

***IMAGERY AS A TECHNIQUE IN THE TREATMENT OF DEPRESSED
ADOLESCENTS UNDER PSYCHIATRIC SUPERVISION***

by

TANYA ELMA ACKERMANN

submitted in **part** fulfillment of the requirements for
the degree of

**MASTER OF EDUCATION -WITH SPECIALISATION IN GUIDANCE AND
COUNSELLING**

at the

UNIVERSITY OF SOUTH AFRICA

SUPERVISOR: PROF J G LE ROUX

NOVEMBER 2001

Student number: 0 834 028 5

I declare that *Imagery as a technique in the treatment of depressed adolescents under psychiatric supervision* is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.

.....
MISS TE ACKERMANN

.....
DATE

Acknowledgements

I would like to express my sincere gratitude to the following persons for their contribution to the success of this study:

- Prof J G Le Roux, my supervisor, for his guidance, support and patience. His honesty and encouragement is much appreciated.
- Dr J Scholtz, Head of Applied Psychology at a psychiatric hospital, for introducing me to the fascinating world of imagery. His enthusiasm is contagious.
- Dr J O Steenkamp for introducing me to the learning therapy, S.H.I.P. It has not only exposed me to a novel and effective technique, but has also allowed for much personal growth.
- The parents and patients for agreeing to the use of imagery as a technique in therapy.
- My family and friends for their endless support, encouragement and understanding.
- Mark Arnold for his assistance with proofreading.

Summary

The majority of adolescents diagnosed with Major Depressive Disorder (MDD) and admitted to a psychiatric hospital in Gauteng complained of being tired of "talk therapy".

This study used imagery as a technique in the treatment of two adolescents suffering from MDD. The initial identification was based on the results of the Beck Depression Inventory (BDI). After a number of sessions of implementing imagery techniques, the BDI was readministered. To determine the long-term effectiveness of imagery, the BDI was again administered a month-and-a-half after completion of the sessions.

The results before and after indicate a reduction in the severity of depression. The results at the month-and-a-half follow-up session indicated a further reduction in the level of depression in both cases. This indicates the long-term effectiveness of imagery in treating depression.

Further research is required, but there are significant indications that imagery may be an effective technique in the treatment of depressed adolescents under psychiatric supervision.

Table of Contents

CHAPTER 1: INTRODUCTORY ORIENTATION

1.1	INTRODUCTION	1
1.2	PROBLEM ANALYSIS	1
1.2.1	Problem realisation	1
1.2.2	Problem exploration	3
1.3	STATEMENT OF THE PROBLEM	4
1.4	AIM OF THE RESEARCH	5
1.4.1	Main aim	5
1.4.2	Secondary aims	5
1.5	METHOD OF RESEARCH	5
1.5.1	The literature study	5
1.5.2	The empirical investigation	6
1.6	TERMINOLOGY	6
1.6.1	Major depressive disorder	6
1.6.2	Adolescence	8
1.6.3	Psychiatric supervision	8
1.6.4	Imagery	9
1.7	THE RESEARCH PROGRAMME	11

CHAPTER 2: IMAGERY AND DEPRESSION

2.1	INTRODUCTION	12
2.2	DEPRESSION	13
2.2.1	Introduction	13
2.2.2	Theories of depression	13
2.2.2.1	The cognitive-affective aspects of a biopsychosocial model of depression	13
2.2.2.2	Psychoanalytical perspective	15
2.2.2.3	Behavioural perspective	15
2.2.2.4	Endogenous (Congenital) factors	16

2.2.3	Symptoms of depression	16
2.2.3.1	Physiological symptoms	16
2.2.3.2	Affective symptoms	17
2.2.3.3	Cognitive symptoms	18
2.2.3.4	Behavioural symptoms	19
2.2.4	The link between depression and suicide	20
2.2.5	Treatment for depression	21
2.2.5.1	Medical approaches to the treatment of depression	21
2.2.5.2	Psychological approaches to the treatment of adolescent depression	22
2.3	IMAGERY	24
2.3.1	Characteristics of imagery	24
2.3.2	Hypotheses of the role of imagery in healing	25
2.3.3	Components of imagery	31
2.3.4	Modalities of imagery	32
2.3.5	Types of imagery	32
2.3.6	Imagery and emotions	33
2.3.7	Function of imagery	34
2.3.8	Imagery techniques	35
2.4	ADOLESCENCE AS A DEVELOPMENTAL STAGE	37
2.4.1	Depression in adolescence	38
2.4.2	Inpatient treatment of depression	39
2.4.2.1	Initial clinical assessment and plans	39
2.4.2.2	The treatment plan	41
2.5	IMAGERY APPROACHES TO THE TREATMENT OF DEPRESSION	43
2.6	SUMMARY	43

CHAPTER 3: THE EMPIRICAL INVESTIGATION

3.1	INTRODUCTION	45
3.2	DESIGN OF THE EMPIRICAL INVESTIGATION	45
3.2.1	Selection of a measuring instrument to measure depression	45
3.2.2	Selection of case studies	47

3.2.3	Implementation of the measuring instrument	47
3.2.4	Application of imagery as a therapeutic technique	47
3.3	CASE STUDY I	49
3.3.1	Biographical background of patient	49
3.3.2	Diagnosis according to the DSM IV	49
3.3.3	First imagery session	49
3.3.4	Second imagery session	52
3.3.5	Third imagery session	54
3.3.6	Summary of imagery session four	55
3.3.7	Summary of imagery session five	55
3.3.8	Evaluation of proceedings	56
3.4	CASE STUDY II	57
3.4.1	Biographical background of patient	57
3.4.2	Diagnosis according to the DSM IV	57
3.4.3	First imagery session	57
3.4.4	Second imagery session	59
3.4.5	Third imagery session	62
3.4.6	Summary of imagery session four	65
3.4.7	Summary of imagery session five	65
3.4.8	Evaluation of proceedings	65
3.4.9	Experience of the imagery sessions	66
3.5	Re-implementation of measuring instrument	66
3.5.6	Gathering, interpretation and discussion of final results	67

CHAPTER 4: FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

4.1	INTRODUCTION	68
4.2	FINDINGS FROM THE LITERATURE STUDY	69
4.2.1	Imagery	69
4.2.2	Depression	70
4.3	FINDINGS FROM THE EMPIRICAL RESEARCH	72
4.3.1	The Beck Depression Inventory (BDI)	72
4.3.2	Selection of case studies	72
4.3.3	Findings before and after imagery sessions	73

4.4	RECOMMENDATIONS	81
4.5	SHORTCOMINGS	82
4.6	FINAL CONCLUSIONS	83

	BIBLIOGRAPHY	84
--	--------------	----

TABLES

TABLE 1:	Patient's level of depression before and after imagery (Case study 1)	73
TABLE 2:	Patient's level of depression before and after imagery sessions (Case study 2)	74
TABLE 3:	Patient's scores for each category in order to determine level of depression before and after the imagery sessions (Case study 1)	75
TABLE 4:	Patient's scores for each category in order to determine level of depression before and after the imagery sessions (Case study 2)	77
TABLE 5:	Patients' scores after implementing the BDI a month-and-a-half after cessation of imagery sessions	79
TABLE 6:	Patients' total scores, indicating their levels of depression, after implementing the BDI a month-and-a-half after cessation of imagery sessions	81

FIGURES

Figure 1:	The cognitive-affective aspects of a biopsychosocial model of depression	14
Figure 2:	Health generating forces	27

Chapter 1

Introductory orientation

1.1 INTRODUCTION

According to Lazarus (1984: 127-128) numerous people suffer a condition where all joy goes out of life and a dark cloud hangs over every facet of their existence. They lose their zest for life. These people are not only 'sad', they are *depressed*. Often they feel at their worst in the morning, but their mood may lighten as evening approaches. They suffer from insomnia intermittently throughout the night and it is often at this time that they have encroaching morbid thoughts. They have little appetite and thus lose weight and they have a low libido. Often negative feelings of worthlessness and despair consume them.

Depression during adolescence may be severe, as it compounds existing hormonal changes and problems accompanying this stage in development.

The treatment of depression includes a variety of methods, inter alia, pharmacological intervention, hypnotherapy and psychotherapy. This study will research the effectiveness of imagery as a therapeutic tool in the treatment of adolescents under psychiatric supervision suffering from Major Depressive Disorder (MDD).

1.2 PROBLEM ANALYSIS

1.2.1 Problem realisation

As an intern psychologist, the researcher was primarily responsible for the adolescent unit at an accredited psychiatric institution. The responsibility entailed, amongst others,

therapy to the adolescent patients. Included in the support offered was pharmacotherapy, occupational therapy, family therapy and behaviour modification. Various psychometric tests were also implemented, namely:

- The Senior Aptitude Test
- The 19 Field Interest Questionnaire
- The Initial Clinical Interview
- The 16 Personality Questionnaire
- The Emotional Profile Index
- The Thematic Apperception Test
- Drawings and other Projection Media

In all cases there were common elements with regards to previous therapeutic intervention, including:

- The difficulties experienced by the patients contained elements of a personal and social nature.
- In many instances there was an element of depression.
- The researcher became aware that many of the adolescents suffering from depression were reluctant to talk in individual therapy.
- Others were tired of talking to therapists as there had been little success in the alleviation of their depression.
- The reoccurrence of depression after using various techniques.

For the above mentioned reasons the researcher became aware of the need for another therapeutic technique and means of intervention in treating depression in adolescents under psychiatric supervision.

1.2.2 Problem exploration

According to Kaplan and Sadock (1998:553), poor academic performance, substance abuse, antisocial behaviour, sexual promiscuity, truancy and running away may be symptoms of depression in adolescents.

Symptoms of depression that are most common in adolescence are pervasive anhedonia, severe psychomotor retardation, delusions, and a sense of hopelessness. Symptoms that appear with the same frequency regardless of age and developmental status, include suicidal ideation, depressed or irritable mood, insomnia, and impaired concentration.

The therapist can implement various assessment techniques such as those listed in paragraph 1.2.1 above, to enable the patient to become aware of the severity of his/her depression. Thereafter it is possible to implement forms of therapy to assist the adolescent in relieving his/her depressive state.

Sheikh (1984:6) notes that imagery has been used effectively in the treatment of a wide variety of disorders. Among them are:

- Allergies
- Skin disorders
- Warts
- Burns
- Abnormal bleeding
- Posttraumatic stress
- Cancer
- Depression
- Phobias
- Sexual problems
- Pain and
- Suicidal tendencies

He further states that imagery also enhances the quality of a person's life, enabling one to fulfill both their biological and psychological potential.

Nucho (1995:ix) observes that empirical research studies have accumulated to show that imagery techniques are cost-effective, short-term treatment procedures. In the current climate of health care reform and managed care, it is imperative that helping methods be employed that conserve the time and efforts of both the help provider and receiver. Imagery, used exclusively or in conjunction with other techniques may be considered as such.

Working with spontaneously developed images is creative for both the client and the therapist. According to Nucho (1995:9), therapists who incorporate imagery techniques in their work find that they themselves become more creative in their treatment of patients. In addition she claims, that for many therapists, surrounded by countless hardships of their clients and chronic shortages of personnel and resources, professional burnout is a real danger. In the light of this, imagery provides a fresh, novel approach, which allows the danger of burnout to recede.

1.3 STATEMENT OF THE PROBLEM

From the foregoing it became evident that the present psychiatric methods of treating depressed adolescents do not provide all the answers. We therefore need to consider additional forms of therapy, which allow us to pose the following question:

Can imagery be used effectively as a technique in the treatment of depressed adolescents under psychiatric supervision?

1.4 AIM OF THIS RESEARCH PROGRAMME

The aim of this research programme can be subdivided into a main aim and secondary aims.

1.4.1 Main aim

The main aim is to determine the effectiveness of imagery in the treatment of depressed adolescents under psychiatric supervision.

1.4.2 Secondary aims

The secondary aims consist of the following:

- To determine the present situation regarding depression amongst adolescents and the treatment thereof.
- To determine the role of imagery as a therapeutic tool.
- To establish if there is any relation between imagery and the treatment of depression.

1.5 METHOD OF RESEARCH

The study will comprise a literature study and an empirical investigation.

1.5.1 The literature study

The literature study will focus on the secondary aims as mentioned previously. Firstly, the present situation regarding the appearance of depression amongst adolescents will be investigated as well as the different techniques being used in treating depression.

Secondly, the role of imagery as a therapeutic tool will be established as well as the relation between imagery and the treatment of depression, if any.

1.5.2 The empirical investigation

As far as the main aim of this study is concerned, the Beck Depression Inventory together with a clinical diagnosis will be used to identify adolescent patients suffering from Major Depressive Disorder. Imagery as a therapeutic intervention will be applied for a period of time after which the Beck Depression Inventory will again be implemented to measure any possible changes, if any, in the depressive state and the extent thereof.

1.6 TERMINOLOGY

1.6.1 Major Depressive Disorder

According to the Diagnostic Statistical Manual IV, as recorded by Kaplan and Sadock (1998:544) the criteria for major depressive disorder is as follows:

- A. Five or more of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.
 - (1) Depressed mood most of the day, nearly every day, as indicated by subjective report (e.g. feels sad or empty) or observation made by others (e.g. appears tearful). Note In children and adolescents can be irritable mood.
 - (2) Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated either by subjective account or observation made by others)

- (3) Significant weight loss when not dieting or weight gain (e.g. a change of more than 5% of body weight in a month), or decrease in appetite nearly everyday.
 - (4) Insomnia or hypersomnia nearly every day
 - (5) Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down)
 - (6) Fatigue or loss of energy nearly every day
 - (7) Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)
 - (8) Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)
 - (9) Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide)
- B. The symptoms do not meet the criteria for a mixed episode
- C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- D. The symptoms are not due to the direct physiological effects of a substance (e.g. A drug of abuse, a medication) or a general medical condition (e.g. hyperthyroidism).
- E. The symptoms are not better accounted for by bereavement, i.e., after the loss of a loved one, the symptoms persist for longer than 2 months or are characterised by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation. (Kaplan and Sadock, 1998:544)

According to Rao, Weissman, Martin, and Hammond (Waterman and Ryan, 1993:230) there is data supporting a high rate of completed suicide on longitudinal follow-up of adolescents with depression.

