Imagery Rescripting in Posttraumatic Stress Disorder

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This article provides an overview of methods of working with imagery to change meanings and ameliorate posttraumatic stress disorder (PTSD). It opens with a description of phenomenology in this disorder, usually characterized by a small number of recurrent images of the trauma, each representing a moment that warned of a threat to the physical or psychological integrity of the client. These intrusions are vivid, distressing, sensory fragments, which appear to signal current threat. Theoretical models of maintenance of PTSD are discussed, highlighting the importance of imagery as a target in therapy. Assessment and possible spontaneous cognitive change is then outlined, followed by an account of methods of prompting for additional shifts in meanings associated with the “hot spots” in memory. These include methods of updating the memories by incorporating corrective information, and also identifying and expressing trauma-related emotions. Finally, there is a description of methods of working with childhood memories that have colored the experience of adult trauma.

Imagery rescripting is broadly defined in this article as a collection of methods for working directly with imagery in order to change meanings and ameliorate distress. Imagery interventions have long been part of cognitive behavior therapy (CBT) and indeed of psychotherapy in general (Edwards, 2007). The earliest recorded form of imagery rescripting is attributed to Pierre Janet (1889; described in L’Automatisme psychologique), who used a form of imagery substitution, replacing one image with another. In more recent research, there has been a surge of interest on the topic, including a special issue on imagery rescripting across disorders in the Journal of Behavior Therapy and Experimental Psychiatry (edited by Holmes, Arntz, & Smucker, 2007).

This article considers phenomenology in posttraumatic stress disorder (PTSD) and discusses theoretical models that indicate what maintains the problem and why imagery may be a good target and an effective vehicle for change. The main body of the article offers an account of how imagery rescripting can be used in various ways to bring about emotional processing.

Phenomenology in PTSD

PTSD is defined in DSM-IV as a disorder in which the person has “experienced, witnessed or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of the self or others.” The response involves “intense fear, helplessness or horror” (American Psychiatric Association, 2000). The three clusters of symptoms include reexperiencing symptoms; avoidance of potential triggers for reexperiencing; and hyperarousal, including hypervigilance or startle responses to trauma reminders. Thus, the definition points strongly to the role of memory for a traumatic event (or events) in this disorder.

Memory in PTSD has two distinctive features: there is involuntary retrieval of intrusive (negative, unwanted) segments of memory from the trauma and its sequelae. Deliberate retrieval of the memory may also be confused, disorganized, and/or incomplete (Ehlers & Clark, 2000).

Several studies (e.g., Ehlers et al., 2002; Ehlers & Steil, 1995; Grey, Holmes, & Brewin, 2001; Hackmann, Ehlers, Speckens, & Clark, 2004; Speckens, Ehlers, Hackmann, Ruths, & Clark, 2007; van der Kolk & Fisler, 1995) have investigated the nature of spontaneously triggered intrusive memories in PTSD. Key findings include:

- Most intrusive memories involve sensory imagery, visual material being most common, followed by bodily sensations, sounds, tastes and smells, in descending order.
- Most patients with single-event trauma have only a small number of recurrent intrusive memories.
- Intrusive images tend to be of moments that are “warning signals” of the onset or worsening of the trauma.
- The intrusions map closely onto what are later revealed as the “hot spots” in the memory (i.e., moments filled with the worst meanings and the greatest emotional impact).
- When the imagery is triggered, it is often felt as something happening now—it is experienced
without the normal “time-code.” At its most extreme level, the client experiences a full dissociative flashback, where all awareness of present reality is lost and the trauma is fully reexperienced.

- Intrusions often carry the meaning they had at the time of the event (e.g., “I am going to die, and I will never see my children again”). Such thinking has little or no connection with the individual’s factual knowledge that these outcomes did not occur.

- Not all the images are veridical: some are of imagined events, recalled as happening at the time of the traumatic event or at a subsequent moment.

- Some images are composite, with input from a number of memories.

- Nightmares in PTSD may be replicative (i.e., the material is identical to that in the memory of the trauma) or they may be thematically linked.

