself from being harmed.”</td>
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<tr>
<td>Disappointment about betrayal</td>
<td>“In you I believed I had someone I could rely on and trust. Now I have lost that.”</td>
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<td>Guilt</td>
<td>“It must be something that I have done that makes him do this. Maybe I led him on, or maybe I was too obvious about my own sexuality.”</td>
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<td>Shame</td>
<td>“I have done something terrible and am therefore completely unacceptable to others as someone who can participate in everyday social activity.”</td>
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<td>Disgust (with phobic avoidance)</td>
<td>“My body has been contaminated, and I should try not to touch it or look at it in case I contaminate myself further; and I should prevent others from touching or seeing my body in case they become contaminated also.”</td>
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<tr>
<td>Worthlessness</td>
<td>“If he treats me like this, I must be no good; there must be something wrong with me.”</td>
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<tr>
<td>Anxiety</td>
<td>(1) “I will be physically harmed.”</td>
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<td></td>
<td>(2) “I will be socially ostracized or ridiculed if the molestation becomes public.”</td>
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<td>(3) “I will be victimized by my father if it becomes public.”</td>
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<td>(4) “I will harm or betray my father if I speak to anyone about it.”</td>
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<td>(5) “I will be ridiculed and not believed if I speak to anyone about it.”</td>
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<td>(6) “I will become pregnant (go insane).”</td>
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<td></td>
<td>(7) “There will be further episodes of molestation, and physical pain and injury may occur during these episodes.”</td>
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*aThis is a fairly comprehensive list. In an individual case not all of these may be evoked.

of it, this schema had been reactivated in the context of the relationship with his friend and his girlfriend, resulting in the fantasy that he described, with the associated emotions. In such a case, to recover the memory and draw the link with
the past can be a major step in enabling the current situation to be reevaluated.

In other patients current situations re-evoke memories of situations perceived to have the same structure. Replay of the memory is a review of the evidence for the basic belief components of the schema, and it serves to reinforce these beliefs in the present (Erskine & Zalcman, 1979). However, two factors enable it to be turned to good therapeutic effect if the memory is activated during the therapy session. The first is that through the memory there is activation of the primitive cognitive system that it is the goal of therapy to change. The second is that an opportunity is obtained to identify the key belief components of the schema and to reexamine the evidence provided by the remembered incident. As Grof (1976) has shown, a specific cluster of beliefs and related memories cohere to form a structure he calls a condensed-experience system. It is not necessary to modify every memory in the system because one or more key memories provide access to the specific distorted cognitions that are central to its structure.

Reevaluation of the Original Interpretations of the Early Episode

In these cases, the work of the therapist is threefold: (1) to support the patient in recovering and reviewing the avoided memory, (2) to facilitate the process through which the patient identifies the meanings/beliefs associated with the emotions that are encountered, and (3) to facilitate the process of reevaluating these beliefs.

In the reevaluation stage, certain beliefs may be confirmed as accurate with regard to the time the events took place. For example, the patient may affirm the validity of her anger by recognizing that the rule that fathers should not molest their daughters is appropriate. She may also conclude that, given the social setting and attitudes of the family at the time, she was indeed helpless to do anything or that if she had told another adult she would not have been believed. There may be other beliefs that she recognizes were not accurate at the time the events took place. For example, she may now recognize that as a small child she was not responsible for being molested or conclude that she was not as helpless as she had believed because if she had told her mother, her mother would have done something to stop it.

