ORIGINAL ARTICLE / PSYCHOTHERAPY

Imagery rescripting of traumatic or distressing stories from childhood

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Abstract

A proportion of patients with mental disorders report significant stressful experiences in their childhood. In many others, basic childhood needs, such as security, acceptance or appreciation, were not met. Without systematic processing of such traumatic experiences, their therapy fails and their problems become chronic. The basic principles in the treatment of patients who have developed mental disorders, contributed to by childhood and adulthood stressful events, include establishment of a therapeutic relationship, explanation of and education on what is happening with the patient and decreasing or removing stigmatization and feelings of guilt. The therapist helps the patient understand how the symptoms are related to burdening events of the childhood and current problems. As a rule, rescripting is initiated only after cognitive processing of basic attitudes (core beliefs) and derived rules. The therapeutic process may be divided into several steps (a) creating a therapeutic atmosphere (security and control, acceptance, appreciation); (b) imaginal exposure to painful experiences; (c) expressing negative emotions towards aggressors or persons who could not protect; (d) expressing the child's needs towards the person who should have protected him or her; (e) experiencing a better end – imagery rescripting of the story; and (f) general calming. The therapist's task is to help the patient to recall his or her memories of the stressful event and express an adequate affective experience, and then help him or her reprocess the experience so that its consequences were less painful. The text provides several examples of imagery rescripting of traumatic events.

Introduction

Psychiatric care is often provided to patients with anxiety, affective or personality disorders who describe severe stressful experiences in their childhood and adolescence such as physical, sexual or psychological abuse, maltreatment, as well as refusal, embarrassment, indifference or coldness from their nearest relatives. Frequently, they show high levels of dissociative phenomena preventing them from complete processing of stressful events (Pastucha *et al* 2009a, 2009b; Prasko *et al* 2009b, 2010b). A population study showed relationship between dissociation, childhood sexual abuse and development of psychiatric disorders in adults (Mulder *et al* 1998). In many of them, basic children's needs such as security, acceptance and appreciation remained unmet. Such patients benefit less from common pharmacotherapeutic or psychotherapeutic interventions and often are resistant to therapy (Prasko *et al* 2009b; 2010c). Imagery rescript-

ing and reprocessing have long been a part of cognitive behavioural therapy (CBT). In recent years, however, this approach has been increasingly used, mainly in patients with stressful intrusive memories and thoughts, such as those who experienced excessive stress or abuse in their childhood or traumatic events in the adulthood (Holmes *et al* 2007). This approach seems to significantly shorten the patient's treatment and suffering and to leed to faster recovery than traditional exposure therapy (Ohanian 2002; Arntz 2007). Reprocessing of both childhood and adulthood intrusive experiences has proved to be an important therapeutic strategy in patients with social phobia (Stopa & Jenkins 2007; Wild *et al* 2008), personality disorders (Weertman & Arntz 2007), posttraumatic stress disorder (Arntz *et al* 2007; Grunert *et al* 2007), specific phobia (Hunt & Fenton 2007), obsessive-compulsive disorder (Lipton *et al* 2010; Prasko 2010) and depressive disorder (Wheatley *et al* 2007; Brewin *et al* 2009). The results also suggest that rescripting makes the treatment more acceptable for patients and leads to better effects on emotions like anger or guilt than imaginal exposure alone (Arntz *et al* 2007).