1.6.2 Adolescence

Adolescence is characterised by profound biological, psychological, and social developmental changes (Kaplan and Sadock, 1998:42). The biological onset of adolescence is signaled by rapid acceleration of skeletal growth and the beginnings of physical sexual development. An acceleration of cognitive development and consolidation of personality formation characterize the psychological onset. Socially, adolescence is a period of intensified preparation for the coming role of young adulthood. Adolescence is commonly divided into three periods: early (ages 11 to 14), middle (14 to 17), and late (ages 17 to 20). These divisions are arbitrary; growth and development occur along a continuum that varies from person to person. Puberty, a physical process of change characterised by the development of secondary sex characteristics, differs from adolescence, largely a psychological process of change. When the processes do not occur simultaneously, adolescents must cope with the imbalance as an additional stress.

When an adolescent, for whatever reason, becomes depressed his/her problems are compounded. This state of depression impacts on all areas of functioning, which in turn exacerbates the severity of the depressed state. In order to enable the adolescent patient to reach his/her potential level of functioning, one needs to alleviate the depression. This process requires making use of a number of techniques, which could also include imagery.

1.6.3 Psychiatric supervision

Beginning in the 1920's, inpatient psychiatric treatment of children and adolescents has included two types of units: acute-care hospital units and long-term hospital units (Kaplan and Sadock, 1998:1276).

The psychiatric institution, where the research for this dissertation was done, is an example of the latter.

Acute-care units generally accept adolescents who display dangerous (suicidal, assaultive, or psychotically disorganised) behaviour. Acute-care units aim at diagnosis, stabilisation, as well as formulation and initiation of a treatment plan. Disposition is usually to go home, to residential treatment centers, or to long term hospitals for continued care.

Long-term hospitalisation may last many months to years. The staff of all inpatient units is interdisciplinary and includes psychiatrists, psychologists, social workers, nurses, occupational therapists and teachers.

1.6.4 Imagery

For centuries people have recognised the gift of imagination:

The soul never thinks without a picture – Aristotle

Imagination is the eye of the soul – Joseph Joubert

Imagination is more important than knowledge – Albert Einstein

Imagination is not a talent of some men, but is the health of every man – Ralph Waldo Emerson

The mind is it's own place and in itself can make a heaven of hell and hell of heaven – John Milton

As Dr. Joseph Shorr, director of the Institute of Psycho-Imagination Therapy in Los Angeles, points out, everybody has images in their heads, regardless of what kind of reasoning, wishing, thinking, or problem-solving is occurring. Imagination is often referred to as 'the eye of the soul.'

The brain is similar to a very intricate computer. It records several photographs or pictures, as does a camera. These pictures or 'mental images' are stored in 'albums' in

our minds and are then, at some point retrieved. The brain itself can be cut without any pain being reported. Whilst operating on a number of patients suffering from epileptic seizures, Dr. Wilder Penfield, a neurosurgeon from Montreal, stimulated various parts of the brain with weak electrical currents and aroused images of past experiences. These images were either visual or auditory or both. The same image could be evoked by successively stimulating the same area. Patients stimulated in the same area of the brain reported having heard music or seeing flashing lights.

Having one particular point stimulated, a particular patient recalled a mother calling her boy. She claimed that this memory went back many years. New information with regards this specific memory was recorded each time this same spot was electrically stimulated. Weak electrical currents can thus elicit images, but so can other stimuli. For instance the word 'Blue' will evoke various images. Significant images are just as easily evoked, for example "Think of your mother's face. See this image as vividly as possible." Concentrating on this particular image will elicit a number of feelings and emotions, and have a stream of associations.

According to Shorr (1983:x), the most important aspect of imagery is its ability to bypass censorship. Often when a person expresses himself verbally, the information is edited. The reason may be that you do not want others to know how you really feel, or you may not want to face certain truths yourself. When one is asked to imagine a specific image or situation, you do not usually know what it will reveal. Imagery thus has the capacity to break through the resistance employed in verbal transactions. The systematic analysis of your mental panorama can lead to greater self-awareness, increased sensuality and creative solutions to your problems. Tuning in to your imagery can reveal to you your internal conflicts and increase your capacity to change effectively. You learn how to reveal you to yourself and you will understand better how others see you.

1.7 THE RESEARCH PROGRAMME

- Chapter 1** This chapter has focused on an introductory orientation to imagery as a therapeutic tool in the treatment of depression. It has reflected the problem, aims and method of investigation. The concepts that are applicable to this study have also been defined.
- Chapter 2** An investigation into Major Depressive Disorder in Adolescents and the impact it has on their functioning. Imagery techniques will be discussed as a technique in the treatment of MDD in adolescents under psychiatric supervision.
- Chapter 3** This chapter will focus on a discussion of the research design and empirical investigation.
- Chapter 4** This chapter concludes the study with a summary of the findings, conclusions as well as recommendations for further research.

Chapter Two

Imagery and Depression

2.1 INTRODUCTION

The awareness that imagination was recognised as a contributor to health was already evident in the time of Aristotle. During the last decade particularly, more and more psychologists and other health professionals have not only become aware, but are also advocating the vital role that the imagination plays in both physical and mental health. They have proved that mental images can have as forceful an impact as reality on emotional, psychological and physiological changes.

Many recent studies have demonstrated the importance of the study of *mental imagery* in order to understand cognitive-emotive processes, as well as its applied use in such fields as clinical psychology, sport psychology, prevention psychology, etc. (Sacco and Ruggieri, 1997-98:313). According to Singer (Sacco and Ruggieri, 1997-98:313) as the methods of research and the theoretical aspects have been refined, the study of *imagery* has for some time now been considered an important topic in the context of psychology, acquiring full scientific dignity in its own right.

This chapter will focus on depression in general as well as how it manifests in adolescents specifically. The more widely used treatments of depression in general and with regards adolescent in-patients in particular will also be discussed. Imagery will be considered in an endeavor to determine its effectiveness as a technique to treat MDD in adolescents under psychiatric supervision.

2.2 DEPRESSION

2.2.1 Introduction

Depression is a negative affective state, which is an almost universal human phenomenon. It is characterised by feelings of despondency, despair, disinterest and boredom and by attitudes of remorse, regret, self-blame, hopelessness, and helplessness. Depression in adolescents may lead to serious consequences including suicidal behaviour (Stanard, 2000:204).

2.2.2 Theories of depression

Akiskal and McKinney (Sheikh, 1984:150) postulate that the depressive syndrome be seen as the psychobiological common pathway of various social, psychological, and biological processes, which result in reversible dysfunction of the diencephalic mechanisms of reinforcement. Their approach conceptualised depression at various levels simultaneously rather than focusing on a one-to-one relationship with a single event. This biopsychosocial model of psychiatric disorder has been extensively used in the diagnosis and treatment of various psychiatric disorders. For the purposes of this research paper this model will be discussed in slightly more detail than the theories which follow.

2.2.2.1 The cognitive-affective aspects of a biopsychosocial model of depression

Some researchers have emphasised the impact of past traumatic experiences and losses in the development of depression. According to Sheikh (1984), others have stressed the role of undesirable life events in the onset of depressive disorders. Schultz (Sheikh, 1984:150) suggested that undesirable recent life events might serve as triggers of memories of more traumatic life events in the person's past. These memories may further exacerbate negative affect and negative self-image. This may result in increased belief in the 'reality' of the negative condition.

Figure 1. The cognitive-affective aspects of a biopsychosocial model of depression

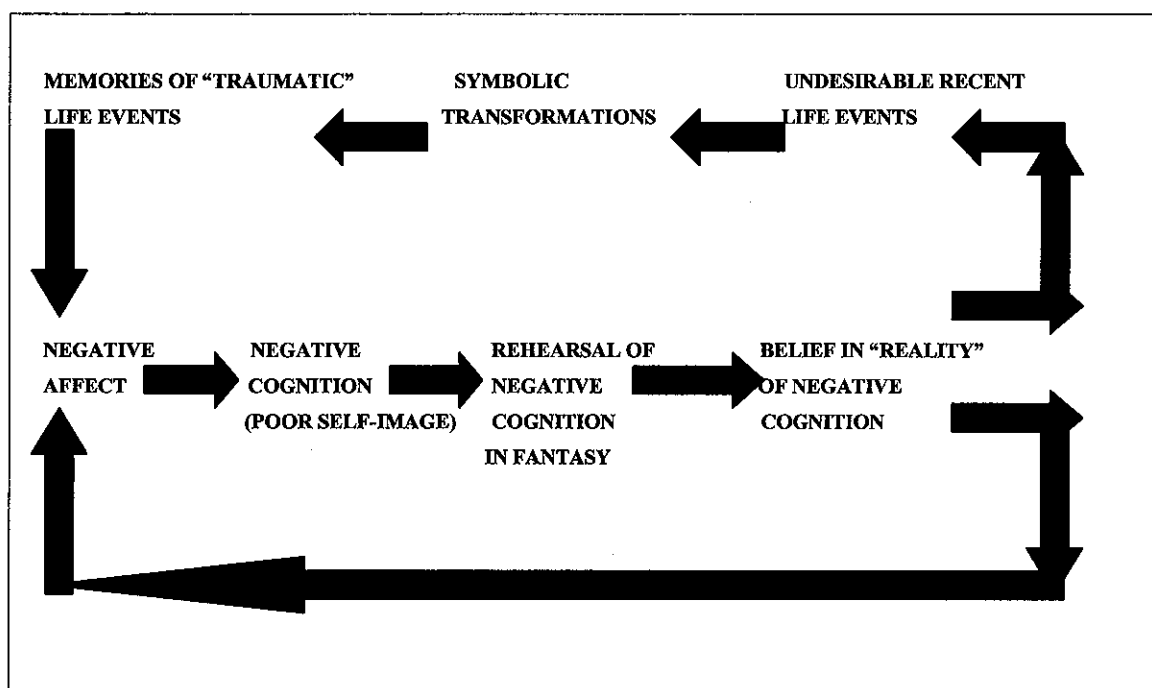


Figure 1 (Sheikh, 1984:151) conceptualises the maintenance of depressive affect in seriously depressed individuals. Current clinical experience and various research findings clearly indicate that various social and psychological interventions are necessary in reducing other factors that contribute to depression. This is also important in helping the individual who has resolved the acute phase of the depressive disorder to maintain his/her current level of functioning and preventing a relapse. In addition, if further research can establish which imagery techniques best suit different types of depressed individuals, clinicians will be able to assign more individuals to the most suitable psychological intervention. This type of research clearly has scientific and practical implications for improvement of the quality of life for many individuals.

The cognitive model of depression is based on the assumption that the individual's conceptions about his somatic sensations determine his feelings. Visual images and fantasy may affect the bodily sensations and feelings, which may be cognitively

misinterpreted. Objective observation of thoughts and images provides a distancing effect. According to Beck (Lusebrink, 1990:179) cognitions precede depression and negative cognitive appraisal of stimuli and situations assist in maintaining the depressive symptoms. Beck sees the depressive cognitive organisation as a closed system incapable of accommodating contradictory information. Discovering an opening of this system and introduction of new information and different view points leads to improvement.

2.2.2.2 The psychoanalytical perspective

According to psychoanalysts, psychological symptoms of depression and anxiety stem from unacceptable sexual and aggressive impulses and from buried memories of traumatic experiences such as separation from the mother, loss or death of a loved one, sexual overstimulation, or great physical pain and suffering. Because these impulses and memories are too awful to be faced head on, they are repressed, or buried, in the unconscious to protect the individual from pain. The problem, however, is that, even though this buried material is hidden from conscious awareness, it remains very much alive below the surface and is the source of a great deal of conflict in the unconscious mind. The underlying conflict, in turn, erupts and emerges as symptoms of psychological distress (Ingersoll and Goldstein, 1995:80-81).

2.2.2.3 The behavioural Perspective

This is based on the premise that specific behaviours are learned because they produce specific effects, or consequences. In general, positive consequences tend to strengthen behaviour. If no consequences follow on the heels of a particular behaviour, the behaviour weakens and may die out. This process occurs even more rapidly when negative, or punishing, consequences follow the behaviour.

Consequences, or reinforcers, need not be dramatic in order to have an effect on behaviour. Timing is critical. Behaviour is effected most powerfully by consequences, which immediately follow the behaviour (Ingersoll and Goldstein, 1995:83).

2.2.2.4 Endogenous (Congenital) factors

Endogenous factors seem to play a vital role in depression. Although genetic studies have not been extensive, evidence has shown that heredity is involved

Mood disorders in general seem to result from an interaction between environmental and biological factors. Thus, they range from mild sadness, through normal grief and the specific affective disorders, to the major mood disorders. Milder instances of depression may be more externally caused. In mood disorders in the middle of the spectrum both external and internal factors may be important. In severe disorders, including psychotic forms of the major mood disorders, endogenous factors may become more prominent.

2.2.3 Symptoms of depression

According to Blackman (Stanard, 2000:205) the requirement for a diagnosis of depressive disorder in adolescents is the same as for adults, but adolescents present symptoms in a different manner. For the purpose of this study the symptoms of depression in adolescents will be categorised under a number of sub-headings, namely physiological, affective, cognitive and behavioural.

2.2.3.1 Physiological symptoms

Hyman (Kirkcaldy and Siefen, 1998:136) makes mention of sleep disturbance, loss of appetite and lack of energy. Other physiological symptoms may include:

- Headaches
- Constipated and no bowel movements for days on end
- Aversion to sexual activity
- Disruption the normal menstrual cycle

2.2.3.2 Affective symptoms

Several affective symptoms have been identified. A number of these are mentioned below.

- feelings of despair
- misery
- hopelessness
- worthlessness
- guilt
- aggressiveness,
- withdrawal
- wanting to leave home
- sulking
- sensitivity to rejection
- inability to concentrate
- drug and alcohol abuse

Stress is also an important factor in adolescent depression. It is caused by pressure placed on the adolescent by parents and teachers, which is normal and presents no threat if the teenager can deal with it adequately. Shamoo and Patros (Swimmer, 1996:14) mention that the ability to deal with stress depends on the young person's perception of self and the stressful experience. It seems that some teenagers are more vulnerable to stress than others.

Hyman (Kirkcaldy and Siefen, 1998:36) adds that the most common symptoms of depressive disorder are depressed mood, loss of interest in usual pursuits, and anxiety. As the depression becomes more severe, feelings of guilt, suicidal thoughts and psychotic symptoms (delusions and hallucinations) may appear. Some clinicians, according to Hyman, prefer the term "dysphoric mood" to depressed mood because the patient often

complains of feeling irritable, fearful, worried, discouraged, or frustrated rather than sad or despondent.