The most damaging effect of a repressed traumatic system of this nature is in the generalization of the beliefs about self and relationships to other situations because this stands in the way of developing healthy and satisfying interpersonal relations. Examples of such beliefs are “Men can’t ever be trusted”; “If people try to hurt me, I am helpless to stop them”; “If people hurt me, it is my fault”; “If I tell people what bothers me, they won’t take me seriously”; “I’m unclean and people won’t want to touch me.” Although the memory remains repressed and the cognitions unintegrated with the rest of her knowledge about the world, the traumatic incident remains as powerful evidence for the truth of these propositions, thus rendering them less amenable to change through contemporary evidence.
CASE EXAMPLES OF MEMORY RESTRUCTURING THROUGH GUIDED IMAGERY

The Case of the Guilty Trial Lawyer

Cognitive restructuring through psychodramatic enactment is a development of Perls's (e.g., 1976) classic technique that has been widely used in Gestalt therapy and transactional analysis (e.g., Goulding & Goulding, 1979; James & Jongeward, 1971). The technique can be employed through the medium of imagery (Edwards, 1989), as is the case in the two examples that follow. Perls (1976) pointed out that in talking about an event (which he called “aboutism”), a person can remain emotionally distanced from it. When this happens, key cognitions that underlie the emotions cannot be identified, and restructuring cannot take place. By activating the memory in imagery, interviewing the characters, and having them dialogue with each other, the patient is kept closely in touch with the emotions evoked; this provides access to the underlying cognitions that comprise the schema.

Richard was a 32-year-old attorney who had presented with dysthymic disorder and a generalized anxiety disorder. He was no longer depressed, but he reported that he still felt helpless and guilty when another attorney was critical or confronting. In the nature of his work as a trial lawyer, this happened frequently. His automatic thought was “I must have done something wrong,” and the thought and feeling did not change when he rationally examined the situation and reminded himself that he had not done something wrong.

I asked him to visualize the type of situation he was describing. This evoked the guilt feeling and the related cognitions: “If the other person is angry, he must be right. If the other person is right, I must be wrong.” The simplistic dichotomous character of these cognitions suggested that a childhood schema was being reactivated, so I asked him to transform the image to portray himself at the age at which he first started to have these beliefs. He at once saw himself as a 5-year-old boy on the farm where he was brought up, being scolded by his grandmother.

Asked to take the role of the grandmother, he revealed that she believed as follows: “I am the ultimate arbiter of right and wrong. If you do wrong, you are a bad person and are not acceptable to the family. If I am angry with you, it is because you have done wrong and are bad.” Richard had accepted this uncritically, and his way of coping with it was to try at all costs not to make her angry. Rather, he had gone out of his way to please her so that he could remain acceptable. Part of the motivation for this was that he did not believe his mother would love him if he was bad and displeased his grandmother. Pleasing his grandmother was thus a way of ensuring his mother’s love.

I asked him to introduce his mother into the scene, and he portrayed her as loving him but intimidated by his grandmother and afraid to say what she really felt. The recognition that his mother was also afraid of his grandmother provided an impetus for the spontaneous restructuring of the original cognitions. I facilitated this pro-
cess by asking him to take the role of his mother and to say aloud this speech: "Richard, I do love you, but I’m also intimidated by Grandma. I’m frightened to let you do what you want. I don’t want you to make her angry. That doesn’t mean I don’t love you. I’m scared, like you, so we’re both really caught in this trap."

When he had said this, he commented spontaneously and with much feeling, "But she never said that. She never let me know that. It was always ‘There’s only one way.’"

I asked, "Do you think she ever understood that?" And he replied, "No, maybe she didn’t. Maybe she doesn’t even now, today."

As he began to see the inaccuracy of the conclusions he had drawn, as a 5-year-old boy, about his acceptability and lovability as a person, I asked him to introduce himself into the image as he is now and to say these words to his grandmother: "Grandma, the picture you gave of right and wrong to Richard when he was a boy was grossly oversimplified and selfish. Children also have feelings and a sense of what’s right and wrong. And you were wrong not to recognize that."

This directly challenged his previous perspective and offered him an alternative framework for viewing the events. He spontaneously commented, "No one ever said that to my grandmother. But if I could have, I would have been a lot happier growing up, instead of taking it and feeling guilty."

