Received: 22 October 2023 | Accepted: 15 May 2024

DOI: 10.1111/papt.12538

RESEARCH ARTICLE

Experiences of imagery-based treatment for anxiety in bipolar disorder: A qualitative study embedded within the image based emotion regulation feasibility randomised controlled trial

Susan Elkington[1] | **Michael Brown**[2] | **Kim Wright**[3] | **Jemma Regan**[4] | **Kate Pattarnaraskouwski**[4] | **Craig Steel**[5] | **Susie Hales**[6] | **Emily Holmes**[7] | **Nicola Morant**[1]

[1]Department of Psychiatry, UCL, London, UK

[2]Pembroke College, University of Cambridge, Cambridge, UK

[3]University of Exeter, Exeter, UK

[4]Devon Partnership NHS Trust, Devon, UK

[5]Oxford Health NHS Foundation Trust and University of Oxford, Oxford, UK

[6]Oxford University Hospitals NHS Trust, Oxford, UK

[7]Uppsala University and Karolinska Institutet, Stockholm, Sweden

Correspondence
Susan Elkington, Department of Psychology, City University, Rhind Building, St John Street, London EC1R 0JD, UK.
Email: susan.elkington@city.ac.uk

Abstract

Objectives: Intrusive mental imagery is associated with anxiety in bipolar disorder (BD) and presents a novel treatment target. Imagery-based treatments show promise in targeting anxiety and improving mood instability. This qualitative study explored experiences of receiving up to 12 sessions of a brief structured psychological intervention: Image-Based Emotion Regulation (IBER), which targets maladaptive mental imagery in the context of BD with an aim to modify the emotional impact of these images.

Design: A qualitative study embedded within the Image Based Emotion Regulation (IBER) feasibility randomised controlled trial.

Methods: Semi-structured interviews were conducted with 12 participants in the treatment arm of the trial who received IBER + treatment as usual. Data were analysed using thematic analysis.

Results: Despite some initial scepticism about imagery-focused treatment, all participants expressed broadly positive accounts of treatment experiences. High levels of engagement with imagery modification techniques, beneficial use of techniques post treatment and improvements in anxiety management and agency were described by some. Three sub-groups were identified: those who reported a

Clinical Trial Registration Number: https://doi.org/10.1186/ISRCTN16321795.

powerful transformative impact of treatment; those who embedded some new techniques into their daily lives, and those who felt they had techniques to use when needed. No participants reported overall negative experiences of the IBER treatment.

Conclusions: Findings from this study highlight the value for treatment recipients of modifying the underlying meanings associated with maladaptive imagery, and the personalised skills development to manage anxiety within bipolar disorders. Findings can inform treatment refinements and further trial-based evaluations.

KEYWORDS

anxiety, bipolar disorder, emotion regulation, intrusive imagery, mental imagery, qualitative research, therapy

INTRODUCTION

Bipolar disorder (BD) affects more the 1% of the global population and is considered one of the most challenging psychiatric disorders, involving mood swings between (hypo)mania and depression, with high rates of relapse and comorbidity with other disorders. (Anderson et al., 2012; Vieta et al., 2018). A lifetime comorbidity rate of 40.5% in BD with anxiety disorders compounds the challenging course of BD and contributes to poorer treatment outcomes (Eser et al., 2018). BD has the highest suicide rates of any psychiatric disorder, 20 times that of the general population, with an estimated 15–20% of suicide attempts being lethal (Chesney et al., 2014; Gonda et al., 2012; Schaffer et al., 2015). In the UK, bipolar disorder is a leading cause of disability and impairment amongst people aged 15–44 years old and is estimated to cost the UK £8.2 billion by 2026 (McCrone et al., 2008).

Pharmacological options form the main treatment (Goodwin et al., 2016; Vieta et al., 2018). In the UK context, the choice of psychosocial interventions approved by the National Institute for Health and Clinical Excellence (NICE) is limited to psychoeducation, cognitive behavioural therapy (CBT), interpersonal and social rhythm therapy (IPSRT), and integrated cognitive and interpersonal therapy. Yet, the evidence base for psychosocial interventions for BD is mainly based on low to moderate quality trials (NICE, 2014 cg 185). BD is marked by heterogeneity and complexity in the range of symptoms and behaviours that therapeutic treatments may target, and psychoeducation remains the recommended first-line intervention (Goodwin et al., 2016). There is evidence that CBT helps with the depressive aspects of BD, but a cognitive model may not account for the range of bipolar symptoms, in particular mood swings (Chatterton et al., 2017; Chiang et al., 2017). Despite the elevated risk of anxiety disorders in BD, few psychological treatments for BD target anxiety as the main treatment outcome (Pavlova et al., 2015; Stratford et al., 2015). Anxiety is understood to increase with the progression of BD (Kessing et al., 2017; Stanislaus et al., 2021), and is associated with increased mood fluctuations and poorer responses to mood stabiliser medication (Keller, 2006; Otto et al., 2006). This points to a pressing need to develop treatments to target anxiety early in the course of BD.