2.2.3.3 Cognitive symptoms

According to Kendall, Catwell, and Kazdin (Hammond and Romney, 1995:668) a number of cognitive factors are likely to contribute to depressive symptomology in adolescents. These are listed below.

- Firstly, Siegel and Griffin (Hammond and Romney, 1995:668), for instance, found a strong correlation between depressive symptoms and external locus of control.
- Secondly, Beck; Carlson and Kashani; and Rutter (Hammond and Romney, 1995:668) found that low self-esteem is associated with clinical depression; depressed adolescents tend to ascribe negative attitudes to themselves and evaluate their performance as evidence of personal inadequacy and social ineptitude. As a result, they are often critical of themselves and predict that they will fail in both achievement and interpersonally.
- Thirdly, cognitive distortion has been highlighted as an important construct in behavioural and cognitive views of adolescent depression. Kovacs and Beck (Hammond and Romney, 1995:668) conclude that depressed individuals often anticipate outcomes of events to be negative, assume that a negative outcome will occur in other situations or take responsibility for negative events.
- Fourthly, helplessness has been noted in studies where a depressed adolescent attributes undesirable events to internal, stable and global causes.
- Fifthly, Kashani; Rotheram-Borus and Trautman; Topol and Reznikoff (Hammond and Romney, 1995:668) mention that hopelessness or negative expectations about the future are considered important, especially in with regards the fact that hopelessness has been demonstrated to correlate with suicidal behaviour in adolescents.

2.2.3.4 Behavioural symptoms

Behavioural symptoms may often be the first indicators of depression in adolescents. A number of these symptoms that may be evident, include:

- wearing black clothing
- writing morbid poetry
- a preoccupation with music with nihilistic themes
- sloppy, dirty clothing
- unkempt hair
- neglect of personal cleanliness
- a dull masklike facial expression
- slow bodily movements
- reduced and slow speech
- social withdrawal
- lowered work productivity
- agitation and restlessness

Adolescent depression may also primarily present as a conduct disorder, substance or alcohol abuse, family turmoil, or rebellion with no typical symptoms of depression.

An article by Finn (2000:253-269) focuses on depression as one of the most prevalent mental health disorders among adolescents today. In the aforementioned article (Finn, 2000: 254) it is argued by Lewinsohn, Clarke and Rhode (1994) as well as Reynolds (1994) that depressive disorders in adolescents are underidentified and consequently undertreated.

Mid to late adolescence represents the most common age of onset for depressive symptoms. Hammen and Rudolph (1996); Lewinsohn, Gotlib and Seeley (1995); Lewinsohn, Roberts, Seeley, Rhode, Gotlib and Hops (1994) in Finn (2000:254) view the most powerful predictor of future depression to be past depression; individuals who experience episodes of depression as children or who attempt suicide in early adolescence

are more likely to develop depressive disorders during later adolescence. Other predisposing factors may include stress, anxiety, medical problems and other internalising problems. According to Garrison, Waller, Cuffe, McKeown, Addy and Jackson (1997) in Finn (2000:255) family discord has also been found to be a predictor of depression.

According to Angold and Costello (1993) in Finn (2000:256) in a recent review of six epidemiological studies, between 20% - 80% of adolescents with depression were also diagnosed with a coexisting psychiatric problem, and as many as 50 % had two or more comorbid diagnoses. Also, anxiety, conduct problems, substance abuse and attention deficit disorder is often associated with adolescent depression. It also suggested that depressed adolescents with comorbid disorders may comprise a distinct subgroup of depression since the symptomology, responsiveness to treatment and long-term prognosis differ from those adolescents who suffer from depression alone. Studies of adolescents have shown relations between life stressors and changes in life events and depression. The most serious potential consequence of adolescent depression is suicide.

2.2.4 The link between depression and suicide

Garfinkel, Froese and Hood (1982) in Swimmer (1996:14) say that the risk of suicide is a very significant factor in any depressive state. The most disconcerting fact according to Carson, Butcher and Coleman (1988) also in Swimmer (1996:14) is that most persons who complete the act, paradoxically do so just when they seem to be emerging from the deepest phase of depression.

One could speculate that the reason for this is two-fold, namely

- the individuals' anticipation of regressing to a depressed state again and the obvious reluctance to re-experience these feelings of despair and
- that the individual now has the energy and the strength to succeed in the suicide.

According to Pfeffer (1986) in Swimmer (1996:14), a teenager who exhibits symptoms of a depressive disorder (affect) and is under a great deal of stress within the family (interpersonal), may be more predisposed to suicide, especially if he or she has poor coping skills.

What follows is a review of contemporary approaches in the treatment of adolescent depression.

2.2.5 Treatment for depression

Treatment of depression ranges from psychoanalysis to behaviour therapy and also includes pharmacotherapy and electroconvulsive therapy (ECT).

These conventional methods used in treating major depressive episodes as well as their goal and effectiveness will be discussed briefly.

2.2.5.1 Medical approaches to the treatment of depression

- *Pharmacological treatments:* These are derived from theoretical models, which argue that depression is the result of neurochemical disturbances in the brain. The aim of this approach is to reduce or eliminate depressive symptoms. Although originally developed for adults, according to Johnston and Fruehling (1994); Sommers-Flanagan and Sommers-Flanagan (1996) in Finn (2000:257) antidepressant medication has been used to treat depression in children and adolescents for the past twenty years. Johnston and Fruehling (1994) in Finn (2000:257) claim the typical course of treatment is six months, although symptoms may reappear if treatment is discontinued prematurely. The most commonly prescribed types of antidepressants for adolescents are Tricyclic Antidepressants (TCAs) and Selective Serotonin Reuptake Inhibitors (SSRIs). The effectiveness of TCAs is still as yet unproven and side effects include, dry mouth, constipation, sleep disturbances, headaches, nausea, vomiting and cardiac problems. SSRIs, on the other hand, despite the lack of empirical evidence

demonstrating their effectiveness with adolescents, are becoming increasingly popular in clinical practice due to fewer side effects.

Psychopharmacological approaches do not represent the first treatment of choice for adolescents with depression. According to Birmaher, Ryan, Williamson, Brent and Kaufman (1996); and Johnston and Fruehling (1994) (Finn, 2000:259) even the most optimistic researchers convinced of the benefits of medication, advocate the use of psychological approaches as an initial means of treatment.

- *Electroconvulsive therapy (ECT)* is a procedure, that consists of applying a moderate electrical voltage to the person's brain for up to half a second. The patient's response to the voltage is a convulsion (seizure) lasting 30 to 40 seconds followed by a 5- to 30-minute coma.

2.2.5.2 Psychological approaches to the treatment of adolescent depression

- *Cognitive-Behavioural Therapy*, according to Reynolds (1994) in Finn (2000:260), is the most widely used and researched treatment modality for depression. Cognitively based techniques are used to change negative views about oneself and the world, and behaviourally based techniques are used to modify environmental contingencies and change behaviour. There is evidence that cognitive-behavioural techniques are effective as a means of treating depressed youth, however, other questions remain unanswered. Marcotte (1997); and Reinecke, Ryan and DuBois (1998) in Finn (2000:261) claim that there is a lack of longitudinal research demonstrating whether treatment gains resulting from the use of cognitive-behavioural therapy with depressed adolescents are maintained over time. Furthermore, due to the lack of comparative studies, it is not known whether cognitive-behavioural therapy as a whole is more effective than other forms of psychotherapy and whether one type of cognitive-behavioural technique is more effective than another.
- *Psychodynamic Therapy* according to Lewinsohn, Clarke, Rhode, Hops and Seeley (Finn, 2000:261) attends to developmental issues that are particularly salient during adolescence. Bemporad (1988) in Finn (2000:261) recommends the use of

psychodynamic therapy for depression in order to provide support for the adolescent and to work through unresolved conflicts.

Psychodynamic therapy seeks, as its primary goal, to help adolescents unblock their development and redirect their energies toward achieving adult milestones; the secondary goal is to prevent adolescents from making decisions that may serve to relieve feelings of anxiety and unhappiness in the short term, but can result in later far-reaching consequences such as dropping out of school or leaving home.

Lewinsohn, Clarke, et al (1994) in Finn (2000:262) mentions that despite the presumed usefulness of psychodynamic therapy to treat adolescent depression, there is little evidence to support its effectiveness. In addition, there are impracticalities with regard the time requirements as well as the cost involved in this type of treatment.

- *Family Therapy* is based on the assumption that depressive symptoms represent general dysfunction in the entire family system. There is a lack of empirical evidence regarding the effectiveness of family therapy in treating depression.
- *Interpersonal Therapy* is an approach that focuses on past and present interpersonal conflicts as the basis for depression according to Mufson, Moreau and Weissman (1996) in Finn (2000:263). The goal is to decrease depressive symptoms and to improve interpersonal relationships. Controlled clinical trials are currently underway in order to further demonstrate the efficacy of this approach.

According to studies by Ambrosini, Bianchi, Rabinovitch and Elia (1993) in Asarnow, Jaycox & Thompson (2001:44) the psychosocial treatments tested to date with clinically depressed youth have shown relatively limited efficacy.

In light of the above-mentioned, it seems worthwhile exploring the effectiveness of imagery as a technique in the treatment of depressed adolescents.

2.3 IMAGERY

2.3.1 Characteristics of imagery

Sheikh and Jordan (1983) in Lusebrink (1990:8) outline the following general characteristics of imagery contributing to its effectiveness in therapy:

- Imagery carries intense affective charges and evokes emotional reactions with associated psychophysiological changes.
- Images and emotions contribute to the meaning of words, providing detailed information, especially of past occurrences and preverbal memories. Words, however, tend to become abstract.
- Imagery spans the continuum between the unconscious and the conscious and is thus effective in presenting patients problematic areas and uncovering repressed material and defenses.
- Images also have a futuristic dimension as motivators to action, as well as a predictive dimension presenting ideas and actions that manifest themselves only later in verbal cognition and behaviour.
- In therapy, free imagery and guided imagery produce therapeutic changes without the mediating action of interpretation.

The unique role of images in information processing is to provide a counterpart to verbal processing. Images appear to be more closely linked to the individual experience than the verbal labels given to the experience.

An image can be an internal or external representation of a feeling or mood, a scheme, an abstract concept, or a representation of an object, scene or person. Images are experienced internally.

Images can be simple or complex, concrete or fleeting, symbolic or abstract. Images provide information about the self, and/or a person's physical, emotional, mental, and spiritual experiences and needs.

2.3.2 Hypotheses of the role of imagery in healing

Imagery influences emotions through the relation of images to hemispheric laterality; through the interaction between images and emotions; and through their combined influence on the physiological processes of the body.

Images and emotions are predominantly processed in the right hemisphere. The right hemisphere directly influences autonomic functions of the body, whereas the left hemisphere commands the musculoskeletal. We communicate to our internal environment via the right hemisphere and imagery and through the left hemisphere to the external environment. According to Achterberg (1985); Achterberg and Lawlis (1980); and Schwartz (1984) in Lusebrink (1990:221) the right hemisphere translates verbal messages from the left hemisphere into images before they can be understood by the autonomic nervous system.

Emotions, as well as their inhibition, influence the health of the person. Positive emotions, such as joy, contribute to the physical well being of the individual and accelerate the functioning of the immune system, suggests Achterberg (1985) in Lusebrink (1990:221). Negative emotions, such as depression, are associated with psychological distress and illness. According to Ley and Freeman (1984) in Lusebrink (1990:221) negative, stressful experiences and images increase the arousal of the sympathetic nervous system, which activates a surplus of corticosteroid secretion and, therefore, depresses the functioning of the immune system. Inhibition of emotional expression has a similar effect.

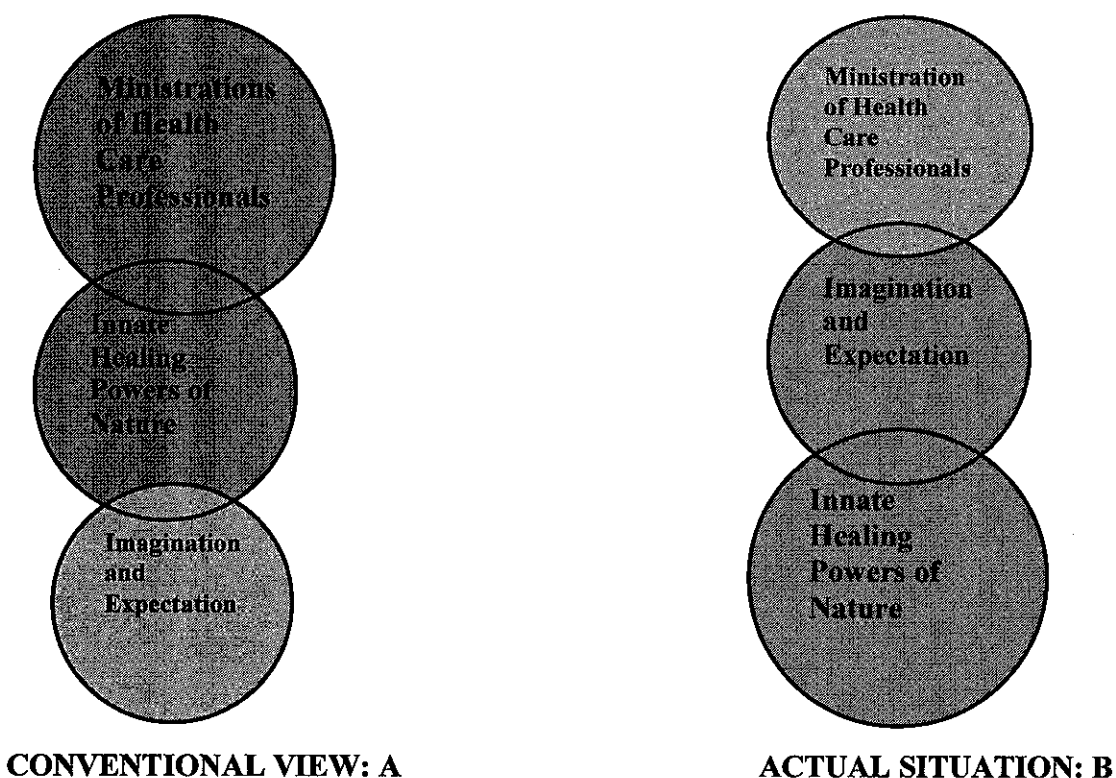
Unexpressed emotions manifest either through their sensory-motor components or through dream images. Stress and conflicting messages not translated into images, continue to affect emotions and later, physiological functioning. The process of translating body sensations and emotions into symbolic images provides the individual with a means to manage stress on a cognitive level.

