Counselling Psychology Quarterly, Vol. 14, No. 2, 2001, pp. 95–101

THEORY AND PRACTICE

Usefulness of emotive imagery in the treatment of childhood phobias: clinical guidelines, case examples and issues

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ABSTRACT *Emotive imagery is a variant of systematic desensitization that has been developed for use in the treatment of children's excessive fears. We outline clinical guidelines for the use of emotive imagery and present several case examples. Although emotive imagery appears to be useful and cost efficient, controlled studies are needed to establish the efficacy of emotive imagery and explore the active treatment ingredients or mechanism.*

Introduction

The excessive fears or phobias of children and adolescents are problematic because of their persistence, maladaptiveness and magnitude (Graziano *et al.*, 1979; King *et al.*, 1988; Silverman and Rabian, 1994). Common examples of childhood phobias include excessive fear reactions to school, animals, darkness and medical/dental procedures. Phobias can be conceptualized in terms of three components: cognitive, physiological, and overt behavioural. King *et al.* (1988) have documented the variety of cognitive responses (e.g., thoughts of being scared, self-deprecatory thoughts), physiological responses (e.g., increased heart rate, changes in respiration) and overt-behavioural responses (e.g., rigid posture, thumbsucking, avoidance) that may occur in the fearful or phobic child. Severe phobic reactions frequently manifest themselves in all three response systems (Silverman and Rabian, 1994).

Children's phobias have a complex etiology (Ollendick, 1979; King *et al.*, 1988). From the viewpoint of conditioning theory, Watson and Rayner's (1920) early laboratory demonstration with 'Little Albert' has provided dramatic testimony to the power of

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Counselling Psychology Quarterly ISSN 0951–5070 print/ISSN 1469–3674 online
http://www.tandf.co.uk/journals
DOI: 10.1080/0951507001110037966

traumatic experience in phobia acquisition. However, it should be noted that replication of this work has not always been successful. Further, conditioning theory has come under criticism on several additional grounds as a comprehensive account of children's phobias (see King *et al.*, 1988; Davey, 1992). Quite simply, traumatic experience is not always reported as a factor in the etiology of the child's phobia reaction. Thus, Rachman (1977) proposed that there are three distinct, though frequently overlapping pathways to the acquisition of fears and phobias: direct conditioning (e.g., child being attacked by a dog), modelling (e.g., child observing fearful night-time behaviour of older siblings), and instruction/information (e.g., child hearing stories and jokes about dentists) (cf. Molloy, 1984).

Despite their complex nature and etiology, childhood phobias have been successfully treated using various behavioural interventions (King and Ollendick, 1997). This review focuses on emotive imagery, a popular behavioural fear reduction procedure that is often used in the management of childhood phobias. We show that emotive imagery is a variant of systematic desensitization and outline clinical guidelines of the use of emotive imagery. The present study puts forward several case examples in order to show the potential usefulness and cost-efficiency of emotive imagery.

Systematic desensitization and its variants

Probably the most frequently used phobia reduction procedure with adults is systematic desensitization (Wolpe, 1958). A number of carefully prescribed steps are to be followed for the successful use of systematic desensitization. Essentially, the individual is trained in a response antagonistic to anxiety (typically progressive relaxation), and then required to imagine a series of anxiety-provoking scenes while deeply relaxed. Real-life exposures to the fear-evoking stimuli are frequently involved for optimal densensitization. Although systematic desensitization has been widely used with adults, difficulties have been encountered in applying this procedure to children (King *et al.*, 1988). For example, training in relaxation can be demanding and tedious for children.

Many variants of systematic desensitization have been applied in clinical practice to children. In her now classic case study, Jones (1924) successfully deconditioned the fear response of a young boy, Peter. The clever use of real-life exposures in conjunction with feeding overcame Peter's fear of a rabbit which had generalized to other animals and objects. Tasto (1969) tried systematic desensitization, with muscle relaxation as the anxiety inhibitor, to treat a 4-year-old child's fear of sudden loud noises. The child moved through the anxiety hierarchy without difficulties. However, when subsequently tested *in vivo* his fear had not diminished. Thereafter, real-life desensitization was embarked upon with good results. Jackson and King (1982) used a hierarchical series of real-life exposures to help an autistic child overcome his phobia of toilet flushing. Using mirth and laughter to compete with anxiety and a simple reinforcer for appropriate use of the toilet, the programme was effective and the gains were maintained at 3 month and 6 month follow-ups. In these case illustrations a preference for real-life exposures and anxiety inhibitors other than relaxation is evident on the part of the therapist.

