

ORIGINAL RESEARCH

# 'Felt security' as a means of facilitating imagery rescripting in psychosis: a clinical protocol and illustrative case study

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## Abstract

People with psychosis do not have routine access to trauma-focused cognitive behavioural therapy (CBT) interventions such as imagery rescripting (IR), partly due to clinical caution. This case study describes the use of a simple imagery task designed to engender 'felt security', as a means of facilitating IR with a woman struggling with distressing memory intrusions, linked to her voices and paranoia. We assessed the impact of the felt security task, which was used before IR to enable Kip to engage in reprocessing of her trauma memories, and again after IR so that she would leave sessions feeling safe. The brief imagery task was effective in improving felt security before IR sessions. Felt security then reduced during IR, when distressing material was recalled and reprocessed, and increased again when the task was repeated. It is not yet clear whether trauma-focused interventions such as IR need to be routinely adapted for people with psychosis. In the event that individuals express concerns about IR, if the person's formulation indicates that high levels of arousal may trigger an exacerbation of voices, paranoia or risk, or where clinicians are otherwise concerned about interventions likely to increase emotional arousal in the short term, the felt security task may facilitate safe and effective reprocessing of trauma memories. This in turn may increase access to trauma-focused CBT for people with psychosis.

## Key learning aims

- (1) To understand that people with psychosis need access to trauma-focused CBT.
- (2) To be familiar with a simple attachment-based imagery task designed to foster 'felt security'.
- (3) To learn that this task may facilitate imagery rescripting in people with psychosis.

**Keywords:** felt security; imagery rescripting; paranoia; psychosis; voices

## Introduction

Many people with psychosis report childhood adversity, and early adversity substantially increases risk of psychosis, with a likely dose–response relationship (Varese *et al.*, 2012). It is unsurprising then that three-quarters of people with psychosis report recurrent, distressing intrusions, often linked to trauma memories (Morrison *et al.*, 2002).

While we have well-evidenced trauma-focused interventions, such as imagery rescripting (IR), most people with psychosis are not offered these, partly due to clinical caution – we are concerned about exacerbating people's psychosis and associated risks (Sin *et al.*, 2017). This is in contrast to the growing number of studies examining cognitive behavioural interventions targeting distressing intrusions in psychosis, including IR (e.g. Ison *et al.*, 2014; Keen *et al.*, 2017; Paulik *et al.*, 2019; Sheaves *et al.*, 2015; Taylor *et al.*, 2018), and evidence that IR affects the same cognitive-affective

processes in non-clinical paranoia as has been shown in people with depression and anxiety (Newman-Taylor *et al.*, 2019). If we are reluctant to offer effective interventions for fear of causing harm, the question is: *how can we offer trauma-focused CBT safely and effectively to people with psychosis?*

There is good evidence for the effectiveness of IR in treating post-traumatic stress disorder (PTSD) and intrusions cross-diagnostically (Arntz, 2012; Morina *et al.*, 2017). Additionally, it may be that IR is more suitable than prolonged exposure for people with psychosis given (i) the shorter duration of exposure to distressing memories (which is likely to be linked to drop-out rates), (ii) the focus on change to meaning and affect linked to memories rather than the perceptual experience of intrusions, which may be particularly important in interpersonal trauma, and (iii) the requirement for fewer sessions per memory, making this approach appropriate for people with multiple traumas, as is often the case for this group (Paulik *et al.*, 2019). Despite initial evidence for IR with psychosis, take-up remains low. Certainly, we need to support clinicians to develop these skills. In addition, it may be that some people with psychosis would benefit from learning to manage increases in affect, to ensure that IR is acceptable, and can be used safely and effectively.

The concept of 'felt security' was developed in the attachment and social psychology literature, and describes the sense of interpersonal safety associated with secure, protective relationships, that in childhood form the basis for healthy psychosocial trajectories. Recent advances in CBT for psychosis draw on the attachment literature to formulate psychosis in developmental context (Berry *et al.*, 2017; Gumley *et al.*, 2008), and preliminary experimental studies show that attachment-based imagery designed to strengthen felt security reduces paranoia and anxiety, and improves mood and self-esteem in analogue groups (e.g. Bullock *et al.*, 2016; Newman-Taylor *et al.*, 2018).