According to Lazarus (1984:39), the deliberate and concerted use of specific images proves to be the key that unlocks and opens the way to solve hitherto problems. Imagery opens up one of the most powerful areas of the personality for overcoming innumerable

stress. In addition, it provides an effective tool for developing a more rational approach to many problems.

According to Jackson (1990:350) a leading physician stated in 1750: "Many diseases arise from a perverted imagination; and some of them are cured by affecting the imagination only. It appears almost incredible, what great effects the imagination has upon patients."

Figure 2 (Nucho, 1995:11) illustrates how conventionally we have contributed the greatest portion of the positive outcome of health care to the ministrations of the health professionals. This is diagrammed in part A. Empirical research as well as practitioner observations, however, increasingly suggest that the largest contributor to the positive outcome of health care is nature's own healing powers, which can be stimulated by various imagery techniques. This is illustrated in part B.

Figure 2**HEALTH GENERATING FORCES**

The technique of guided affective imagery was developed by Leuner in Germany and has connections to other psychiatric techniques employing active imagery (Rojcewics, 1990:271). The technique involves having the patient vividly imagine himself in certain settings. The therapist may suggest certain details, actions or outcomes, which the patient then visualises through his/her imagination. Richardson (1982) in Farr (1990:45) says the ability to generate images, mental pictures of people, objects, and things which are not immediately available to the senses, and then to reshape these into new and complex forms, is thought to be a specifically human capacity.

According to Farr (1990:45), an acknowledgement of the importance of internal experiences and the growing possibility of studying these phenomena have led to an increase in objective research in this area. The purposeful use of the imagination appears to be a most effective and fruitful means to explore inner processes.

Crampton (1978); and Crocker (1984) in Farr (1990:46) claim that when used in a disciplined way, mental imagery offers the integrative possibility of exploring the unconscious while maintaining contact with conscious verbal faculties.

According to Houston (1982); and Watkins (1976) in Farr (1990:46), imagery appears to operate within multidimensional, subjective time, which is different from clock time, and contains many patterns of possibility, so a great deal of material can be experienced within a short time span. In order to facilitate this area of awareness, guided imagery exercises are most often used in conjunction with relaxation exercises.

Doll (1982) in Farr (1990:46) mentions that many therapists believe that the imagery process is similar to the unconscious production of dreams, in that it stimulates the generation of spontaneous images, which are affectively related. Like dreams, the procedure of imagery making appears to avoid the rational, semantic processes in which clients may become stuck; processes which actually serve to avoid the underlying problem or issue.

Horowitz (1970); Sheehan (1972); and Singer (1979) in Farr (1990:46) observed that images have the capacity to uncover or arouse complex and intense affective reaction and to take individuals into deep emotional exploration. Imagery can also move personal exploration into deep symbolic, universal formulations relevant to the specific individual's life and concerns.

According to Nucho (1995:7-8) a new paradigm is emerging. In this, the mind and the body are regarded as one, essentially a cybernetic, self-regulating entity. Information is the essential regulator of biological processes. Foss (1994) in Nucho (1995:7) proposes the term infomedicine for this paradigm. It was not just the bell or its sound, Foss reminds us, that made Pavlov's dogs salivate, but rather the interpretation of the meaning attached to the bell. The somatic or physiological reaction, salivation, which belongs to a matter-energy modality, was generated by a semantic or informational modality.

Foss proposes that the body may be thought of as a system. As any system, the body has feedback loops that regulate the course of the system. Feedback is a process whereby a portion of the energy or informational output of the system is channeled back into the system to stabilise or direct its actions. In this manner a system can rearrange its own circuitry. Energy exchange with the environment can steer the system to new levels of organisation.

Both an upward and downward causation is recognised. Patients can refocus their minds and revise their message processing programs. They can actively participate in the therapeutic process. This is where imagery techniques come in. Images are the natural feedback devices each human being is equipped with. Images convey and contain information in the non-linear, right brain modality of thought.

It is known that each cerebral hemisphere is specialised for different cognitive functions and controls movement in the opposite half of the body. Thus, stimuli and experiences from the one half of the body are projected to the opposite hemisphere. This is known as cerebral laterality. As said, the right cerebral hemisphere plays a primary role in imagery processes (Sheikh, 1984). The right cerebral hemisphere also mediates affect; thus imagery arouses strong emotions in the subject. There is strong evidence that there are functional hemispheric differences in emotionally disturbed individuals. It was also indicated that disorganisation of the right hemisphere may result in depression.

Robbins and McAdams (1974) as noted by Sheikh (1984:61-62) claim that engaging in imagery stimulates the right hemisphere. It has been indicated that activating the right hemisphere electrically, for instance by using imagery, leads to elevated cerebrospinal fluid levels of Serotonin metabolites, whilst activating the left hemisphere leads to an increase in levels of norepinephrine (NE) and dopamine metabolites (DA). Depletion of NE and DA results from exposure to unavoidable stress, is related to depression, and may be involved in immunosuppression. If there is a relationship reciprocal inhibition between the cerebral hemispheres, imagery may activate the right hemisphere and thus inhibit activation of the left hemisphere. Therefore, right hemisphere imagery may decrease the

rate at which NE and DA are utilised in the left hemisphere. By conserving these substances it will reduce the probability of depression and illness.

The function of the therapist in imagery is to teach the client how to devise his/her own images spontaneously, not to offer a script for the imagery of the client. The spontaneously emerging imagery of the client is creative in that it generates new ideas, attitudes and new behaviours in the real world. It starts a chain reaction with far-reaching implications for the client's physical and mental health.

According to Nucho (1995:10) images are self-programming devices. Experiences produce feelings and feelings congeal into images. In turn, images generate feelings and feelings lead to action. Induce images in yourself, feelings will follow and action will occur thereafter. Images are a concretisation of a feeling. They are symbolised feelings. Information surrounds us and images are like spoons we can use to scoop out the information for our use.

The body is a cluster of small yet powerful intelligences, of which just a small portion is in our conscious sphere of experience. According to Achterberg and Lawlis (1980) as noted by Nucho (1995:10), every cell has sensors, which can be stimulated by healing visualisations. The contribution of the medical profession may be but a fraction of the total sum of forces available that generate healing. The greatest proportion of healing comes from the innate powers of the human being.

Bugelski (1986) in Nucho (1995:13) mentions that scientists are discovering that in many respects the human body is like a computer that is programmed by images. Increasingly psychologists are now returning to the Aristotelian view that the soul does not think without an image. Imagery is now considered an essential part of cognition and as such even behaviourally oriented psychologists eagerly investigate it.

Images, suggests Langer (1942) in Nucho (1995:16), denote things from which they were derived originally. They are repositories of experience. Out of sensory impressions and

perceptions we form images and these become our primitive abstractions. Images are the spontaneous embodiments of general ideas and they have the power to suggest new things and experiences by analogy. Thus images can function as symbols. Images are elements of thought, and as such, important in creativity.

According to Lusebrink (1990:6), inner experiences of images and their external representations influence each other. Simultaneously, the media in which the images are presented and represented are also different. The internal image is based on sensory, affective and thought processes. The image is externalised through verbal descriptions or by manipulating the media. The expressive medium has its own qualities and limitations. The representation of inner images is perceived internally by the viewer. Therefore, the external images interact with and influence the internal experience.

Images (Lusebrink, 1990:7) are appraised for their emotional response and conceptual content. Simultaneously, they undergo two transformations: they decrease in intensity and vividness, and they are translated into other forms of representation. The emotional aspect of images is very important in that traumatic images retain their intensity for longer, and the strong associated emotions make verbal labeling more difficult.

2.3.3 Components of imagery

Ahsen (1973, 1982, 1984) notes Lusebrink (1990:6-7) conceptualises images as a three-dimensional unity between vivid visual or 'light' images, somatic pattern and a meaning. This structure is termed ISM. The sequence indicates that an image is followed by the somatic response or meaning. The image serves as a stage for the expression of the body response and meaning. The sequence can start with the somatic response or with a meaning in any combination with the other two components.

Each image, according to Nucho (1995:18), consists of three subsystems, or components. Firstly there is an attention component, or a degree of awareness. Some of this attention may be conscious and vivid and some may be outside conscious awareness and vague. A

great deal of information may be absorbed and only reach conscious awareness much later.

The second component is physiological, meaning that there is a somatic manifestation in the organism.

The third component is the interpretive or cognitive element. Some meaning may arise spontaneously in the mind, or later when one tries to make sense of the event.

Therefore, it is possible to say that an image is a system consisting of a conglomerate of awareness (A); physiology or bodily response (P); and an interpretation (I). That is, an image is an "API" phenomenon.

2.3.4 Modalities of imagery

According to Lusebrink (1990:28) the images dealt with in therapy are usually visual. Images can, however, be experienced in all sensory modalities, namely visual, olfactory, gustatory, tactile, audio, kinesthetic and somatosensory. The three main imaginal modalities are visual, audio and kinesthetic. The other modalities elaborate on these and assist in recalling complex images involving affect.

2.3.5 Types of imagery

Three types of imagery will be discussed below, namely:

- Thought and memory images: these tend to dissolve under fixed attention. Voluntary thought images are formed as a result of instructing oneself or receiving instruction to imagine something. These images can be present in any of the modalities and can have present specific somatic activity. For instance, the instruction 'imagine lemon juice in your mouth' may produce salivation according to Richardson (1883) in Lusebrink (1990:32).
- Spontaneous thought imagery emerges into awareness of itself whenever goal-directed verbal thought is blocked or becomes confused or uncertain.

- Imagination imagery represents the inner world. These are often not connected to direct memories, but may have an absorbing quality for the person. Relaxation enhances imagination imagery. Leuner's Guided Affective Imagery, exhibits similar qualities to imagination imagery.

Both imagination and thought images can be emotionally coloured and experienced as emotionally pleasant or unpleasant. Both spontaneous thought images and imagination images might be symbolic and also represent psychic or somatic phenomena. Therefore, the image of a rose can represent the perceptual experience of a rose, or the image can represent inner centeredness, or the petals can form the image of a womb-like protective structure. Ultimately, the inner psychic or physical or emotional experiences elude representation through images or words.

2.3.6 Imagery and emotions

When considering the relationship between imagery and emotions, one needs to differentiate between objective visual-spatial and subjective imagery, which is closely linked to imagery. Silberman and Weingarten (1986) notes Lusebrink (1990:41) conclude that both the left and right hemispheres process emotional information, but show differences in the manner of processing as well as the type of emotions processed. The right hemisphere integrates information across modalities, whereas the left hemisphere plays an important role in verbally mediating emotional information and mood states. The right hemisphere is involved in processing negative emotions and the left in positive emotions.

Emotional imagery activates the right hemisphere, whereas the latter is deactivated following an intensive expression of emotion. Right hemispheric functioning can be activated with high imagery words and words laden with emotion. Left hemispheric functioning can be enhanced through verbal analytical evaluation of images.

Subjective imagery and emotions have a number of commonalities and interrelationships. Emotions, like imagery have several levels on which they are processed, namely physiological, schematic and cognitive.

The reciprocal interaction between subjective imagery and emotions is particularly important in therapy. Imagery portrays emotions and emotions can be aroused through imagery, according to Epstein (1981); and Horowitz (1972) in Lusebrink (1990:124). Images retain the emotions associated with them, as well as the somatic correlates of these emotions. Images play an important role in modifying emotional states and warding off threatening content and emotions, claims Horowitz (1970) as noted by Lusebrink (1990:124). According to Singer (1974) also in Lusebrink (1990:124) the control of imagery contributes to the control of affect as well as behaviour.

Images are distorted by negative emotions as these transform or arrest image flow. The physiological arousal concomitant to strong negative emotions, tends to generate additional negative images, based on past experiences encoded at this level of arousal.

Strongly charged emotions may be accessed through images by elaborating on the sensations associated with these images. Emotional discharge helps reconnect the sensory, emotional and imaginal levels.

2.3.7 Function of imagery

According to Kaufman (1984) in Lusebrink (1990:45) imagery as associated with the holistic mode of experiencing, is a means for the individual to express subjective experiences and to process information relating to self. Images provide insight into personal functioning and problem solving and also facilitate creative understanding and insights.

Images arise spontaneously in the mind as a response to external as well as internal stimuli. It is similar to a stimulus and a response reaction. Images are like telegrams we can send to deeper, usually inaccessible parts of the system.

Dean Ornish (1990) notes Nucho (1995:24) points out that our bodies respond to images as they do to events in the real world. Image generating ability is an internal, private level of mental activity. It is not accessible to an outside observer unless the person chooses to share the imagery. Imagery nevertheless has important consequences in life. Images leave "footprints" in the bloodstream, and thus they shape behaviour. Imagery can, amongst others, generate the production of endorphins, the natural morphine-like substances that accompany the sense of well being (Nucho, 1995:25). This is one reason why the researcher hypothesised that imagery would be an effective technique in treating depression in adolescents.

According to Shorr (1972) in Nucho (1995:118-119), imagery is valuable because it stimulates associations and evokes emotions. Imagery is a dry run, a foresight, and through it, alternatives can be tested. Image is the synthesis of what we know, feel and think. Images are the roots and stems. Words are the blossoms.

2.3.8 Imagery techniques

A number of imagery techniques used to treat various disorders exist. They include:

- Desoille's Directed Daydream Method: According to Nucho (1995:116) his method is similar to Leuner's Guided Affective Imagery in which the subject is first asked to relax in order to reach the desired state between full alertness and sleep. The reason being that the person is then more likely to allow a full range of feelings to become conscious. Desoille's technique consists of presenting an image and then asking the person to describe it as well as the scene suggested by the image, as thoroughly as possible, using all senses- vision, hearing, taste, smell, and touch, evoking as many details as possible about the surroundings in the image. In order to promote spontaneity, the therapist is not critical of any imagery productions.
- Shorr's approach to imagery (Nucho, 1995:118) is a cross between psychological testing and therapy. Some of his more useful techniques are the methods to clarify sense of identity and to resolve conflicts.

- The concept of the Hurt Inner Child (Annexure 3). This exercise assists the subject in being his/her own good parent. This is imperative for the patient to become a responsible adult.
- The notion of the Inner Guide (Annexure 4) was originally derived by C.G.Jung. According to Nucho (1995:102) these guides assist sufferers in identifying what is going on in their lives and what might be contributing to their pain. This method is a way of devising a symbol that represents to us our inner wisdom. We are capable of contacting the right brain – intuitive holistic thought processes – with the inner guide technique.

