

## Using Imagery Rescripting to Treat Major Depression: Theory and Practice

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*This paper considers the role that intrusive memories may play in maintaining depression and the rationale for using imagery rescripting in order to target these memories. Potential mechanisms of change underlying imagery rescripting are discussed. The relationship between depressive rumination and memories is considered, as well as potential links with mindfulness-based approaches. The paper also discusses the practical applications of imagery rescripting with depressed patients, including basic principles and some common problems, such as how to deal with multiple memories, avoidance, and suppression of memories. Finally, the relative merits of different types of imagery rescripting that may utilize different affective systems are considered.*

### Why Use Imagery Rescripting to Treat Depression?

Those unfamiliar with imagery rescripting might wonder why we would want to use imagery in cognitive therapy with depressed patients when the cognitive behavioral treatment of depression has traditionally involved either verbal restructuring of negative thoughts and/or behavioral activation (Beck, Rush, Shaw, & Emery, 1979; Martell, Addis, & Jacobson, 2001).

However, we know from recent experimental work that imagery has a greater impact on emotions than verbal thought (Holmes & Mathews, 2005) and this raises the possibility that imagery techniques might be more effective at eliciting and transforming emotions than verbal techniques such as thought records. This paper will first explain why intrusive memories might be a potential treatment target in depression, and why imagery rescripting (an approach originally developed to treat distressing memories in other disorders) might be useful in the treatment of this disorder. The bulk of the paper will then focus on practical considerations of how best to make use of imagery rescripting when working with depressed clients.

### Intrusive Memories and Life Events in Depression

Distressing intrusive memories are common in depression. Previous studies have found that the percentage of depressed patients reporting intrusive memories has ranged from 44% to 87% (Brewin et al., 1996; Kuyken & Brewin, 1994; Patel et al., 2007). These memories are

reported to be very intrusive, ranging from daily to weekly frequency. The wide variance here may be attributed to methodological differences between studies, the high rates of comorbidity with anxiety disorders, or possibly to the tendency for depressed patients to try to avoid and suppress their distressing memories. These studies indicate that intrusive memories are almost as common in depression as in PTSD. The content of the memories is somewhat different from that in PTSD, with more emphasis on loss of loved ones and interpersonal crisis in the depressed population as opposed to personal assault or injury in PTSD. Frequent intrusive memories may play an important role in maintaining depression because they predict whether or not patients are still depressed at follow-up even when initial symptoms of depression are controlled for (Brewin, Reynolds, & Tata, 1999).

The reporting of intrusive memories in depression is perhaps unsurprising given that several studies have found that depression is associated with distressing life events from childhood or later life (e.g. Brown & Harris, 1978). Ma and Teasdale (2004) researched patients who had a chronic relapsing history of depression and argued that there might be two different populations of depressed patients: one with a history of childhood adversity and another with later onset of depression associated with severe negative life events. In their 2004 study, patients who had experienced three or more depressive episodes reported more adverse early experiences (typically experiences of parental indifference and abuse) than patients who had only one or two previous episodes. The latter group tended to have a later onset of depression, which was preceded by negative life events. Both groups may well be left with distressing memories of

these experiences. Whether the adverse events occurred in childhood or in adult life, if patients continue to experience frequent intrusive memories of these events, then they might potentially benefit from imagery rescripting.

### Methods of Imagery Rescripting and Potential Underlying Mechanisms of Change

There are theoretical mechanisms underlying imagery rescripting that may provide a rationale for its potential use in treating depression. Therapeutic procedures that are effective in reducing intrusive memories in personality disorders and posttraumatic stress disorder (PTSD) could potentially be applied to reduce intrusive memories in depression. Imagery rescripting is an effective treatment for personality disorders (Arntz & Weertman, 1999; Weertman & Arntz, 2007). It has also been successfully used to treat PTSD resulting from childhood sexual abuse (Smucker & Dancu, 1999/2005) and from industrial accidents (Grunert et al., 2007). It has also been used to treat social anxiety disorder (Wild, Hackmann, & Clark, 2007). Rescripting aims to reduce the distress associated with memories of past events that color the patient's experience of the present.