Pioneered by Lazarus and Abramovitz (1962), another variant of systematic desensitization is emotive imagery. In their now classic paper, Lazarus and Abramovitz point

out that emotive imagery refers to 'those classes of imagery which are assumed to arouse feelings of self-assertion, pride, affection, mirth, and similar anxiety-inhibiting responses' (1962, p. 191). The basic idea is to incorporate these images into an engaging story to evoke a strong positive affect in the child. As in systematic desensitization, anxiety-provoking items are introduced in a gradual manner by the therapist. Consistent with Wolpe's (1958) principle of reciprocal inhibition, the positive emotional feelings are expected to counteract any anxiety elicited by the feared stimuli. Sometimes known as 'story form' desensitization, emotive imagery has been used in the treatment of many different types of childhood phobias including school phobia, animal phobia and darkness phobia (Jackson and King, 1981; Chudy *et al.*, 1983; Blagg and Yule, 1987; King *et al.*, 1989).

Guidelines for emotive imagery

The procedure involved in emotive imagery is outlined by Lazarus and Abramovitz (1962) as follows:

1. As in the usual method of systematic desensitization, the range, intensity, and circumstances of the child's fears are ascertained, and a graduated hierarchy is drawn up, from the most feared to the least feared situation.
2. By sympathetic conversation and enquiry, the clinician establishes the nature of the child's hero-images — usually derived from radio, cinema, fiction, or imagination — and the wish-fulfilments and identifications which accompany them.
3. The child is then asked to close his or her eyes and told to imagine a sequence of events which is close enough to his everyday life to be credible, but within which is woven a story concerning his favourite hero or *alter ego*.
4. If this is done with reasonable skill and empathy, it is possible to arouse to the necessary pitch the child's affective reactions.
5. When the clinician judges that these emotions have been maximally aroused, he introduces, as a natural part of the narrative, the lowest item in the hierarchy. Immediately afterwards he says: 'If you feel afraid [or unhappy, or uncomfortable] just raise your finger.' If anxiety is indicated, the phobic stimulus is 'withdrawn' from the narrative and the child's anxiety-inhibiting emotions are again aroused. The procedure is then repeated as in ordinary systematic desensitization, until the highest item in the hierarchy is tolerated without distress (pp. 191–192).

In addition to the above guidelines on emotive imagery, Rosenstiel and Scott (1977) provide several procedural recommendations on the use of imagery techniques with children:

1. Imagery scenes should be tailored to the age of the child. There is some evidence that between 6 and 8 years children can begin to utilize complex images to alter their behaviour. Although 4-year-olds can use simple images when directed by others, no lower age limit has been established. Leaving aside the arbitrariness of the cut-off age, some attempt should be made to adjust the complexity of the imagery according to the age of the child.

2. Treatment should incorporate children's fantasies and cognitions. Children have an active and psychologically important fantasy life, incorporating imaginary playmates, superheroes, and so on. Tapping children's naturally occurring imagery as the basis for therapeutic techniques may be advantageous in a number of ways. The use of existent thoughts and fantasies is likely to increase the familiarity with the scenes, as well as heighten the child's overall interest in the treatment.
3. Non-verbal cues supply important information about the treatment process. Given that children have difficulty in describing emotional arousal during the imagery based treatments, the therapist should be alert to the non-verbal cues as a means of gauging the child's progress. Non-verbal cues include flushing of the skin, alterations in breathing patterns, changes in facial expression, increased body movements and muscular tension, and crying.

Case examples

The following example of emotive imagery was reported by Lazarus and Abramovitz (1962) in the treatment of a 14-year-old boy who experienced school attendance difficulties due to an intense fear of dogs. After much questioning, the therapist ascertained that the boy had fantasies of racing motor cars. In fact, he had a burning ambition to own a certain Alpha Romeo sports car and race it in the Indianapolis 500. Emotive imagery was induced as follows:

> Close your eyes. I want you to imagine, clearly and vividly, that your wish has come true. The Alfa Romeo is now in your possession. It is your car. It is standing in the street outside your house. You are looking at it now. Notice the beautiful sleek lines. You decide to go for a drive with some friends of yours. You sit down at the wheel, and you feel a thrill of pride as you realize that you own this magnificent machine. You start up and listen to the wonderful roar of the exhaust. You let the clutch in and the car streak off. You are out in a clear open road now; the car is performing like a pedigree; the speedometer is climbing into the nineties; you have a wonderful feeling of being in perfect control; you look at trees whizzing by and you see a little dog standing next to one of them . . . An item fairly high up on the hierarchy was: 'You stop at a cafe in a little town, and dozens of people crowd around to look enviously at this magnificent car and its lucky owner, you swell with pride; and at this moment a large boxer comes up and sniffs at your heels'. (Lazarus and Abramaovitz, 1962, p. 192).