In this case study, we sought to prime felt security as a means of facilitating engagement in IR following the three-stage protocol set out by Arntz and Weertman (1999), which involves recalling traumatic memories in a particular way to allow reprocessing of intrusive material. We predicted that priming felt security would enable the person to manage the temporary distress elicited by IR, engage fully in the process, and so benefit from the intervention.

## Method

### *Participant and formulation*

Kip presented with frequent derogatory voices, paranoia and intrusive trauma memories. She was 36 years old and had been assessed by her psychiatrist to have psychosis at the time of referral. A past diagnosis of emotionally unstable personality disorder (EUPD) had led to psychological therapy to manage her emotions more effectively, and she now sought help to address her psychosis and trauma symptoms. Kip had a history of hurting herself (through cutting) and others (through attempted strangulation) from adolescence, and had been arrested once and admitted to hospital on several occasions due to her risks.

Our initial CBT sessions focused on making sense of Kip's current experiences in the context of her trauma history. She had been physically and sexually abused by her father from the age of 3 to 15 years, and bullied at secondary school. From an early age, she learnt to see herself as worthless and disgusting, and others as unpredictable and threatening. During adolescence, she started to hear voices echoing her fears, and became convinced that demons had taken over her body. When we met, Kip described a pervasive sense of threat, indicating that others were planning to harm her and that she was unable to protect herself. These beliefs were reiterated by a powerful male voice that issued commands to kill herself. She also heard a jeering crowd of voices, which left her feeling terrified although she was unsure why. Kip managed her fears by withdrawing socially, listening for the voices, and either ruminating or trying to push difficult thoughts and voices out of mind. She was isolated, lonely, and low in mood.

Following formulation, Kip was able to start to reconsider her beliefs about herself, others and the voices in developmental context. She was prompted to extend her use of emotion regulation skills (learnt in her previous therapy) when feeling fearful of others or distressed by the voices. She learnt to recognise unhelpful thinking patterns, articulate previously unspoken feelings including fury, shame and disgust, and engage with valued activities and safe relationships. This work resulted in Kip being able to respond more calmly and kindly to her voices and herself, with the result that her paranoia and the distress associated with the voices reduced. However, frequent intrusive memories persisted, linked to her early abuse, bullying at school, an arrest as a young woman, and events while an in-patient. At this point, Kip decided she was ready to address her trauma memories directly, something she had wanted to do for several years, although she was fearful about the likely distress of recalling past events, and her ability to manage the feelings elicited without becoming unwell or suicidal.

### Measure

The Felt Security Scale (Luke *et al.*, 2012) assesses the degree to which a person feels safe and unthreatened, as would be expected in a secure attachment relationship. Ten descriptors (e.g. safe, protected) are rated on a 6-point scale (1: not at all, to 6: very much). For the purpose of clinical use, the descriptors were rated 'right now' to assess state felt security. Scores range from 10 to 60, with higher scores indicating greater felt security. The scale has excellent internal consistency ( $\alpha = .97$ ).

### Felt security imagery task

The felt security imagery (FSI) task was developed from an imagery priming script for social anxiety (Hirsch *et al.*, 2003) and secure attachment priming instructions (Bartz and Lydon, 2004), and adapted for people with paranoia (available on request). The task takes approximately three minutes to complete and involves recalling a specific interpersonal memory of a time when the person felt safe and relaxed, and knew that s/he could trust and rely on the other person or people present.

### Procedure

Kip's fears about addressing past trauma were consistent with her formulation, which indicated that recall of certain memories increased her paranoia and linked distress. To enable her to engage in IR of the intrusions, we agreed to use the FSI task to engender a sense of felt security immediately before the reprocessing, and then again after IR so that she would leave sessions feeling safe. One trauma memory was rescripted per session, over six sessions. Kip attended therapy weekly, and completed IR on each occasion she felt able to do so; occasionally, her level of distress was such that she declined. IR targeted memories of being bullied and assaulted, and took approximately 30 minutes per session. Memories were rescripted until Kip reported a reduction in intrusions and linked affect over the following week. Over the six sessions reported, four key memories were rescripted. Kip rated the frequency and distress (0–10) of intrusions pre- and post-intervention.