Cognitive models of PTSD (Ehlers & Clark, 2000) suggest that traumatic memories are stored with the meanings that they had at the time of the event. The highly successful treatment approach (Ehlers, Clark, McManus, & Fennell, 2005) based on this model involves accessing the meanings of these memories through imaginal exposure. These meanings are discussed with the therapist to discover new information that challenges the toxic meanings of the memory. This new information is then incorporated into the memory structure using imagery techniques. The meaning of the memory is updated by asking the patient to imagine the event once more, but this time inserting corrective information. This method of imaginal reliving usually involves updating the memory to include information about what *actually* happened (e.g., that the patient did not die). In contrast, the method of imagery rescripting allows for more "artistic license," as the memory may be transformed in ways that couldn't possibly have happened at the time. For example, patients may imagine their adult "survivor" self intervening to protect themselves as an abused child. Imagery rescripting can be thought of as a kind of mental time travel in which the patient imagines him- or herself traveling back in time, revisiting key scenes from their past. This rescripting process must be closely related to the key cognitions of the patient in order to be meaningful. Simply asking the patient to imagine some fantastical outcome that could never have happened will not be helpful unless the imagery transformation

challenges the toxic meaning of the original memory. This process allows the patient to construct a new representation of the original memory that challenges its original meaning, and will hopefully be preferentially recalled over the toxic one. According to the retrieval competition hypothesis (Brewin, 2006), our sense of self consists of different representations, such as memories that compete with each other. These competing representations directly influence our beliefs and behavior. The implication of this hypothesis is that it might be possible to create new representations of key memories using imagery techniques. If these new representations are memorable and meaningful, then they may be strong enough to compete with the original representation that had been stored with all its negative meanings.

### Exploratory Study of Imagery Rescripting With Depressed Patients

An exploratory study was recently conducted to see whether imagery rescripting could be effective as a stand-alone treatment for depression in patients with intrusive memories (Wheatley et al., 2009). This study included 10 patients with a long history of depression; in some cases depression was associated with a history of childhood adversity, and in others depression had been precipitated by severe life events in adult life. Several patients had experienced distressing events in both childhood and adulthood, and were troubled by a variety of intrusive memories from key scenes throughout their lives. The average age of patients was 41.3 (range: 30–56), the mean length of their current depressive episode was 2.3 years; all had experienced previous depressive episodes and 6 also had comorbid anxiety disorders. Prior to treatment, half the patients scored in the severe range and the other half scored on the moderate-severe range on the Beck Depression Inventory (Beck, Steer, & Garbin, 1988).

The exploratory study found that memories of childhood and adult life events responded equally well to rescripting. For detailed case examples, see Wheatley et al. (2007 and 2009). The average reduction in Beck Depression Inventory scores was 16.60 (*SD* 13.47) after an average of 8.1 sessions of imagery rescripting and gains were very well maintained at 1-year follow-up. Rescripting was most effective when intrusive memories were frequent and therefore more likely to be a maintaining factor in the disorder (for further details, see Brewin et al., 2009).

One problem that potentially complicates treatment is that intrusive memories may be associated with a ruminative thinking style. Rumination itself has been shown to predict depressive episodes and is associated with more severe levels of depressive symptoms (Nolen-Hoeksema, 2000). Studies have shown that intrusive

memories may be experienced within processes of ruminative thinking (Birrer, Michael, & Munsch, 2007; Pearson et al., 2008). This echoes the findings of Speckens et al. (2007), who found that in PTSD rumination can often trigger intrusive memories, and vice versa. Brewin et al. (2009) found that depressed patients with intrusive memories also reported high levels of rumination, and that their rumination decreased as the frequency and distress of their intrusive memories decreased. This reflects the tendency for intrusive memories and rumination to occur together and perhaps indicates that they are mutually self-supporting. For example, memory intrusions may provide powerful reminders of specific meanings concerning the self and thus trigger depressive rumination. It is therefore difficult to separate memories from their meanings and from the predominantly verbal process of rumination, as they are all connected. In summary, there is evidence that both intrusive memories and rumination maintain and exacerbate depression, and we have some promising initial evidence that imagery rescripting may be effective in targeting both these processes.