An important area for innovation is the field of mental imagery. The ability to create a rich vivid internal experience through mental imagery is important for our daily lives, imagination and ability to plan and pursue goal-based activities (Koenig-Robert & Pearson, 2019; Pearson, 2019; Pearson et al., 2015). Mental imagery occurs when perceptual information is accessed from higher cognitive functions such as perception, motor control and memory in the absence of actual stimuli or physical objects (Thompson et al., 2001). Imagery can also be used to flash forward to emotional events, to 'time-travel' into the future, or to imagine never-experienced events. While mental imagery frequently includes visual components, it

may include any of the senses such as auditory or olfactory senses. (Kosslyn, 2003). Mental imagery has been found to play a maintaining role in a variety of disorders such as PTSD, phobias, anxiety disorders, eating disorders and psychosis (Gregory et al., 2010; Holmes & Mathews, 2010). Interventions that target mental imagery typically use four techniques: imagery rescripting (IR) to change or modify the content of maladaptive images; meta-cognitive techniques to modify the relationship with imagery; building positive imagery to aid wellbeing; and imagery-competing tasks that disrupt imagery (Edwards, 2007; Hackmann et al., 2015; Holmes et al., 2007). For example, IR aims to change underlying meaning, emotion and behaviour associated with maladaptive imagery via updating or modifying the content of the image. This has been an effective component of CBT for anxiety disorders and PTSD (Hackmann, 2011; Kaur et al., 2016; McEvoy & Saulsman, 2014; Reimer & Moscovitch, 2015; Romano et al., 2019).

In BD, positive or negative mental imagery may be understood to act as mood amplifiers, stimulating swings between depression and mania (Holmes et al., 2008; Holmes & Mathews, 2010; O'Donnell et al., 2018). A pre-occupation with suicidal imagery has been identified as greater in individuals with bipolar than unipolar depression, increasing the urge to act on suicidal imagery (Hales et al., 2011; Holmes et al., 2011) and imagery that is overly positive can also present challenges in BD (Ivins et al., 2014). In research using qualitative and experimental tasks, individuals with BD compared to healthy controls reported higher self-involvement, and greater abnormalities in imagery, notably more vivid and lifelike negative images in daily life (Di Simplicio et al., 2016). Differences in the clinical characteristics of individuals with BD have been found compared to healthy controls and are associated with action and high emotional ratings (Petit et al., 2021) and recent evidence suggests that suicidal and self-injury imagery are associated with a heightened risk for self-harm behaviour (Lawrence et al., 2023).

Holmes et al. (2019) developed a brief structured imagery-based cognitive therapy for BD, based on a detailed 'imagery based micro-formulation'. This is a detailed assessment in which images associated with maladaptive mood states are identified, then the content and corresponding meanings, emotions and behaviours are mapped out. This forms the basis of a personalised treatment plan in which the most salient images are targeted for treatment. Various imagery-focussed cognitive therapy techniques are outlined in Holmes et al. (2019). An uncontrolled case series using imagery-based therapy in a BD population provided preliminary evidence of reductions in anxiety and depressive episode relapses (Holmes et al., 2016), and importantly, a large effect size in the reduction of weekly self-reported anxiety symptoms.

The Image Based Emotion Regulation (IBER) programme translates experimental work on mental imagery and emotion into a psychological skills training programme to improve the regulation of intrusive and emotional mental images in people with BD and anxiety (Hales et al., 2018; Holmes et al., 2019). This has recently been evaluated in a randomised feasibility trial to develop an evidence base and the viability for a full randomised controlled trial (Steel et al., 2023). The current qualitative study is embedded within this UK-based trial and is the first to investigate the experiences of people with BD who have received the IBER treatment. It aims to explore experiences of receiving the treatment and to assess recipients' views of the acceptability and feasibility of this treatment as delivered within the IBER trial. The qualitative research allowed us to give to those with the lived experience of BD, an opportunity to describe the impact of mental imagery, and whether they found the techniques relevant and helpful to their experiences. It allowed the clinical team an opportunity to evaluate and investigate a number of aspects of the treatment which the quantitative results of the same feasibility trial did not, especially patterns in the application of imagery techniques learned during the treatment, engagement, and how the adoption and practice of new techniques influenced levels of anxiety.

METHOD

Setting

The IBER feasibility randomised controlled trial recruited 57 participants with a bipolar disorder (I/II) diagnosis aged 18 or above, and with a baseline score of 5 or above on the GAD-7 (Spitzer et al., 2006),

indicating at least mild levels of anxiety. Participants were randomised to IBER treatment + treatment as usual (IBER + TAU $n = 28$) or TAU alone ($n = 29$). In the treatment arm, two participants did not receive the intervention due to illness. Participants in the treatment arm received up to 12 sessions of the IBER treatment within 16 weeks. Both arms continued to receive NHS standard care which includes risk and long-term management plans, and pharmacological treatment for acute episodes (NICE, 2014 ng 185). Measures of anxiety, depression, mania, mood stability and health care were conducted at baseline, end of treatment and at 16-week follow-up. Full details of the study design and findings are reported in Steel et al. (2020, 2023).

IBER treatment is a skills-based therapeutic programme designed to improve emotion regulation and anxiety, via targeting mental imagery (Holmes et al., 2019). Treatment comprises three stages: assessment, treatment and skills consolidation. In the assessment stage, individuals identify salient mental imagery to work on and map out the image using an imagery micro-formulation. Treatment follows four distinct imagery modules (imagery rescripting, meta-cognitive techniques, positive imagery and competing tasks) to develop skills enabling the modification and regulation of emotional reactions to intrusive mental images. In the consolidation stage, skills learnt during treatment are consolidated into an action-plan and documented visually in a personal video. Treatment was delivered and supervised by clinicians trained in the IBER treatment protocol.