This new perspective evoked feelings of anger, that his grandmother had put him through such emotional pain, and of sadness, remembering his feeling of not being part of the family when he was scolded. This revealed the restructuring that was taking place. The anger showed he could challenge the idea that his grandmother was unquestionably right. The sadness showed that he was accepting that he had lost a sense of being cared for during his childhood. This was a positive discovery because he was able to attribute the loss to his grandmother’s and mother’s insensitivity and not to his own shortcomings or unworthiness.

Evidence that the childhood schema had now been modified and integrated was obtained when I questioned him at further sessions over the next few weeks. The feelings of discomfort and guilt when criticized had gone completely, and he felt much more sure of his ground and able to use his mature judgment about the rights and wrongs of particular legal issues. The question as to how change takes places in this type of intervention is addressed below, under "Planning for Generalization."

Educating the Patient About the Process

The second example illustrates problems that arise when the patient is afraid of entering into the process. In such a case she needs to be educated about the technique, and faulty beliefs about the consequences of recovering the memory need to be corrected.

Patty, a 28-year-old unmarried woman had been working on issues regarding personal relationships. She reported at a previous session that while talking with her boyfriend at a restaurant about the termination of their relationship she had
suddenly felt a rush of emotion, had got up, thrown her handbag at him, and momentarily collapsed on the floor. Although she described the episode as “an anxiety attack”—and indeed it was accompanied by a high level of autonomic arousal—it was clear that there was a mixture of anxiety and anger in her reaction. Following this and a rather less intense but similar episode in the same situation a week later, she reported sleeping badly and having to fight to prevent feeling emotionally overwhelmed during the day. She had been given as a homework assignment the task of examining some of her current beliefs about relationships and the way these might have developed during her childhood. She had not been able to do this because of the strong emotions it evoked.

By the beginning of the session Patty recognized that there was a period that she did not want to recall, a period during which, as a young girl, she had moved out of her alcoholic mother’s home and gone to live with relatives. It seemed that she was fighting to keep from consciousness recollections associated with that time, and these had been restimulated by the events with her boyfriend.

When an early memory is recovered and used to give access to early schemata in this way, the emotional pain evoked at the time is restimulated. In Patty’s case the incidents were developmentally earlier, more traumatic, and more emotionally painful than in Richard’s case. It was therefore much more frightening for her to allow the memory to be recovered. As a result, her beliefs about whether it was safe or helpful to go through such a painful process had to be addressed.

She was familiar with standard cognitive restructuring procedures, so I explained that it was important to allow herself to experience these emotions because only then would the cognitions associated with them become available for restructuring. She recognized her conflict about entering into this process and said, “I don’t feel I’m going to get anywhere with it unless I get rid of it. And I don’t feel like I can get rid of it because I don’t want to touch it.”

I offered to guide her through the process by means of an imagery technique, but not push her, and she agreed to begin. I then asked her to pay attention to what she was feeling right now and to report on that to me (this is the technique called “feeling focusing” by Edwards (1989).

Patty: I feel anxious about not knowing what it is that I’m going to know or recall. When I think about it, I don’t get any clear image. I feel this “big black hole in space” sensation. That’s the only thing I can compare it to.

DE: If you close your eyes and visualize, do you get a picture of a black hole?
Patty: I haven’t attempted to do that. (laughs) I don’t want to visualize it any more than I am. I don’t have to close my eyes to visualize it.

DE: So what can you see?
Patty: Nothing. I can’t see anything. It’s just like a large dark empty space that doesn’t have any boundaries.

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1 In the therapy transcript, ... indicates a pause, and *** indicates that an omission has been made for the sake of brevity.
DE: Can you just inspect the image a bit more? Tell me if you notice anything about it.

Patty: Well, I feel like ... I can say what I think it might be ... *** I feel like maybe it’s a dark room. *** I don’t know. It sounds too strange. It’s too ... *** It sounds like it fits what it should be, you know. I see myself as a small child with my mother when we lived in Chicago in the first apartment that we lived in. I see where my bed used to be. I was still sleeping in a crib then. It was in this little recessed part that was off the kitchen, and it wasn’t a separate room. It was like a little boxed-in place that was set back from the room. That was where my crib was stuck, and I see that ... DE: How old are you?