### **How to Use Imagery Rescripting in the Treatment of Major Depression**

This section describes the basic procedure of imagery rescripting before addressing some of the common clinical problems that may be encountered when attempting this technique with depressed patients. There are several protocols for imagery rescripting with different disorders (e.g., Arntz & Weertman, 1999; Hackmann, 1998; Smucker & Dancu, 1999/2005; Wild et al., 2007). These procedures nevertheless seem to share some fundamental ideas about good practice. It is advised that while reliving a distressing memory the patient should have “one foot in the memory and one foot in the room.” This means that they need to be reliving the memory in sufficient detail in order to be able to access the emotions and appraisals that are associated with it, but that they should not become so absorbed in the memory that they dissociate from the fact that they are in the therapy room in the present day. In order to best access the memory it is helpful for patients to close their eyes (if they feel comfortable doing so) and then visualize and verbalize the scenes that they see unfolding in their mind's eye, using the first person present tense, as if it were happening now. If the patient slips back into using the past tense, it is often helpful for the therapist to prompt them by simply repeating back to them what they have just said in the present tense. In order for the patient to access the entire memory network, it may be helpful for the therapist to inquire about the full range of sensory experience — what can the patient see, hear, taste, smell, or feel in their body when they hold the image in mind? It

may also be a good idea for the patient to name the different parts of themselves that they are imagining (e.g., their child self, adult self, survivor self, etc.) in order to avoid confusion during the procedure. It is helpful for the therapist to keep checking that the patient is visualizing a clear enough image and to inquire about associated emotions and sensations, but if the therapist prompts or inquires too much then this runs the risk of interfering with the patient's experience of reliving. Similarly, it is best for the emotional stance of the therapist to be relatively neutral during the imagery procedure; expressions of empathy should be made both before and after. If the therapist becomes too empathic during the procedure, this might bring the patient too far out of the memory and back into the room. As high levels of affect may be experienced by the patient when using imagery, it is advisable to begin the procedure early on in the session and to ensure that sufficient time is left for debriefing and discussion so that the patient returns to baseline levels of emotion before leaving the room.

We have suggested the following procedure when working with depressed patients (as described in Wheatley, Brewin, & Hackmann, 2009), drawing on ideas from Brewin, Arntz, Smucker, Ehlers and Clark, Holmes, and other colleagues. We summarize the steps in the process below before addressing some common problems and concerns that therapists might encounter.

Steps of the rescripting process:

1. It is often helpful when introducing the rationale for imagery rescripting to use the metaphor of the patient being haunted by the distressing memory (or memories). These ghosts from the past don't need to be banished, because memories cannot be erased, but the patient needs to be able to see them as “normal” bad memories of things that can no longer hurt them, and that do not have implications for their present.

2. The patient is asked to vividly imagine and describe the event represented in the distressing memory, bringing all the associated sensory detail, key associated emotions and cognitions into awareness. This stage of the process can be described as “imaginal reliving.”

3. After this reliving, the meaning of the memory is explored through Socratic questioning, and affect and belief ratings are taken. It is best to do this after, rather than during, the imagery exercise because taking such ratings may bring the patient out of imaginal reliving. It will, however, need to be done immediately after reliving so that affect is still “hot.”

4. The next stage is to begin rescripting the memory. The patient is asked what needs to happen in the scene that they are imagining in order for their distress to be reduced. The patient may need to try imagining several different ways of transforming the image before they settle on one that successfully reduces their distressed

affect and introduces feelings of safety, soothing or control (depending on what they may have needed at the time).

5. Belief and affect ratings are then repeated once a satisfactory transformation of the affect has been achieved. This is vital to check that the transformation has been meaningful and has led to a reappraisal of the original memory.

6. The patient rehearses and elaborates this alternative, more positive representation of the event from their past until the distressing affect and unhelpful beliefs associated with the original toxic memory are significantly reduced.

7. Finally, the therapist asks whether any other similar memories may have emerged either during the procedure, or in the days and weeks following the session. If new memories have emerged, then it is important to ask the patient whether the affect and meanings accompanying these memories are similar to or different from those associated with the original memory that had been targeted in therapy. Sometimes working on the original memory will be enough to change the meanings of other memories also, but it is possible that patients may access additional memories that they believe to be consistent with deeply held negative beliefs about the self, and these may require rescripting in their own right until those beliefs begin to change.