Approach to work with negative childhood experiences in imagery therapy

The following text will provide descriptions of the approach to work with past negative experience as proved to be useful in our patients. It was developed by adapting techniques of prolonged exposure (Foa *et al* 1999; Foa & Kozak 1986), imagery of childhood experiences used in schema-oriented therapy (Weertman & Arntz 2007; Arntz & Weertman 1999; Young *et al* 2003), imagery rescripting of traumatic stories or images (Stopa & Jenkins 2007; Hunt & Fenton 2007; Prasko *et al* 2010a) and treatment for nightmares (Davis & Wright 2006). It is frequently complemented by therapeutic letters and role-play (Prasko *et al* 2007, 2009a). The basic principles in the treatment of patients who have developed mental disorders, contributed to by childhood and adulthood stressful events, include establishment of a therapeutic relationship, explanation of and education on what is happening with the patient and decreasing or removing stigmatization. The therapist helps the patient understand how the symptoms are related to burdening events of the childhood and current problems. The need for gradual emotional reprocessing of painful experiences (Prasko *et al* 2007). As a rule, rescripting is initiated only after cognitive processing of basic attitudes (core beliefs) and derived rules. The therapeutic process may be divided into several steps:

(1) Creating a therapeutic atmosphere (security and control, acceptance, appreciation)
The first step is to establish a therapeutic atmosphere and *create feelings of security and control* for the patient. These feelings form a basis for further work and enable the patient to take control of processing the event. Initially, emotional support and calming are most important. The aim is to achieve the patient's inner balance by relieving emotional tension. This is helped by the therapist's calmness and equanimity, stressing that the patient did the right thing when he sought help, personal interest, empathetic listening, acknowledging concerns and worries, and facilitating to express negative emotions (Prasko *et al* 2010a). Only after the basic feeling of security is created, the therapist may explain that his or her offer is to work on painful experiences from the past (childhood, adolescence or adulthood) already mentioned by the patient during history taking or on some other occasion. Also at the beginning, the patient is told that discussing such painful experiences may be stressful and is asked to tell the therapist that he or she feels too overloaded so that they together may draw attention to another topic, calm down and continue when the patient feels ready to continue or terminate the session and postpone further work on painful experiences to when the patient is prepared for it (Prasko *et al* 2007). The therapist stresses that it is important that the entire processing of painful experiences is fully under the patient's control and will be carried out at his or her own pace. Throughout the therapy, the patient's control over processing of the events is repeatedly stressed to help him or her to stop feeling like a victim which is typical on presentation to the therapy.

Another important feeling for the patient is the *feeling of acceptance*. Then the therapist shows empathetic interest in what was painful in the patient's life, focusing the questions on the childhood and adolescence. This step aims especially at providing a brief description of the most important childhood and adolescence painful experiences. Usually, the patient depicts them briefly, being upset by the memories themselves. He or she is often very emotional, cries and rapidly turns attention from a more detailed description. Frequently, there are feelings of guilt, shame, stigmatization, rejection from others, difference, helplessness or anger towards his or her relatives or himself or herself. The therapist listens empathetically (I understand, it must have been very difficult for you... as you say that, I have the same feelings... etc.). It is important that the patient feels

Table: Sequential steps in imagery rescripting of negative childhood experiences.

(1)	Creating a therapeutic atmosphere (security and control, acceptance, appreciation)
(2)	Imaginal exposure to painful experiences
(3)	Expressing negative emotions towards aggressors or persons who could not protect
(4)	Expressing the child's needs towards the person who should have protected him or her
(5)	Experiencing a better end – imagery rescripting of the story
(6)	General calming

accepted by the therapist. Therefore, all feelings must be validated. The therapist must show that he or she trusts and understands the patient and wants to find a common way of how to process the past events so that they do not interfere with the patient's life any longer. The feelings of guilt should be reduced by pointing to the child's helplessness to defend oneself and to the fact that adults were supposed not to harm the child and obliged to protect the child. The feelings of shame must be first openly understood and then normalized (Unfortunately, many people had similar experiences that were always very painful for them; many people are ashamed of them although it was not their fault). An atmosphere of acceptance is crucial for decreasing the feelings of guilt, shame and anger at oneself. If the patient feels accepted by the therapist with all his or her feelings and thoughts (including a desire to take revenge for one's childhood and wishing the worst to the aggressor), he or she gradually begins to accept himself or herself in a better way. Throughout the therapy, the patient must feel understood by the therapist.