Patty: Three.

DE: *** How are you feeling right now?

Patty: I don’t feel anything when I visualize that. That’s why I don’t think it’s accurate. (laughs) ***

DE: Is your mother there?

Patty: Uuhh. *** She’s passed out on the bed. (Laughs)

DE: Do you think that’s related to something that happened?

Patty: I tend to think it’s a recollection of something that happened, yeah. I know that she used to do that frequently.

She described how the crib had bars so that she could not get out, and she said, “I’m annoyed because I want to do things, and my mother has passed out on the bed. I want to get up and walk around and do something.”

I suggested that Patty should say to her mother that she felt angry. She said the words flatly and with a laugh. I pointed out that she was distancing herself emotionally from the scene, and we explored this for a while. She began to cry.

Patty: I get the sensation of ... If I look at it too much, I get the sensation of nonreality — a confusion between the lines of then and now.

DE: Are you scared that if that happens you won’t be able to come back to now?

Patty: Yes.

DE: Has it ever happened that you’ve gone back to then and haven’t been able to get back to now?

Patty: No.

DE: Has it ever happened that you’ve gone back to those feelings and have come back?

Patty: Yes. *** And especially lately during the last couple of weeks, ever since I had that anxiety attack ... If I even start to think about it ... If I start to think back about that time and what was going on for me, then I start to have that same feeling that I’m ... going to go right with it and never get out of it again ... And it’s frightening that I can’t keep away from it.

During the next interchange, Patty expressed the concern that she would not be able to recover an accurate memory, that she would not be able to restructure it. This, she believed, made the work useless. I explained that what we had to work with was her construction of events, whether accurate or not, and that construction would emerge spontaneously into awareness if she allowed it.

She then explained that she was feeling responsible for the way her boyfriend was behaving, just as she had felt responsible for her mother’s alcoholism.
Patty: If I was perfect, if I was just wonderful, she would stop drinking and this would stop. *** I guess it’s happened in other situations too, but I don’t think I realized it before. The same sort of situation sets itself up. Then, if things don’t work out, I think, “If I had behaved more perfectly ... things would be all right.” So that game starts to play itself out.

I asked her to return to the imagery and see Patty in her crib.

DE: Just let three-year-old Patty say, “Mum, if I can just be very very good, you’ll stop drinking and it’ll be OK.”

Patty: ... (Long pause) I don’t feel like I can say that.

DE: What would happen if you said that?

Patty: ... Like I told you, if I start thinking about it ... I won’t allow myself to drift into that.

DE: Would you allow yourself to drift into it in order to step out of it? ... (Long pause) To see how compellingly logical it was for three-year-old Patty to believe that ... This was the one way she could get control over an impossible situation ... Is there a belief that she’s responsible for her mother’s drinking, so she’s bad?

Patty: Yeah.

DE: Hold that image, but put yourself in there as your adult self, looking at your mother and three-year-old Patty.

Patty: OK.

DE: Could you tell three-year-old Patty that she was wrong to believe that she caused her mother’s drinking?

Patty: (As adult self) You were wrong to believe that you caused her drinking.

DE: Tell her some more about that.

Patty: Well, as you’re going to find out fifteen years from now, your Mom was drinking before you were born, and you don’t really have anything to do with her drinking. She had a lot of problems which had nothing to do with you. You just happened to be an untimed accident that got in the middle of things. But that’s nothing to do with you. She would have been this way anyway.

DE: I’m going to give three-year-old Patty some lines, OK? You stay as adult Patty and reply to her. ‘But I’m scared when she gets drunk. I just so much want to stop her. And I really think it must be because I’m bad that she’s doing this, leaving me all alone.’

Patty: And then I’m supposed to reply as I am now? (Laughs) Mmmm. There’s nothing you can do, whether you’re good or bad, that’s going to stop her. She’s going to go ahead and drink whenever she wants to. And it doesn’t really have anything to do with your behavior. It has to do with how she feels about things.