Guided Affective Imagery (GAI) was developed by Leuner in Germany and has connections to other psychiatric techniques employing active imagery (Rojcewics, 1990:271). It consists of having the patient vividly imagine himself/herself in certain scenes. The therapist can suggest certain details, actions or outcomes, which the patient then visualises through imagination.

Leuner (1977) in Rojcewics (1990:271) maintains that GAI provides an opportunity for a patient, otherwise inhibited, to develop a fantasy production related to his/her problems, to experience the affects involved, and to allow the emotional responses to run their full course. This method gives the patient the opportunity to re-examine situations associated with childhood fears and anxieties that are often central to adult psychopathology, and to work on the roots of the conflict. It can lead to resolution of neurotic conflicts on a symbolic level. It has been used successfully in patients with neuroses, borderline states, psychosomatic disturbances, and in the training of psychotherapists. In addition, Klagsbrun and Brown (1984) notes Rojcewics (1990:271) claim the use of imagery can be particularly effective in resolving impasses in therapy.

In itself, the use of Guided Affective Imagery emphasises the point that the potential for growth lies basically within the patient (Rojcewics, 1990:277).

Guided imagery approaches, such as Leuner's Guided Affective Imagery provide structure and basic symbolic images containing both positive and negative aspects. The depressed adolescent can endow these images with his/her own feeling and meaning,

which could be negative in the early stages of therapy. The negative images undergo transformation in the subsequent daydreams, and the positive aspects of the symbolic images begin to emerge.

Leuner's Guided Affective Imagery is less a matter of guiding than prompting the client's imagination (Nucho, 1995:112). According to Leuner, the experience itself produces curative results, not the interpretation offered by the therapist or attained intellectually by the therapist. Leuner does not engage in a rational discussion of the imagery experience with the client. As is common to most imagery techniques, Leuner asks his clients to attain a relaxed state prior to engaging in the imagery and encourages them to use their own judgement rather than to follow whatever suggestions they think they have received from the therapist.

2.4 ADOLESCENCE AS A DEVELOPMENTAL STAGE

Almost all youth face the uncertainty and challenges brought about by adolescence, a time of significant life transitions in which young adults must cope with changes associated with physical and emotional maturation claims Sands (1998:42). Occurring simultaneously with these changes is the emergence of identity as the adolescent strives for greater independence and autonomy. The adolescent experiences a number of maturational changes namely, coping with the physical changes of puberty, separating from the family and developing his/her own identity, developing intimate relationships with the opposite sex, as well as discovering his/her aptitude and talents in order to earn a living. Emery (1983) notes Swimmer (1996:13) claims that in order to become an autonomous individual the adolescent has to shed, or at least change the nature of his or her attachments, in particular to close family members, which may be experienced as a form of loss for the young person. As Greenacre (1953) Swimmer (1996:13) writes: "Depression as a symptom is as ubiquitous as life itself, and, in a mild degree, appears naturally as a reaction to loss which no life escapes."

According to Allen (1990) in Ramsey (1994:257), unlike normal depression, which is induced by external events, chronic depression is often thought of as a “trait” versus a “state”.

For the adolescent much of the future represents the unknown, many teenagers feel confused, overwhelmed and ambivalent, as increased independence is accompanied by increased responsibility. Peer or parental rejection too may result in loss of self-worth and self-esteem as the adolescent is continuously under pressure to be accepted by peers, and simultaneously trying to meet parents’ and teachers’ expectations. Shamoo and Patros (1989) in Swimmer (1996:13) suggest that this, together with oversensitivity and feelings of inadequacy, may be very stressful for the adolescent and can often lead to a change in mood.

2.4.1 Depression in adolescence

According to Lewinsohn et al (1993) in Finn (2000:253) depression is one of the most common mental health disorders among adolescents today, and over the past two decades substantial literature on the prevalence, assessment, and treatment of adolescent depression has emerged.

Herbst and Paykel (1989) as noted by Swimmer (1996:13) say some adolescents cope with this transition with only mild periods of depressed mood, but it is important to recognise it when the mood persists and the teenager becomes overwhelmed by feelings of sadness, hopelessness and apathy to such an extent that it begins to have a marked effect on his or her functioning. Until recently it was thought that depression did not occur in children and teenagers, but it is now accepted that depression is a serious mood disorder and, if left untreated, may have dire consequences such as suicide.

Hammen and Rudolph (1996) in Finn (2000:254) mention that mid to late adolescence represents the most common age of onset for depressive symptoms and a number of risk factors have been identified. The most powerful predictor of future depression is past

depression; individuals who experience episodes of depression as children or attempt suicide in early adolescence are more likely to develop depressive disorders during late adolescence.

Depression is more influenced by environmental factors in adolescence than in adulthood. Thus, when the mood is lower it is still subject to fluctuations, which are entirely in keeping with the normal mood swings that teenagers experience. In emotionally disturbed adolescents, however, these mood fluctuations are exaggerated. Criteria in determining depression involve duration, severity and quality of the symptoms as well as the dysfunctional effects on behaviour.

2.4.2 Inpatient treatment of depression

Katherine A. Raymer (Shafii & Shafii, 1992:233), outlines the essential features of inpatient psychiatric treatment of depressed adolescents. When the adolescent is diagnosed with a depressive disorder, admission is indicated for suicidality, feelings of hopelessness leading to risk-taking behaviour, sleep pattern disturbance endangering the physical health of the adolescent, and the suspicion of physical or sexual abuse. Psychosis complicating these symptoms makes the need for admission even more urgent. Depressed adolescents with a comorbid diagnosis such as alcohol and drug abuse and conduct disorder are at a high risk for suicide, and immediate hospitalisation is indicated.

2.4.2.1 Initial clinical assessment and plans

On admission a period of intensive assessment begins, during which professionals from a number of disciplines are involved. These will briefly be discussed below.

- **Medical assessment**

The medical assessment encompasses the medical history, physical and neurological examination as well as investigations performed by a physician.

- **Investigations**

Adolescents with suspected depression should be prescribed a number of laboratory studies, namely a complete blood count with differential, urinalysis, serum tests, free thyroid index, thyroid-stimulating hormone, toxin screens of the blood and urine, as well as checking for sexually transmitted diseases.

- **Nursing assessment**

Grossman and Mayton (Shafii & Shafii, 1992:239) maintain that the first phase of nursing assessment of the adolescent begins at the time of admission and the second phase continues for approximately seven to ten days thereafter. This second phase includes observation and direct interaction with the patient daily.

Nursing diagnosis relevant to the depressed adolescent specifically could highlight sleep pattern disturbance, suicidality, hopelessness or low self-esteem.

- **Psychological assessment**

Bolton (Shafii and Shafii, 1992:239) claims the specific tasks of the psychologist are concerned mainly with the cognitive functioning of the adolescent, which includes screens for brain dysfunction; formal tests of educational attainment in reading, spelling, and arithmetic; tests of personality traits; projective testing; structured and semi-structured interviews; self-report measures; clinician rating scales; and assessment of the appropriate treatment modality.

- **Psychosocial assessment**

The social worker usually performs this assessment, with additions by the supervising psychiatrist, the nursing staff, and the primary therapist. This evaluation includes current and past family structures and relationships, biographical information, significant relationships of the primary caregivers, significant interpersonal relationships of the

adolescent, characteristics of the various environments in which the patient interacts, and the identification of internal and external stressors and strengths of the family. Pertinent to the depressed adolescent would be history of abuse or neglect, maternal deprivation, parental divorce, lack of social support, the presence of parental psychopathology, particularly mood disorders, and low socioeconomic status.

- **Educational assessment**

Schulman (Shafii & Shafii, 1992:240) mentions that this includes the request for a comprehensive report from the child's school; formal testing to discern the particular strengths and weaknesses of the patient; observation by the hospital school teacher which provides valuable information with regards the adolescent's interest and motivation, memory and concentration, self-concept, and peer relations. This information is valuable in the eventual formulation of a diagnosis.

- **Occupational therapy assessment**

Dunn (Shafii & Shafii, 1992:242) defines Occupational therapy as "services to address the functional needs of a child related to the performance of self-help skills, adaptive behaviour and play, and sensory, motor, and postural development".

2.4.2.2 The treatment plan

The minimal criterion for discharge of a depressed adolescent must be that the patient is of no immediate danger to self or others. This should be mentioned as a goal on the treatment plan. According to Raymer (Shafii & Shafii, 1992:243), the method of treatment for suicidal patients could include milieu, individual, family, pharmacotherapy and group therapy. Ultimately the treatment plan must suit the needs of the individual and the therapist must be flexible in his/her approach.

- **Milieu therapy**

The time spent with other patients and the staff in less formal activities is of much value. Therapeutic interventions can be reinforced in routine activities of daily living within the milieu. Within the treatment of depressed adolescents specifically, the milieu staff can, for instance, work with a patient behaviourally on obtaining more positive reinforcement from the environment.

- **Individual psychotherapy**

Individual therapy is the cornerstone of the various interventions and must suit the specific need of the adolescent in question. Depressive themes may be clarified, thus allowing the inclusion of other necessary therapies such as family therapy.

- **Group psychotherapy**

Involvement in group therapy decreases social isolation and encourages social interactions in other situations on the inpatient unit. Peer relationships have much influence in this stage of a child's development and thus peer feedback has powerful effects on the thoughts, feelings and behaviours of adolescents. In group therapy adolescents can learn about themselves, their families, as well as the issues that affect the course of their depression.

- **Pharmacotherapy**

The inpatient setting provides the opportunity for close observation of patients' responses to medication in general and antidepressants specifically. The respective staff is also then able to make rapid adjustments in dose or type of medication prescribed, especially as combination medication therapy has not been that intensively studied in children and adolescents.

- **Family therapy**

When approaching family therapy in the hospital setting one must think of ways to change identified family factors that contribute to the depressive symptoms of the adolescent, as well as ways to assist the family in coping with stress associated with the deterioration of the patient's functioning.

2.5 IMAGERY APPROACHES TO THE TREATMENT OF DEPRESSION

Although not much evidence exists to draw a direct link between imagery and the treatment of depression, research clearly indicates that imagery might be an effective tool in the treatment of depression. Schultz (1978) as noted by Lusebrink (1990:185) investigated the effect of different imagery approaches on depressed adults. Engagement in directed/guided imagery produced significantly lowered levels of depression than free imagery. With the free imagery approach, the depressed subjects were able to generate positive imagery, but were unable to block the negative thought intrusions. The appropriateness of the imagery to the individual's concerns has to be considered in therapy.

Work done by Nucho (1995:121) indicates that images convey information in the non-linear modality of thought. It is evident that imagery is able to relieve depression in certain ways. Imagery exercises can reprogram the organism so that the old negative messages derived from previous painful experiences, do not hamper the attainment of health. Not only hormones and electrical charges carry information in the human system, but semantic entities as well.

2.6 SUMMARY

This chapter focused on depression in general as well as how it manifests in adolescents specifically. The more widely used treatments of depression in general and with regards adolescent in-patients in particular was also discussed. Imagery was also discussed as a

consideration in an endeavor to determine its effectiveness as a technique to treat major depressive disorder in adolescents under psychiatric supervision.

A number of theories on depression were briefly mentioned, namely:

- The Cognitive-Affective Aspects of a Biopsychosocial Model of Depression
- Psychoanalytical perspective
- Behavioural perspective
- Endogenous (Congenital) factors

The treatment of depression covers a broad spectrum of approaches, these include:

- Medical approaches, or more specifically, pharmacological intervention and electroconvulsive therapy (ECT)
- Psychological treatment can be sub-divided into a number of approaches, namely
 - Cognitive-Behavioural
 - Psychodynamic Therapy
 - Family
 - Interpersonal Therapy

It is hypothesised that imagery plays a vital role in the healing process in that it influences emotions through the relation of images to hemispheric laterality, through the interaction between images and emotions and through their combined influence on the physiological processes of the body.

In short, imagery is a means for the individual to express subjective experiences and to process information relating to self. Images provide insight into personal functioning and problem solving and also facilitate creative understanding and insights.

Images arise spontaneously in the mind as a response to external as well as internal stimuli. It is similar to a stimulus and a response reaction. Images are like telegrams we can send to deeper, usually inaccessible parts of the system.

Chapter Three

The Empirical Investigation

3.1 INTRODUCTION

The literature study has revealed that the possibility exists that imagery might be used as an effective tool in the treatment of depressed adolescents under psychiatric supervision. It will be the aim of the empirical investigation of this study to verify this assumption.

3.2 DESIGN OF THE EMPIRICAL INVESTIGATION

The following steps will be introduced to execute the empirical investigation:

- Selection of a measuring instrument to measure depression
- Selection of case studies
- Implementation of the measuring instrument
- Application of imagery as a therapeutic technique
- Re-implementation of measuring instrument
- Gathering, interpretation and discussion of final results

3.2.1 Selection of a measuring instrument to measure depression

The BDI is a clinically derived self-report measure that consists of 21 items relating to affective, cognitive, motivational and physiological symptoms of depression. It was designed as a standardised device to assess the depth of depression according to Beck (Corey, 1996:344). This instrument will be used to determine the level of depression of the patients.

Each item consists of four statements reflecting increasing depressive symptomology. Statements are ranked from 0 to 3, with 0 being the least serious and 3 representing the most serious. In terms of readability, Teri (Hammond and Romney, 1995:671) classified the BDI as requiring a fifth-grade reading level, making it readily comprehensible to an average adolescent age 13-16.

The items are based on observations of the symptoms and basic beliefs of depressed people. The inventory contains the following 21 areas of symptoms and attitudes (Corey, 1996:334):

- Sadness
- Pessimism
- Sense of failure
- Dissatisfaction
- Guilt
- Sense of punishment
- Self-dislike
- Self-accusations
- Suicidal ideation
- Crying spells
- Irritability
- Social withdrawal
- Indecision
- Distorted body image
- Work inhibition
- Sleep disturbance
- Tendency to become fatigued
- Loss of appetite
- Weight loss
- Somatic preoccupations and
- Loss of libido

According to Baron and Perron (Hammond & Romney, 1995:670) it has been validated as a reliable self-report measure of depression in both clinical and non-clinical samples of adolescents.

The range of possible summated scores extends from 0 to 63. Scores of 01 to 10 are generally considered normal; 11 to 16 mild mood disturbance; 17-20 borderline clinical depression; 21-30 severe; and 30 to 63 extreme.