### **How to Proceed if the Patient Reports More Than One Distressing Memory?**

The prospect of attempting to rescript distressing memories can be a daunting one for inexperienced therapists (or for experienced therapists who may not be familiar with using imagery techniques). A common difficulty is that therapists are unsure which particular memory to work on and how many memories they might need to address before they can hope to bring about emotional and cognitive change. As mentioned earlier in this article, imagery rescripting can be used to treat either very recent memories of a distressing life event (Grunert, Weis, Smucker, & Christianson, 2007), or memories of childhood events (Arntz, van Genderen, & Drost, 2009; Arntz & Weertman, 1999; Weertman & Arntz, 2007). Our recent exploratory study used imagery rescripting successfully with a single memory and with multiple memories of events that had been experienced throughout the life span. The good news (for both clinician and patient) is that it seems we do not need to attempt to search for all the toxic memories that the patient might have. Our task is to change the toxic affect and meanings that are associated with particularly distressing memories, and we have found that working on just one highly emotional memory may be enough to change important strongly held beliefs about the self. In clinical practice we have often found that there is a network of self-defining

memories that are linked in terms of their meanings. It may be helpful to think of thematically linked memories as being located at the same “address in the mind.” It therefore happens that if we change the meanings associated with just one or two key memories, then the beliefs associated with other memories in the network may also change. We suggest a pragmatic approach of beginning with either the most frequent or the most distressing intrusive memory reported by the patient (often the memory that intrudes the most *is* the most distressing one).

Both therapist and patient will also be reassured that it does not seem to be necessary for the patient to relive the events of their intrusive memory in their entirety before they start to rescript the memory. It seems to be sufficient to ask the patient to visualize and verbalize the key moments from the memory that elicit high affect and associated toxic meanings. This approach is comparable to working on the “warning signals” (Ehlers et al., 2002) or “hot spots” (Grey, Holmes, & Brewin, 2001) of traumatic events in PTSD. These might be moments when the meaning of an event changed for the worse. For example, one patient in the study cited above reported that her distress was highest when she saw an image of her father, who had formerly been a boxer, collapse helplessly onto the floor of the hospice where he was being cared for. This was the moment when the patient realized that her father was no longer the strong man that he had once been and that she would soon be losing him. Another good place to start rescripting a memory might be at the moment in the memory that signaled that a distressing experience was about to happen. To give an example (again from the case series described by Brewin et al., 2009), for one patient simply imagining the sound and smell of an abuser as he approached her as a child was enough to elicit the associated emotions and meanings (“I am powerless and a bad person”). It has also been observed in work with personality disorders that it is not necessary for the patient to relive the whole distressing memory before rescripting it (Arntz & Weertman, 1999). How much of the original toxic memory needs to be “relived” by the patient before the memory is rescripted will be a judgment call that is more based on clinical art than clinical science.

It is important that the therapist does not make any assumptions about what the most meaningful aspects of a distressing memory might be. For example, one patient from the Brewin et al. (2009) case series had experienced several terminations of pregnancy during her twenties and was distressed by three different aspects of this experience: her perception that the medical staff had morally condemned her, her experience of feeling lonely and rejected following the procedure, and images of the tormented souls of her dead babies in the afterlife. Her

intrusions were therefore a combination of memories based on actual experience and her imagination of what may have happened to the souls of her babies. Accessing the meanings of a distressing experience might therefore require some detective work from the therapist, similar to the process of eliciting hot spots when treating PTSD (Grey, Young, & Holmes, 2002).

In summary, imagery rescripting can be used to treat memories of distressing events from both childhood and adulthood. Clinical experience suggests that there is often a network of distressing memories that are similar in terms of their associated meanings and emotions. Changing the meaning of one memory may transform the meaning of other memories in the network.