The third feeling crucial to creating a therapeutic atmosphere is the *feeling of appreciation*. It is very important to *encourage* the patient and *praise* him or her for being brave to talk about painful experiences, and to appreciate how difficult and stressful such depiction is. If the patient describes how he or she coped with painful experiences, overcame stress, tried to change anything, open up to somebody, and yet was able to learn, help others or care for siblings, he or she should be repeatedly praised for that. Gradually, appraisal contributes to the feelings of control. The inner attitude of control gradually helps to neutralize lifelong feelings of defeat, helplessness and a lack of control that the patient was often unable to cope with on his or her own.

The atmosphere of security, control, acceptance and appreciation should be created at the beginning of each session since this facilitates the work on painful and stressful matters. The therapist makes the patient return to this atmosphere before the session ends.

(2) Imaginal exposure to painful experiences

The patient recalls one of important events experienced during the childhood. The patient is asked to close the eyes and describe, in the present tense, what is happening. He or she is encouraged to describe not only the outer events but also inner experiences: thoughts, emotions, behaviours and physical reactions. The individual experiential systems are repeatedly alternated to make painful experiences emerge from denial and dissociation and to integrate them as a conscious part of the psyche.

(3) Expressing negative emotions towards aggressors or persons who could not protect

The key step in processing stressful childhood memories is to express emotions towards aggressors or persons that could not provide protection or security and acceptance. The emotions are often both negative, such as anger or rage, and asthenic, such as helplessness, sadness or fear. This step helps to express emotions that have not been expressed and could have been hold in for years (traumatic emotions) and to release them. It is particularly important for patients suffering from strong feelings of guilt for what happened during their childhood (such as sexual or physical abuse) who are persuaded that it was their fault (due to their character, awkwardness, mistake etc.). They may rationally know that it was not their fault but feel it that way emotionally. Particularly strong feelings of guilt are observed in patients accused by their relatives of harming the family, ruining its reputation or provoking the traumatic events. With the patient, this step may be elaborated in several ways – by writing a letter to the aggressor or relative who could not provide protection or security and acceptance (Prasko *et al* 2009a) or by sitting the person on a chair imaginarily and asking the patient to express everything that he could not say directly and without censorship, with the person having no right to respond. Another possibility is to let the patient close his or her eyes and have the conversation in imagination, that is the patient imagines the person and talks to him or her.

(4) Expressing the child's needs towards the person who should have protected him or her

Another step is to express the needs that were not met in the particular situation in the childhood. In imagination, the patient tells a close person what he or she would need, his or her most important needs that should be met. He or she asks for help, defence, protection or punishment of the aggressor.

(5) Experiencing a better end – imagery rescripting of the story

The final step is reprocessing the story so that the patient experiences feelings of another, better end. If it is possible to imagine that the patient solves the situation in a different way and by himself or herself, he or she is asked to do that in imagination. If it is unimaginable, the patient may imagine himself or herself as an adult protecting a small child in the traumatic situation. Another possibility is to imagine that another person or the therapist enters the situation. The patient is asked whether in the past, there was a person he or she trusted and loved and who could have protected him or her in the traumatic situation. Frequently, this is a grandparent, sometimes a parent or an aunt. The patient is asked what that person could have done to help him or her in the situation. In imagination, the traumatic situation is recalled and the "protector" is let step in. The patient is supposed to narrate what happens after the protector steps in, how he or she treats the aggressor (usually pacifies him or her) and, subsequently, the traumatized child (usually calms, hugs, shows security and love). It is necessary to ensure that the patient is afforded the

imagery experience of being protected, copes with the situation, is accepted etc. In the real past this was not true but the new better ending aids in current emotional coping with the past situation.

(6) General calming

Once again, the imaginary experience is verbally discussed and put in the context of the patient's entire story. It is important to praise the patient both for having the courage to enter the experience and for how he or she managed to rescript it. If tension or physical symptoms of anxiety appear, it is advisable to relax with the patient or imagine a secure place. In most cases, however, after recapitulation of the experience and strengthening from the therapist, the patient is calmed and experiences an overall relief.