On closer inspection, the content of intrusive memory is equally interesting. The most distressing parts of the trauma (often reflected in intrusions and hot spots) include the expected reactions of fear, helplessness, or horror, but other emotions such as guilt, anger, and shame are also prominent (Grey & Holmes, 2008; Holmes, Grey, & Young, 2005). In addition, particular personal significance may be attributed to the moment, often on the basis of the client’s previous experience, assumptions, or beliefs (e.g., “This is happening to me because I deserve it”; “I am weak to be responding like this, how typical of me”; or “This is happening because I attract bad luck”). It is clear from the content of intrusive imagery that a traumatic event may cause not only a threat to the physical integrity of the body, but also to the person’s sense of self (Stopa, 2009).

Intrusive memory images are sometimes given idiosyncratic significance in the present. For example, there may be metacognitive appraisals, such as, “This image of the car crash is a premonition that I will be involved in another accident”; “The image is a portal to the other world: I will travel back in time, experience the same trauma, and this time I shall die”; or “The image is a warning that I can expect further punishments for being bad.”

Clinically it has been observed that strenuous efforts are often made to avoid triggers for the intrusions, or, if they are triggered, clients use suppression, distraction, or other safety behaviors to deal with them. Rumination may also ensue, frequently triggering more intrusive images (Speckens et al., 2007).

**Emotional Processing**

In 1980, Rachman wrote about emotional processing, a concept that has subsequently been addressed by many others. Rachman provided a pragmatic definition of the desired outcome by suggesting that successful emotional processing can be gauged by the person’s ability to talk about, see, listen to, or be reminded of the emotional events without experiencing distress or disruption (Rachman, 1980, p. 51). This is clearly our objective when treating PTSD. Rachman returned to the topic in 2001, extending the model by including a discussion of cognitive influences on emotional processing, with particular reference to the treatment of PTSD.

He focuses on the model suggested by Ehlers and Clark (2000). This in turn draws upon the work of many other theorists (Brewin, Dalgleish, & Joseph, 1996; Foa & Rothbaum, 1998; Janoff-Bulman, 1992; Joseph, Williams, & Yule, 1997; Resick & Schnicke, 1993; van der Kolk & Fisler, 1995, among others) and is intended to provide a new synthesis and framework for CBT. It also draws on the theoretical framework concerning general autobiographical memory with applications to PTSD, advanced by Conway and Pleydell-Pearce (2000). These authors have observed that PTSD memories are not well integrated with other long-term autobiographical knowledge. Instead, they are easily triggered because they threatened the person’s sense of self. In order to become less intrusive, these memories need to be integrated with other, more positive memories, rather than being avoided and hence remaining distorted and threatening in their content (Conway, Meares, & Standart, 2004).

Ehlers and Clark’s (2000) model suggests that PTSD becomes persistent when individuals process the trauma in a way that leads to a sense of serious, current threat. Such an emotion is thought to arise as a consequence of excessively negative (i.e., distorted) appraisals of the trauma and/or its consequences, and a disturbance of autobiographical memory, characterized by poor elaboration and contextualization of memories (and strong associative memory and perceptual priming). This means that intrusive memories carry distorted meanings, do not connect with other knowledge the person has, and are easily triggered. Three treatment targets are suggested:

- The trauma memories need to be elaborated and integrated into the wider context of preceding and subsequent experience, rather than persisting as distressing fragments that do not connect with anything else.

- Problematic appraisals of the trauma and/or its consequences need to be modified. It is noted that previous experience and beliefs may have played an important role in coloring such appraisals, and need attention in their own right.

- Dysfunctional strategies that maintain the problem (e.g., suppression, avoidance, and rumination), need to be relinquished.

As Ehlers and Clark point out, a wide range of techniques have been used to bring about change in
these three areas (see, for example, Foa & Rothbaum, 1998; Joseph et al., 1997; Resick & Schnicke, 1993). This present article focuses on techniques using imagery rescripting to achieve these ends, in memories formed as an adult or in childhood. However, imaginal exposure (or reliving) is often introduced as a precursor to rescripting imagery, as an aid to bringing as much of the memory as possible to consciousness, in order to investigate associated affect and meanings that have been given to the event. Of course imaginal exposure has been used extensively and effectively in the treatment of PTSD (particularly in treatment trials by Foa’s group), and in itself can bring about cognitive change (see Foa, Molnar, & Cashman, 1995; Jaycox, 1998). Foa coined the term “reliving.” Here we describe the way in which reliving is presented and utilized in (some) imagery rescripting sessions, largely as a method of assessing meanings and associated affect in the hot spots.