Ethics approval

Approval was provided by Berkshire-B Research Ethics RES NHS Committee (ref. no. 18/SC/0164).

Participants, sampling and recruitment

Participants ($N = 57$) in the main clinical trial were referred and screened from in-patient services from primary and secondary care and self-referral, from people aged 18 or above who presented with symptoms consistent with a DSM-V diagnosis of bipolar disorder (I, II or otherwise specified) assessed using the Structured Clinical Interview for DSM-5 (SCID) (American Psychiatric Association, 2013; First et al., 2015). Potential participants were required to have a sufficient understanding of English in order to be able to engage in the study, and to exhibit at least a mild level of anxiety by scoring 5 or above on the GAD-7 (Spitzer et al., 2006). Exclusion criteria were (i) a current episode of mania or depression (ii) unable to provide informed consent (iii) acute suicide risk (iv) DSM-5 diagnosis of substance use or alcohol use disorder, moderate or severe, assessed using the SCID (v) a change in medication within 3-months prior to randomisation or (vi) currently engaged in psychological intervention.

As per the trial protocol paper (Steel et al., 2020), we aimed to recruit 50% of those allocated to the IBER treatment arm ($n = 28$). We aimed to recruit a diverse sample by purposive sampling using the following participant attributes: demographic characteristics; referral source (self, primary care, or secondary mental health care); clinical characteristics (bipolar I or II, PTSD symptoms present or not, and pre-existing anxiety levels); and trial site (rural and suburban areas of southern England). Interviewees were invited to participate in the current study after they had completed the final 8-month assessment of the IBER trial (approximately 4–6 months after they had completed treatment). They were contacted initially by the trial research team, and those who were interested received further information and provided informed consent in advance of data collection.

Data collection and procedure

Our epistemological position was phenomenological with our aim being to understand the lived experiences of receiving the IBER treatment. A phenomenological approach seeks to stay close to the

participant's account and to understand the quality and texture of the experience, rather than the research team's theoretical account of what is going on (Willig, 2013).

A semi-structured interview schedule designed to explore experience of IBER treatment was developed by the research team which included clinicians with expertise in delivering IBER, and those with lived experience and qualitative methods expertise. Questions covered the following: overall experiences of IBER treatment; views about the value of specific treatment components, including work with mental imagery; perceived impacts of treatment during and following treatment, including any onward use of IBER techniques; and suggested treatment modifications, Interviews were conducted by three members of the research team, one research associate and two peer researchers, with lived experience of mental health difficulties who received additional training in qualitative interviewing and who disclosed their lived experience to participants in advance of interviews. The peer researchers enhanced the research process by contributing a lived experience/service user perspective to the interview schedule design. None of the interviewers had been involved in delivering the IBER treatment. Interviewers were briefed about IBER treatment components and techniques ahead of data collection. Prior to the interviews, participants were encouraged 8 bring any materials they had developed during IBER treatment to the interview to facilitate interview processes and recall. Interviews lasted around 45 minutes and were audio-recorded and transcribed verbatim, with all identifying information removed.

Data analysis

Data were analysed thematically using NVivo software, following guidelines described by Braun and Clarke (2006, 2013), and using an approach that corresponded most closely to "codebook" thematic analysis (Braun & Clarke, 2021). Analysis aimed to explore patterns in the data including both common and atypical views, using a primarily inductive approach, with some deductive elements to answer specific research questions (such as suggested treatment modifications). Analysis was led by SE with support from NM. Our approach followed the six overlapping thematic analysis stages of familiarisation, coding, generating initial themes, reviewing themes, defining and naming themes and writing results (Braun & Clarke, 2006). Initial familiarisation included listening to audio recordings to understand the emotional tone of interview narratives. An initial coding framework was developed based on close engagement with four selected transcripts. This was iteratively modified, refined and developed as analysis of the full dataset progressed. We used a collaborative approach throughout to enhance validity and encourage reflexivity, particularly about research team positionality. The main analyst (SE) was independent of the main clinical trial research team, and discussed initial findings with NM, a specialist in qualitative methods. Other team members involved in the main IBER study (service users with lived experience of BP, clinical academics and clinicians with experience of delivering IBER) contributed to later analytical processes through discussions about theme development. Here, we were mindful of some team members' expertise and investment in the IBER treatment, particularly in relation to any potential enthusiasm for reported positive experiences or resistance to critical comments about the intervention. In the later stages of analysis, SE re-listened to audio recordings and re-read all transcripts in order to validate the conceptual coherence of the thematic map and ensure that data was fully encapsulated.

