ORIGINAL ARTICLE

Imagery rescripting for the changes of adverse memories and preparation for future

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Abstract

One of the leading modern methods used to treat traumatic memories is imagery rescripting. A therapist helps a patient (at least partially) to go through a stressful memory, express their unmet needs, and rescript the experience to become less painful.

Introduction

Classical approaches used in psychotherapy usually focus on dialogue, thinking, and experiencing emotions that are verbalized by language. Nevertheless, therapeutic and scientific attention has increasingly focused on the entire experience of the individual, their imagination, narrative and experiential approaches (Dadomo *et al.* 2016; Krupnik 2019). Integrative approaches have become the mainstay in psychotherapeutic care. The most researched therapy, cognitive behavioural therapy (CBT), which is integrative itself, continues to incorporate new elements as mindfulness, an experiential, narrative, and existential approaches.

Previous research has shown that intrusions of memories from different periods of life and in different experiential modalities are part of the symptoms of mental disorders (Andrade *et al.* 1997; Holmes & Mathews 2010; Arntz 2020; Tallon *et al.* 2020). Imagery work seems to be effective in treating such intrusive memories (Arntz 2012). One of the principal methods used to treat traumatic memories is imagery rescripting (Smucker & Niederee 1995; Hackmann *et al.* 2011; Arntz 2012). A similar approach can also change fears and worries related to anticipated difficulties (Reiss *et al.* 2017; Prinz *et al.* 2019; Maier *et al.* 2020). During rescripting, a therapist's job is to help a patient (at least partially) to go through the memory of a stressful event, express their unmet needs, and rescript the experience so that impact is less painful and more empowering (Hackmann *et al.* 2011; Arntz 2012).

Imagery rescripting is used in several types of psychotherapy, including cognitive-behavioural

therapy, schema-focused therapy, compassion-focused therapy, and emotion-focused therapy (Gilbert 2005; Holmes *et al.* 2007; Arntz 2011). A mental image that is being "rescripted" can be an aversive memory, which is transformed from a problematic image-based memory into a more tolerable image (Holmes *et al.* 2007).

Mechanism of imagery rescripting

Experimental studies have shown that imagination elicits a more robust emotional response than thoughts expressed in words (Holmes *et al.* 2008; Holmes & Mathews 2005) and acts as "an emotional booster" (Holmes *et al.* 2008) for both positive and negative emotions. The imagery rescripting is hypothesized to function in several ways (Stopa 2011). The cognitive hypothesis of imagery rescripting postulates that painful memories change a cognitive framework through rescripting because of a shift in critical cognitions (Wheatley & Hackmann 2011), modification of the "core beliefs" (Ohanian 2002; Cooper 2011), and a change of the negative meaning of the memory content (Arntz 2012). The imagery also decreases avoidance of sensitive material (Wheatley & Hackmann 2011). Providing a connection to maladaptive beliefs related to the imagery helps with modification of such beliefs (Grunert *et al.* 2007).

Although the cognitive hypothesis of imagery rescripting shows that rescripting must be closely related to the patient's key cognitions (Wheatley & Hackmann 2011), there is no evidence that the cognition change is essential for its effectiveness. In a traumatic film experiment performed in 83 non-clinical volunteers (Hagenaars & Arntz 2012), participants were randomly assigned to either an imagery rescripting, positive imagery or a control condition in which the traumatic film scene was recalled. During the rescripting, the participants directly focused on the memory of the film. In the conditions of positive imagery, the autobiographical memory unrelated to the traumatic film was evoked. Intrusions were reduced only after the direct rescripting. Dysfunctional traumatic cognition and distress were reduced more in the positive image group than in the controls, although the relevant stimulus associated with memories of the film was not explicitly targeted.

Further doubts about the need for an explicit focus on the meaning-relevant content of the aversive imagery come from research into the underlying mechanisms of EMDR, a therapy recognized as an effective treatment for PTSD (Bisson *et al.* 2007). In EMDR, patients remember a traumatic memory while performing horizontal eye movements. The formation of eye movements does not target the (semantic) meaningfully relevant content of memory as such but reduces the discomfort and vividness of memories during recollection (Andrade *et al.* 1997). Also, performing eye movements during recollection affects how memory is stored in long-term memory, which also makes subsequent recollection less vivid and unpleasant (van den Hout *et al.* 2001; Van den Hout & Engelhard 2012; Leer *et al.* 2014). A meta-analysis of 14 studies (Lee & Cuijpers 2013) concluded that the eye movement component significantly increases the effectiveness of EMDR. However, it should be noted that eye movements are evidently not the only therapeutic factor of EMDR, and other characteristics may also contribute to memory effects.

