

Imagery Rescripting for Personality Disorders

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Imagery rescripting is a powerful technique that can be successfully applied in the treatment of personality disorders. For personality disorders, imagery rescripting is not used to address intrusive images but to change the implicational meaning of schemas and childhood experiences that underlie the patient's problems. Various mechanisms that may be involved in the application of the technique when applied in the treatment of personality disorders are discussed. Next, the empirical evidence for the effectiveness of the technique is discussed. Then four practical applications are presented: diagnostic imagery; imagery of a safe place; imagery rescripting of childhood events; and imagery rescripting of present and future events. The paper ends with a general conclusion.

ALTHOUGH in the last decades our view of personality disorders (PDs) as being untreatable has considerably changed, PDs are still considered to be a challenging group of disorders. The patient's reliance on specific survival strategies can be very difficult to break through, despite their dysfunctional character. These forms of "resistance" are nowadays better understood and several techniques have been developed to address them. But, without their usual survival strategies, people with PDs can feel completely lost and overwhelmed by despair, fear, or anger. Therapies aiming to help patients recover from their PDs must therefore also have techniques to address these underlying problems, often related to childhood maltreatment (e.g., Johnson, Cohen, Chen, Kasen, & Brooks, 2006; Lobbestael, Arntz, & Bernstein, 2010). Imagery rescripting (ImRS) is such a technique. In this paper the use of ImRS in the treatment of PDs is discussed. Readers should be aware that ImRS is not a complete treatment of PDs, but rather a technique, or a set of techniques that can be used as part of a comprehensive treatment of PDs. Data so far indicate that ImRS is an effective technique, but no study has yet proved that ImRS is particularly effective or necessary to produce essential changes at the characterological level.

Rationale of ImRS

Many people associate ImRS with the treatment of involuntary images, like the images that trouble people

with PTSD, nightmares, or OCD (Arntz, Tiesema, & Kindt, 2007; Grunert, Weis, Smucker, & Christianson, 2007; Kindt, Buck, Arntz, & Soeter, 2007; Rachman, 2007; Speckens, Hackmann, Ehlers, & Cuthbert, 2007). ImRS has also been successfully applied to patients with depression, eating disorders, or social phobia, but often only in the subgroup of patients that suffer from intrusions and/or traumatic experiences that are related to the disorder (Brewin et al., 2009; Wheatley et al., 2007; Wild, Hackmann, & Clatk, 2007). In contrast, most PD patients do not report intrusions, at least not as a major symptom, nor do they usually report concrete traumas as underlying their problems. In the treatment of PDs, ImRS is usually not used to address intrusions, but to change the meaning of experiences from childhood that have given rise to the schemas that underlie the PD. (With "schema" a construct is denoted that represents a theoretically assumed knowledge structure that guides information processing, including implicit and explicit meaning that is given to perceptual information.)

Early attempts to treat PDs with cognitive therapy primarily used techniques known from the treatment of depression and anxiety disorders (i.e., challenging cognitions and beliefs). Such techniques tended to focus on propositional aspects of schemas, which are aspects that can be formulated in logical terms (e.g., "If my heart beats fast and there is a pressure feeling on my chest, then the chances are high that a heart attack will occur"). But such techniques were found to be of limited value in the treatment of PDs. That is, patients might respond by saying that they see the flaw in the logic yet they still feel the same. The insight grew that techniques aiming at propositional knowledge changes were more suitable for specific Axis I disorders, and that other techniques, focusing on what is called the "implicational

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meaning level”—the kind of meaning that is not logically represented but that arises on a feeling level—were needed for the treatment of PDs (e.g., Arntz & Weertman, 1999; Edwards, 2007; Young, Klosko, & Weishaar, 2003). ImRS is one of the techniques addressing knowledge representations on a more implicational level.

With ImRS the therapist tries to activate the memories of childhood experiences that are assumed to underlie the PD and to help the patient to reprocess them. Several aspects of this reprocessing are probably important. An incomplete overview follows:

1. *Reattribution.* Patients start to attribute what has happened to different causes than they did when they were a child. For instance, the lack of attention the patient received in childhood when in need of emotional reassurance is no longer attributed to inherent worthlessness of the patient, but to psychological problems that the parents had in dealing with emotions and attaching to any child.
2. *Emotional processing.* Difficult experiences from childhood are usually far from completely emotionally processed. One reason for this is the lack of safety or even the straightforward threats these patients experienced when expressing emotions and looking for emotional support. For instance, one of the author's patients, as a child, was locked in her room when she became emotional, and she was not taken care of until she stopped crying. The rejection and abandonment when in need of safe attachment obviously created even more negative emotions. PD patients are usually very uncomfortable with emotions, and ImRS helps them to feel more comfortable with emotions and to process them. Why is this important? First, the strategies the patient uses to not experience emotions related to issues that are associated with such childhood experiences are very dysfunctional and form an important part of their PD pathology. Most of the *DSM-IV* criteria of PDs reflect coping strategies used to prevent activation of emotions associated with difficult childhood experiences. Second, PD patients have generally not experienced care from somebody when they were in emotional need. ImRS repairs this: part of rescripting involves a secure adult that meets the child's needs to be reassured and comforted. This in turn changes the basic views of patients about emotions (as being threatening, useless, bad, leading to loneliness, etc.), about themselves and about other people (so that they develop healthier relationships in their present lives). It also teaches them how to deal with emotions so that their emotion regulation capacities improve.
3. *Receiving care.* Many PD patients have been emotionally neglected, if not abused (Johnson et al., 2006; Lobbestael et al., 2010). In ImRS they will have the experience, although in fantasy, of somebody taking care of them as a child, often for the first time in their life.
4. *Changing meaning on the child level.* It has been argued that it is of only limited value to use corrective information adapted to how adults would reason in order to correct representations that were formed during childhood. It is more helpful to adjust the corrective information to levels on which children reason. This can be accomplished by activating the childhood memory and providing corrective experiences and other types of information to the child in the image. Not only can the content and the reasoning style be adjusted to the child level, but also the channel through which the information is given can be changed. For example, for children, bodily contact with a safe figure is the primary channel through which safety and soothing is conveyed. In ImRS, the patient can imagine being soothed as a child by a trustworthy person.
5. *Transforming the rule to the exception.* Children understandably tend to view their primary environment as a prototypical representation of the world in general. Thus, if their parents react with threats to their needs, they start to believe that everybody will do this and that nobody can be trusted. With ImRS, patients start to learn that their environment was the exception. A similar logic holds for moral issues: moral rules that were understood to be universal can also be changed through ImRS.