RESULTS

Participants demographics and clinical characteristics

Twelve participants from the IBER treatment arm agreed to participate in a qualitative interview. This fell slightly short of the 50% target of the IBER treatment arm ($n = 28$). Seven were female, and there

was a mean age of 50.41 years and an age range of 30–70 years. Participants' mean trial baseline (pre-treatment) Generalised Anxiety Disorder Assessment (GAD7) score was 12.72. GAD7 anxiety scores ranging from 10 to 14 are considered moderate, and greater than 14 are considered indicative of high anxiety (Spitzer et al., 2006). Five participants scored greater than 14, with a range of 5 to 21. Trial baseline measures included the Quick Inventory of Symptomology (QIDS-SR), a 16-item questionnaire on depressive symptomology. Scores above 16 are considered moderate to very severe (Masson & Tejani, 2013). The Altman Self-Rating Scale for Mania (ASRM), is a validated 5-item self-report questionnaire for detecting the presence or severity or manic symptoms. Scores of 6 or above may indicate the presence of a manic or hypomanic condition (Altman et al., 1997; Table 1).

Qualitative findings

Interviews were conducted in person prior to March 2020, or via video, or telephone between April 2020 and January 2021. For one interview, the interviewee was unable to focus on questions about the IBER treatment, despite numerous attempts by the interviewer to engage them with the interview topic. Following repeated and careful review of the audio recording and transcript by two research team members, this interview was excluded from further analysis as no data meaningful to the research aims could be extracted. The qualitative findings below are therefore based on data from 11 participants. Findings are presented as shown (Table 2).

IBER treatment: Expectations, overall views and treatment comparisons

Scepticism & doubt

Prior to starting treatment, participants described not being aware of the role mental imagery played in promoting anxiety and mood swings, suggesting little understanding of this relationship, even when experienced as distressing. Many recalled their doubt and scepticism that an image-based treatment would be effective in helping them manage anxiety. Some participants self-identified as being a 'cognitive

TABLE 1 Demographic and clinical details of study participants ($N = 12$).

Demographic data	Mean (SD; range)
Age in years	50.41 (11; 30–70)
Gender (female/male)	7/5
Clinical characteristics	
Bipolar I	7
Bipolar II	3
Unspecified	2
Age at first contact with BP Services	39 (11.47; 30–70)
Baseline measures	
GAD7	
Possible range 0–21 (minimal to severe anxiety)	12.72 (5.10; 5–21)
QIDS-SR	
Possible range 0 to 37 (higher score indicates higher depressive symptoms)	9.17 (5.6; 1–19)
ASRM	
Possible range 0 to 20 (higher score indicates increased manic symptoms)	2.58 (4.01; 0–14)

Note: *r* = range of scores of participants.

Abbreviations: ASRM, Altman Self-Rating Scale for Mania; GAD7, Generalised Anxiety Disorder Assessment; QIDS, Quick Inventory of Depressive Symptomatology.

TABLE 2 Summary of themes within topic domains.

Topic domains	Themes
IBER Treatment: Expectations, overall views and treatment comparisons	Scepticism & doubt
	Validation of anxiety and imagery & comparisons with other therapies
Specific experiences of IBER treatment	Treatment targets
	Important techniques
	Personalisation and engagement
	The therapeutic relationship
Perceived impacts of IBER treatment	Autonomy and confidence
	Managing anxiety and improvements in clinical symptoms
Uptake and patterns of use	Three sub-groups: 'Transformative journeys': 'Practical daily use'; 'Techniques when needed'
Suggested improvements	Treatment structure
	Setting
	Disruption, Covid 19 and lockdown

type' and said they had underestimated the negative impact of their mental imagery. Some participants described believing that 'verbal thinking' was the mainstay of mental processes, with little recognition of the power of their other senses, especially imagery.

> I was a bit sceptical because … I think… I am a very thinking person, so I found it hard to accept that some of the trauma…that I was suffering was, was to do with images going through my brain …so I think that refocussing on that …was overall a good thing.
>
> [P12]

Validation of anxiety and imagery and comparisons with other therapies

All eleven participants expressed gratitude for the opportunity for specialised treatment that included recognition of their anxiety and imagery, and some hoped that the treatment would be available for individuals with BD and anxiety in the future. Among participants who compared IBER to their experiences of other therapies such as CBT or art therapies, some participants expressed unfavourable opinions of prior CBT treatment that they felt had not been helpful for anxiety or had included irrelevant homework.

> I've had CBT in the past, and I've had CAT therapy and … it's quite different. Whereas the IBER therapy – particularly someone like me, who does have a lot of imagery; using… touch, smell and taste to deal with the images was something I had never done before.
>
> [P11]

Some felt they could integrate IBER techniques with other techniques they already used to manage their BD symptoms. Others described IBER techniques as novel to them and more practical for daily life than other therapies, in their direct relation to daily activities.

Specific experiences of IBER treatment

Treatment targets

All participants described at least one distressing or destabilising image-based target for intervention, identified jointly during the initial "mapping" (micro-formulation) stage of treatment. Some interviews

featured powerful and traumatic images, identified as having a strong relationship with symptoms of anxiety. Several participants described these images in striking detail and related them to situations characterised by an anxiety-provoking sense of lack of control. The content of the images described varied, with examples including rats, "a gun to my head", a routine street or childhood memory. Treatment targets included imagery with multisensory elements such as intrusive olfactory experiences, described as powerful smells of burning flesh and experienced as extremely distressing; tactile experiences included the feeling of being touched by a man's beard as a child.