3.2.2 Selection of case studies

The empirical information will be obtained by making use of four case studies. Four patients suffering from depression, currently in the adolescent unit at a prominent psychiatric institution in Gauteng, will be chosen. The Beck Depression Inventory (BDI) as well as a clinical interview will be used to assess the level of depressive symptoms.

3.2.3 Implementation of the measuring instrument

The patient receives the questionnaire (Annexure 1) and pencil. Four contrasting statements are given. The patient has to decide which of these descriptions, best describes him/her. No time limit is given. The patient is, however, encouraged not to contemplate his/her response for too long. The total scores represent different levels of depression (Annexure 2).

3.2.4 Application of imagery as a therapeutic technique

The researcher is currently partaking in a training programme to perform imagery techniques in therapy and received assistance with regard specific imagery techniques to use for the purposes of this study from a qualified senior clinical psychologist who uses this technique extensively in therapy.

In this chapter a description will be given of the empirical investigation that was undertaken. This will be presented according to the following outline:

- Biographical background of patients
- Proposed plan of action
- For practical purposes a detailed account of only the first three sessions will be given for each case study. A short summary of sessions four and five will follow
- Evaluation of proceedings

An initial assessment of the level of depression for each of the patients will be calculated by using the BDI and a clinical interview. Thereafter patients will come for five sessions of imagery and thereafter the Beck Depression Inventory will again be implemented in order to assess if therapy had been successful in treating the depression.

Each imagery session will be preceded by a relaxation exercise (Annexure 5) adapted by Lazarus (Nucho, 1995:85). The imagery sessions will be selected to suit the patients' needs specifically. The relevance of each image will be discussed below prior to the account of each session.

Imagery will be suggested to the patients' respective caregivers.

Imagery as such will be discussed with the patients, allowing them to ask questions and to eliminate any uncertainty they have with regard imagery.

3.3 CASE STUDY I

3.3.1 Biographical background of patient

Name: Kay (Name has been changed for reason of confidentiality)

Date of Birth: 07/10/1984

Age: 17 years

Gender: Female

Race: Caucasian

Grade: 11

3.3.2 Diagnosis according to the DSM IV

Axis I: Major Depressive Disorder

Axis II: None

Axis III: None

Axis IV: Psychosocial problems; Stressors: Mother-child relationship; poor social support system

Axis V: 51 - 60

3.3.3 First imagery session

It was decided to start with Desoille's starting image of a vase as the patient is female, as opposed to a sword for a man. The patient is asked to describe this object as thoroughly as possible. According to Dessoile, the image of the sword or the vase is equivalent to asking the person in what we would term the right brain language: "What do you think of yourself as a man/woman in the broadest sense of the term?" (Nucho: 1995:117). The patient is encouraged in the imagery session to also describe the location of the object and to move it around.

The following is a detailed account of the first session:

- **Relaxation exercise (Annexure 5)**

- *I would like you to see an image of a vase and to describe it in detail using all your senses. I would also like you to tell me what you are experiencing emotionally and physically.*

I see a plain, simple vase with a plain, simple flower. It's not big...brown...rough...I hope the sand inside is wet...just a plain stem with a plain flower inside. It is not made of glass so I can't see through it.

The flower smells very nice...a funny smell...a strange smell. I am crazy about this plant, but I don't know its name.

If I smell this flower I feel good...free...happy...

- *Can you remember when else you experienced similar emotions?*

Never...when I was with my mother, long ago...then...I felt good when my Mom was happy and I knew that she loved me...it was nice to talk to her about everything that happened to me...I told her everything.

- *How do you feel now that you are thinking about that time with your Mom?*

I feel good in my heart...sharp pains in my stomach...hurts me...they want to go away, but I also don't want them to go away.

- *Stay with that feeling and tell me if it intensifies or subsides or changes location.*

I feel hate and love, but I don't know which is the stronger feeling...my feet feel as if they are floating in the air...my right foot feels higher, but they are both in the air.

I don't want to speak about how I feel because it hurts too much...when I am alone I feel bad...sad...

The sharp pains in my stomach are gone...I usually feel them when I am alone, not when I hear my mother speak.

It feels like I want to turn in circles.

- *Stay with that feeling and tell me if there are any changes.*

Long pause

It doesn't feel as if I am turning anymore.

- *I would now like you to please do something with the vase and to move it somewhere.*

I cut all the dead leaves off and water it...and put it in my bedroom.

It looks nicer then...with new leaves and it's wet so it will grow some more...it looks healthy.

It makes me feel good in my heart...it's a climbing plant with tiny pink flowers...can smell the scent from a mile away. The leaves are small and soft...when you touch them it hurts the plant.

- *How does the plant feel when you touch it?*

I don't know, but it feels good touching the leaves...nice and soft...

- *When was the first time that you smelled this scent?*

It smelled strange then...at my Dad and then when I went for a stroll one evening...now I'm thinking of my father...does he love me...why doesn't he care..?

I don't care...why did he even bother making me...why didn't he just leave it..?

I am angry and irritated when I think of my father...

Now I just see an image of a wild horse on an open veld...I love horses...then I feel free...away from everyone and everything...I don't want the horse to stop...I just want to keep running...

The veld looks pretty...brown grass, but still pretty...I can love the horse very much...I wonder what is going through the horses mind.

- *What do you think?*

I don't know, but I wonder if he can sense my love? I think he can when he slowly blinks his eyes,..but I don't really know...I touched a horse for the first time on Saturday...now cats aren't my favourite anymore...but horses are a lot of work...you can't lock them up because then they look angry.

- *What are you experiencing now?*

Nothing...empty and alone.

My body feels relaxed.

- *Good. When you are ready I would like you to please open your eyes slowly and when you're ready to return to the chair.*

3.3.4 Second imagery session

In the second session it was decided to use Shorr's procedure of asking the patient to imagine a flower, and then to describe it. Next, the patient is asked to imagine a bird approaching the flower, and then, to describe it. How does the flower react? How does the flower feel about the approaching bird? Then the client imagines how the bird feels while approaching the flower and describes the bird's reaction (Nucho: 1995: 118). Shorr mentions that this exercise relates to feelings of inadequacy and sexual fears which then may be discussed directly in a talking type treatment (Shorr, 1972).

The following is a detailed account of the second session of imagery:

- **Relaxation exercise**

- *I would like you to please see the image of a flower and then to describe it.*

I don't know...it has a thin stem...a soft flower...smells nice...there are many of them...they grow easily...and die easily...it's a soft flower and if you touch it it will break...dainty...orange flower...

If I think of this flower it reminds me of my Mother because she planted it ...I feel like a child...how I felt at that time...happy...I just wanted to play...I wish I could still be there and change everything.

- *Please imagine a bird approaching the flower and describe it.*

Nice, colourful bird...long beak...very beautiful bird...small...precious...it makes me think of Xian (ex-boyfriend)...I feel sad about yesterday because his mom phoned me saying that I must stop calling him...then Xian came to the phone and said he will call me later. I don't know what his mom has against me...I just want to be his friend...it makes me angry and sad because I care for him...we were together for quite a while and shared a lot...I don't want to lose him. I think you should call him...it feels as if I can pull my stitches out (attempted suicide) what does she have against me.

- *Where do you feel this hurt?*

I feel it in my heart...it feels like a knife...ten knives stabbing into my heart. I just want to cry...we fought a lot and she thinks it's all my fault, but there are two sides...he played just as big a part. Now I'm shivering ten times worse.

- *Stay with that feeling. Don't fight it.*

I don't want to. I want to relax.

I stood by Xian's side when his father passed away and now he's not allowed to support me...he makes me feel good.

My stomach hurts...a sharp pain...I get it a lot when I'm angry.

- *Tell me when there's any change in the sensation or if it subsides.*

It's gone now. I feel relaxed.

- *How does the flower react to the bird approaching?*

He can't sit on the flower as the stem is too weak so he must keep flying to get to the nectar...he can't sit.

- *How does the flower feel?*

It feels okay...it feels the bird can take some nectar, but not all of it...it feels good to give the bird nectar...good to share...

- *How does the bird feel?*

It's a loving bird...but doesn't worry how the bird feels it just wants the nectar...but it won't hurt the flower deliberately.

- *How does the bird react towards the flower?*

Normally...he wants to sit and will get tired because he has to fly the whole time...it's uncomfortable for the little flower and the bird.

It makes me think of me and uncle Marius...he wants to tell me to do this and that...and then I crack because I cut my wrists...the flower feels as if the bird won't go away...it's he's starting to bother the flower. I want to take the bird away from the flower.

- *How do you feel that you can't take the bird away?*

I won't accept it...I want to take the bird away from the flower if he's bothering it...I feel irritated on behalf of the flower.

- *Stay with that feeling.*

It reminds me of the guy who used to fiddle with me at night.

- *Where do you feel this sensation?*

In my stomach again...

- *Stay with the feeling. Don't fight it. Tell me if the sensation changes.*

It doesn't feel good...I just want to get up...

- *It's very important to live through the sensation however difficult it may be. Tell me when it subsides or changes in any way.*

LONG PAUSE

Okay, I feel more relaxed now.

3.3.5 Third imagery session

During this session the patient was asked to bring the image of her mother's face to the fore and to describe it in detail. The reason she was asked to bring this image to the fore is because of the mother-child conflict. Being a projective technique it would also give the researcher a good indication of the patient's feelings towards the self. She was then asked to touch her mother's hand and to describe what she experienced using all her senses as well as what emotions this evoked in her. She was then asked to allow her mother's hands to enfold her and to then describe this experience in detail.

- **Relaxation exercise**

Today I feel nothing.

- *How does that feel?*

Upset...I don't want to know anything.

- *Where is it that you feel upset?*

My heart and head...not nice..I don't want to feel like this...I want to be myself. I want to live with Uncle Marius and them, but it's not going to work out even if I try really hard...I just want to cry...it doesn't feel nice.

- *Are you experiencing any physical sensation?*

No...

- *I want you to please see an image of your mother's face and describe what you are experiencing.*

I feel happy and sad...my mother's smile makes me feel better...good memories, but mostly bad...I miss her...I want to go back to her...I feel a pain in my heart.

- *Describe that feeling please.*

It's an empty feeling...I feel alone.

- *Stay with the feeling.*

I love her and I'm angry with her...I feel happy and sad...I don't want to stay with this feeling.

- *It's important to stay with the feeling. Let me know when it changes in any way please.*

LONG PAUSE

I feel calmer now...yet I'm lying here and shaking.

Due to the limited scope of this research paper, only a brief summary of sessions 4 and 5 will be provided.

3.3.6 Summary of imagery session four

- Kay saw herself as a child with her mother at a young age. She was happy until her mother became interested in other men and her father become interested in alcohol.
- The outcome of this session is for the patient to love, accept and nurture the child-that-you-were.
- The patient plays the role of the good parent.
- Towards the end of the session, Kay no longer responded in the child, but rather in the adult state.

3.3.7 Summary of imagery session five

- Kay described very vivid images in peaceful settings with much detail.
- Kay was unable to give her inner guide a name.

- The figure she described was comforting and nurturing, yet she found it difficult to verbally communicate with it.

3.3.8 Evaluation of proceedings

- Kay complied with the requirements of the therapist the majority of the time.
- At the beginning of our second session she was a little oppositional, however after having performed the relaxation exercises she participated enthusiastically. Thereafter she eagerly anticipated each session.
- After our five sessions of imagery had been completed she informed the therapist that she has learned so much about herself on a much deeper level than 'talking-type' therapy has ever provided her.
- According to Kay, the imagery sessions made her realise that she wants to form a bond with her mother again and that she must accept others as they are.
- She realised that she must make a mind-shift and take control of her life.
- She wants to be loved, but first and foremost she must love herself.
- She says she no longer takes what others' say so personally and she says she realises that she is ultimately in control of her own life.

3.4 CASE STUDY II

3.4.1 Biographical background of patient

Name: Tracey (Name has been changed for reason of confidentiality)

Date of Birth: 20/03/1986

Age: 15 years 6 months

Gender: Female

Race: Caucasian

Grade: 10

3.4.2 Diagnosis according to the DSM IV

Axis I: Major Depressive Disorder

Axis II: None

Axis III: None

Axis IV: Psychosocial problems; Stressors: Mother-child relationship; father-child relationship; poor social support system

Axis V: 51 – 60

3.4.3 First Imagery Session

The researcher has used the same imagery prompts with both case studies. Please refer to imagery session one of case study one.

- **Relaxation exercises**

- I would like you to please imagine a vase and then describe it to me in as much detail as you can.

It's round at the bottom and thins out and then flares out towards the top. It's light blue in colour and goes lighter towards the bottom. It fades into yellow and becomes

darker towards the top. I can see the stems of the flowers through the vase, but not through to the other side.

- What size is it?

It's about 30/40 centimeters long and the base is about 20/25 centimeters.

- When you run your fingers over it what does it feel like?

It feels smooth, yet it has a few scratches and chips in it, but the colours are smooth.

- What do you experience looking at this vase?

I want to escape...I imagine it being peaceful and being away from everything.

- What other sensations are you experiencing?

The scent of the flowers is not very strong...a weak scent of yellow flowers.

- Where is this vase?

It is in my room.

- What do you experience emotionally looking at this vase?

I feel at peace.

- Are you experiencing any physical sensation?

I feel a little tingling sensation in my feet and my legs.

- I would like you to please stay with the feeling and tell me if the sensation changes in any way or moves to another part of your body.

It becomes irritating...and then it goes away.

- How is it irritating?

It's like it's obstructing me...it's supposed to feel nice, but it irritates me. I don't want to feel anything in my body.

- How is it that you feel that way?

I'm not sure, but I want to be more in touch with the anti-material world...more in touch with myself...what's inside of me...emotionally not physically.

- What are you experiencing emotionally?

Nothing.

- Please would you move the vase somewhere.

It's in my grandparent's house now...in the dining room. I love it there. We have Christmas Eve dinner there and the vase is there.

- What are you experiencing now?

It looks happier there.

- Has anything changed as you look at the vase now?

The scratches and chips don't bother me anymore.

- I would like you to do something with the vase please.

I put fresh flowers in it...they're yellow and some white ones too. I changed the water and cleaned it out.

- What are you experiencing physically?

Nothing.

- What are you experiencing emotionally?

I am feeling happier.

- Where do you feel happy?

In their house...it's nice there...sunny...positive atmosphere.

- Where do you feel this happiness physically?

In my soul.

3.4.4 Second Imagery Session

The researcher has used the same imagery technique with both case studies. Please refer to imagery session two of case study one.