A helpful framework to understand ImRS is to view it as a form of unconditioned stimulus (US)–revaluation (Arntz & Weertman, 1999; Davey, 1989, 1997). According to modern learning theory, a conditioned stimulus (CS) does not directly evoke a conditioned response (CR), but triggers a representation of the US, and it is the memory trace of the US, or the expectation that the US might occur again, that leads to the CR. Experimental research has demonstrated that if information is given about the US that changes its meaning (e.g., information that makes it more, or less, dangerous), the CS leads to a CR that is changed in accordance with this information (Davey, 1997). ImRS can be viewed as a direct way to reactivate the US representation and to change its meaning. Research has shown that imagined conditioned and unconditioned stimuli can have similar effects to real stimuli (Dadds, Bovbjerg, Redd, & Cutmore, 1997), although as far as the present author knows, no laboratory classical conditioning experiment has been published testing whether ImRS can change the US representation and hence the CRs.

Obviously, this is an issue that should have a high place on the ImRS research agenda. If ImRS does indeed change the meaning of the US representations underlying many of the problems in PDs, the technique must have, theoretically speaking, great power. This is because US reevaluation is potentially a more fundamental way to bring about change than extinction procedures. The limitation of extinction procedures is that, at least according to most modern conditioning theories, the US representation is not changed, and the patient only learns that the CR is no longer a predictor of the US in a specific context. This makes treatment rather an elaborate enterprise as the patient has to learn that the CS does not predict the US by applying extinction procedures in virtually any context to which the problem is generalized. In the case of learning early in development, the chances are high that for the individual the CS–US relationship is the general rule that is assumed to be valid in any context. Thus, applying extinction procedures would be a lengthy process. If ImRS directly changes the US representation, context dependency is less of a problem, and generalization should be much faster. Our first laboratory tests indeed support the hypothesis that ImRS changes the meaning of the US representation and improves generalization of extinction learning over contexts (Dibbets, Poort, & Arntz, 2011; Hageraars & Arntz, 2011).

Empirical Evidence

ImRS is not a completely new treatment. Edwards (2007) described various forms of imagery work that have been used over more than a century by clinicians with very different backgrounds. One of the major ways in which it became known to academic psychotherapy researchers is probably through Gestalt therapy, but it is only recently that imagery work has received a solid place in academic research (Edwards, 2007). For a long time, ImRS was viewed as suspicious and nonscientific, and only recently have effectiveness studies been published. Evidence that ImRS is an effective technique in the treatment of a range of Axis I disorders is rapidly accumulating (e.g., Arntz et al., 2007; Brewin et al., 2009; Grunert et al., 2007; Hunt & Fenton, 2007; Kindt et al., 2007; Wheatley et al., 2007; Wild et al., 2007). However, evidence that ImRS is an effective technique in the treatment of Axis II disorders is lagging behind. Perhaps the most direct test is a study by Weertman and Arntz (2007) that compared experiential techniques focusing on the past to techniques focusing on the present in the treatment of PDs in a within-subject crossover design. In this study, we found that the techniques focusing on the past were as effective as the techniques focusing on the present, whereas merely exploring the background of the problems had no positive effect. Although ImRS was only one of the possible experiential techniques that therapists could apply, it

was the most important technique. Results of this study can therefore probably be interpreted as supporting the effectiveness of ImRS in the treatment of PDs. However, given the design, only relatively short-term effects could be investigated. No study has yet tested whether using ImRS yields long-term results that are better than the effects of techniques that only focus on the present.

Other studies have used ImRS as part of an extended package (usually schema [focused] therapy) and found favorable effects (Farrell, Shaw, & Webber, 2009; Giesen-Bloo et al., 2006; Nadort et al., 2009; Nordahl & Nysaeter, 2005). Nonetheless, it is clear that more investigations are needed to test the effectiveness of ImRS in the treatment of PDs more directly.

There are good reasons, however, to expect that ImRS is a powerful and effective technique. Imagery evokes more emotions than just talking about issues (Holmes & Mathews, 2005), and basic experiments testing the effects of experimentally manipulated interpretation biases on stress-responsivity have found that the experimental manipulation of interpretations is strongly promoted by having participants imagine the situation (Holmes & Mathews). In many respects, the brain does not seem to differentiate between real and imagined experiences, and imagined stimuli might act as conditioned and unconditioned real stimuli (Dadds et al., 1997). Thus, ImRS is probably as effective in the treatment of PDs as it is in the treatment of Axis I disorders.

Application With PDs

Four applications will be discussed: (a) the use of diagnostic imagery; (b) imagery of a safe place; (c) ImRS of childhood memories; and (d) the use of ImRS in addressing current and future problems. Examples of applications can be viewed on DVD (Bernstein & van den Wijngaart, 2010; Nadort, 2005).

Diagnostic Imagery

Usually, the treatment starts with a case conceptualization phase, for which a variety of sources of information is used: semistructured interviews to assess Axis I and Axis II disorders; questionnaires; and anamnestic interviews of the patients' histories, current problems, current life situation, reasons to seek help, and what patients hope the therapy will bring about (e.g., Arntz, 2004; Arntz & van Genderen, 2009; Beck, Freeman, Davis, & Associates, 2004; Young et al., 2003). As an aid to case conceptualization, therapists can use diagnostic imagery. For example, in Session 4 the therapist states,

Today I would like to do an exercise that will help us to better understand how your present problems are related to your childhood. I will ask you to close your eyes and imagine that you are a child again,

being with your mother. I'll ask you to imagine this as vividly as possible and I'll ask you what happens in the image and what you are experiencing being a child. This technique is a better way to get an understanding on an emotional level than just talking about the past. The whole exercise will take about 5 to 10 minutes. Afterwards we will discuss what we can learn from it. Do you have any questions?

If the patient doubts whether imagining is a good technique, the therapist can point out that research has demonstrated that imagery is more powerful than just verbally processing material, both in evoking affect and in changing emotional-related meaning (e.g., Holmes, Arntz, & Smucker, 2007; Holmes & Mathews, 2005). If the patient has experienced severe traumas with the parent, the therapist can reassure him or her that traumatic memories should not be the focus of this diagnostic imagery. Simply to have an image will suffice. During the imagery the therapist asks questions such as the following:

Where are you?