> … I used to (get) bad smells. So, that was like burning flesh … and the sewage was probably the worst one.
>
> [P8]

Participants' feelings about their imagery were similar: intrusiveness, vividness, anxiety, a perceived lack of control over images, and anxiety over potential related actions.

> We talked about this thing when you are standing close to an edge, and you feel like oh my God! I can't trust myself not to jump. And I'm not suicidal, but it is just something in the back of the mind that plays.
>
> [P3]

Important techniques

Reworking the image, unlocking the senses and managing difficult moments. Certain techniques stood out as being well recalled, valued or significant features of the treatment for participants. These related to ways of changing a difficult or distressing images, using sensory cues or managing emotionally challenging moments while working with difficult imagery.

Participants valued learning novel techniques to rework a difficult image by reducing their threat or creating a more empowering scenario. Specific elements of an image were remodified e.g., rats, associated with fear, were modified to rabbits which were associated with gentleness and calm. Often a repetitive scenario was rescripted, providing a practical means to change the outcome with a feasible resolution.

> … swimming around in circles would keep coming into my head… we …developed a … narrative to it …imagery of having an anchor and cutting the anchor loose, and then being able to swim off towards the shore, towards some kind of resolution… something other than…going around in circles.
>
> [P6]

Building and enhancing positive imagery with olfactory cues was described by five participants as they learnt to associate the pleasant smell of a fruit, oil, or perfume with a new, adaptive image to enhance its content, or to evoke a happy memory when needed. These techniques were experienced as a novel and effective approach in therapy, including for the participant who suffered from imaginal bad smells of burning flesh.

> … And [therapist] taught me things … So, I got a grapefruit and smelled the grapefruit and had that in my head…to the point that for the rest of the six weeks I didn't get it at all, this bad smell …that's been like it since….
>
> [P8]

Several participants described working with the recall of difficult imagery challenging. The encouragement within IBER treatment to use competing tasks, such as playing Tetris, Candy-crush, or a musical instrument to displace distressing imagery following a difficult treatment session was valued

(Iyadurai et al., 2018). This practical way of recovering from distress also engendered trust in the treatment process.

> I think the most difficult bits were very well managed, and everything set in place – even distractions from coming away from the image, you know… were all in place before I even started talking about them.
>
> [P5]

Personalisation and engagement

A strong theme across participants was the value of personalisation relating to both choice of target imagery to work with and how this was modified in treatment. Participants described mental images that had specific meaning or significance to them. Their accounts of how these were then explored and modified in treatment suggested a creative reworking of meanings and emergence of new narratives.

> … the image, a token of a banana, which related to you know, childhood instances of… emotional blackmail … then becoming a bit of a symbol of being able to set some boundaries and …to challenge those kinds of behaviours in other people, particularly family members….
>
> [P6]

> then there is an image of sand in a glass. But it was all stirred up. And then we tried to separate the sand so that you had some self-worth. So, that's really – that's really helpful!
>
> [P9]

The personalisation achieved through micro-formulation also related to the creation of positive imagery. A participant described the image of a small bird accompanying them when they left home as a tool to manage social anxiety:

> …it was very good… an allegorical thing of having like a robin … perched on my finger as like a positive image that wouldn't necessarily happen in real life as a way of… counterbalancing the impending anxiety.
>
> [P7]

Engagement in practice between sessions and homework was high, with seven participants describing aspects of personal practice. Practice often generated thoughtful new thinking about practical issues, such as the portability of personal objects which might be used as cues to promote positive imagery. Imagery techniques were described as a new skill that raised confidence and a sense of control.

> like anything new, I was like slow and cumbersome with it, but as the weeks went by, I felt I got better and slicker… when I first generated images, I was a bit fuzzy about the image… and when we got to the last session, it was becoming quite a regular, natural, almost like a habit.
>
> [P12]

The use of IBER treatment materials such as a weekly postcard, written by the participant in the session, with a personal note as a session reminder was valued and appeared to encourage engagement, personalisation and ownership of imagery-based techniques. Some participants described how this had sparked an independent and creative process between treatment sessions. For example, they described identifying preferred personal photos or objects at home in order to cue and support new imagery skills and producing their own materials as session reminders.

> The postcards really helped because I kept them next to my bed. So, they were reminders of what it was appropriate to what I was doing… So, to remind myself, I'd write on the back of the postcard, and I'd look at it and I'd be like …that's this technique – that sort of thing.
>
> [P1]

The therapeutic relationship

All 11 participants spoke of their experiences of a strong therapeutic relationship, some recalling the challenges of working with difficult imagery. Three aspects were highlighted: trust in support during difficult moments; the development of understanding of bipolar disorder; and a sense of therapy-client equality.

> She could see if I was struggling a bit in each session and was able to sort of reflect maybe a couple of things that I'd said the session before that might be causing it… I got to the point where I actually looked forward to it – to the sessions.
>
> [P11]

Perceived impacts of IBER treatment

Autonomy and confidence

Participants gave many examples of how they had continued to use techniques successfully after treatment. These descriptions were imbued with a sense of autonomy and confidence. Habitual use pointed to a strong sense of agency, as participants described using positive imagery to promote reassurance which built self-confidence to control moods and to engage in self-care. Participants also demonstrated a meta-cognitive process of understanding that the imagery is not real, and that they can consciously implement a cognitive process to change its impact.