DE: I can’t let myself believe that she doesn’t love me. It must be because I’m bad that she does this to me.

Patty: ... In order to be healthy you have to understand that what your mother’s doing has nothing to do with you personally. It’s just the way she is.

DE: But I think if I’m really good, I could change her.

Patty: But you are very, very good. And as you’ll find out later, your mother tells you you were always very good and you never did any of the things that children weren’t supposed to do, and she’s still drinking and it didn’t make any difference.

DE: But I could have been better if I’d really tried. I just wasn’t good enough to get
her to love me, to get her to stop.
Patty: Being good has nothing to do with what she does. You can’t be perfect and she can’t be perfect, and she can’t live with that.
DE: Can you still picture three-year-old Patty? How is she looking?
Patty: Bewildered.
DE: Is there something you want to do for her or give her? . . . Is there anything she wants to say to you?
Patty: (Crying) I want to comfort her and tell her it’s all right.
DE: Do that . . . What do you see?
Patty: I can see myself doing that and she’s crying. ***
DE: What is she sad about?
Patty: That there’s nothing she can do.
DE: Can you tell her it’s true that there’s nothing she can do; but that doesn’t mean she’ll be powerless for the rest of her life . . . (Long pause while she continues crying)
What’s happening now?
Patty: Even though I don’t have the image of the black hole, I have the same sensation of it coming right out . . . ***
DE: What’s the main thing you’re feeling?
Patty: I don’t know. *** Well, I sort of feel a relief that I feel as if I’m not responsible for some things I believed myself responsible for. But . . . I’m wondering how much more of this there is to process. (Laughs)

The effectiveness of this type of intervention is discussed below. My impression was that the schemata addressed had a much stronger and more pervasive effect on her everyday emotions and behavior than was the case with Richard. Although not resulting in an immediate relief of symptoms the effect of this session was to reduce her fear of tackling the issues involved. These were taken up in later sessions.

**Contributions of Memory Restructuring to the Course of Therapy**

There are three contributions that this restructuring of early memories can make to the course of therapy. The first is that, by giving access to the more primitive cognitive mechanisms, key beliefs may be identified that were not apparent from an analysis of current automatic thoughts. Or, where beliefs have been identified previously but have been difficult to shift, the hidden evidence maintaining them is revealed and can be challenged (Bowlby, 1985).

The second contribution is that beliefs that may seem exaggerated and oversimplified in the context of present relationships may be seen to be rational or adaptive in the context in which they developed. In the case of Patty, her belief that if only she could be perfect people would not hurt her can be seen as the magical solution of a helpless child to an uncontrollable situation. Other beliefs of hers were “I don’t have any impact on or control over other people’s behavior’ (which, in regard to her mother at that time was pretty accurate), “If relationships go wrong, it is my fault” (which even then was incorrect), and “It’s best to keep myself apart and as uninvolved with people as possible” (which was probably the best decision she could have made at the time to protect herself in the relationship with her
mother). Uncovering the context in which the belief developed provides the basis for a reexamination of its validity and pragmatic value for the present (Bowlby, 1985). It also enables the patient to counter self-critical thoughts such as “How stupid I was to have believed that. I must have been dumb not to have seen it clearly at the time.”

Third, the cognitive components of the primitive schema can be directly restructured by means of the imagery psychodrama. Through the dialogue that the therapist directs, these are identified, challenged, and changed. Restructuring the long-term memory does not, of course, mean altering the details of the content. Nor is the process merely one of catharsis, the discharging of a reservoir of dammed-up affect (Nichols & Zax, 1977). Accessing the memory is not in itself curative unless the key cognitive distortions are identified and altered.