Socialization and Assessment

Before imagery rescripting can be undertaken in a CBT framework, a period of assessment takes place. First, the client is asked to give a brief journalistic account of the traumatic event (or events). A discussion follows on the nature of trauma memories and on what strategies the client uses to cope with reexperiencing symptoms. Typically, clients speak of how easily the intrusive memories can be triggered, and how they attempt to use distraction, suppression, or avoidance of possible triggers. Clients describe how they ruminate and dwell on other memories/knowledge. As a memory loses its upsetting meanings, it is less likely to intrude inappropriately in the client’s mind.

The assessment proceeds with the therapist inviting the client to elaborate further on the trauma memory. Often, but not always (see section below on precautions), it is suggested that the client relive the traumatic memory, with their eyes closed, speaking in the first person, present tense, with as much detail as possible concerning all the sensory and emotional aspects of the experience and the thoughts that are passing through the mind as events unfold. The main purpose of reliving at this stage is to unpack the distressing meanings given to the event, and to subsequent intrusions. This can be a distressing experience, and plenty of time is required for the client to access and relive the memory, reflect on the contents, and then be gently regrounded in the present (see next section). For some clients it may be preferable for them to do this with their eyes open, particularly if they have trust issues or if the affect is overwhelming.

Precautions When Reliving Memories

It is important to note that even an initial reliving session may not always be part of the protocol when carrying out imagery rescripting. It may be avoided in cases where there has been multiple trauma, or where there is some substantial ongoing threat, or when the affect threatens to be totally overwhelming. In such cases a good relationship is even more important than usual, and other forms of treatment and social support may be utilized.

If any reliving is introduced it is essential to ensure in advance that there will be enough time for the client to approach the material, and then reflect and recover before the end of the session, or the resumption of normal activities. If the client is thought to be vulnerable to dissociation, grounding techniques can be taught—for example, opening their eyes and being asked to describe features of the room; playing favorite music; lighting a scented candle, or engaging in any other pleasant or neutral activity which brings them back into the present. This can be used, if required, after reliving in order to ground the client in the present.

In treatment for adverse childhood memories, Arntz, Tiesma, and Kindt (2007) recommend that, in some cases, reliving be used only up to the point when the client realizes that something terrible is about to happen: rescripting commences from then on. In a similar vein, Krakow and colleagues (for example, Krakow & Zadra, 2006) no longer recommend imaginal reliving of
distressing nightmares, but suggest that clients simply start by rescripting new, more preferable dreams in imagery, which are then repetitively practiced. It is an empirical question for further research whether and when reliving all or part of a traumatic memory or nightmare, at least once, before attempting any rescripting, adds or subtracts value to the client's treatment.

**Spontaneous Cognitive Change as a Result of Evoking Imagery**

One great benefit of going through the reliving process (if this is possible) in one or more sessions is that it provides an opportunity for some spontaneous cognitive restructuring to occur. As the memory is brought more fully into consciousness, the following changes might occur:

- The client begins to put an appropriate “time-code” on the memory, seeing that it is not happening in the present.
- The client starts to appreciate that the image is only input from memory, not a warning of future danger, and so forth.
- A more coherent narrative may emerge, gaps may be filled in, and the worst moments may begin to be connected with the rescue and/or coping that came later and softened the impact.
- The client may appraise his or her own behavior or that of others on the basis of the fuller information that emerges. This can lead to a reduction of guilt, self-blame, or anger.
- The client may realize that avoidance is not as important as was assumed, if the affect is less than they imagined, or begins to decrease.

For further discussion on the nature of cognitive changes following reliving, see Foa, Molnar, and Cashman (1995), Jaycox (1998), and Butler, Fennell, and Hackmann (2008).