### Avoidance and Suppression of Distressing Memories

Although depressed patients frequently experience intrusive memories, they may attempt to avoid experiencing the emotional impact of these memories in various ways. Some of the patients in the Brewin et al. (2009) case series used drugs and alcohol in order to block out emotional memories. Fortunately, their substance misuse decreased as treatment progressed and their intrusions ceased. All patients in the series reported frequent and prolonged periods of rumination associated with their distressing memories prior to treatment. The functions of rumination as escape and avoidance strategies in depression have been suggested by Watkins (2004, 2005). Potential functions of rumination may include cognitive and emotional avoidance and anticipating negative responses from others or the environment in order to avoid criticism. Rumination about the implications of intrusive memories may indicate an overly evaluative thinking style. Imagery rescripting is an experiential technique that aims to switch patients out of the abstract-evaluative processing style of rumination into the actual experience of emotions, thoughts and sensations. The technique of imagery rescripting brings emotional material that may have previously been avoided “on-line” and into the patient's awareness, so that it can be processed and transformed with guidance from the therapist.

An important function of rumination may be to suppress the high affect that is associated with distressing memories. It has been suggested that the predominantly verbal activity of worry suppresses emotional imagery and its associated somatic sensations in patients with generalized anxiety disorder (Borkovec & Inz, 1990). As the process of rumination in depression is similar to the process of worry in GAD, rumination might function as motivated avoidance of emotional imagery and may have the effect of inhibiting the full sensory and emotional recall of distressing images and memories. The model of

PTSD developed by Ehlers and Clark (2000) suggests that such avoidance of emotional memories might be problematic as it may mean that the distressing memories are not carefully considered or elaborated, so that they are more likely to be stored with the meanings that they had at the time of the event (even if these were distorted). The past experiences of abandonment, loss, indifference, or abuse that are common in depression might therefore be appraised as having threatening implications for the patient's experience of the here and now, and influence their predictions about likely future experiences.

Active suppression of distressing memories might also have an unhelpful rebound effect. Dalgleish and Yiend (2006) found that when subjects tried to suppress one particular distressing memory, other upsetting past memories intruded more frequently—for example, when attempting to suppress a specific memory of failure, other experiences of failure came into mind. This possible rebound effect might go as follows: “I don't want to think about that memory of failure” spreads to “I don't want to think of any failure memories,” leading to intrusions of several memories in attenuated form.

In our clinical work we have found that patients often start to recall networks of associated memories when they are accessing one particular memory in therapy. It may be that rescripting helps people to bring memories that they have previously avoided to mind, perhaps because their metacognitive beliefs about the memories change (e.g., “It's only a memory or a ghost from the past, therefore I don't have to suppress it”). We have found that patients often report an initial increase in the frequency and intensity of their intrusive memories at the start of treatment and that this then fades as treatment progresses. This might be the result of an initial change in the metacognitive meanings of the memories (“I no longer have to avoid these memories”), followed by changes in the meanings encapsulated by the memories that had previously been avoided. In summary, it seems that trying to suppress a particularly distressing memory may have the paradoxical effect of bringing negative memories of similar experiences to mind, which may in turn fuel rumination. When patients are asked to bring a specific distressing memory to mind during the rescripting procedure, this will often result in recall of memories of similar distressing experiences. However, it is hoped that the meanings of these memories might change during the process of rescripting (e.g., “That was a painful experience but it may not have the toxic meaning that I once thought it did”). If a network of related memories are all to be found at the same address in the mind, then when the meaning of one memory changes it may also change the “post-code” of other associated memories.

There is a potential overlap here between imagery rescripting and the practice of mindfulness-based cognitive

therapy (Segal, Williams, & Teasdale, 2002). Mindfulness-based cognitive therapy (MBCT) encourages patients to allow emotional material that may previously have been avoided or else endured with distress into their awareness. MBCT does not aim to change the content of patients' cognitions, but to help them learn a new relationship to their thoughts as simply "events in the mind." Patients are encouraged to experience the contents of cognition, thoughts, images, memories and the emotions that accompany them without their habitual reactions of aversion or judgment. Imagery rescripting has a similar rationale of allowing cognitive and emotional phenomena that may previously have been avoided into awareness, so that patients can learn a new relationship to their memories of these events (perhaps also coming to see them as simply mental events). This provides an opportunity for the meanings of the memories to be updated. Images rarely remain static and sometimes simply encouraging the patient to hold an image in awareness will lead to reflection and perhaps a new understanding of the experience that is represented in memory, which may result in spontaneous emotional change. In addition, the therapist does not suggest imagery transformations to the patient; rather the therapist Socratically helps the patient to envisage and elaborate their own rescript, based on their wider experience of the world and their understanding of how they need to feel when holding the memory of mind.