Problems in Implementing the Technique

When memories are associated with such strong and unpleasant affect that they are vigorously avoided, tackling the avoidance must be the initial therapy target. Essentially the therapist needs to desensitize the patient so that the avoided material is allowed into awareness a bit at a time. As Beck (personal communication) has pointed out, there is a similarity between this type of cognitive avoidance and a phobia, with the affect-laden cognitions serving as the phobic object. Gauthier and Marshall (1977) make the same point about avoidance of thoughts or memories of a deceased loved one in pathological grief.

One approach to this desensitization is illustrated in the description above of the session with Patty. She was gradually encouraged to allow more of the avoided material into awareness. At each point where she drew back, the belief that led her to avoid was identified and dealt with, allowing her to go on to the next step. This process gave her an increased tolerance for the affect and showed her that her beliefs about being overwhelmed or being unable to return to a calm state were false. As a result, in a second session a few weeks later she was able to enter the process with much less hesitation.

In cases where the avoidance is more intractable, the therapist may have to make the desensitization the main target of therapy until the patient can allow the material sufficiently into awareness for the cognitive restructuring phase to be entered. It may be necessary to have the patient set up a hierarchy of avoided material, ranked from the most to the least threatening, and then have him experiment with allowing the least threatening into awareness for short periods (Beck, personal communication). The time and the intensity of threat can gradually be increased.

This technique is contraindicated in those patients who are already so overwhelmed by emotion that they have little access to mature cognitive structures, as it will serve only to increase the emotional intensity and make rational reevaluation even more difficult. Patients with histrionic traits who have a diffuse and global cognitive style are especially susceptible to this.

Patients with a circumstantial style, who fail to keep focused on the key issues
being dealt with, also present a problem because the process of restructuring is impeded when they follow loose chains of associations. They can easily become bogged down and muddled by this failure of focus, and the necessary components of the restructuring process cannot be covered. When this happens, the therapist can use the material obtained through the imagery but will need to structure the cognitive reevaluation very firmly in a verbal mode.

The process is greatly facilitated if the patient has a good understanding of the aims of the imagery restructuring. Some patients do not acquire this easily, or they react against imagery work for various reasons. It is better to use other techniques with them. Conversely, some patients have a special affinity for imagery work, and for these the modality is particularly suitable and effective.

Planning for Generalization

The therapist using this approach needs to combine three sets of skills. The first is the use of the imagery psychodrama to identify and restructure cognitions during the session. The second is the ability to work with resistance to the process as has just been described. The third is the integration of the work with other techniques of cognitive behavior therapy to ensure that permanent restructuring takes place and that there is effective behavior change.

Does a single session of memory restructuring, such as those described, lead to permanent change? This article presents two case studies, and the data do not allow for formal conclusions on this question. However, the question itself conceals a number of problems. When we talk about change, we are talking of change in specific thoughts, beliefs, fundamental schemata; change in the frequency or intensity with which distorted schemata are evoked; and change in the patient’s skills in dealing with occasions when distorted schemata are evoked. Change is not, therefore, a unitary phenomenon that can easily be quantified.

In effective cognitive therapy, the process of change is a process of several simultaneous and interlocking changes occurring through a cumulative and self-reinforcing learning process as the therapy proceeds. Some patients enter into this process fully and readily, and the therapist does not need to monitor and work specifically with every aspect of it. In other cases, each component of the learning is hard-won and achieved only through painstaking, detailed work.

Evaluation of the effectiveness of the approach described here can best be made with this framework in mind. Richard was a patient in whom the process of “learning to learn” (Beck & Emery, 1985, pp. 186–188) was already well established. Informal feedback from him over the several weeks following the session described indicated that the intense feeling of being wrong that had previously been evoked was no longer evoked in similar situations. Probably this can be attributed to the restructuring of the early schemata that occurred during the session itself; spontaneous restructuring after the session, in which he thought through the issues; and his ability to recognize, distance from, and rationally reevaluate these particular distorted
cognitions when they were evoked in new situations. The single session appeared, therefore, to have removed the specific symptom. The effect is not always so powerful. The effectiveness in Richard’s case was potentiated by his general level of cognitive skillfulness.