• Relaxation exercise

- I would like you to form an image of a flower and to describe it to me in as much detail as possible.

It's a yellow daisy. I can see it opening up. The petals are long and sleek...very pretty.

- What do you experience looking at the flower?

It's as if I don't have to think about anything else except the life of this flower.

- How do you feel?

...it's nice

- What else are you experiencing?

Everything's quiet...it's like there's nothing, but this flower...

- What are you experiencing emotionally?

I feel at peace.

- What physical sensations are you experiencing?

My arms feel strained and my head feels heavy.

- Please stay with this feeling. Don't fight it. Tell me what happens to the sensation.

It's shifting to my right side...it feels like the floor's going to fall in on the right side and it's going to turn at 360 degrees.

- Stay with the feeling and tell me if you experience any change.

It's now moving to the left side.

- What is happening to the feeling?

It's subsided and the floor seems stable now.

- Are you certain?

Yes.

- Whilst looking at the flower you see a bird approaching. Please describe this bird to me in as much detail as possible.

It's a small little bird and it's just flying around. It reminds me of innocence. Then it sits on the ground across from me and looks at the flower.

- How does the flower feel with regards to the bird?

Tense at first, but when it sees the bird just sitting there it thinks it's okay and that the bird doesn't intend to attack it.

- How does the bird feel approaching the flower?

I don't know. I can't connect to something that innocent.

- How does the bird react around the flower?

It's as if he sees the same things that I see and he just wants to sit and look at the flower. It's as if he can escape in the life of the flower.

- What does the bird see?

The same as me.

- What do you see?

It looks the same as before...it seems to be dying...getting older.

- How does it make you feel?

I don't want to see it die. I want to look away and find another flower.

- What emotions are you experiencing?

I feel as if I'm sinking away from this need to escape...I'm losing interest in it. I'm concentrating on my life.

- How do you feel emotionally?

Frustrated.

- Stay with the feeling please and tell me what happens to it.

It's still there, but it feels like I should control it now. I can take the feeling of frustration away and see the flower like I did before. I know it's not really dying...it's just in my mind.

- Are you okay with that feeling?

Ja.

- What are you currently experiencing physically?

My shoulders are tense.

- Please remain with the feeling and describe to me what happens to it. Does it intensify, subside, or move to another place in your body?

It's moving up to my neck.

- Just stay with it please. Don't fight it.

My head feels very heavy.

- Focus on that feeling please.

LONG PAUSE

- What are you experiencing now?

I keep getting twitches in my body. It did intensify, but it's becoming less now.

- Please stay with the feeling and tell me what happens.

They just come and go.

- Tell me when they've subsided please.

LONG PAUSE

Ja, they have gone now.

- When you're ready please open your eyes and take your time to return to the chair.

3.4.5 Third imagery session

The researcher has used the same imagery prompts with both case studies. Please refer to imagery session three of case study one.

Relaxation Exercise

- I would like you to see an image of your mother's face and tell me what you experience.

She has this mole above her top lip on the left. Her lips are always thin and tight. She looks angry. I can't look into her eyes because she's angry with me. I feel guilty.

- Are you experiencing any physical sensation at the moment?

My chin feels like it's shaking.

- Please stay with the feeling.

It's not going away.

- Don't fight it.

PAUSE

It seems to have subsided.

- What do you feel guilty of?

I'm not sure. I don't know. She just makes me feel guilty. Like last night I had a fight with her on the phone. I said to her "You want to know why I have such a low self-esteem? This is why." Then she says she's sorry that she's such a shit person. Then I feel guilty...like I'm not the daughter she wanted.

- What emotions are you feeling?

I don't know how to describe it...almost longing. I want to be close to her.

- Are you experiencing any physical sensation?

I feel tense in my neck and shoulders

- Stay with the feeling and tell me what happens please.

My head feels heavy now. My neck is feeling really uncomfortable. It's like...tense.

- Please focus on that and let me know if you experience any change in the sensation

PAUSE

It's gone now.

- I would like you to please touch your mother's hand and tell me what you experience.
Her hands are soft, but it's like she's holding back. Like...if our souls were speaking, I'd be begging her to speak to me, but she's holding back.
- How does that make you feel?

I feel angry with myself and lonely. My arm feels warm. The one that I took her hand with. My right arm.

- Do you still have that warm sensation?

No.

- I would like you to please allow your mother's hands to enfold you and tell me what it is you experience.

I want to cry.

- Stay with that feeling. Cry if you want to cry.

PAUSE

- What do her hands feel like around you?

Soft and warm.

PAUSE

- How do you feel there enfolded in her arms?

I feel strange...a bit confused and in a way I don't really want her to hold me. I don't feel like I deserve it.

STILL CRYING

- Is there any particular reason why you feel this way?

No.

- Are you experiencing anything physical at the moment?

My head feels heavy.

- Stay with the feeling and tell me what happens to it.

It seems to be subsiding again.

- What else are you experiencing?

It's not real. I kind of feel angry now.

- You're allowed to feel angry.

I'm not sure who I am angry at. Maybe my dad and step-dad for hurting her. Angry at me for hurting her, but also angry at her for hurting me.

- Where do you feel this anger?

It's like a flame...heat in my body. Especially in my chest

- Please stay with that sensation.

PAUSE

I just feel like breaking something and then hiding away.

- What do you hope to gain from doing that?

Just release.

- What is it that you would like to break?

A glass or a plate...something that will make a big noise.

- I would like you to do exactly that. Find that object and do with it what you want.

PAUSE

- What are you experiencing at the moment?

I feel satisfied. There seems to be a particular spot on the back right side of my head that feels sore. I think I'm going to get a headache.

- Please stay with that feeling. Don't fight it.

It doesn't want to go away.

- Just stay with the feeling.

It is still not going away. (CRYING) It reminds me of the time my mom hit me on the head. I had three or four bruises on my head. She told me that she hates me. I know I did the wrong thing, but it still hurts. Afterwards she said she didn't mean it, but I don't think I would do that to anyone. Maybe she does hate me.

LONG PAUSE

- How are you feeling?

I feel like I want to get away from my mom and step-dad.

PAUSE

- What are you experiencing now?

Nothing.

Due to the limited scope of this research paper, only a brief summary of sessions 4 and 5 will be provided.

3.4.6 Summary of imagery session four

- Tracey saw herself as a young child of four, content in her mother's company. Thereafter, she remembered feeling rejected when her mother met her second husband.
- The outcome of this session is for the patient to love, accept and nurture the child-that-you-were.
- The patient plays the role of the good parent.
- Tracey too no longer responded in the child, but rather in the adult state.

3.4.7 Summary of imagery session five

- Tracey had very vivid images in peaceful settings with much detail.
- Tracey was unable to name their inner guides.
- The figure was comforting and nurturing, yet she found it difficult to verbally communicate with it.

3.4.8 Evaluation of proceedings

- Tracey was co-operative during the imagery sessions and indicated a willingness to work with the therapist.
- She mentioned that the imagery sessions were a strange, yet very relaxing experience.
- She enjoyed the fact that she could be creative in therapy and use her imagination.
- According to Tracey the therapy made her reflect afterwards on why she disclosed what she did in each session.

She also said that it made her think about herself and her issues on a much deeper level than 'talking-type' therapy. As she mentioned, she gets tired of talking at times

3.4.9 Experience of the imagery sessions

- The method appeared to facilitate the generation of vivid images for both patients.
- Both patients experienced the powerful intensity and realness of the images and the ability of the imagery process to take them quickly into deep emotional exploration.
- In both cases some physiological reaction at some time during the imagery sessions was reported.
- Each adolescent also mentioned that not having to communicate on an intellectual/analytical level as in verbal therapy was an advantage as it allowed him or her to be creative and to “feel” more.
- Both subjects also stated that they were able to see issues in a new light and more clearly.
- More alternatives with regards to their respective concerns became available too.
- The experience of the imagery promoted affective release or expression for both participants, as well as facilitating the recovery of old concerns or memories.
- Both subjects claimed that they became aware of how they operated in their world which in turn made their own needs known, that is to love themselves.
- The images were perceived by both patients as being representative of events and relationships at some time in their lives, either directly (the same/similar image) or indirectly (the “feeling” was the same).
- Both subjects claimed that changes in their lives, for instance feeling more in control, and feeling more self-confident coincided with the time of the imagery sessions.

3.5 Re-implementation of measuring instrument

The re-implementation of the measuring instrument will occur on two occasions. Firstly, on completion of the sessions with the patient, the Beck Depression Inventory will again be implemented. The results will be compared with those that were obtained previously in order to establish if there were any noticeable changes in the depressive symptoms of the patient.

Secondly, it will be implemented to measure the level of depression a month-and-a-half after the imagery sessions in order to assess the long-term effectiveness of imagery.

Please refer to chapter four for results.

3.6 Gathering, interpretation and discussion of final results

The data is gathered, interpreted and analysed. Please refer to chapter four where this information will be discussed.

Chapter 4

Findings, conclusions and recommendations

4.1 INTRODUCTION

As mentioned in chapter one, the aim of the study was twofold, namely

- (1) To examine the appropriate literature to gain a better understanding of imagery as a therapeutic technique.
- (2) To establish the extent to which imagery will contribute toward treating major depressive disorder in adolescents under psychiatric supervision.

This chapter concludes the study and will present the findings as follows:

- Findings from the literature study
- Findings from the empirical study

The following will also be addressed:

- Conclusions
- Recommendations
- Shortcomings of this research

4.2 FINDINGS FROM THE LITERATURE STUDY

4.2.1 Imagery

Research findings show that imagery has a number of general characteristics that contribute to its effectiveness in therapy. These are as follows:

- Imagery carries intense affective charges and evokes emotional reactions with associated psychophysiological changes.
- Images and emotions contribute to the meaning of words, providing detailed information, especially of past occurrences and preverbal memories. Words, however, tend to become abstract.
- Imagery spans the continuum between the unconscious and the conscious and is thus effective in presenting patients problematic areas and uncovering repressed material and defenses.
- Images also have a futuristic dimension as motivators to action, as well as a predictive dimension presenting ideas and actions that manifest themselves only later in verbal cognition and behaviour.
- In therapy, free imagery and guided imagery produce therapeutic changes without the mediating action of interpretation.

The human body is referred to as a system with feedback loops regulating its course. Images are likened to these natural feedback devices that contain data in the right brain modality of thought. As the right cerebral hemisphere mediates affect, imagery arouses intense emotions in the subject. Mention is made that disorganisation of the right hemisphere may result in depression. Research indicates that if there is a relationship reciprocal inhibition between the cerebral hemispheres, right brain imagery may decrease the rate at which norepinephrine (NE) and dopamine (DA) metabolites are utilised in the left brain and thus reduce the probability of depression.

As mentioned, researchers claim that an image consists of three components, namely an awareness, which may be conscious or unconscious; a physiological component; and a cognitive component where meaning arises spontaneously. Thus, an image is referred to as “API” phenomena.

Strongly charged emotions may be accessed through images by elaborating on the sensations associated with these images. This emotional discharge helps to reconnect the sensory, emotional and imaginal levels.

4.2.2 Depression

Depression is referred to as a negative affective state, which is experienced universally. Feelings of despondency, despair, disinterest, boredom, and attitudes of remorse, regret, self-blame, hopelessness, and helplessness characterise this phenomena.

The biopsychosocial model is extensively used in the diagnosis and treatment of numerous psychiatric disorders.

There are a number of specific symptoms of depression, namely aggressiveness, withdrawal, wanting to leave home, sulking, sensitivity to rejection, inability to concentrate, and substance abuse. Depressed mood, loss of interest in usual activities and anxiety are the most common symptoms of depressive disorder. This is followed by disturbances in sleep, decrease in appetite, decrease in energy and inability to concentrate. Guilt feelings, suicidal ideations and psychotic symptoms may appear in severe depression.

A number of cognitive factors may also contribute to depressive symptoms in adolescents. These are as follows:

- There is a strong correlation between depressive symptoms and external locus of control.

- Low self-esteem is associated with clinical depression
- Adolescents often anticipate negative outcomes of events. This is referred to as cognitive distortion.
- Depressed adolescents may attribute undesirable events to internal, stable and global causes, thus they experience a feeling of helplessness.
- Studies have also shown relations between life stressors and changes in life events and depression.

A number of conventional methods used in treating major depressive disorder include:

- Pharmacological intervention
- Psychological approaches which include cognitive-behavioural therapy; psychodynamic therapy; family therapy; and interpersonal therapy.

According to research, psychopharmacological treatments do not represent the first treatment of choice for adolescents with depression. Psychosocial treatments with clinically depressed adolescents, too, have shown limited efficacy.

In-patient treatment of depression, specifically, includes a clinical assessment as well as a treatment plan. The stringent evaluation involves a multidisciplinary approach, namely:

- Medical assessment
- Investigations
- Nursing assessment
- Psychological assessment
- Psychosocial assessment
- Educational assessment
- Occupational therapy assessment

The goal of the treatment plan is to ensure that, on discharge, the depressed adolescent is of no immediate danger to himself or to others. The following are included in the treatment plan:

- Milieu therapy
- Individual psychotherapy
- Group psychotherapy
- Pharmacotherapy
- Family therapy

It is important that the therapist be flexible in his/her approach and that the treatment plan meets the needs of the individual.

4.3 FINDINGS FROM THE EMPIRICAL RESEARCH

4.3.1 The Beck Depression Inventory (BDI)

The BDI (Annexure 1) served as the diagnostic tool to identify patients suffering from depression as well as the level of severity of the depression. The findings of the Beck depression inventory were confirmed by an intensive initial assessment by the multidisciplinary team.

4.3.2 Selection of case studies

A number of depressed adolescent in-patients as well as their respective caretakers were approached with regards to the patients undergoing imagery. Unfortunately, a number of patients were discharged and did not follow-up as outpatients, and a number of parents were un-cooperative and non-committal in this regard. The initial plan of using four patients did not, therefore, materialise.

4.3.3 Findings before and after imagery sessions

The respective scores for each patient has been calculated and recorded in table 1 and table 2. The results in tables 1 and 2 represent the total score indicating the level of depression of each patient. The scores before the imagery sessions are given and compared to the scores after the imagery sessions had taken place.