As an alternative to the cognitive hypothesis, the idea of mental imagery acting as "an emotional amplifier" (Holmes *et al.* 2008) opens up a possibility that other underlying imagery rescripting mechanisms may be present; namely, those that benefit from the properties of the imagery. The influence of imagery rescripting on changing emotional memories can be explained (at least partly) by a direct change in the perceptual aspects of memory representation, thus evoking a corresponding change in the related emotions. Making perceptual changes to imagery can include, for example, changing colours in the image or inserting objects in it. The image can also be changed to an alternative one by replacing the aversive image with actively generated positive images (without first creating an explicit semantic reference to the original image). Neither perceptual changes nor general positive images need to explicitly focus on cognitions, beliefs, or meanings associated with the original aversive images (content-relevant content). The possible advantages of these two types of imagery rescripting over traditional conceptual imagery rescripting (which is directly focused on the meaning-relevant content of aversive memory) are more straightforward and may require less therapeutic skills. That may be especially important in patients who do not appear to be able to create adaptive memory changes on their own (Arntz 2011). These types of rescripting can also be less burdensome for patients because less emphasis is placed on the content of the adverse memory.

Indication of imagery rescripting

Research studies have repeatedly shown that imaging techniques are effective in relieving the stress associated with stressful memories and have therefore become an essential part of cognitive-behavioural therapy and schema therapy in patients with severe emotional difficulties (Wild & Clark 2011; Nilsson *et al.* 2012; Frets *et al.* 2014; Arntz 2012). Imagery rescripting can sometimes be used as a complete treatment (e.g. in nightmares or PTSD) but is usually part of a more comprehensive treatment package (CBT, schema therapy).

Imagery rescripting is commonly used in patients with the following mental disorders:

- post-traumatic stress disorder (Smucker & Niederee 1995; Ehlers & Clark 2000; Grunnert and 2003; Holmes *et al.* 2007; Arntz *et al.* 2007; Long *et al.* 2011; Raabe *et al.* 2015; Morina *et al.* 2017);

- childhood trauma-related PTSD (Jung & Steil 2013; de Haan *et al.* 2017);
- nightmares (Krakow *et al.* 2001; Davis & Wright 2007; Davis *et al.* 2011; Hansen *et al.* 2013; Kunze *et al.* 2019);
- simple phobia (Hunt & Fenton 2007; Keyes *et al.* 2020);
- depressive disorder (Wheatley *et al.* 2007; Brewin *et al.* 2009; Holmes *et al.* 2009; Weslau & Steil 2014);
- eating disorders (Somerville *et al.* 2007; Cooper 2011);
- personality disorders (Weertman & Arntz 2007; Arntz 2011, 2012, 2015);
- social phobia (Wild & Clark 2011; Frets *et al.* 2013; Romano *et al.* 2020);
- obsessive compulsive disorders (Strachan *et al.* 2020);
- health anxiety (Tolgou *et al.* 2018; Nilsson *et al.* 2019);
- dissociative disorders (Hansen *et al.* 2013; Farrell *et al.* 2014; Morina *et al.* 2017).

However, the scope of this technique is even more extensive; imagery rescripting can also be used in patients with bipolar disorder, delusions, paranoid personality disorder, bulimia, or obesity (Arntz 2012; Holmes *et al.* 2008; Ociskova *et al.* 2018).

Imagery rescripting is more effective in relieving PTSD symptoms than exposure alone, and the combination of both is associated with less premature treatment discontinuation and a more significant reduction in negative emotions (Arntz *et al.* 2007).

Imagery procedures

The beginning of the imagery

The leading principle in guiding the imagery is to use as few verbal instructions as possible. It is essential that the imagery is done really by the patient and not suggested by the therapist. The therapist says general instructions such as:

Now close your eyes and open your mind to imagery ..... Tell me what will begin to appear inside your inner vision. Look at it as a film that you are experiencing, and at the same time, you will tell it to me.

The therapist can help the patient with these questions:

What do you see now? What do you hear? Do you see yourself in your imagery? How do you view yourself?

Once the imagery is created, the therapist asks about the thoughts, emotions, and all the other characteristics associated with the imagery:

How do you feel? What do you think? Do you have any urge to do something? What is going on in your body? What do you want the most at the moment?

The work with the imagery ends when the therapist asks the patient to open their eyes and then asks them questions:

What was this experience like for you? What does this imagery mean to you? What topics emerged? Which schemas are associated with these topics?

The therapist helps the patient to experience their images as intensely as possible so that all the crucial emotions associated with them appear. The therapist's empathic understanding helps the patient to immerse themselves fully in particular emotions.

Subsequently, the therapist and the patient discuss the whole experience. The patient expresses a new understanding of the situation. It is essential to focus on the moments that were helpful in the rescripting and patient´s needs were satisfied. If possible, the therapist can record the exercise, and the patient listens to it as apart of the homework.