**Unpacking the Meaning of “Hot Spots”**

When treating PTSD in a cognitive therapy framework, meaning is considered to be of central importance. After discussing or reliving the whole memory, the client and therapist may reflect on the hot spots in the trauma memory (i.e., those where the affect was greatest; Holmes et al., 2005). These hot spots become the focus of subsequent treatment. As described earlier, hot spots are the moments of greatest emotional impact, when the meaning of the event changed, usually for the worse (Ehlers et al., 2002). Janoff-Bulman (1992) has suggested that traumatic events may shatter a person’s positive assumptions and beliefs, or strengthen negative ones. Several possible categories of images follow:

- At the simplest level, the client’s images are memory images of shocking moments, depicting the state of

there is a substantial range of possible images along the lines of those exemplified. A great variety of emotions are attached to the imagery: fear, helplessness, horror, sadness, guilt, anger, and/or shame. The content can encapsulate meanings about the self, the world, other people, the past, and/or the future.
Introducing Corrective Information Into the Meanings of Distressing Adult Memories in PTSD

Once the process described above—of reliving the memory, identifying the hot spots, and considering their meanings and their metacognitive significance—is complete, the task of prompting for further cognitive change can begin. The goal is to introduce new information that helps the client to view the material in a less toxic, more realistic way. The new information is often arrived at using guided discovery, and may subsequently be useful in a process called “cognitive restructuring of hot spots within reliving” (Grey, Young, & Holmes, 2002). To begin, the client relives the hot spot with eyes closed. When the client reaches a distorted appraisal, the therapist asks, “And what do you know about that now?” The client supplies information from the new perspective arrived at by guided discovery.

If this process does not result in an adequate shift in affect or beliefs, other imagery techniques may be introduced to give a more vivid representation of the wider perspective. The idea here is to bring in information, often obtained through guided discovery in one or more earlier sessions, which updates the meaning that the person gave the event at the time. The distorted appraisal is placed in the wider context of the client’s previous and subsequent experience. Some examples are given below.

Correcting a Distorted Image

During an actual trauma, clients may imagine a worst-case scenario about to take place, although this does not occur. Here the image needs to be replaced by an image closer to what actually happened. A client involved in the London bombings imagined all the stairways collapsing after an explosion, so that she could not get out of the building. She replaced this with a realistic image of the stairways not collapsing, so she could in fact escape when help arrived. Another client had an image of ending up in a wheelchair as the result of a car crash. This was updated by asking him to remember having that image, then guiding him to “run the memory on” until he experienced images of receiving the good news at the hospital that his injuries were not critical.

Seeing Events From Another Perspective

A client who was involved in a car crash saw two nurses walk straight past her car instead of asking if they could help. She appraised this as meaning that no one cared about her anymore and that she was just as alone as she had been as a child. In reality, only moments after the nurses walked past, several other people who had heard the crash ran straight up to help her. Logic told her that these other people had not neglected her, but the emotional sense of neglect persisted. The distorted appraisal was challenged by asking the client to view the scene from the perspective of a bird in the sky. At once she visualized both the off-duty nurses walking by, and the helpful others who did come to her aid. This shifted her affect and the false belief that nobody cared.

The Survivor Self Travels Back Through Time to Reassure the Traumatized Self

A client had a persistent intrusion of a near-death experience that occurred to her after a serious accident. From an out-of-body perspective, she could see her badly injured body, and had the sense that she was dying. She imagined traveling back in time and being present to reassure her traumatized self that she was not going to die: further, she would not lose her arm or her eye as she had feared after the accident. The client told her younger self that she would be there to support her, even if her parents were not.

The Survivor Self Travels Back to Explain to Others What the Traumatized Self Is Experiencing

A client had a serious car accident during which his legs were badly injured. When the ambulance arrived he phoned his wife to ask her to meet him at the hospital, reassuring her that he was fine. In truth, he was terrified that his legs would have to be amputated. As he had married just recently, it would be a disaster. In imagery, he chose to travel back into the past to reassure his injured self that he would not lose his legs, and to explain to his wife how afraid he had been about becoming disabled. He was able to explain to his wife how this fear had arisen; not long before a friend’s father had lost a leg in a car crash that happened very much like his own.

The Client Curtails the Sense of Interminable Suffering by Imagining Being the Victim and Moving Beyond the Point of Death or Serious Injury

Sometimes, examining a hot spot involving a dead person reveals that the client is distressed by the sense that the deceased is still somehow stuck and suffering inside their dead body. It can be helpful to imagine moving the person on. An elderly client, Jane, had been traveling across London by Underground, when suddenly her train was bombed. Uninjured herself, she had comforted a number of people who had been hurt. She also saw a man who had died in her carriage. The horror of this incident was softened by Jane imagining actually being the dead man and having a “near-death experience” during which his soul left his body, went down a tunnel, and came out into the light.