Clinical vignettes

The following examples are to illustrate several cases of imagery rescripting.

A woman raped by her brother at the age of 11

Marie, aged 40, presented to the department with a prolonged depressive disorder resistant to antidepressant therapy. After one-week stay at the department she said she recalled being sexually abused by her brother at the age of 11. At nights, she was woken up by terrifying dreams of that or other dangers such as falling into depths or being chased by unknown persons. As a child, Marie went through a lot of painful experiences. Both her parents were heavy drinkers, fighting with each other. She recalls being repeatedly woken up late at night by the noise of them returning from pubs. On one occasion, her father burst into her room and locked the door, her mother broke the door with an axe, being thrown to the floor and beaten up by him. She repeatedly remembers asking them not to hurt each other. Eventually, her father left the family and her mother kept drinking and coming home late. The only person Marie could trust was her grandmother, the father's mother. But she was not allowed in by the mother and Marie had to go and see her in her flat on the other side of the village. When Marie was about nine years old her older brother started to touch her private parts. When she complained to her mother she was scolded for not telling the truth and repeatedly called "a little liar". Her mother had doted on her brother and ignored his faults since his early childhood while she had picked on Marie since she had been a young child. When Marie was eleven her brother got into her room and raped her while she was asleep. She has been haunted by memories of that for her entire life. Once she came of age she got married to escape the family. But she could not enjoy her sexual life that reminded her of that traumatic event. However, the memories did not come back on other occasions. But three years ago, when her husband started to drink excessively, intrusive memories of the incident began to appear regularly. She was woken by repeated terrifying dreams and gradually developed depressive mood. Two-year outpatient therapy with repeatedly changed antidepressants failed. Therefore, Marie was referred to a hospital. There she complained of terrifying dreams. After a physician asked her about their content she started to cry and gave an account of what had happened in her childhood. Comprehensive therapy during her hospitalization also comprised exposure to the traumatic event and its imagery rescripting.

T: Try to sit comfortably. Relax your body... breathe calmly... Describe how you feel now.

M: A bit tense here... in the neck... and the legs... they shake. I am a bit worried that we will discuss those unpleasant things... But at the same time I want that.

T: You are right, we will discuss them as agreed this morning. But I want you to control the pace of that. Any time you feel that the tension is too high or any time you decide to interrupt the talk, just do it. It is very important that you have control over what we discuss and the pace. So that you may protect yourself from excessive stress during your narration and imagination. There is always stress but you should control it so that it is not too difficult for you. Can we agree on that?

M: Yes, we can... if it is too much, we will stop.

T: Exactly, it will be under your control... Now try to tell me how you feel... physically as well.

M: A bit better since we started our talk. I have relaxed.

T: Well, try to describe the incident with your brother. Go back to that memory and describe what happened at that time, how you felt...

M: I woke up at night, my brother was lying on me and he raped me... (she cries). Then he left. I felt filthy... in fact, I have felt like that all my life. I should have locked the door but I forgot to. It was my fault...

T: Errr... I can see that the memory is difficult... you are very sad because of it and you blame yourself. Whose fault was it, yours or his?

M: Definitely his, but mine as well. I should have locked the door!

T: Do you think that most little girls have to lock themselves in their rooms?

M: No but I should have done that because he had felt me up before. But I never thought he would do it... I used to lock myself in the room... I was scared of him.

T: It must have been very difficult for you... that constant fear from him... locking the door all the time... and once you forgot and the thing happened... I am very sorry... I know it is difficult to describe but would you recall what happened and describe it... kind of a little bit from inside... with your eyes closed... everything you experienced... slowly, step by step, as if in slow motion... but again, if it is too intense do stop and I will help you calm down... then you will decide whether to continue or not... to have a complete control.