## Results

### Felt security

Figure 1 shows the first six felt security ratings pre- and post-FSI task, which was used before and after IR in each of these sessions.

The figure indicates a similar pattern for each session; felt security increased over the period of the FSI task, then fell during IR (when key trauma memories were recalled and rescripted) and increased again over the period of the second FSI task.

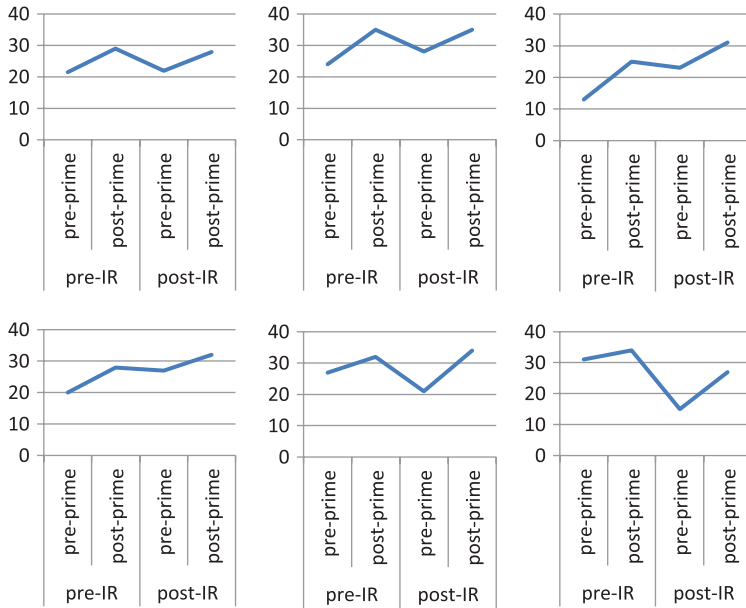


Figure 1. Felt security before and after imagery rescripting.

**Subjective feedback on trauma intrusions and psychosis**

For each of the memories rescripted, Kip reported a reduction in frequency (from up to several times a day to nil most days) and distress (from 10/10 to 3/10) of related intrusions. She had not heard the jeering crowd since rescripting a memory of being bullied at school. She hears one remaining voice less frequently, which she now understands as an expression of her mood and worst fears (‘inner me’), and uses as a stress gauge and to prompt self-care and help seeking. She also reported a further reduction in her paranoia over this time.

**Discussion**

Our collective caution regarding trauma-focused CBT for people with psychosis is partly due to concerns about causing harm (Sin *et al.*, 2017). This case study illustrates the use of a brief imagery (FSI) task to facilitate imagery rescripting of trauma memories linked to one woman’s voices and paranoia. We found that the FSI task resulted in an increase in felt security when used before and after IR. Despite fears about engaging in IR, and managing the temporary distress elicited, Kip was able to do both and this proved effective in reducing the frequency and distress of her intrusions.

As a case study, we cannot draw conclusions about whether the imagery task was either instrumental or necessary in facilitating IR. It may be that Kip would have benefited from standard IR with no adverse effects. However, Kip and her care team were reluctant to pursue this option. Additionally, the lack of other measures means we cannot determine how specific the task was in increasing Kip’s felt sense of security as opposed to general anxiety. A single case experimental study would be the next step in assessing the impact of the felt security task for people who decline or have concerns about engaging in standard IR.

With an increasing recognition of the role of early adversity in the development of psychosis, and evidence that the majority of people with psychosis report related intrusions, we need to find ways to offer trauma-focused CBT that are acceptable, safe and effective. If some people with psychosis are concerned about tolerating IR, the FSI task may provide a simple means of regulating emotion and therefore increasing the acceptability of IR. If their formulation

indicates that heightened arousal exacerbates voices, paranoia or risk, the FSI task may enable IR to be used safely. Where clinicians are hesitant, the task may increase the likelihood that IR is offered.

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### Key practice points

- (1) People with psychosis can engage in trauma-focused CBT.
- (2) A brief attachment-based imagery task may provide a simple means of facilitating 'felt security'.
- (3) This in turn may enable people with psychosis to engage in imagery rescripting.

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