In summary, avoidance of distressing memories seems to be common in depression. Imagery rescripting is an experiential technique that aims to help patients to allow this emotional material into awareness so that the meanings of key events from the past can be reappraised. This process sometimes leads to spontaneous cognitive change.

### **How to Help a Patient to Effectively Rescript a Distressing Memory**

One reason that therapists might avoid using the technique of imagery rescripting is that they are unsure exactly how a rescript of a memory is supposed to unfold. The therapist cannot predict what the patient will be imagining or where the rescript might lead. There are parallels here with the process of conducting behavioral experiments (Bennett-Levy et al., 2004), another technique that generates high levels of affect. When engaging in the experiential techniques of imagery rescripting or behavioral experiments, neither therapist nor patient can predict exactly what the outcome will be. As Aaron Beck has said, cognitive change takes place "within the fires of affect" (cited by Edwards, 2009) and the high levels of affect that are generated by these techniques may partly explain why they can be powerful methods to activate and

then reappraise beliefs. In cases where the patient is anxious about engaging in imagery work, it may be helpful for the therapist to frame the exercise to them as a behavioral experiment and to ask them to make predictions about the process: for example, how much distress do they think they will experience or to what extent do they think they will be in control of what they imagine?

It has been suggested that Socratic imagery is likely to be more powerful than therapist-directed imagery (Smucker & Dancu, 1999/2005), and our own clinical experience would concur with this. Asking Socratic questions—such as, "How do you need to feel when you hold this memory in mind?" "What would need to happen (in the image) in order for you to feel okay?" "Can you imagine that happening?"—might help the patient to arrive at a rescript that works for them (i.e., one that allows them to access more positive emotions and that challenges the original toxic meaning of the memory).

Just as when you are planning effective behavioral experiments, it is important to specify the key cognitions and emotions associated with any memory before attempting to rescript it. Any changes in affect or belief ratings must be carefully tracked both before and after the rescripting process. Tracking cognitive and affective change in this way serves as a manipulation check to see whether or not the rescript is reducing toxic affect and changing the associated meanings. Taking belief and affect ratings before and after any rescripting is important because sometimes powerful shifts in degree of belief can take place within a single session, and the belief ratings provide a marker of such shifts. For example, in cases of childhood abuse, sometimes asking the adult patient to vividly imagine themselves as they were when they were a child can produce spontaneous feelings of compassion towards themselves ("She's so little and defenseless") and reappraisals of the abuse ("It's not her fault, she's only a little girl—it's him that's the bad one"). A further reason why it is so important to take these ratings is that different memories in the associative network may be associated with similar emotions and beliefs. For example, one patient recalled three different memories from different ages that all had the same cognitive theme of being at the mercy of more powerful people and the same sensory qualities of being unable to stand up on her feet: an early memory of being placed on a donkey against her will during a seaside holiday as a little girl; a childhood memory of being pushed down some steps by a gang of older children; and an adult memory of having her legs held in stirrups during a termination of pregnancy. Taking affect and belief ratings helped the therapist to keep a check on the process of change in the key cognitions and emotions associated with these memories.

A final reason to take belief and affect ratings before and after the rescripting procedure is to see whether any

positive emotions and meanings associated with a rescript are retained by the patient once they leave the therapy room. A significant shift in belief ratings might occur immediately following an intensely emotional imagery exercise within the session, but if the rescript is not distinctive or meaningful enough, then the old representation and meaning of the memory may be retrieved in response to environmental triggers when the patient leaves the safety of the therapy room. As Brewin has suggested in his retrieval competition hypothesis (Brewin, 2006), our emotions and behavior are under the control of alternate memory representations that compete for retrieval. This means that any new representation that is created in therapy must be able to compete effectively with the old toxic representations of the memory. As the intrusive negative memories are likely to have been well-rehearsed, any new representation will need to be distinctive and meaningful if it is to effectively compete with them. The task in therapy is to help the patient construct competing representations of the memory that are similar enough to the old toxic representation to be retrieved by environmental reminders of the event, but different enough to access positive feelings and beliefs. It would therefore be ineffective for the patient to simply substitute a “good” memory for a “bad” one, or for a new representation to gloss over the distress associated with the old memory. The new representation is not a replacement for the old memory, but rather an elaboration of it, taking into account information from a wider context. During the rescripting process the patient holds the distressing experience in working memory while introducing positive visual and sensory content. Competing representations of the memory are linked to the imagination of positive states such as mastery over adversity or compassionately relating to the distressed self. At the end of treatment the patient will still be able to recall the negative experience, but with a new understanding of the meaning of that experience; perhaps the knowledge that they survived, that they coped with it as best they could, or that it wasn't their fault. One further implication of the retrieval competition hypothesis is that any avoidance of distressing memories by the patient during treatment might make it difficult for them to construct a new representation of the memory that will be robust enough to compete with the old representation. This might leave the patient vulnerable to relapse because the old memory network may be easily triggered by reminders and because key parts of the memory may not have been updated.