M: I woke up... he was lying on me, spreading my legs apart... I thought I would choke to death under his heavy body... a terrible fear... I wanted to scream but I could only wheeze... he covered my mouth with his hand... my legs were shaking... vibrating, I could not control them... (she stops as she is unable to continue and opens her eyes)

T: The memory is too painful. You were shaking. It was courageous of you to talk about it because it is so difficult. How are you feeling now?

M: Much better, now that I have opened my eyes... but when I was recalling I started to shake... I felt tightness in my throat... and my whole body was kind of heavy... as if I could not move.

T: And what is it like now?
M: Now it's okay...
T: Let me ask you, was there anyone in your life who could have helped you in such a situation... if he or she came there... I know that nobody came there but was there anyone who would have protected you if he or she knew about it?
M: Not my mum, when I told her the whole thing when I was eighteen she said that I was lying against my brother and that I had lied since my childhood... the only person that really loved me was my granny. But she lived on the other side of the village.... far from our place...
T: What do you think your granny would have done if she had entered the room?
M: She would have beaten him black and blue!
T: Do you think you could imagine... her beating him... black and blue?
M: Oh yes, I sure could...
T: Try it then... try to reenter the imagination and get as far as to where you had to open your eyes... and let your granny enter... what will she do?
M: I'm waking up... my brother is lying on me, trying to get between my legs... it hurts a lot... I'm scared, I want to scream...
T: Yes, you want to scream... it hurts, you are scared... consider when your granny might come in...
M: My granny flings the door open... she is in the room... shouting at him... she grabs his hair and drags him to the floor, beating him, kicking him... she has already kicked him out of the door...
T: Has she kicked him out?!... is she returning to you?
M: Yes, she is returning to me... giving me a hug... she is lying next to me and hugging me...
T: How are you feeling?
M: Very well... I'm crying... I am very well, nothing can happen to me now that my granny is here... (she is crying)
T: How do you feel in your granny's arms?
M: I feel fine... such a relief from everything, I 'm fine...
T: How do you feel physically?
M: Such a pleasant relief... all the tension is gone... I feel fine...

A catastrophic scenario of aggressive obsessions and rescripting the experience of shame in childhood

Aleš presents with sudden worsening of obsessions and compulsions 12 years after the last treatment. At that time, he was treated with a combination of clomipramine and CBT and achieved remission. About two years later he stopped taking the medication and mild problems appeared. But he lived another 10 years with occasional obsessions and little rituals that did not cause him much trouble. He graduated from a university, got promoted at work and bought a flat in Prague. He seemed to have a successful life. But suddenly severe obsessions and compulsions appeared. Now he is unable to sleep due to a fear of losing control. He sleeps in the bathroom since he fears that when falling asleep he might lose control and throw heavy dumbbells onto expensive cars parking under his windows. But even there he is not calm and fears losing control when falling asleep. So he rents another place to sleep which is better as it is on the ground floor. But due to other obsessions his sleep is still poor. During the day he is tired at work. Due to the lack of sleep, he cannot concentrate and experiences other aggressive obsessions. Sometimes he feels that he no longer wants to live like this. Then he is angry at himself for having the aggressive obsessions. Yet as a very religious person, he considers any aggression to be a bad thing. During the interview he first denied any stress before worsening of his condition. He was not aware of any changes in his life and yet there had been a sudden aggravation 4 months earlier. Another interview has revealed prolonged overwork. He thinks that recently, his subordinates have demanded solution of an increasing amount of problems from him. He is always on the go. But he is persuaded that they do not want any extra work from him and tries to deal with all the demands. He feels that he is angry at them but he is persuaded that he has no right to that. He is angry at himself for being angry at them. Most of all, he is angry at himself for the aggressive obsessions.