> I tend to … anchor myself with some slightly more positive imagery as a way of sort of reassurance… that's given me confidence to take ownership over my own ability to… self-care and self-regulate to most degrees. I haven't … felt particularly too out of control at any point. So, I think that's been quite good.
>
> [P6]

> I have used the work we did with the rats recently… because I was really struggling with the kind of those experiences… and just using a kind of re-imaging of it when I was feeling quite distressed…. That's made me go okay, they're not real, it's not anxious, change the image. So, I've been quite successful a few times with that.
>
> [P11]

Managing anxiety and improvements in clinical symptoms

Several participants recalled the powerful impact of anxiety on their lives, prior to IBER treatment, suggesting a new ability to observe themselves with greater clarity, insight and perspective. Implementing new skills to manage anxiety and alter its impact on daily living contributed to this sense of autonomy and confidence.

> I had a toolbox of coping strategies, but nothing like…this… I was coping with flashbacks as they were happening. … And the anxiety that went along with it… to the point where sometimes I wouldn't go out, and sometimes if I was out, I would hide away somewhere. You know, the triggers were having a powerful effect on my day-to-day life, and that's no longer the case
>
> [P5]

Participants described beneficial improvements in recognising and managing their triggers for anxiety and for self-harm, hearing voices, suicidal thoughts, and rumination. Image techniques acquired in treatment continued to be used post-treatment, for example visualising an imaginal zip in the arm to reduce self-harm:

> … then I started self-harming because I was so stressed… then I remembered the zip and that was really helpful… I'd just started self-harming and then I stopped…. So yeah. I think that's probably been the most helpful image I've got.
>
> [P9]

Uptake and patterns of use: Three sub-groups

From our exploration of variations in how participants engaged with IBER techniques following therapy, three sub-groups emerged that were defined by their views of IBER, degree of perceived treatment impact and levels of application in daily life. Five participants experienced a powerfully transformative impact of the therapy; three described finding the treatment useful and had incorporated techniques into their daily lives, and three described less overall impact but felt they had the techniques to use when needed.

Transformative journeys

Five participants talked about re-scripting of mental imagery within IBER treatment as a transformative experience in relation to how they understood and managed their mental health. Three of these people suggested that treatment helped modify traumatic childhood memories, and several described having adopted daily, habitual use of the imagery techniques they had learned.

> it's turned my life around…I have been living …with the effect of my childhood trauma for thirty years … having not remembered it prior to then… the re-scripting has completely changed my life, because if I get a trigger now, I immediately go to the re-scripts. It is just so powerful that I immediately take myself there.
>
> [P5]

Practical daily use

A sub-group of three participants described how they had embedded imagery techniques into daily life to help them tackle anxiety-related challenges such as leaving home or regulating sleep. Their narratives suggest that while new techniques and learning had been assimilated and effectively applied in their daily lives, this was not accompanied by the more profound psychological changes described by the first group.

> I've used it … so many times since it finished… probably every day, or every other day to some degree – particularly if I'm not sleeping well… particularly with the anxiety and actually using the pictures… and thinking well, you know …when I see bad things … it's very visual in my head…. I build up this repetitive picture of what I think's going to happen…I've learnt that actually, that's all it is.
>
> [P8]

Techniques when needed

A third sub-group of three participants expressed a capacity to use techniques with ease, or to know they had imagery-based tools to use when needed. In this example, when the participant suffered a bipolar episode, they returned to using IBER techniques several months later, suggesting techniques were retained and could be recalled at key points, but had not become daily or habitual.

> I found the actual IBER treatment really beneficial, but I don't think I found it beneficial just straightaway because I crashed with my bi-polar. It's only been since… September… that things have been a bit better. So, it's a bit like it takes a while I think sometimes to think about these things and to put them in place and to then to have them in place when you need them.
>
> [P9]

This sub-group's described pattern of use suggested a readiness to combine IBER techniques with existing practices that participants had already acquired to manage anxiety.

> When I get anxious, sometimes I forget the images and then … I can then recall them, and they have a very positive effect on umm feeling anxious. I use reading techniques with that now just to bring the anxiety levels down.
>
> [P29]

Suggested improvements to IBER treatment

Treatment structure

Participants were invited to comment on practical issues (e.g., structure, duration, frequency of treatment sessions) and make suggestions for amendments. Several participants suggested greater flexibility in session duration, e.g., a session duration of 90, rather than 60 minutes, especially when working on difficult imagery. Participants descriptions of the purpose of each stage of treatment (Assessment, Treatment and Consolidation) suggested these were well understood, and this clarity built confidence and engagement. Five participants made specific suggestions for onward "revision" or "booster" sessions to support the maintenance of newly acquired skills.

> [therapist] was very steady and clear in the agenda of the whole process…. I was in no doubt as to what we were doing…she gave me plenty of time to do my side of things… I went away and came back every week, thinking this is a familiar thing … and it didn't hold any fear for me….
>
> [P4]

> What would have been really interesting, is if you had a top-up maybe a couple of times half a year later, just to refresh the ideas.
>
> [P3]

Setting

Three participants expressed specific concern over the location of therapy, of which two related to therapy being in a clinical setting with a desk, bed and cctv on the wall, prompting memories of earlier hospitalisation, and a comparison with a police cell. This suggests previous traumatic experiences in their bipolar histories.