How old are you?

What is happening in the image?

What do you feel (as little X)?

Is there anything you would need?

Is there anything you would want from your parent?

Is there anything you would like to say or do?

During imagery, now and then the therapist should check whether the patient is imagining the scene from the perspective of the little child. If not, the therapist gently instructs the patient to take again the perspective of the little child. Similarly, the patient is instructed to use the present tense and experience from the "I" perspective (not "the little child needs to be praised," but "I need to be praised"). The therapist might gently correct:

PATIENT: The little child needed recognition.

THERAPIST: "I" need recognition.

PATIENT: I need recognition.

The therapist might stimulate the patient to talk to the parent and see what happens in the image. However, rescripting of the image is not done at this stage. It suffices when the emotional meaning of the image has become clear. Afterward, therapist and patient discuss the emotions that were apparent in the imagery, the needs of the little child, and the degree to which the needs were (not) met by the parent.

A diagnostic imagery with the other parent is done in the following session. Therapists are discouraged from asking the patient to imagine being with both parents at

the same time, as this might not allow for the focus that is needed on a specific parent (i.e., different issues might be related to each parent). However, *additional* imagery of the child with both parents or with the whole family is informative at a later stage.

Information elicited from these diagnostic imagery exercises and the discussion following them is integrated in the case conceptualization that will be used to steer the later treatment.

Imagery of a Safe Place

Imagery of a safe place is an option, but it is not essential. One can start with imagery by teaching the patient to imagine a safe place so that the patient gets used to imagery. With a powerful image of a safe place, patients can return to that safe place at any time if the other imagery exercises become too intense and evoke high levels of negative emotion. They can also use the image any time they are in need of safety. Ask the patient to close his or her eyes or, if this is uncomfortable, to pick a point on the floor and stare at it. Then ask the patient to imagine a safe place. This can be a real place or it can be a fantasy. If the patient cannot create a safe place in imagery, the therapist can make suggestions: a place in nature; an image of the patient sitting in the therapist's office surrounded by a big, protective balloon; or perhaps another setting based on something the patient said during the intake interview. Some patients cannot think of a safe place because, in their experience, the world is simply too dangerous and there are no safe places. For these patients it is important that the therapist develop a very strong, safe therapeutic relationship. In such cases it is essential that the therapist actively protect the patient during ImRS so that safety is brought in to the script. One of the present author's patients used an image of being with him in his office as an image of a safe place. Understandably, it took some time to experience the therapy and the therapist as safe before she could use this experience to create a safe image. The imagery of a safe situation is not a prerequisite for ImRS, so if the patient cannot imagine a safe place, the therapist should reassure the patient and proceed with ImRS.

ImRS of Childhood Memories

The best approach to introduce ImRS in the treatment of PD is not yet clear. A recent qualitative study of Cluster-C PD patients' opinions about ImRS suggests that some patients preferred more preparation and explanation of the technique than their therapists did, because the strong emotions ImRS evoked were quite overwhelming. However, patients who had been in treatment for longer had a different view: through practicing ImRS, they

understood it better, felt less fearful of the procedure, and acknowledged its effectiveness (ten Napel-Schutz et al., 2011-this issue). One could argue that lengthy explanations could lead to high levels of anticipatory fear and avoidance or refusal. Therefore, some therapists prefer to start with ImRS after a short introduction as a completely normal part of therapy. If the patient feels overwhelmed, care should be taken after the exercise to validate the patient's emotions, to fully explain the technique, and to provide emotional support.

In ImRS, an image of a childhood memory is rescripted by having an adult person enter the scene and intervene, thus changing the script. In PD patients, it is advised that, at least initially, the therapist should enter the image and rescript. Because many PD patients did not receive adequate parental care/support/nurturing as a child (Young et al., 2003), it is important that they learn, on the child level, to receive and accept care. Arntz and Weertman (1999) suggested that the basic approach should be that patients themselves enter the image to intervene. Our experience with treating patients with PDs has, however, indicated that this is not a good approach for these patients. They might be unable to intervene because they feel overwhelmed by fear, lack healthy views on the situation and on what the child needs, and don't know what to say or how to behave. The absence of a healthy schema makes it too early in treatment for the patient to intervene. Moreover, many PD patients did not have the experience of somebody else standing up for their rights and needs and/or taking care of them. Learning to *receive* care is essential for a healthy development, in our view. Arntz and van Genderen (2009) give instructions on how to use ImRS for BPD. For PDs, the following approach is suggested.

1. Start with a problem of the last week (or a strong feeling emerging during the session).
2. Ask the patient, with eyes closed, to imagine the recent problem. Let the patient describe, in here-and-now terms and from his or her own perspective, what happens and what is experienced. Ask for emotions and needs.
3. Instruct the patient to stick with the feeling but to let the image go, and to see whether an image from childhood pops up. Don't let the patient try to find an image in a rational way—request that the image arise spontaneously.
4. Ask the patient how old (s)he is, where (s)he is, with whom, and what happens. Let the patient talk in the present tense, from the perspective of the child. Gently correct if the patient uses another perspective, or doesn't use the present tense. After factual details are clear, ask for emotions, then thoughts, and then needs. It is always good to ask

for needs. But the patient might not yet be able to express any need, or only something rather unarticulated (avoidance, denial, and overcompensation are defining characteristics of PDs). If severe abuse is (nearly) happening, don't wait but intervene. If it is not completely clear what is happening and what the emotional problem is, let the image continue. The basic questions are as follows:

What do you see (hear, smell, etc.)?

What is happening?

What do you feel?

What do you think?

What do you need?

After each intervention in the script, these questions can be asked again.