First of all, we focus on the most prominent obsession – his fear of losing control when falling asleep, taking his heavy dumbbells and throwing them out of the window onto expensive cars in the parking lot. In imagination, I let him go, step by step, through the worst scenario he himself could not even think of. He closes his eyes and depicts what is happening: "I am going to the balcony and I am throwing a dumbbell onto a car below. The dumbbell is going through the bonnet. I can see it making a hole in the metal. Now I am throwing another dumbbell. It penetrates the metal and hits the engine. (What is happening next?) People are running out into the street, shouting at me. Now they are running upstairs, breaking my door open. They are beating me up, I am on the floor being kicked. The police are coming. They are twisting my arms behind my back and handcuffing me. I am being taken out wearing only a T-shirt and it's freezing. The door is broken, the neighbours are demolishing furniture in my flat, taking my credit cards, destroying everything. I am spending long hours in a police cell. I am being interrogated and I am talking about my mental illness, that's the most difficult thing. I am being taken to a mental home. All of them, both doctors and nurses, know what I have done. (What next?) They are treating me... (What is it like?) a relief, I don't care at all. I feel sorry that everything I have accomplished is gone now... but I feel a relief that I do not have to try hard any longer..." Once again, we go, step by step, through the entire experience of imagination of the worst scenario. He is surprised by the feeling of relief at the end. He would let everything go and would not have to try to keep everything under control. We return to his feelings in the flat – he was embarrassed about everybody knowing that he was insane and about his confession. He felt like crying. I ask him whether he was that embarrassed at any time in the past, for example in his childhood. Many times. Which was the first experience he can recall? At the age of about eight, his mother took him for endocrine examination to assess his obesity. When the doctor undressed him she shrieked with surprise as she saw his extremely small penis. Then she was discussing that with his mother in front of him. Finally, she gave him a thorough examination and found his penis buried in fat. He was terribly embarrassed. He was just lying and felt helpless, lost and pitiful. Since then he has been concerned about having a small penis. Yet his sexual partners had a different opinion and were mostly satisfied. Objectively, he thinks that his penis is smaller but not extremely small and that it has not affected his sexual life.