After three sessions using this method the child reported a marked improvement in his reaction to dogs. He was given a few field assignments involving real-life exposure to dogs during the next two sessions, after which therapy was terminated. Twelve months later, reports both from the boy and his relatives indicated that there was no longer any trace of his former phobia. In the same report, Lazarus and Abramovitz (1962) applied emotive imagery to eight other phobic children aged between 7 and 14 years. In all, seven children were treated successfully. The method failed with one child who refused to co-operate and who later revealed widespread areas of disturbance, which required broader

therapeutic handling. The other failure was a phobic child with a history of encephalitis. He was unable to concentrate on the imagery and could not enter into the spirit of the 'game'.

Jackson and King (1981) employed emotive imagery in the treatment of a 5-year-old boy with a phobia of darkness. He was also afraid of noises and shadows associated with the night, which caused many sleepness nights for the child and family. According to the boys parents, the phobia seemed to have been caused by a frightening incident involving a prowler breaking into the house. Having determined that the child was fond of the comic character Batman, the therapists created a fear hierarchy and then asked the child to imagine that 'he and Batman had joined forces and that he was appointed a special agent'. Next he was asked to close his eyes and to imagine the fear-producing stimuli in a graduated fashion, while accompanied by Batman. The following transcript illustrates the build-up of the imagery and the introduction of anxiety-provoking items. The child's active involvement in the treatment is also evident:

Therapist: Close your eyes — now I want you to imagine that you are sitting in the lounge room watching TV with your family. You're dressed for bed and the last programme before bedtime has finished. Your mother tells you it's time for bed but just then Batman, who you really wish you knew, appears out of nowhere and sits down next to you. Think about it as best you can. Can you see Batman in your head?

Child: Yes.

Therapist: Can you tell me what Batman's wearing? What colour are his clothes?

Child: He's got black and red clothes and big shoes and a gun.

Therapist: Oh, you can see him with a gun?

Child: Yeah he needs it for the Joker.

Therapist: That's terrific M. Now I want you to imagine that Batman tells you he needs you on his mission to catch robbers and other bad people and he's appointed you as his special agent. However, he needs you to get your sleep in your bedroom and he will call on you when he needs you. You're lucky to have been chosen to help him.

Child: Yes.

Therapist: Now your mother puts you in your bed and leaves both the lights on and leaves the three blinds up. Batman is also there looking as strong as he always does. Think about it as clearly as you can. Can you see it?

Child: Yes. I can see mummy and Batman in my room and all the lights are on.

(Jackson and King, 1982, p. 327).

After only four sessions of emotive imagery, the child showed marked clinical improvements. In this case, muscular relaxation had been attempted and was unsuccessful, leading the therapists to use the child's favourite character as the fear-inhibiting agent. However, exposure was an integral part of the emotive imagery treatment with the child

being encouraged to sleep through the night in his own room. A flashlight was also provided to enhance treatment effects and develop appropriate coping skills. An 18-month follow-up showed that therapy gains had been maintained.

Clinical and research issues

The case examples suggest that childhood phobias may be successfully treated via emotive imagery in a few sessions. However, far more clinical research needs to be undertaken before we can claim that emotive imagery has strong scientific support. Recently, Cornwall *et al.* (1996) conducted a randomized clinical trial on the efficacy of emotive imagery with children experiencing severe darkness phobia. Relative to waiting list controls, emotive imagery produced significant clinical improvements on various self-report measures and behavioural indices of darkness phobia. Although these results are encouraging, further controlled studies are urgently required on the efficacy of emotive imagery. Furthermore, more is needed to be known about the mechanism(s) of behaviour change. As shown in our case illustrations, real-life exposure usually plays a pivotal role in the use of emotive imagery. Consequently, emotive imagery alone may not be sufficient to overcome childhood phobias. Along with other clinicians and researchers (Cornwall *et al.*, 1996), the authors advise therapists to supplement emotive imagery with real-life exposure tasks in the natural setting to ensure complete phobia reduction.