> I had my therapy in the local hospital … research block, but the rooms were like clinical rooms… they had like a bed in them…medical equipment, as well as a desk and a chair… which really triggered a really bad flashback for me… it was like being in a police cell or something… It wasn't particularly nice.
>
> [P11]

Disruption, Covid 19 and lockdown

Treatment sessions were provided via Zoom for participants still participating in treatment in March 2020. There were variations in participants' ability to adapt, and comments suggest that digital delivery of treatment may be difficult for some with bipolar disorder.

> …I sometimes have experiences where I see people in a different way, they're not quite human when I'm getting a bit unwell, and I found doing it by zoom … I thought I was talking to a computer and thought who was this person…if I'd had all the sessions by zoom, I would have struggled to get as much out of it.
>
> [P11]

DISCUSSION

Study aims and outcome

This qualitative study investigated experiences of a 12-session programme of Image Based Emotional Regulation (IBER) treatment for anxiety within bipolar disorder, delivered over 16 weeks within a randomised feasibility trial. Findings suggest high levels of acceptability and treatment engagement within this sample. Imagery-based work was novel, and participants appreciated the therapeutic focus on anxiety symptoms. No participants reported overall negative experiences of IBER, and the majority of interviews were characterised by accounts of learning and engagement. For many, the novel imagery-based skills were marked by personalisation and beneficial effects on anxiety management and other clinical symptoms since treatment had ended. A sub-group of participants developed new understandings about the relationship between mental imagery and anxiety or distress, and techniques for modifying the meaning and impact of imagery that were described by some as enabling a profound shift. Impacts of treatment were often described in terms of increased levels of confidence, control or agency in relation to their anxiety or mental health problems more generally. Many participants described a sense of ownership over personalised tools or techniques. The scaffolding techniques and materials introduced during treatment to cue or support the development of imagery skills (e.g., session reminders, postcards, the use of personally meaningful objects) had facilitated embedding imagery techniques post treatment. Some suggestions for improvements were made, most commonly relating to flexibility in session duration, especially where difficult imagery was being shared, and "booster" session(s) to help reinforce commitment to newly acquired skills.

Many participants described working with powerfully distressing mental imagery sometimes incorporating other senses such as smell or touch. This is consistent with findings indicating how 'real' multi-sensory mental imagery can be, with the potential to act as an emotional amplifier and increase the likelihood of action (Holmes et al., 2008; Mathews et al., 2013; Stevenson & Case, 2005). As such, elements of treatment were sometimes very challenging, and imagery-competing tasks (such as playing a computer game or the piano) that enabled distraction or dampening of emotional intensity post-session were appreciated. Several participants described working with imagery related to past trauma, social anxiety, or feelings of negative self-worth if these were formulated as linking to anxiety currently experienced. This accords with data indicating that trauma and childhood adversity are risk factors for bipolar disorder (Palmier-Claus et al., 2016).

There is considerable current research interest in non-pharmacological interventions for BD, particularly CBT-based interventions (Ellard et al., 2017; Jones et al., 2018, 2020). Recent research has shown promising results in the value of an image focussed cognitive therapy for BD compared to psychoeducation and is contributing to our understanding of the role of imagery in mood variability in bipolar disorder (Van den Berg et al., 2020, 2023). An investigation of 8 interventions (CBT and MBCT) for residual anxiety in BD found 2 RCTs showing preliminary results of improvements in anxiety where a transdiagnostic and highly personalised approach was used (Seeberg et al., 2021). Research is increasing our understanding of the impact of

imagery content on individuals with BD (Van den Berg et al., 2023) and of image based therapies (Lau-Zhu et al., 2023). In the current study, participants reported being initially unaware of or sceptical about the role of mental imagery but appreciated the focus on anxiety in IBER that they felt other treatments had not addressed. Several participants described incorporating imagery-based skills learned in IBER with other techniques (e.g., mindfulness, sleep and exercise) suggesting that the addition of new imagery skills was useful and incremental, rather than confusing. They valued the bipolar expertise of IBER clinicians and their liaison with existing mental health professionals that is a component of IBER (Holmes et al., 2019) and recommended in clinical guidelines (Goodwin et al., 2016; NICE, 2014).

Study limitations

This is the first qualitative study to explore experiences of receiving IBER treatment. Interviews generated rich and insightful reflections on treatment experiences and their perceived impacts on individuals. A lived experience researcher contributed to the design, conduct and analysis of interviews, and our emerging findings were discussed with the research team. The first author, who led the analysis, was not part of the IBER trial team, and we were mindful of the positioning of other team members as developers of IBER or trial leads and reflected on this in finalising our findings.