Another client had witnessed someone being blown to pieces in an explosion and needed to imagine that the body parts had all been magically joined back together again before the person was buried.
In each of these cases, the client’s distress arose as a result of the sense that the dead person was somehow “stuck” in their dead or shattered body. Upon corrective imagining, both clients could experience the sense that the dead were now at rest. Neither client believed at a rational level that dead people continue to suffer, but the intrusive image conveyed that emotional meaning before the imagery rescripting took place.

**Dialogues With Dead People**

If consistent with the client’s wishes and beliefs, it may be helpful to explore events from a wider perspective by having a dialogue with someone who is no longer alive. A client’s father committed suicide and left a note for his daughter telling her where to find the body. When the client found the corpse, she was shocked to see that her father had hung himself. In this hot spot, the daughter had concluded that her father could not have loved her if he had left her to make this terrible discovery. However, following some Socratic questioning and guided discovery, a new perspective was explored. By imagining, from her father’s perspective, how much he had suffered during the last weeks of his life, the client realized that (although misguided) his father had meant to honor her rather than cause her a great shock. Her father had thought that his daughter was the only person who would be capable of dealing calmly with the suicide. In imagery, the client went on to explain to her father just what a blow this event had been to her as a young woman. She felt she experienced her father’s remorse about what had been forced on her.

**Reducing the Sense of Current Threat From a Past Abuser**

A client was troubled by recurrent intrusive images of her ex-husband breaking into her home and attacking her, as he had often done in the past. This was despite the fact that her ex-husband was serving a prison sentence, and that she had moved to an address unknown to him. In imagery she decided to make him smaller and smaller, to the point where he was no bigger than a mouse, and then to imagine that she swept him into a dustpan and threw him into the dustbin. Another client (whose abuser was actually dead) told him in imagery to go back into the past, and reminded him that he could not hurt her any more.

Imagining the perpetrator getting smaller, moving further away, or going back into the past can remove the sense that the abuser still represents a current threat to the client, even though they know this is not true.

**Imagining Actions the Client Regrets Not Taking, and Testing the Likely Outcome**

Often clients regret not acting differently at the time of the trauma. Verbal discussion usually suggests that this would not have been possible, or would probably not have worked out well. However, as we have seen before, the client remains unconvinced, ruminating about what might have happened if they had tried to act differently. In these situations, a thought experiment can be helpful. The client is asked to close their eyes and vividly imagine doing what they wish they had done, and experiencing for themselves how it would have worked out. For example, a client was a passenger in a car crash during which he (erroneously) thought that his wife had died. He had anticipated the crash, and thought he should have shouted out to warn the driver. He was tormented with guilt because he feared that his wife could easily have been killed, and he had not intervened to prevent the crash. Reliving the accident, and imagining that he did actually shout to warn the driver made it clear to him that this would have made no difference at all, as the driver would not have had time to take evasive action. The client continued with the image to the point where he realized that his wife was not seriously hurt. These changes in the imagery relieved his sense of guilt.

Such techniques for elaborating, contextualizing, and updating fragments of trauma memories have been used as part of a very effective range of strategies for treating PTSD in several recent research trials (Ehlers et al., 2003; Ehlers et al., 2005). The vividness and frequency of intrusive imagery diminish over time (Hackmann et al., 2004), along with decreases in nightmares and a corresponding increase in the quality of sleep (Hackmann, 2005a).

**Discovering and Expressing Any Trauma-Related Inhibited Emotional Responses, With Particular Reference to the Work of Smucker, Arntz, and Their Colleagues**

Overlapping to some extent with the variety of interventions described above are those that involve opportunities to discover and express any trauma-related inhibited emotional responses. This may be particularly important with clients who have experienced a sense of mental defeat, alienation, or permanent change in response to the trauma (Ehlers, Maercker, & Boos, 2000). Mental defeat is defined as “the perceived loss of all autonomy, a state of giving up in one’s own mind all effort to retain one’s identity as a human being with a will of one’s own” and predicts later PTSD status in adult assault victims” (Kleim, Ehlers, & Glucksman, 2007).