However, he still has that feeling of embarrassment at not being a real man. Therefore, he has to try to manage and control everything to show that he is a real man. He begins to understand why he tries so hard not to fail at work and to oblige everyone. I suggest that in imagination, we return to the endocrinology experience. He closes his eyes to recall the memory and narrates. He can see his unhappy mother and the endocrinologist who tries to rectify her fault. Yet she gives him hormone injections. I ask him whether today, as an adult person, he would tell the doctor something to protect the small boy. He hesitates and then says: "Don't you realize that you hurt him? Why do you talk about it in front of him?" I ask him whether someone else could protect him more. His father. The one who left his mother. What would his father say to protect him? "How dare you talk like that? He is normal, his penis is normal and the function will be normal. It only seems like that because he is fat now. My penis used to be like his and now I have this boy." After this imagination he feels satisfied and relaxed. Once again, we discuss how his partners were always satisfied with his penis. He thinks that the aggression in his obsessions is meant to show his masculinity – breaking a car with a dumbbell. We laugh at this Freudian idea (15 years ago, he attended psychoanalysis sessions for 4 years). For him, a dumbbell making a hole in a car is an association with the penis (a big heavy dumbbell). He shows the nouveau riche with expensive cars that he is a real man who can easily break them. We return to the first imagination. He was most embarrassed when he had to confess to his mental disorder at the police station. Why was it that embarrassing? Because he is insane, strange, different. This is different from the feeling of embarrassment in the endocrinologist's office. I ask him whether in the past or childhood, he had the same feelings of difference, strangeness and embarrassment. Yes, many times. He instantly recalls his being at school, wearing a T-shirt and another boy, also obese, laughing at his breasts in front of other schoolmates. I ask him to return to this experience in imagination. He sees a boy who ironically says: "Your tits are even bigger than mine." He wishes the ground would open and swallow him up. He is helpless as he sees the others laughing. Once again, I ask him what he would do to defend himself. "I would punch him." We try this in imagination. He recalls the other boy laughing at him. He shouts and pounces on him. He beats him up until the other boy begs him to stop. "If you say that again I will smash your face in. And I will smash everybody's face in", he tells the others. I ask him how he feels. Fine, relaxed. I suggest that we return to the catastrophic scenario in imagination. We get to the moment when his neighbour breaks his door open. What would he do to defend himself? "I shout at him to get off or I will tear him up." He feels fine about it. "I don't think I would ever do it but I would stand up for myself, I would not let anyone beat me up and kick me." Once again, we discuss what we've been through. Yes, he does not feel like a real man so he tries hard at work. This is related both to his feeling of embarrassment in the endocrinologist's office and to being laughed at by his schoolmates. He also felt anger at that time but he could not express it. How is it associated with the presence? He realizes that now he is angry at his subordinates for demanding so much from him. He should defy them to make them deal with problems independently instead of trying to oblige everyone. On the one hand, he is a real man solving all problems instead of others, on the other hand, he fears being a real man and saying no to them. The obsession is a kind of an outlet for his aggression. In fact, it is "masculine", albeit excessive. But he wants neither to beat his subordinates nor to be verbally aggressive towards them. He would have to be ashamed. They do not even deserve that. He actually taught them to see him with every problem. We consider other options than verbal or physical aggression. He realizes that if he were able to tell his subordinates to let him relax he would not feel angry at them. We try to figure out how to express that. It appears to be a problem for him and he prefers to deal with everything again to avoid talking to them. In that case, he would overdo again. We try to return to those good feelings when he defended himself against the endocrinologist or schoolmate. What would he tell the subordinates to have a similar feeling? Ultimately he suggests saying: "Today, I've had enough. You try to do it by yourselves and let me alone today." It is important to prevent overburdening by giving them more responsibility and demanding solutions from them instead of looking for them by himself. He is satisfied with this suggestion but he is not sure that it will work in reality. He has never defended or objected like that. We try to play the situation repeatedly. My role is his subordinate. After a while, he does it quite well. Then we try to tackle his evening obsession. My suggestion is to use exposure. Instead of sleeping in the rented flat or bathroom he might try to sleep in his bed. We try to make it really difficult. He will put the dumbbells directly to the balcony and possibly leave the door open. He will probably not sleep and be tired at work again. He is very concerned and hesitant about that. It is likely that for 2 or 3 nights he will not sleep. But finally sleep will take him. If he can do that he probably will not be afraid any more. He would like that very much but he is not sure whether he will really do the exposure. I suggest that he will imagine throwing the dumbbells onto the cars and go through the entire catastrophic scenario in the evening to escalate his anxiety and "make it tired". He knows the principle from exposures 12 years ago. I also explain that the exposure is not obligatory. He may, but does not have to, try it – it is up to him. He will also write all today's imaginations down and imagine them repeatedly, including handling the situation.

Abuse by an uncle and rescripting

Martina has been admitted to a psychotherapy ward. What she expects from the stay is mostly memory training and improved physical condition. Her life changed dramatically two and a half years ago when she had severe encephalitis. After spending several days in a coma, she had to learn to walk and talk again. During the convalescence, her husband was her main support. For her, a very traumatic memory is the moment when she woke up in the ICU where, besides her husband, her parents were also present. When talking, she repeatedly returns to her life "before sick Martina". Prior to her illness, she was a successful entrepreneur and a mother of two students. Always successful in anything she did. After the illness, she tried to return to her work but her performance was significantly decreased. She was unable to work independently and after several months she decided to go on long-term sick leave. During her admission, she briefly mentioned that she had been abused by her uncle as a child but she flatly refused any talks about this issue. Only during the third interview she was willing to return to the topic of her abuse but

she claimed that she did not remember anything. We agreed that first she would try to write down the whole story. During the following session, Martina read the story of her abuse. Immediately afterwards we started imagination.