5. Tell the patient that you will now enter the scene. Don't ask permission, as chances are high that you won't get it! Act on your own healthy views. It might help you to visualize the situation yourself, so that you see the little child who is in a nasty situation. Act as if you are responsible for the child. Do what you feel you need to do. The patient might protest (for instance, preferring to avoid or be subordinate, because he or she is too afraid, and might want you to do the same), but you have to trust that what you do is healthy. When you intervene, describe what you are doing to the patient, and what you are saying. If there is abuse or the threat of abuse, stop or prevent it. Ask the patient what happens next in the image, and how (s)he feels now, and what (s)he needs. Rescript further until the threat is under control. Every time you ask the patient what happens in the image, what is felt, and what is needed (as a little child). Then take care of the little child. Create safety (which might involve taking the child out of the house, and bringing it to another family, or to your own family). Comfort the child, or find a trustworthy person who can do that (e.g., the mother of the child's friend, or an aunt). For comforting a sad or stressed child, bodily contact is the most important channel. So let the patient imagine receiving comfort with bodily contact as you would do with your own child. Correct misinterpretations that the child makes, explain what is wrong with the parent's behavior, why you intervened, etc. Finally, ask if the child wants to play or have fun.
6. When it is okay for the patient, the therapist can request the patient to open eyes and return to the therapy room. Discuss the ImRS, but expect that most of the effects have already started on an

experiential level. Ask the patient to listen to the recording you made and to try to do the whole exercise at home (but don't be disappointed if the patient avoids doing that; this is to be expected with PD patients—accept it as being too difficult at the moment, but continue to suggest that the patient tries it at home).

7. If the patient is not satisfied, don't worry. Just try another way of rescripting. It is a fantasy, so we can easily rewind the movie and rescript in another way. Invite the patient to develop variations of the scripts and try them out.

A typical start of a session would be to ask how the patient has been doing since the last session. The patient's response informs the therapist about the patient's present state, and the discussion will teach the therapist about emotional events that took place after the last session. The therapist can then use an important emotional experience from the last week to find and address a childhood memory. Alternatively, the therapist can use the present emotional state of the patient to find a childhood image. For example:

TERAPIST: How have you been doing since last week?

PATIENT: Hmmm, I don't know.

T: Is there anything you would like to share with me?

P: Guess not.

T: Or you would like us to focus on today?

P: No [*yawns*].

T: It feels to me that at this moment you are not experiencing any emotions. Could it be the case that you are very detached right now?

P: Could be. Feels not so bad.

T: Since when are you in this state?

P: I guess the whole week, after our previous session. Discussing my childhood during the session raised all kinds of difficult feelings. When I left the session, I did not feel anything anymore.

T: OK, I can understand that. Our last session must have been quite upsetting to you. You don't know yet what to do with all these feelings, so it seems

that you became detached and this helped you to survive the last week.

P: Yes, I guess you are right.

T: Was there anything in particular that was bothering you during or after last session? Can you try to tell me?

P: Well, I started to realize that I have always felt very lonely. Not only now, but already as a child. A feeling I rather not want to feel.

T: OK, I understand this is a difficult feeling that you rather avoid and that you remember already from your childhood. I would like to do an exercise with you, in which we return, in fantasy, to your childhood and assist little Ben¹ in his loneliness. I'll ask you to close your eyes, and get an image of yourself when you were a child and had this dreadful feeling of loneliness. I'll then enter the image to support little Ben. In a way, we will rescript the image and give it a new, better outcome. Or, if that is not possible, we will organize emotional support for little Ben to help him to deal with the difficulties he experienced. It may sound strange, but although we cannot change the reality of what happened in patients' childhoods, with this technique we can help them process the emotions that are related to these childhood experiences, that lie at the root of their problems, and we can help them to give new and more adaptive meanings to these early experiences. The whole exercise will take about 30 minutes. Do you have any questions?

P: Not really. Seems quite strange, but let's give it a try.

T: If that is okay with you, can you then close your eyes and focus on the loneliness underneath your detachedness?

Thus, if the patient does not report an emotional event that happened in the last week, the emotional state of the patient during the session can be used as a starting point. Therapists can also ask patients to access an image of a memory of an adverse event from their childhood that is known to the therapist, or the therapist can ask the patient to close his or her eyes and find a safe image. If the patient has a safe image, the therapist can instruct the patient to let the image go, and to see whether an image from childhood pops up. Usually there is some connec-

¹ Details and names have been modified to protect the identity of the clients.

tion between the safe image and the adverse childhood image. Note that it is possible to use three or more images in succession—for example, start with an image of a difficult situation that occurred in the past week, then have the safe place imagined, then a childhood image, and after rescripting return to the safe place before opening the eyes. Using the safe place image might help some patients to feel less afraid of the technique and to engage more fully in ImRS.

The use of an “affective bridge” between the image of a recent difficult situation and childhood images is, however, the most frequently used way to find childhood images that are associated with the patient's present problems and that are good candidates for rescripting. Here is a complete example of an ImRS exercise starting with a recent difficult feeling.

T: Can you close your eyes and get an image of this experience last week when you felt so guilty?

P: Yes, I have it. T: Can you tell where you are?

P: I am at the office.

T: What is happening?

P: I already worked an hour's overtime. Everybody has left, now my boss also leaves. I was not able to complete all the tasks.

T: What do you feel?

P: I feel guilty, I feel that I failed. And I am panicking. I'm afraid that I will be fired.

T: What would you need?

P: Certainty. Less work to do. Reassurance that I will not be fired.

T: OK. Could you now keep the feeling but let the image go and see whether a memory from your childhood pops up?

P: Hmmm ... [*After some time*] Yes, I have an image.

T: Can you tell where you are?

P: I am in the kitchen.

T: How old are you?

P: Nine or ten, I guess.

T: What is happening?

P: My mother just left. She was disappointed in me and now she went to bed. I know she will lie in bed the coming days and will not talk to me.

T: How come?

P: I had a low grade in school and now I have to do extra homework and cannot help on the farm.

T: What do you feel?

P: Guilt. Failure. And panic. I caused my mother to get depressed again. I am afraid she will not recover.

T: What would you need?

P: To not have this burden on me.

T: OK. Now imagine that I am with you. I am with you in the room. Can you see me?

P: Yes.

T: We walk to your mother's bedroom and this is what I say to your mother: “Madam, I understand that you are disappointed that Peter had a low grade in school and you worry about how all the work on the farm has to be done now that Peter has to do extra homework. But your reaction is excessive. By lying in bed, feeling depressed, and not talking to Peter you punish him for something he did not do on purpose. And you punish him excessively. He feels extremely guilty and anxious about your condition. You should not charge a child with responsibility of your excessive reaction. What Peter needs is understanding and reassurance that it is not a problem that he had a low grade and that with some extra homework everything will be fine. So can you step out of your bed and take care of him? He really needs you.” What is happening? How is your mother reacting?