In the case of Patty, the schemata evoked by the technique were developmentally earlier and more emotionally charged, and they had a more pervasive effect. From the transcript it can be seen that there were a large number of interlocking beliefs that required restructuring; before the session these were very convincing to her, and they constituted her reality as far as intimate relationships were concerned. It would not be expected in such a case that the distorted schema would have lost its power the next time the same situation arose with her boyfriend. In this case the gains made in the session described needed to be consolidated and built on, both through the patient’s practicing her cognitive skills in later situations that arose in her life and through work in therapy identifying the way the particular beliefs that emerged were activated and controlled her behavior.

The next step would be to guide her in reevaluating her perception of herself in relationship to her boyfriend and in experimenting with new and more appropriate assumptions. Aspects of this process often take place spontaneously because the primitive cognitions are being exposed to reality testing and a mature perspective. However, some patients whose most developed schemata are still very oversimplified need direct guidance from the therapist in reality-testing the original cognitions, searching for alternative explanations of the events, and testing them out in the context of contemporary life situations.

CONCLUSIONS

When a patient enters into cognitive psychotherapy, she is invited to participate in a complex learning process through which she will be able to reevaluate fundamental beliefs about self, world, and relationships; acquire new skills; and live with less emotional distress and more authentic satisfaction.

The practice of cognitive psychotherapy is not merely the mechanical application of specific techniques to specific symptoms. There is a range of techniques, each of which can be very powerful if the therapist is skillful in choosing when to introduce it into the learning process.

The technique of working with an early memory, as described here, does not work automatically, but it is very powerful if used with the right patient at the right time. This is because imagery work can often provide a more direct access to primitive schemata than purely verbal techniques can (Edwards, 1989). In imagery, the emotional impact of the schema is evoked, and this provides a situation in which change can occur. Therapists sometimes talk about the greater effect of working with “hot cognitions” than with “cold” ones. Rational discussion may cool the emotional tone and reduce the impact of change, whereas imagery work has the
opposite effect.

The sessions described here show the value of tracking cognitions back to their historical development in the patient’s life. They also show that this tracking does not have to be a systematic and painstaking process. Very often, as in the cases described here, once the schema is activated and the emotional quality associated with it is present, the key early memories are readily available and arise spontaneously if the imagery technique is used. As Grof (1976) suggests, memories and beliefs are organized around themes. A recurring pattern is stored in a “condensed experience matrix,” which is a schema that has associated with it not only the patterns of behavior and cognition but also memories of occasions when that pattern was played out.

The imagery method takes advantage of this aspect of cognitive organization. It provides a means of keeping the schema activated during the session, it allows the structure of the schema to be revealed, and it provides a way of changing the schema itself through the reevaluation of the memory and its associated cognitions.

A quantitative study applying the technique to a sample and evaluating its effectiveness in relieving symptoms would not do justice to its power. The technique cannot be used indiscriminately. It is appropriate only where an early memory can be elicited, as in the cases described here. There are occasions when the initial exploration by the therapist fails to reveal a clear specific memory, and then another approach has to be taken. In this article a case study approach was followed, documenting the manner in which the technique contributed to the ongoing learning process of therapy. This is a more appropriate research method when a complex process is being examined (Bromley, 1986).

The present article has concentrated on the imagery sessions themselves, but it would be valuable for future research to document the interplay between the memory-restructuring work, the key cognitive and behavioral patterns that have been identified in therapy, the patient’s progress in “learning to learn,” and the application of other cognitive and behavioral techniques. A set of such case studies would provide clearer guidelines as to the conditions under which the method is of most value.

REFERENCES


**Acknowledgments:** The draft of this paper was written while the author was a postdoctoral fellow at the Center for Cognitive Therapy at the University of Pennsylvania in Philadelphia. The content owes a great deal to those who led or participated in workshops or seminars during that time, and I gratefully acknowledge their contribution. An earlier version was presented at the Annual Congress of the Psychological Association of South Africa, Rand Afrikaans University, Johannesburg, October 1986.

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