The techniques discussed below were originally developed to deal with traumatic childhood memories (Arntz & Weertman, 1999; Smucker, Dancu, Foa, & Niederee, 1995), as described in the next section. However, these techniques have also been used more recently to enhance treatment for survivors of adult trauma who meet DSM-IV criteria for PTSD. Arntz, Tiesma, and Kindt (2007) and Grunert, Weis, Smucker, and Christianson (2007)
hypothesized that this may not only alleviate PTSD symptoms, but also change trauma-related schemas and beliefs (e.g., the sense of powerlessness, victimization, or badness), despite the fact that there is less overt attention to changing meanings. The method involves changing the traumatic imagery to produce a more favorable outcome, without denying the reality of the original traumatic event. For example, clients are encouraged to experiment in imagery with gaining control over situations by expressing their needs and their feelings and imagining behaving in different ways.

In their study, Arntz et al. (2007) contrasted eight sessions of imaginal exposure (IE) with three sessions of IE plus five sessions of imagery rescripting (IE + IR). Their IE protocol was provided by Foa. In the IR sessions, the therapist worked with the client to discover if there were any reactions the client regretted not enacting. In subsequent sessions the clients were exposed to the most difficult moments, and asked to imagine reacting in the way that they wished they had done. Overall, these treatments were found to be equally effective, but there were fewer dropouts in the IE + IR group. In addition, the latter treatment also produced greater changes in anger control, externalization of anger, hostility, and guilt (but not shame). Therapists favored IE + IR because they felt less helpless themselves.

The study by Grunert et al. (2007) also produced interesting results. Imagery Reprocessing and Rescripting Therapy (IRRT) was originally developed for adult survivors of childhood sexual abuse (Smucker et al., 1995) and has been adapted for use with survivors of industrial accidents (Grunert, Smucker, & Weis, 2003). Grunert et al. (2007) described the rationale as being one in which traumatic images and associated beliefs are transformed and placed in a newly created associative framework that leads to the resolution of PTSD. IRRT was offered to 23 clients who had failed to respond after between 6 and 15 sessions of prolonged exposure treatment, without any symptomatic change or decrease in distress ratings during imaginal exposure. Grunert et al. (2007) describe the IRRT protocol, which involves reliving, developing adaptive positive imagery, and updating the trauma memory by inserting positive imagery after the original hot spots. The client imagines their survivor self arriving at the scene of the traumatic event and assisting the traumatized self in that past situation, in a variety of ways. These include gaining a sense of mastery and providing nurture to the traumatized self. Socratic questioning is used to help the trauma victim develop and imagine their own mastery, with coping, self-calming and self-soothing strategies. After as few as 1 to 3 sessions of IRRT, 18 of the 23 clients who had failed to respond to prolonged exposure no longer met diagnostic criteria for PTSD.

Making a Bridge to the Past

So far, only memories of adult trauma have been addressed. A complicating factor is described by Ehlers and Clark (2000): the way in which adult trauma is processed may sometimes be heavily colored by past experience. The adult trauma can be simply seen as yet another example of the way life has generally treated the person, reflecting their core beliefs. Where this is the case, distorted appraisals of the latest trauma can be hard to shift. One strategy is to investigate the possible origins of such strongly held beliefs, using the “emotional bridge” technique, borrowed from hypnotherapy literature (Watkins, 1971). The client is asked to evoke the troublesome hot spot, with all its sensory, emotional, and meaning qualities—and to reflect on the moment in the past when an experience reminiscent of the felt sense in the hot spot first occurred. Where schemas are involved, it is common for this inquiry to elicit one or more key memories from much earlier in the client’s life, carrying similar meanings. The therapist and client choose an early memory that most strongly encapsulates the schematic material and attempt imagery rescripting. They test the effects of the rescripting by taking ratings of beliefs associated with this early memory, and also belief ratings of meanings given to the adult trauma. A typical case of adult PTSD colored by childhood trauma using this technique is provided by Hackmann (2005b).