P: She says that she is not able to come out of her bed as she is feeling too depressed.

T: “But Peter is really upset now. He is very frightened. He is still a child and he needs you to take care of him.” How is your mother reacting?

P: She says that she feels too bad to do something.

T: Then I say to her: “Madam, if you are too depressed to come out of your bed, that is bad enough, but don't blame Peter for it. I think you are

emotionally not healthy and that you need professional help. I'll arrange that you will get treatment for your depression." Come, Peter, we leave the room and return to the kitchen. We are now in the kitchen. How are you feeling?

P: A little bit relieved because you said so clearly that it wasn't my fault.

T: Yes, it is not your fault. You must understand that every child has now and then a problem with learning and that every child needs a parent that reassures him and tells him that that is not a problem. You know, I really think your mother has an emotional problem. You are not to blame for her despair and depression. Some way or another, she cannot handle a minor disappointment. I understand she gives you the feeling that it is your fault that she feels like that, but it isn't your fault. She has an emotional problem and somebody has to take care of her, and I'll arrange that. So that means that you don't have to worry about that anymore. How do you feel now?

P: Relieved, but still not at ease. I am so afraid of my mother's despair and her suicide threats... I don't want to stay here...

T: So what is it that you need?

P: I need a home where I can live without all these worries.

T: Is there someone you can imagine you would like to live with?

P: My aunt.

T: OK, then imagine that I take you to your aunt. We leave the house and I bring you to your aunt. Can you see that?

P: Yes.

T: OK. And I say to your aunt: "Madam, Peter and I have come to ask you whether Peter can live with you. His mother is so depressed and stressed, and with even a minor disappointment she lies for days in bed and doesn't talk anymore to Peter. He is feeling so guilty and so panicky that it is not sensible that he stays with her, at least not until her emotional problems are treated. Peter needs a safe home, and he needs somebody who takes care of him and reassures him and doesn't make him feel guilty when

he has a minor problem at school. Could he live with you?" What is your aunt saying?

P: She says that is OK.

T: How do you feel now?

P: Better now.

T: Is there anything else you need?

P: I feel sad. I need to be soothed.

T: Can your aunt comfort you? What could she do?

P: I want her to hold me.

T: OK, ask her to hold you.

P: Aunt, can you hold me? I feel so sad.

T: OK, and imagine that your aunt holds you—feel how she holds you.

P: [*starts to cry—emotional release*]

T: That is OK... [*after a while, when P calms down*] How do you feel now?

P: Quiet.

T: Is there anything else you need?

P: I want to play. I want to play with my nephew.

T: That's OK. Can you imagine playing with your nephew now?

P: Hmmm.

T: [*After some time...*] How are you feeling now?

P: Fine.

T: Is there anything else you need?

P: No, I am fine.

T: OK, then you can slowly open your eyes and return to this room.

From this example it is clear that stopping the threatening event is only half of the story. Care should be taken that needs that only become apparent when the

threat is taken away are addressed. Furthermore, it is clear that the father is completely missing. Therefore, ImRS addressing the father's role is something that should be done in a later session.

In some cases the therapist must be very determined and strong to win from the abuser. The therapist should not allow the abuse to continue. Here is an example from Arntz and van Genderen (2009, p. 58).

T: I say to your mother “STOP, you may not hit Nora. Don't you see that she's seriously injured?”

P: Watch out, my mother is bigger than you are.

T: Don't worry, I may be small, but I'm very strong. I'm holding your mother's arm. What happens now?

P: My mother is very angry with you. I see it in her face, but she doesn't dare hit me as long as you're here.

T: “Mrs. X, your daughter needs to see a doctor; that looks like a very nasty cut.”

P: Now my mother is swearing at you and says that I'm a pain in the ass and —

T: Stop that immediately and leave Nora alone. She needs medical treatment.

P: She wants to hit you.

T: I'm picking her up and putting her in the hallway, out of the kitchen and I lock the door. She's gone!

P: Yeah now she can't hit you.

T: And she can't hit you either. She may not come back in as long as she behaves like that.

Therapists should be prepared to deal with abusers who were, at least in the eyes of the child, extremely powerful and sometimes unconquerable. Thus, they might tell the patient that they are specialists in Eastern fighting sports, or that they will bring in four very strong policemen, or that they have a secret weapon that temporarily paralyzes the abuser.

As mentioned above, the therapist should not forget to focus on the child after the abuse has stopped. First, safety should be created. If the child is afraid that the abuser will take revenge, it might help to give the child a secret apparatus that warns the therapist if there is danger so that the therapist can return immediately to intervene again. Other options include taking the child out of the abusive situation and finding a safe home for the child or putting

the abuser in jail. There is a debate over the degree to which it is therapeutic to have abusers killed. Some argue that it is healthy to kill abusers in fantasy, as it makes one's revenge fantasies less frightening, and acting aggressive revengeful impulses out in fantasy might actually lead to better anger control (Arntz et al., 2007). Others doubt whether this is safe with PD patients who have aggressive acting-out problems. The present author once had a patient who killed her extremely abusive father in fantasy, after which she was dissatisfied, so the image was rewound and the father was put in jail, which satisfied the patient more.

Following creating safety and satisfying feelings of justice and revenge, the therapist should take care of further needs of the patient. Usually there is the need to be comforted and the therapist can ask the patient who could do that, or comfort the child him/herself. A common next need is the need for recreation, joy, or playfulness. Thus, the child likes to relax, play, and have fun. The example continues as follows (Arntz & van Genderen, 2009, pp. 59–60):

T: How are you doing, Nora?

P: I'm still scared because soon she'll come back in and hit me. And now she's even madder because you helped me.

T: Then I think it's a good idea if she's locked up somewhere where she cannot get you. Where shall I lock her up? In jail?

P: Yes, but far away and somewhere where she can't escape.

T: OK, I'll have her locked up on an island on the other side of the world. How do you feel now?

P: Calmer but still very sad.

T: You're still very sad. I see that as well. What do you need?

P: I don't know. I feel so alone now! [*crying*]

T: Shall I come and sit next to you? Would you like a tissue? Let me put my arm around you. It's ok, she's gone and I'm going to help take care of your leg. I'll call the doctor and say that he needs to come here and take a look at it. [*Patient sighs and slowly begins to stop crying.*]

T: How do you feel now?