Conclusions

Behavioural treatment procedures such as systematic desensitization are used in the management of both adult and childhood phobias In its traditional form, however, systematic densensitization is developmentally unsuitable for use with children. In particular, training in relaxation can be fairly demanding and tedious for children. Pioneered by Lazarus and Abramaovitz (1962), emotive imagery has emerged as an age-appropriate variant of systematic desensitization. Case examples attest to the usefulness and cost-efficiency of emotive imagery provided exposure is an integral part of treatment. More controlled research needs to be undertaken on the efficacy of emotive imagery.

References

Blagg, N. (1987) *School phobia and its management*. London: Croom Helm.

Chudy, J.F., Jones, G.E. & Dickson, A.L. (1983) Modified desensitization approach for the treatment of phobic behaviour in children: a quasi-experimental case study. *Journal of Clinical Child Psychology, 12,* 198–201.

Cornwall, E., Spence, S.H. & Schotte, D. (1996) The effectiveness of emotive imagery in the treatment of darkness phobia in children. *Behaviour Change, 13,* 223–233.

Davey, G.C.L. (1992) Classical conditioning and the acquisition of human fears and phobias: a review and synthesis of the literature. *Advances in Behaviour Research and Therapy, 14*, 29–66.

Graziano, A.M., DeGiovanni, I.S. & Garcia, K.A. (1979) Behavioral treatment of children's fears: a review. *Psychological Bulletin, 86*, 804–830.

JACKSON, H.J. & KING, N.J. (1981) The emotive imagery treatment of a child's trauma-induced phobia. *Journal of Behavior Therapy and Experimental Psychiatry, 12*, 325–328.

JACKSON, H.J. & KING, N.J. (1982) The therapeutic management of an autistic child's phobia using laughter as the anxiety inhibitor. *Behavioural Psychotherapy, 10*, 364–369.

JONES, M.C. (1924) A laboratory study of fear: the case of Peter. *Journal of Genetic Psychology, 31*, 308-315.

KING, N.J. & OLLENDICK, T.H. (1997) Annotation. Treatment of childhood phobias. *Journal of Child Psychology and Psychiatry, 38*, 389–400.

KING, N.J., CRANSTOUN, F. & JOSEPHS, A. (1989) Emotive imagery and children's nighttime fears: a multiple baseline design evaluation. *Journal of Behavior Therapy and Experimental Psychiatry, 20*, 125–135.

KING, N.J., HAMILTON, D.I. & OLLENDICK, T.H. (1988) *Children's phobias: a behavioural perspective*. Chichester: Wiley.

LAZARUS, A.A. & ABRAMOVITZ, A. (1962) The use of 'emotive imagery' in the treatment of children's phobias. *Journal of Mental Science, 108*, 191–195.

MOLLOY, G.N. (1984) A five-factor framework for conceptualizing human behaviour change: old wine in newly arranged casks. *Behaviour Change, 1*, 18–24.

OLLENDICK, T.H. (1979) Fear reduction techniques with children. In M. HERSEN, R.M. EISLER, & P.M. MILLER (eds), *Progress in behavior modification*, vol. 8. New York: Academic Press.

RACHMAN, S. (1977) The conditioning theory of fear acquisition: a critical examination. *Behaviour Research and Therapy, 15*, 375–387.

ROSENSTIEL, A.K. & SCOTT, D.S. (1977) Four considerations in using imagery techniques with children. *Journal of Behavior Therapy and Experimental Psychiatry, 8*, 287–290.

SILVERMAN, W.K. & RABIAN, B. (1994). Specific phobia. In T.H. OLLENDICK, N.J. KING, & W. YULE (eds), *International handbook of phobic and anxiety disorders in children and adolescents* (pp. 87–109). New York: Plenum Press.

TASTO, D.L. (1969) Systematic desensitization, muscle relaxation and visual imagery in the counter-conditioning of a four-year-old phobic boy. *Behaviour Research and Therapy, 7*, 409–411.

WATSON, J.B. & RAYNER, R. (1920) Conditioned emotional reactions. *Journal of Experimental Psychology, 3*, 1–14.

WOLPE, J. (1958) *Psychotherapy by reciprocal inhibition*. Stanford, CA: Stanford University Press.