Rescripting Childhood Memories in Cases of PTSD

Smucker and colleagues pioneered the first systematic attempt to use imagery rescripting for adult survivors of childhood sexual abuse presenting with PTSD (for a protocol see Smucker & Niederee, 1995). In the first 4 sessions, imaginal exposure is used to capture all the content and pathogenic meanings of the abuse memories. This is followed in each of these sessions by mastery imagery, in which the client visualizes herself rescuing her child self, and driving out the perpetrator. On completion of the mastery imagery, the client is encouraged to develop imagery of her adult self nurturing the child. From Session 5 to Session 8 the imagery all centers on the adult self nurturing the child. This process can be lengthy, as the adult self may initially have a poor opinion of the child, even blaming her for the abuse. The therapist endeavours to assist the client by suggesting that she dialogues with the child to see how she is feeling, and/or moves closer to her, looking carefully at her facial expression, her small size, and pathetic appearance. The authors conclude by describing how this kind of imagery rescripting can help reduce abuse flashbacks, identify and modify trauma-related beliefs, and facilitate a shift in schematic representations of the self and others.

Arntz and Weertman (1999) describe their development of this protocol for the treatment of childhood
memories in adults more generally. There are three phases. First, there is a lively visualization of the original scene, as experienced by the child. The authors stress that there is no need for prolonged exposure, nor for exposure to the whole memory (initially at least) in severe cases. Second, the client is asked to imagine going back in time and to experience the scene as an adult bystander, with an awareness of what the child might be feeling, thinking, and inclined to do. The client moves on to imagine intervening. Often this involves the adult self gaining some mastery over the situation, such as calling the police or hitting the perpetrator. Finally, the scene is imagined again from the child’s perspective, viewing the adult self and their interventions, and asking for anything else the child may need from the intervening adult. This often involves the child requesting comfort, cuddling, or more nurture of some other kind.

This procedure differs from the Smucker protocol, in that the scene is ultimately viewed from the child’s own perspective, rather than the adult perspective. This results in high levels of affect with some different emotions, such as sadness, and its resolution coming into play. Viewing the rescripted events as the child may mean that the new information is fed more directly, and from the same developmental level, into the original schematic representations. As in Smucker’s protocol, there is emphasis on the possible “solutions” being offered by the client rather than the therapist. A number of different approaches may have to be tried by the client before any success or resolution is achieved. The therapist would only make suggestions if the client were stuck. The therapist may offer to play a supportive role in the imagery, in the absence of a kindly relative or friend who could be incorporated into the imagery in a helpful way.

A controlled trial was recently published (Weertman & Arntz, 2007) comparing 24 sessions of imagery rescripting of early memories with 24 sessions of more present-focused standard schema change work. The results showed a significant change in both groups, but with no difference in the magnitude of change. All clients had both treatments and expressed a preference for working on the early memories first, then moving into the present, rather than working in a reverse order.

**Summary**

Imagery rescripting attempts to replace a traumatic image with one that encapsulates a more realistic and/or less toxic appraisal of the significance of the original incident. The client moves to an appropriate sense of the imagery as part of something that happened in the past, without implications for the present. Using imagery can be more effective than verbal discussion when it comes to changing meanings and associated affect. This observation is supported by evidence from experimental work that changes in imagery are accompanied by larger affect shifts than changes in verbal thought (e.g., Holmes, Mathews, Dalgleish, & Mackintosh, 2006). New memories are formed of what might have happened; research suggests that imagining things makes the client feel it is more likely that they have actually occurred (e.g., Garry, Manning, Loftus & Sherman, 1996). In Brewin’s (2006) framework these new memories should potentially have a retrieval advantage in the presence of cues that previously triggered the old traumatic memories. Placing the content of old distressing fragments in the wider context of previous and subsequent knowledge could have the effect of decreasing their intrusiveness (Conway & Pleydell-Pearce, 2000; Ehlers & Clark, 2000).

It may seem strange to alter the previously imagined outcome when rescripting trauma memories, but modern learning theory suggests a way in which it may help. This theory postulates that what is learned first in a totally new situation forms the basis for a generalized rule, and that each subsequent experience is likely to be seen as an exception to the rule, rather than disproving it. Going back and working on their memories may help a client to realize that the original experience was so toxic and atypical that it is better seen as the exception to how life generally works, rather than as the basis for a general rule.

In this article, we have looked at a number of possible ways to use imagery rescripting in cases of PTSD. The outcome trials published so far indicate potential benefits, but many empirical questions remain to be answered. For example, we could look at how much reliving (if any) is required during imagery rescripting, in various diagnostic groups. We could also study the relative merits of verbal and imagery rescripting.

**References**


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