P: Much better. Is the doctor really going to come here for me?

T: Of course, because your leg looks very bad and I don't think you can walk to the doctor's office.

P: OK, he can come in, but please stay with me because it really hurts. [*Patient remains agitated and looks anxious.*]

T: Is there something else you want to say?

P: Yeah, I'm scared that my mother will come back and really let me have it because I said you should lock her up.

T: So you're scared of being left here alone? [*Patient nods.*]

T: Is there anybody who you could live with? Anybody who is nice to you and who would like to take care of you?

P: Perhaps Auntie Rose... Yes, she is always nice to me.

T: Shall I take you to your Auntie's? You'll be safe there and you can call me if you need to. [*At last the patient begins to relax and carefully laugh.*]

T: Come with me, does your Auntie live far away? [*Patient shakes her head no.*]

T: I take you to her house... So, here we are. Let's ring the bell. Your Auntie opens the door and is very happy to see you. Do you see that? [*Patient nods and smiles.*]

T: Auntie Rose, I've brought Nora to you because she's had a nasty fall from her bike and I have called the doctor to come to check out her leg and she would like to stay here with you. [*To patient*] What does your Auntie say?

P: She says it is fine and has me sit on the sofa by the TV.

T: OK, we'll wait for the doctor and then I'll leave. I'll arrange it with your Auntie that you can live with her, and that I visit you daily until you're better. What do you think of that?

P: That's nice.

T: Is that enough or are there other things you would like?

P: No, this is good. I'm glad that I can stay at Aunt Rose's and that you'll visit me every day.

There are some general guidelines for ImRS for treating the childhood roots of PD problems. First, the

general rule is that the younger the child is, the better the technique works. This is partly because earlier experiences lie more at the root of the problems, and partly because it is more convincing for the patient that she or he was not guilty of the problems when very young. Cluster-C patients might, however, strongly avoid memories of when they were young, because they are afraid of the strong emotions that they evoke. Second, there is a guideline on how to deal with problems patients might have with doubt: whether the memory was correct or the intervention was not real or felt unrealistic. Interestingly, such objections are not relevant for the effectiveness of the technique. In a certain sense, the brain does not differentiate between real and imagined experiences—that is why the technique is so effective. The therapist should explain the technique and reassure the patient. Of course, one doesn't want to create false memories. Thus, the fact that the patient gets an image is not in itself a proof of its correctness. But even when incorrect, the image probably reflects important emotional issues and ImRS can be used. Third, when there was extreme trauma, it is not necessary to relive the whole trauma. Therapists should enter the scene before the trauma takes place and bring the child into safety. It might be necessary to provide reassurance and explain this to the patient. Unlike prolonged imaginal exposure, the technique does not use extinction, but actively changes the meaning of the trauma and its context. Fourth, be prepared that using imagery rescripting can bring about a period of mourning when the patient realizes that his or her basic needs were not met in childhood and—this is the challenging part of the technique—will *never* be met by the parents, either because it is too late (the patient no longer being a child) and/or because the parents are incapable or unwilling to meet the patients' needs. Thus, rather than magically repairing what did not go well during childhood, the technique brings about a shift in meaning, which confronts the patient with the reality of his or her childhood. The therapist should explain this to the patient, provide reassurance, and bring comforting into the image when the little child is sad.

Later Treatment Phases: Patient Rescripts

Later in treatment, the therapist invites the patient to enter the scene as an adult to rescript. Basic questions are:

What do you see?

What is happening?

What do you feel?

What do you think about the situation?

Is there anything you would like to do? (Is there anything that should be done?)

First, the patient experiences the adverse event from the child perspective. When the moment has come, the

therapist asks the patient to step into the scene as an adult. As the patient is usually not yet strong enough, the therapist initially assists the patient. So the instruction could be:

T: OK, I would like you to enter the image as an adult, and I'll join you. Can you imagine that we are both standing in the same room as little Rose is?

P: Yes, I can see that.

T: Good. What do you see? ...

Therapist and patient then discuss in the image what has to be done and intervene together.

P: I feel that Rose's brother should stop abusing her.

T: OK, and how could we stop him?

P: Perhaps we can tell him to stop.

T: Good idea. Imagine that we tell him to stop.

P: "Stop this! You are not allowed to abuse Rose."

T: Excellent. What happens now in the image?

P: He is getting really angry. I'm afraid.

T: Is there anything you want to do?

P: I want that he stops threatening me but I don't know how.

T: Don't be afraid, I am with you. Let us discuss what we can do to stop him threatening you.

P: I have no idea.

T: Well, we could take him up and throw him out of the house. Or tell him that if he doesn't stop threatening, we will alarm our four policemen who will put him in jail. Or we could bind him up and tape his mouth so that he cannot speak anymore.

P: That is a good idea! Yes, let's do that...

After the maltreatment has stopped, the therapist asks the patient (as an adult) to look at the little child—as patients sometimes forget to take care of the child.

T: Now look to little Rose. What do you see?

P: She looks sad.T: What do you think?

P: I think she needs to be comforted.

T: What would you like to do?

P: Hold her and comfort her.T: OK, do that!

The cycle is repeated until the patient (as an adult) feels satisfied. An important next step is to let the patient experience the whole intervention by the adult patient and the therapist again, but now from the perspective of the little child.

T: OK, now I would like you to experience the whole rescripting again, but now from the perspective of little Rose. Can you please rewind the image and be little Rose again, and imagine that the abuse threatens to happen again?

P: OK, yes, I have the image again.

T: What happens . . . ?*[After the whole image is vivid again and emotions are triggered...]*

T: Now adult Rose and I are entering the room. Can you see us?

P: Yes.T: What happens? What are they doing?

P: They tell my brother to stop abusing me. He gets angry at them, but they bind him on a chair and tape his mouth.

T: What do you feel? *[if unclear: "as little Rose"]*

P: Relief. But still angry.

T: What do you need?

P: That he is punished.

T: What kind of punishment do you have in mind?

P: He should clean the toilets for the coming five years.

T: OK, ask adult Rose and me to punish him with this.

Thus, from the child perspective new needs may come up, and the therapist asks the patient to ask her adult self to fulfill them.