T: I appreciate your courage to describe that. Do you think we could return to the situation once more?
M: Yes.
T: Sit comfortably and try to close your eyes. Can you do that?
M: Yes I can.
T: Now try to return to the situation again and describe it to me. Imagine it like a film. Proceed slowly and do not leave anything out. If you feel that you cannot continue just stop. We will relax for a while and then continue if you want to. Can we start?
M: I think so. I remember that we were celebrating my aunt's birthday. In the night I could not sleep. I wanted to go to my parent's bed but they told me to leave. So I went to the kitchen to have something to drink. As I passed an open door to my uncle's room he invited me to his bed. I considered that perfectly normal. I was about seven years old and I did not know what to do. And then he gave me a stroke... then put my hand on his penis. I remember being confused. Then he asked me to kiss "it"... but that seemed strange to me. So I started to scream. My mum ran into the room, grabbed me from the bed... I still remember how it hurt... and yelled terribly. They forced me and my sister into the car and we rushed home. We never talked about it and I never let anyone know.
T: Can you think of anyone who could have helped you in that situation?
M: I don't think so... maybe my mum. She would definitely yell a lot but she probably wouldn't do anything to my uncle. And I wish someone hurt him!
T: And could anyone like that come there? Try to remember.
M: Well, I remember my other uncle being a very strong man. I am sure he would not be afraid of him.
T: You say that no one talked to you about it and that you did not know what was happening. Could there be someone to hug you at that moment, someone you could open up to?
M: Well, definitely not my mum... maybe my sister. We always were very close to each other. I would not be afraid to tell her.
T: Fine. Now, could you try to imagine a bit different story? Like your mum comes in and starts to yell. What would the other uncle do?
M: He would burst into the room and as he saw that he would grab his hair and throw him to the ground. Then he would kneel down on him and punch him with his fists... (Martina is sitting with her eyes closed and smiles happily.) It would be so nice.
T: And your sister? Could she help in any way?
M: Definitely. I would run to her, we would give each other a hug and she would comfort me... that would be nice.
T: So let's start the story again! Would you close your eyes and start from the beginning?
M: Fine, so I want to my mum and dad's bed but they do not let me in. I am going along the hall again. I see the open door... I'd rather not enter it at all...
T: I know but try it. Don't be afraid.
M: Okay then, I enter the door and there is my uncle, inviting me in. And I go to lie in his bed. He gives me a stroke and puts my hand on his penis and tells me to "kiss him there". And I know that this is not right and start screaming.
T: What do you scream?
M: Mummy, help! Quick!
T: And your mum's coming?
M: Sure. She bursts in, takes me from the bed and yells at my uncle terribly. Now the other uncle comes and pounces on him. He simply grabs his hair and throws him to a bedside table. And starts beating him black and blue.
T: What are you doing?
M: I run to my sister to tell her exactly what happened. She puts her arms around my shoulders and comforts me.
T: What does she tell you?
M: Martina, don't worry, it's not your fault, it will be fine again, I am here with you. Then we all drive away, the whole family, talking about it in the car.
T: Excellent. How do you feel now?
M: Perfect. It is a great weight off my shoulders.

Conclusion

Numerous patients with personality disorders, depression, dissociative or anxiety disorders as well as those with psychotic disorders experienced traumatic events in their childhood. Recalling traumatic childhood events and their emotional processing is often the most important approach that helps to increase personality adaptation and reduce resistance to treatment in patients who went through significant stressful experiences in their childhood. The therapist's task is to help the patient to recall his or her memories of the stressful event and express an adequate affective experience, and then help him or her reprocess the experience so that its consequences were less painful. After repeated rescripting of the event, the patient feels relieved and at the same time, the trauma no longer influences his or her concerns and attitudes. Rescripting of the stressful event alone does not mean entire therapy. Further steps must follow that help the patient solve current problems that have long not been solved due to traumatic memories or dissociation or have not been admitted by the patient.

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