There are some study limitations: Our qualitative sample was broadly similar to the demographic and clinical characteristics of the larger group of 28 people in the intervention arm of the IBER trial but showed slightly higher levels of anxiety at baseline (GAD7, $m = 12.72$, SD = 5.10), than the larger group ($n = 28$) in the intervention arm of the feasibility trial ($m = 8.2$; SD = 4.8) (Steel et al., 2023). It is possible that this led to higher levels of response to treatment in our sample, though our sample showed baseline scores for QIDS and ASRM consistent with the participants in the IBER arm ($N = 28$) of the feasibility trial. Engagement with and satisfaction with treatment were generally high in our sample, and we acknowledge that this may be related to who agreed to participate in an interview. The context of a randomised feasibility trial should also be considered. Participants may not reflect the full diversity or comorbidities of the larger population of people with bipolar disorder diagnoses, and ethnic minorities may be underrepresented due to the limited diversity profiles of the geographical locations where the trial was conducted. Clinicians delivering IBER within the trial were close to the original developers of the intervention and received clinical supervision from these people. The perception that researchers conducting interviews were connected with the IBER trial may have limited full expression, although interviewers reassured participants in their introductions that hearing about both positive and negative treatment experiences was valuable.

Clinical and research implications

Findings indicate good treatment acceptability. Participants reported valuing a range of novel learned techniques that could be applied in anxiety-provoking situations. This suggests that 'bipolar anxiety' (Goodwin et al., 2016) can be targeted by a high-intensity image-based treatment, with potentially beneficial outcomes. Findings from the IBER feasibility trial (Steel et al., 2023) suggest recruitment, retention and outcome completion are all feasible in further treatment trials. It may be useful to investigate the effect of additional booster sessions following treatment in helping to retain and consolidate new skills.

Our qualitative findings enable a better understanding of what worked and did not work for participants who received IBER treatment. Several participants were very grateful to have experienced a novel treatment approach that recognised and focused on modifying anxiety in BD. The personalisation and ownership of new imagery-based techniques participants reported developing may be a valuable way of encouraging self-management of bipolar symptoms (Lean et al., 2019), and a sense of increased confidence and agency over anxiety and mood instability was commonly reported. Success in modifying

one or two personally significant mental images and their meanings, and being able to do this independently, was powerfully highlighted by participants, some of whom reported a profound impact of these new techniques. Some participants expressed hope for the future development of new therapies for BD. Imagery-based treatments or other novel talking therapies would offer greater choice for people with BD, especially given variations and the sometimes unrecognised association between powerful and distressing mental imagery and anxiety in this clinical population.

IBER treatment was delivered to participants in this study by an expert clinician group. A key clinical consideration will be the training of clinicians to deliver high fidelity treatment, together with high quality clinical supervision to ensure the consistent integrity of treatment delivery. Whilst knowledge of imagery-based therapy techniques is growing amongst mental health professionals, this is still an under-developed area of training. Future research could examine whether, in addition to use of IBER as a standalone therapy, a greater focus on imagery work within routine psychological therapy for people with bipolar results in improved acceptability and outcomes.

Conclusions

This qualitative study provides rich data on experiences of receiving IBER treatment within a feasibility RCT. Data suggests that the scaffolded learning environment and specificity of mental imagery-based treatment allowed participants to identify distressing or maladaptive imagery, and change the meaning and emotionality of it, or their relationship to it. Participants reported varying levels of onward use of learned imagery techniques, and many found these beneficial in managing anxiety. Results suggest good acceptability of IBER treatment and further research on the effectiveness of this treatment approach as a promising addition to psychological interventions for people with bipolar disorder.

AUTHOR CONTRIBUTIONS

Susan Elkington: Writing – original draft; formal analysis; methodology; writing – review and editing. **Michael Brown:** Methodology. **Kim Wright:** Methodology; investigation; conceptualization; data curation; writing – review and editing. **Jemma Regan:** Methodology. **Kate Pattarnaraskouwski:** Methodology. **Craig Steel:** Conceptualization; investigation; methodology; resources; supervision. **Susie Hales:** Methodology; investigation; conceptualization. **Emily Holmes:** Methodology; investigation; conceptualization. **Nicola Morant:** Writing – review and editing; supervision; methodology; conceptualization.

ACKNOWLEDGEMENTS

The authors wish to thank all the participants who shared their views and experiences in interviews for this study and members of the research team.

FUNDING INFORMATION

The IBER study was funded by the National Institute for Health Research, Research for Patient Benefit programme, (ref. PB-PG-1216-20,009). The funding body has not influenced the design, conduct, analysis, or dissemination of this study. The views expressed in this publication are those of the author(s) and not necessarily those of the NHS, NIHR or the Department of Health.

CONFLICT OF INTEREST STATEMENT

SH and EH have co-authored a book on image based cognitive therapy (Holmes et al., 2019) and published research on BD. All other author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

DATA AVAILABILITY STATEMENT

 The de-identified data that support the findings of this study are available from the corresponding author upon reasonable request.

ORCID

Susan Elkington https://orcid.org/0000-0002-9770-0550
Craig Steel https://orcid.org/0000-0002-1643-516X
Emily Holmes https://orcid.org/0000-0001-7319-3112
Nicola Morant https://orcid.org/0000-0003-4022-8133

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How to cite this article: Elkington, S., Brown, M., Wright, K., Regan, J., Pattarnaraskouwski, K., Steel, C., Hales, S., Holmes, E., & Morant, N. (2024). Experiences of imagery-based treatment for anxiety in bipolar disorder: A qualitative study embedded within the image based emotion regulation feasibility randomised controlled trial. *Psychology and Psychotherapy: Theory, Research and Practice*, *00*, 1–18. https://doi.org/10.1111/papt.12538