With this perspective reversal, the child might have different wishes than the patient realized as an adult (e.g., to be comforted, or to live elsewhere). That is one of the main reasons why this reversal of perspectives has been

added. The other main reason is that we found that using ImRS without feeding the new experiences into the child level was not as effective. The adult intervening is one thing, the child experiencing the intervention is perhaps even more important (Arntz & Weertman, 1999).

Frequency of Application of ImRS

Although one good ImRS session sometimes brings about impressive changes, in its application to PDs it should be used repeatedly. Usually there are many childhood experiences that are related to the patients' problems that should be addressed. In a case of PDs, adverse childhood experiences were not isolated phenomena. On the other hand, there is no need to target every experience. Usually, many of the adverse events were repeatedly experienced (otherwise, they would probably not have contributed to the origination of a *personality* disorder) and it suffices to address some prototypical examples. We trust that the events that come up spontaneously in the process are good ones to address, but sometimes it is obvious that some important experiences are not addressed when the therapist only relies on letting the patient come up with an image. Examples include traumatic events that the patient avoids addressing, or the role of more passive or absent parents in the child's problems. In such cases, the therapist should propose to address these events directly with ImRS.

ImRS of Present and Future Situations

ImRS can also be used to address current and anticipated problems. This usually occurs in the later phases of therapy, when patients have already undergone a considerable change, but still need to make changes on a behavioral level in their present life (e.g., Arntz, 2004; Arntz & van Genderen, 2009; Young et al., 2003). As we all know, insight is one thing, but actually changing one's behavior is another. ImRS can be used to help the patient to bring about actual behavioral change. Here the therapist asks the patient to imagine a recent or an anticipated difficult situation, requesting that the patient describe what happened—or what is expected to happen. Usually the way the patient felt and acted is dominated by old patterns, which is why the situation is still problematic (or is feared). Next, the therapist asks the patient to rewind and to act, in the image, in a new, more functional way. It helps to ask what the patient needs and what the patient would like to say or do, and to stimulate the patient to try it out. If the patient doesn't like it after trying it out, the situation can be modified. In the beginning, the therapist might support and coach the patient in the image. The patient would imagine that the therapist is also present and the patient and the therapist would discuss in the image what options there are to address the problem.

In the following example, the patient brought in the problem that she felt powerless, humiliated, and completely dominated by her mother-in-law when they met. Her description of her feelings suggested that from the first domineering remark by her mother-in-law, she flipped into a sort of dissociation, completely detached from her own opinion and feelings, and underwent the visit as a robot. Afterwards, she was extremely angry, but even later in treatment when she intended to be assertive, she flipped into this dissociative-like state as soon as her mother-in-law started to make denigrating comments. There were obvious similarities with her responses as a child to her father's intimidating and maltreating behavior. ImRS with these childhood experiences helped her, although she never came to the point where she entered the image as an adult and confronted the father herself. We tried out ImRS with a typical image of a visit—a new visit was planned the next week. Here is the rescripting phase:

T: Can you close your eyes again and now imagine the whole situation again, but now from the perspective of how you would like to be and act?

P: We are entering the house and my mother-in-law is in the hall and says to me: "For goodness sake, what robe do you wear!"

T: What do you feel?

P: Anger, but I also feel that my feelings shut off—I get this feeling, "There are we going again," and there is nothing I can do and I just have to sit it out until my husband decides to go home.

T: Stay with that anger for a moment. What are you thinking?

P: That she made an impolite remark.

T: And what do you need?

P: The right to make my own choices and that these are respected by her.

T: Listening to that need, what would you like to do?

P: I would like to tell her that she should be more respectful of my taste.

T: OK, tell her!

P: Oh no, I feel that powerlessness again...

T: OK, now imagine that I am with you in that hall. I am standing behind you and support you. Can you see me?

P: Yes.

T: OK, and I tell you: “You are an adult person now and you don't depend on your mother-in-law and you don't need to subordinate. You are a free person and you have the right to express your opinion and to assert yourself.” What could you say to her?

P: I guess that her remark was impolite and that I expect her to respect my taste.

T: OK, try to tell her—remember this is only a fantasy so you can try out everything you want!

P: “That is not a very polite remark. I would like you to respect my taste.”

T: Good. What happens in the image? How is mother-in-law reacting?

P: She looks surprised. She doesn't expect that from me.

T: What happens next?

P: She says that she didn't want to quarrel.

T: How do you feel now? [*the ImRS cycle is repeated until the patient is satisfied*]

The essence of what the patient learned from this exercise was that she had to take care not to flip into her dissociative mode, but to stay in her competent adult mode, so to speak. In preparation for the next visit, she listened to the tape of this ImRS exercise. During the visit, she was very keen to not let her dissociative coping dominate, but to try to stay in her adult mode, which she managed by using the image she had rehearsed, including the therapist supporting her. For the first time she stood up to her mother-in-law. Afterwards she said that more than preparing what to say exactly, it was the *feeling* of her new self in the image that helped her to act differently. For many patients, ImRS with difficult situations in their present or future life is very empowering.

Difficulties

The major difficulties that can be encountered with the application of ImRS and how they can be addressed

are summarized below. More details can be found in [Arntz and Weertman \(1999\)](#) and [Arntz and van Genderen \(2009\)](#).

The Patient Will Not Experience ImRS With Eyes Closed

The therapist should try to determine why the patient will not close their eyes. Some patients, for instance, are very distrustful and afraid that the therapist will laugh at them when they close their eyes. If the reason is clear, therapist and patient can work on a solution. For example, the therapist can agree to close his or her eyes as well. Another option is to place the chairs with their backs to each other, so that the therapist cannot look at the patient's face. In other cases, the therapist initially allows the patient to keep his or her eyes opened in order to get used to the technique. Later the therapist can again encourage the patient to try to close his or her eyes (as ImRS will have more impact with eyes closed).

The Patient Cannot Find a Memory From Childhood

Again, the reasons for this phenomenon have to be clarified before any solution can be tried. Patients might, for instance, avoid remembering, and the reasons for the avoidance should be explored. Some patients think that they should start immediately with the most severe traumas and that they will be fully exposed to them in imagery. In such cases, the therapist should explain that it is better to start with less severe adverse events, that traumas do not need to be fully relived, and that it is the patient who ultimately decides whether to address a traumatic memory or not.