In summary, just as in standard cognitive therapy methods, the therapist should take belief and affect ratings associated with each intrusive memory before and after rescripting them. These ratings will help the therapist and patient to Socratically create a meaningful

competing representation of the experience and serve as a manipulation check of the techniques' effectiveness. The therapist needs to ensure that any competing representations of a memory will be memorable and meaningful enough to be able to compete with the original intrusion.

### **How to End a Rescript: Is Mastery or Compassion More Important When Treating Depression?**

The greater artistic license that therapists have when using imagery rescripting as opposed to imaginal exposure or reliving can cause some confusion. Imagery rescripting allows the patient to give a distressing memory an alternative ending. This does not mean that we invite patients to simply imagine that the distressing event never happened (e.g., that they were not abused and that their parent did protect them). The aim is to give the memory a different meaning by rescripting it according to what it might have been helpful for the patient to have known or experienced at the time of the event (e.g., to know that the abuse wasn't their fault or to feel a sense of safety). Imagery rescripting is essentially an experiential technique with a cognitive rationale; the aim is to change the key cognitions associated with a distressing memory by asking the patient to imagine altering events of the past in ways that challenge their original appraisals of them. Whereas imaginal exposure would have a habituation rationale, imagery rescripting aims to create an alternative representation of the memory that will give new meaning to the experience.

When constructing a competing representation that is linked to positive affect, clinicians are often unsure about to what degree the rescript should involve elements of mastery imagery (during which the patient accesses feeling of power and resourcefulness) or compassionate imagery (during which they access feelings of being soothed or nurtured). Depression is frequently associated with feelings of helplessness (Abramson, Seligman, & Teasdale, 1978) and shame (Andrews, 1998). Furthermore, depressed patients often have high levels of self-blame and self-attacking (Gilbert & Irons, 2005). Imagery rescripting for depression therefore needs to find ways to address these core cognitive and emotional problems. It has been suggested that when using imagery rescripting to treat anxiety disorders, elements of both mastery and compassion are necessary in order to reach positive reappraisals (Hackmann, 2005). This has also been suggested when treating depression (Wheatley et al., 2007) to address the common themes of helplessness, shame, and self-blame. However, it is currently unclear how best to combine these two elements in a rescript, and what their relative contributions might be towards change. How can we judge whether or not a rescript

contains the right proportion of mastery and compassion? This is an empirical question that we cannot currently answer and so our best guide will be the belief and affect ratings made by patients as the process unfolds. If a key cognition or emotion is not changing, we may need to ask whether this can be linked to a theme of shame, helplessness, anger, or some other emotion not yet addressed. We will then be able to consider various ways in which the patient may need to try altering the events that they are imagining so that they will have a different emotional experience of them.