TABLE 1: Patient's level of depression before and after imagery (Case study 1)

LEVELS OF DEPRESSION	These ups and downs are considered normal	Mild mood disturbance	Borderline clinical depression	Moderate depression	Severe depression	Extreme depression
	01 - 10	11 - 16	17 - 20	21 - 30	31 - 40	Over 40
Before Imagery						45
After Imagery				27		

There is a significant decrease in the total depression scores for the patient (case study one). Before imagery the patient's score indicated that she was extremely depressed. The scores after the imagery sessions indicate that her level of depression has now decreased to a moderate level.

TABLE 2: Patient's level of depression before and after imagery (Case study 2)

LEVELS OF DEPRESSION	These ups and downs are considered normal	Mild mood disturbance	Borderline clinical depression	Moderate depression	Severe depression	Extreme depression
	01 - 10	11 - 16	17 - 20	21 - 30	31 - 40	Over 40
Before Imagery						42
After Imagery	10					

The overall level of depression of the patient has decreased remarkably. Before the imagery sessions, the patient's score indicated an extreme level of depression. After the imagery sessions the patient's score indicated that she was now experiencing normal ups and downs.

The Beck Depression Inventory consists of 93 statements that have been grouped into 21 categories for research purposes (Annexure 1). The patient's score for each category is recorded before as well as after the imagery sessions (Table 3 and Table 4).

TABLE 3: Patient's scores for each category in order to determine level of depression before and after the imagery sessions (Case study 1)

CATEGORIES		SCORES			
		0	1	2	3
1 Sadness	Before				3
	After		1		
2 Pessimism	Before				3
	After	0			
3 Sense of failure	Before				3
	After		1		
4 Dissatisfaction	Before			2	
	After		1		
5 Guilt	Before			2	
	After		1		
6 Sense of punishment	Before				3
	After				3
7 Self-dislike	Before				3
	After	0			
8 Self-accusations	Before	0			
	After		1		
9 Suicidal ideation	Before				3
	After		1		
10 Crying spells	Before				3
	After				3

11 Irritability	Before				3
	After		1		
12 Social withdrawal	Before			2	
	After		1		
13 Indecision	Before				3
	After		1		
14 Distorted body image	Before			2	
	After	0			
15 Work inhibition	Before			2	
	After		1		
16 Sleep disturbance	Before			2	
	After			2	
17 Tendency to become fatigued	Before				3
	After			2	
18 Loss of appetite	Before		1		
	After		1		
19 Weight loss	Before		1		
	After		1		
20 Somatic preoccupations	Before	0			
	After		1		
21 Loss of libido	Before				3
	After			2	

TABLE 4: Patient's scores for each category in order to determine level of depression before and after the imagery sessions (Case study 2)

CATEGORIES		SCORES			
		0	1	2	3
1 Sadness	Before				3
	After	0			
2 Pessimism	Before				3
	After	0			
3 Sense of failure	Before				3
	After		1		
4 Dissatisfaction	Before	0			
	After	0			
5 Guilt	Before				3
	After			2	
6 Sense of punishment	Before				3
	After		1		
7 Self-dislike	Before				3
	After		1		
8 Self-accusations	Before				3
	After		1		
9 Suicidal ideation	Before				3
	After	0			
10 Crying spells	Before		1		
	After		1		
11 Irritability	Before		1		
	After		1		

12 Social withdrawal	Before	0			
	After	0			
13 Indecision	Before				3
	After	0			
14 Distorted body image	Before				3
	After		1		
15 Work inhibition	Before			2	
	After	0			
16 Sleep disturbance	Before			2	
	After	0			
17 Tendency to become fatigued	Before		1		
	After	0			
18 Loss of appetite	Before			2	
	After	0			
19 Weight loss	Before	0			
	After	0			
20 Somatic preoccupations	Before	0			
	After	0			
21 Loss of libido	Before				3
	After	0			

The maximum score for each category is a score of 3. This indicates possible depressive symptoms. The lowest score is a score of 0. The majority of both patients' scores lie in the 3-point range indicating definite depressive symptoms. After the imagery sessions both patients' scores were more concentrated around the 0-point and 1-point range indicating a reduction of depressive symptoms.

The researcher proceeded to implement the BDI a month-and-a-half after the imagery sessions to determine the long-term effectiveness of the technique. Unfortunately, for the purposes of this paper, the researcher was unable to implement the BDI after a longer

period, which would have provided us with a better indication of the success of the imagery techniques. The results are as follows:

TABLE 5: Patients' scores after implementing the BDI a month-and-a-half after cessation of imagery sessions

CATEGORIES		SCORES			
		0	1	2	3
1 Sadness	Case 1		1		
	Case 2		1		
2 Pessimism	Case 1	0			
	Case 2	0			
3 Sense of failure	Case 1	0			
	Case 2		1		
4 Dissatisfaction	Case 1	0			
	Case 2	0			
5 Guilt	Case 1		1		
	Case 2			2	
6 Sense of punishment	Case 1		1		
	Case 2				3
7 Self-dislike	Case 1	0			
	Case 2	0			
8 Self-accusations	Case 1		1		
	Case 2		1		
9 Suicidal ideation	Case 1		1		
	Case 2	0			

10 Crying spells	Case 1	0			
	Case 2	0			
11 Irritability	Case 1	0			
	Case 2	0			
12 Social withdrawal	Case 1	0			
	Case 2	0			
13 Indecision	Case 1	0			
	Case 2	0			
14 Distorted body image	Case 1				3
	Case 2		1		
15 Work inhibition	Case 1		1		
	Case 2	0			
16 Sleep disturbance	Case 1		1		
	Case 2	0			
17 Tendency to become fatigued	Case 1		1		
	Case 2	0			
18 Loss of appetite	Case 1	0			
	Case 2	0			
19 Weight loss	Case 1		1		
	Case 2	0			
20 Somatic preoccupations	Case 1	0			
	Case 2	0			
21 Loss of libido	Case 1				3
	Case 2	0			

TABLE 6: Patients' total scores, indicating their levels of depression, after implementing the BDI a month-and-a-half after cessation of imagery sessions

LEVELS OF DEPRESSION	These ups and downs are considered normal	Mild mood disturbance	Borderline clinical depression	Moderate depression	Severe depression	Extreme depression
	01 - 10	11 - 16	17 - 20	21 - 30	31 - 40	Over 40
Case Study 1		15				
Case Study 2	9					

These scores indicate the long-term effectiveness of imagery as a technique in treating depressed adolescents. They also indicate the progressive and spontaneous healing that occurs even after the imagery sessions have been terminated.

4.4 RECOMMENDATIONS

As is evident from the research, the depressive syndrome can manifest at various levels simultaneously, namely social, psychological and biological.

From the research the following recommendations could be considered:

- Psychologists/therapists should consider imagery as another therapeutic technique in treating adolescents presenting with major depressive disorder.

- The function of the psychologist/therapist in imagery is not to provide a script for the imagery of the client, but to teach the client how to devise his/her own images spontaneously.
- The therapist must diagnose the need of the patient accurately and must be flexible in his/her approach so as to provide effectively for the specific client's needs.
- Guided imagery appears to be specifically effective when deep exploration of an issue is desired.
- Imagery may be used in therapy to reveal the patients' attitudes, strengths, and conflicts.
- It also appears to be valuable in enabling the patient to contact, explore and express his/her inner experiences in a creative manner, yet being in a supportive, trusting therapeutic relationship.
- There is ample evidence that imagery in its various forms is an effective, cost-efficient means of improving social and emotional functioning of patients coping with every possible health predicament.
- Medical practitioners should make room for other approaches such as imagery techniques.

As Shorr (1983:221-222) says, "...imagery can have a tremendous impact upon your life and upon those persons you are dealing with. It can arouse emotions; it can affect your health; it can produce changes in your environment- both physical and social...Let imagery free your activity. As you learn to be more creative in your imagery, you can develop deeper understanding of your feelings and your life. Utilising your imagery expands your horizons. You are starting an endless process of fulfilling your potential."

4.5 SHORTCOMINGS

As every human attempt in any situation reveals certain shortcomings, this study is no exception. The following are some of the shortcomings noticed by the researcher:

- A shortcoming of this study was the use of only two case studies. It is therefore not possible to make any generalisations. There are definite indications that imagery could be an effective therapeutic technique to treat depression in adolescents, but this will have to be further researched. A greater number of adolescent in-patients suffering from major depressive disorder should be selected. These patients should undergo imagery sessions and the results will be more meaningful and reliable.
- The decrease in the level of depression need not necessarily have been as a result of the imagery sessions alone. Other interacting variables could have played a role. The researcher could have used a control group and the results of the case studies could have been compared with that of the control group.
- The Beck Depression Inventory used to identify the patients' level of depression is an effective diagnostic tool, however; perhaps another such diagnostic instrument should be used in addition to this.

4.6 FINAL CONCLUSIONS

The limited scope of this research paper does not give any conclusive evidence in order for generalisations to be made concerning the effectiveness of imagery techniques in the treatment of depression.

However, considering the findings of the respective case studies, it does appear that with these particular adolescent in-patients imagery techniques were efficient in treating their depressive symptoms.

Hopefully, this will lead to further research in imagery as a technique in the treatment of depressed adolescents under psychiatric supervision.

BIBLIOGRAPHY

- Asarnow, J.R., Jaycox, L.H. & Thompson, M.C. 2001. 'Depression in Youth: Psychological Interventions', *Journal of Clinical Child Psychology*, 30 (1): 33-47
- Brooks-Gunn, J. and Petersen, A.C. 1991. 'Studying the Emergence of Depression and Depressive Symptoms during Adolescence', *Journal of Youth and Adolescence*, 20 (2): 115-119
- Corey, G. 1997. *Theory and Practice of Counseling and Psychotherapy*. 5th ed. California: Brooks/Cole Publishing Company
- Enns, C. Z. 2001. 'Some Reflections on Imagery and Psychotherapy Implications', *Journal of Counseling Psychology*, 48 (2):136-139
- Farr, C. 1990. 'A Study of the Guided Imagery Process: Awareness and the Discovery of Personal Meaning', *Canadian Journal of Counseling*, 24 (1):45-52
- Fezler, W. 1990. *Imagery for Healing, Knowledge, and Power*. New York: Simon and Schuster Inc.
- Finn, C.A. 2000. 'Treating Adolescent Depression: A Review of Intervention Approaches', *International Journal of Adolescence and Youth*, 8 (4): 253-269
- Fredericks, C.R. 1998. Hypnotherapy: A Technique in Building Positive Self-Esteem. MEd dissertation. University of South Africa, Pretoria.
- Gold, S.R., Jarvinen, P.J. & Teague, R.G. 1982. 'Imagery Elaboration and Clarity in Modifying College Students', *Depression. Journal of Clinical Psychology*, 38 (2): 312-314
- Hammond, W.A. and Romney, D.M. 1995. 'Cognitive Factors Contributing to Adolescent Depression', *Journal of Youth and Adolescence*, 24 (6): 667-683
- Ingersoll, B.D. and Goldstein, S. 1995. *Lonely, Sad and Angry: A Parent's Guide to Depression in Children and Adolescents*. New York: Doubleday.
- Jackson, S.W. 1990. 'The Imagination and Psychological Healing', *Journal of the History of the Behavioural Sciences*, 26 (4): 345-358
- Kaplan, H.I. and Sadock, B.J. 1998. *Synopsis of Psychiatry: Behavioral Sciences/Clinical Psychiatry*. 8th ed. Maryland: Williams & Wilkins

- Kirkcaldy, B. and Siefen, G. 1998. 'Depression, Anxiety and Self-Image among Children and Adolescents', *School Psychology International*, 19 (2): 135-149
- Klosinski, G. 1992. 'Stones and Other "Transitional Objects" as Mediators in Psychotherapeutic Dialogue', *ACTA Paedopsychiatrica: International Journal of Child and Adolescent*, 55 (4): 225-230
- Lazarus, A. 1984. *In the Mind's Eye: The Power of Imagery for Personal Enrichment*. New York: The Guilford Press.
- Leuner, H., Horn, G. & Klessmann, E. 1983. *Guided Affective Imagery with Children and Adolescents*. New York: Plenum Press.
- Locke, S. and Colligan, D. 1987. *The Healer Within: The New Medicine of Mind and Body*. New York: Mentor Books
- Lusebrink, V. B. 1990. *Imagery and Visual Expression in Therapy*. New York: Plenum Press.
- Miller, E.E. 1986. *Self-Imagery: Creating Your Own Good Health*. California: Celestial Arts
- Nucho, A.O. 1995. *Spontaneous Creative Imagery: Problem-Solving and Life-Enhancing Skills*. Illinois: Charles C Thomas.
- Pinto, A. and Francis, G. 1993. 'Cognitive Correlates of Depressive Symptoms in Hospitalised Adolescents', *Adolescence*, 28 (111): 661-672.
- Ramsey, M. 1994. 'Student Depression: General Treatment Dynamics and Symptom Specific Interventions', *The School Counselor*, 41 (4):256-262
- Richardson, J.T.E. 1999. *Imagery*. UK: Psychology Press Ltd.
- Rojcewics, S.J. 1990. 'Body Image Changes During Guided Affective Imagery', *The Humanistic Psychologist*, 18 (3): 270-278
- Sacco, G. and Ruggieri, V. 1997-98. 'Mental Imagery and Symptom Patterns', *Imagination, Cognition and Personality*, 17 (4): 313-321
- Sands, T. 1998. 'Feminist Counseling and Female Adolescents: Treatment and Strategies for Depression', *Journal of Mental Health Counseling*, 20 (1): 42-54
- Shafii, M. and Shaffi, S. L. 1992. *Clinical Guide to Depression in Children and Adolescents*. Washington, DC: American Psychiatric Press, Inc.

- Sheikh, A.A. 1984. *Imagination and Healing: Imagery and Human Development Series*. New York: Baywood Publishing Company, Inc.
- Shorr, J.E. 1983. *Go see the movie in your head-Imagery: The Key to Awareness*. Santa Barbara, CA: Ross-Erikson Publishers, Inc.
- Stanard, R.P. 2000. Assessment and Treatment of Adolescent Depression and Suicidality. *Journal of Mental Health Counseling* 22 (3):204-217
- Swimmer, S. 1996. Adolescent Suicide and Depression: A sign of our Times. *UNISA Psychologia* 23 (2):12-16
- Waterman, G.S. and Ryan, N.D. 1993. Pharmacological Treatment of Depression and Anxiety in Children and Adolescents. *School Psychology Review* 22 (2):228-242
- Witztum, E. et al. 1988. The Use of Metaphors in Psychotherapy. *Journal of Contemporary Psychotherapy* 18 (4):270-290