The Patient Dissociates

This is one of the most complicated issues, as dissociation might block almost any information processing, so the patient does not profit from treatment. As soon as dissociative symptoms appear, the therapist should bring the patient back to reality, for example, by opening the eyes, walking around with the patient, etc. Dissociation suggests high fear levels; thus, perhaps less frightening memories should be tried out first. It is important that the therapist brings safety into the image as soon as possible. The use of imagery of a safe place is also indicated with these patients.

The Patient Feels Disloyal to Parent(s)

Feelings of being disloyal to the parent(s) might lead to resistance to rescripting. Therapists can explain that if they address the parent in the image, they are not addressing the complete parent, but only his or her behavior at that moment. They can also explain that there are two kinds of loyalty: positive and negative. Positive loyalty is when you feel loyal to other people or to a group because you get positive things from them (e.g., for

children: care, love, and protection). Negative loyalty is when you feel loyal to other people because you are afraid that if you are disloyal, you will be punished. This is not the kind of loyalty that should be used towards children (it is more what the mafia uses). If negative loyalty is prominent in the patient's actual present life, the therapist should help the patient to get away from the threats of the family. If that is not possible, the therapeutic possibilities are probably limited. In general this explanation helps the patients to get a different view of their resistance. It also helps to make clear that parents often maltreated their children because of their own psychological problems (see ImRS example above, and where this is weaved into the rescripting). Lastly, therapists can explain that it is ultimately up to the patient to decide what he or she wants to do in reality with her parents or family in general. Some patients can talk the issues over with their parents and come to a mutual understanding, others find a way to deal with them, and still others break with them.

Conclusion

At the clinical level, much knowledge has been acquired on how to approach PD-related problems with ImRS. But there are still many things we do not know. The approach outlined in this article is just one way of using imagery. ImRS can also focus on perceptual characteristics (e.g., putting the image on a TV screen and tuning the TV to another station). The reason for choosing the current approach is that PD patients should learn to better acknowledge their emotions and needs, and it is important that they process many negative feelings related to adverse childhood experiences in a safe, interpersonal context. This is what this form of ImRS offers. It is an empirical issue whether this choice is justified or not.

Readers might wonder in what respect ImRS differs from (other) trauma-focused approaches. Compared to CT, it is clear that ImRS, although many cognitive processes are involved, is more of an experiential than a cognitive approach. The focus is on experiencing needs, emotions, and impulses. By acting them out and having needs fulfilled in fantasy, cognitive and emotional processing takes place. The highly emotional and fantasy-like character of ImRS is very different from the logical, reality-based character of the major CT technique, which involves verbally challenging automatic thoughts. ImRS not so much addresses what is logically and empirically true, but what the individual feels and needs.

Compared to exposure approaches, like imaginal exposure, there is a similarity in that both ImRS and exposure encourage patients to fully expose themselves to emotions and other avoided stimuli. But there are

important differences. *First*, whereas exposure primarily addresses fear, ImRS can address all emotions. Interestingly, one PTSD treatment study found superior effects of ImRS over imaginal exposure for shame, guilt, hostility, and anger control (Arntz et al., 2007). This is important for the treatment of PDs, because all kinds of emotions play a role in PDs. *Second*, whereas (imaginal) exposure needs prolonged confrontation with the most feared and avoided aspects of a (traumatic) memory, ImRS doesn't need prolonged exposure to the most horrible aspects. Because the patient knows what is going to happen, it suffices to start rescripting the phase before the actual trauma occurs. In the case of horrible traumas, we strongly recommend that the therapist intervenes before the trauma happens—as this is what a child primarily needs. *Third*, whereas (imaginal) exposure involves passive exposure to fear-evoking material, ImRS involves actively changing the memories in fantasy. This includes imagining that all kinds of needs are met, and acting out of impulses (including taking revenge and aggression). With exposure, such responses are usually prevented. On the clinical level this means that the patient has to be exposed to painful experiences for a much shorter time with ImRS than with exposure. Another implication is that fear of thinking of acting out needs and wishes diminishes with ImRS, and control over impulsive acting out increases, probably better than with exposure (Arntz et al., 2007). *Fourth*, with ImRS, a developmental position is taken; this is extremely important in the case of PDs because they are based on early experiences. For instance, no healthy parent would deal with a young child's fears by forcing the child to expose himself to feared stimuli without organizing a safe context. With young children, this would involve the presence of a reassuring caregiver. Children learn what is safe through their attachment relationships with their caregivers. If these attachments are safe, they will learn which situations are safe, and they will also learn to feel safe with emotions, needs, and frustrations. Accordingly, in applying ImRS to PD patients, safety is brought actively into the image by the therapist. This is in sharp contrast to the second phase of dialectical behavior therapy, where borderline patients' traumas are treated with prolonged imaginal exposure (Linehan, 1993). From the ImRS point of view, such a treatment would be developmentally inappropriate, unnecessarily painful, and only partially effective. *Fifth*, ImRS involves perspective changes, helping the patient to develop different and more functional views on what happened. This is not an ingredient of exposure.

Finally, compared to EMDR, ImRS involves the therapeutic relationship more in the trauma processing. Especially in the treatment of PDs, therapists play a very active role in the rescripting, thereby partially correcting early experiences with caregivers. Also, there is no

repeated escape from the traumatic memory by a distracting procedure (e.g., eye movements) followed by installation of new thoughts. Rather, the occurrence of the trauma is prevented (in fantasy) by a new powerful and empathic caregiver entering the image, changing the intra- and interpersonal meaning of what originally happened.

To summarize, ImRS differs in important ways from other trauma-focused approaches. ImRS focuses less on the horrible aspects of the trauma, and more on the needs that were not met (including the need to be protected, to take revenge, and to be playful). It places negative experiences in a relational context, which is believed to be so important in the development of PDs, and tries to partially repair the pathogenic relationships that the patient experienced as a child by having the therapist and others actively behave in a healthy way in the rescripting of the memory.

An important issue is the degree to which ImRS helps to attain a deeper and longer-lasting change for PD patients than therapy without ImRS. Many therapists and patients endorse this feeling; however, this should be put to the test. Finally, not all PD patients are willing or able to engage in ImRS. It is unclear what phenomena account for unwillingness to engage in ImRS, and what good alternatives for ImRS exist in such cases.

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