The distinction between mastery and compassionate imagery can be important as different types of positive affect may be experienced quite differently by the patient. It has been suggested that positive affect associated with affiliation might be very different to positive affect associated with mastery (Gilbert, 2008). In clinical practice we have observed that patients might initially want to begin a rescript by increasing their sense of power or control, for example, to banish an abuser or stand up to a critical figure. Following these mastery-based transformations, patients may then express more of a need for soothing or nurturing their distressed self. Paul Gilbert's work would suggest that it might be best to end a rescript at a point when the patient is accessing and experiencing feelings of soothing and affiliation through imagery rather than feelings associated with mastery or "drive." However, it may not be easy for some patients to generate such compassionate representations. Patients who are highly self-critical may find it much harder to create compassionate images, and may even find being asked to do so aversive because of associative links to memories of neglect or abuse in previous attachment relationships (Rockliff et al., 2008). If patients *are* able to access emotional memories of affiliation, then the task of therapy is simply to bring those feelings and experiences on-line. In such cases, simply asking the patient to imagine themselves as a child may lead to spontaneous feelings of compassion. However, if patients do not have sufficient access to memories of affiliation or nurturance, then they may need some guidance from the therapist before they can imagine these experiences. Creative imagery techniques aimed at helping patients to construct an image of their "perfect nurturer" in order to access feelings of soothing and safeness have been described elsewhere (Lee, 2005).

One final example from the Brewin et al. (2009) case series illustrates some ways in which patients can be helped to access ways of relating to themselves compassionately during imagery rescripting. A severely depressed patient in her mid-30's had been emotionally neglected by her parents, whom she had experienced as being either preoccupied with their marital difficulties or highly critical of her. We went through the following steps in

therapy before she was able to generate a compassionate representation that could effectively compete with her dominant intrusive memories. First, the patient chose to bring photographs of herself as a child to the therapy sessions to help her imagine the key scenes from the past. She then brought a compassionate figure into the image (an aunt whom she had experienced as kind, but who had not known the full extent of the child's distress at the time). The patient was able to imagine this aunt intervening to protect her child-self. During the imagery exercise the patient recalled new information that had previously been outside her awareness—that as a child she had regularly taken her pocket money and put half of it into each of her parent's coats in the hope that this might stop them fighting. This memory helped the patient to feel some compassion for herself as a child and she now felt more inclined to intervene in the image as her adult self. However, she was unsure how to respond compassionately to her child self, perhaps because she was unable to access memories of this actually happening to her. The patient was then asked to think of someone in the present whom she felt compassion towards. The patient thought of a cousin who had Down's syndrome and imagined hugging him. Holding on to that feeling of affiliation, she was then able to imagine her adult self hugging her child self. Following this session, the patient started to grieve that her parents had been so preoccupied with their problems that she had not received the care that she had needed as a child. This resulted in feelings of sadness, then of anger, before the patient was able to arrive at a more balanced and compassionate adult perspective of her childhood experiences (for a more detailed account of this work see Wheatley et al., 2009).

In summary, creating an alternative representation of a distressing memory is a creative process that often involves elements of both mastery and compassion. The alternative representation is not a replacement for the original memory, but the process of rescripting allows the patient to bring in new perspectives that hopefully change the meaning of the original event.

### Summary, Conclusions, and Further Questions

Imagery rescripting can be a powerful way of first accessing and then transforming distressing memories that might be maintaining depression. Our sense of self and our memories are closely intertwined (Stopa, 2009), and so working on key memories may lead to reappraisals of negative or traumatic experiences that can result in fundamental shifts in how patients see themselves. As one patient commented at the end of treatment (quoted in Brewin et al., 2009), "It's like I've salvaged my self, my soul."

However, although the initial results that have been obtained using imagery rescripting to treat major



depression seem promising, we should remain cautious as this evidence is thus far restricted to a small sample size. Imagery rescripting can currently only be said to be evidence-generating practice rather than evidence-based practice. In order for the results obtained in Brewin et al. (2009) to be placed on a more secure footing, there would need to be a randomized controlled trial comparing rescripting with standard cognitive restructuring procedures.

There are also many unanswered questions about the possible mechanisms of change underlying imagery rescripting. An explanatory framework may be offered by cognitive models of posttraumatic stress disorder, or by the retrieval competition hypothesis. One important question is whether rescripting works by creating more functional self-representations during therapy, or by improving access to positive representations that previously existed, but that had been outside the patient's awareness. We also do not know precisely what the most powerful elements of an effective rescript might be. Given the current limitations of our knowledge base and the high levels of affect that can be generated through imagery techniques, many therapists may feel cautious about using imagery rescripting with depressed patients. However, imagery rescripting may prove to be a useful addition to standard cognitive behavioral therapy for depression, particularly when distressing intrusive memories are reported.

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