In the next phases of therapy, it is possible to return to the rescripting in situations where they need previously processed in the imagery re-emerges. The therapist helps the patient to find out how the experience of rescripting can be transferred to life and how they can now meet their needs. In the advanced phase of therapy, when the patients themselves are more able to take care of their needs, they learn to set appropriate life goals and adaptively direct their actions, they can enter the imagery and take care of themselves.

The imagery of the safe place

The imagery of the safe place is essential for many patients to have grounded possibility to feel well, relaxed, and safe. The patient is asked to image a personal safe place from childhood or adult life, in which they felt relaxed and calm. During the dialogue with the therapist, patients explore their safe place focusing on four elements of experience – body sensations, emotions, cognitions, and behavioural tendencies (Young *et al.* 2003; Prinz *et al.* 2019). The homework is to practice the safe place imagery between sessions. Patients are also encouraged to continue practising this imagery for the duration of the therapy and beyond.

Imagination from childhood

When the patient previously developed the imagery of the safe place, it is time to start processing the painful images from their childhood. The therapist typically emphases on following images (and works with one childhood imagery per session):

- Any stressful memory from childhood
- One painful childhood image with each parent
- Painful memories with other close people, including peers, who were involved in developing the maladaptive schemas.

40-year-old George has problems with speaking with authorities and also a problem to express his needs in close relationships.

Therapist: We can try to go back to the upset memory of a situation with your father in childhood.

Patient: Yes, we can.

Therapist: OK, close your eyes and relax.

Patient: Hmm (closes eyes).

Therapist: All I want to ask you is to keep your eyes closed and imagine yourself with your father when you were a little boy. Do

not force yourself to let the memory appear on its own. When it shows up, try to tell me.
Patient: OK, I'll try. (pauses, after a while he starts breathing fast) ... I can already see dad.
Therapist: Tell me what you see?
Patient: (breathing deeply) He is standing over me and shouting at me. He is extremely big compared with me, I'm so scared. Blood is flowing from my mouth because I cut my lip when I fell from a wall. He's terribly upset, he screams, I don't know what ... I'm afraid he'll beat me. My tongue and mouth hurt terribly, my blood flows from it, but I am even more afraid of my father.
Therapist: What else is happening to you?
Patient: I'm terribly scared. I'm afraid of both that blood and my father. I'm afraid he'll beat and drive me out. He will abandon me. He forbade me to climb that wall. It's my fault. I'm crying. At the same time, I really want him to take me by the hand. I'm still very small. I'm three years old (crying).

Imagery rescripting

It is crucial to ask carefully about the patient's needs in the situation they remember. It is better to scrutinize the needs and make sure that these are their needs, not our ideas of what they would need. However, this rule does not apply universally, because some severely traumatized patients in childhood are unable to realize their needs - then a therapist enters as a protector. In the alternative end design, they act as a good parent to protect the patient in a stressful situation. In this case, the therapist asks the patient to allow them to enter the picture. Then they meet the needs of the child (prevents abuse, ensures safety, interest, and reward). They ask the patient what to do to be the best for the patient. Only when the patient does not know what they need, the therapist offers them their own ideas about what to do to reach the needs of the patient. Most patients can say what they needed with the help of a sensitive questioning at the beginning or during the rescription or by playing the situation with toys. Unless a simple question leads to the discovery of the needs, a creative approach will often help. During the process, the therapist repeatedly asks the patient what they still need and meets their needs.

The protector has two main tasks:

(1) Protect the patient against the adverse situation (e.g. stop the aggressor)
(2) Ensure that the needs that have been endangered are saturated.

The third task may also be to express negative emotions towards the aggressor or towards people who could not protect the patient. This can be done directly in the imagery, or by working with chairs after completing the imagery rescripting. After saturating the need in the imagery, the therapist asks the patient if they feel it is OK or if they need something else. In this way, they can chisel the rescripting imagery together until the patient is satisfied with it. When the needs are met, the therapist ends the imagery.

If possible, the imagery itself takes place in the present tense ("I come, I see…") and with patient´s eyes closed. However, we respect the need for safety, so for more difficult memories or patients, we accept open eyes and return the patient sensitively to the present time. The task of the therapist is to sensitively and safely perform and respond to the patient's needs during rescripting. Patients sometimes tend to forget the protector - the therapist's job is to help them not to stop, not to experience negative emotions again unnecessarily, so as not to traumatize again. If the therapist notices this, they will ask if the protector can already enter. Imagery ends with "a good ending", where it is advisable to "keep the patient longer", for example, "How do you feel when your mother hugs you now?", "You don't have to hurry…" or "You can stay in the embrace for as long as you need…".

Therapist: What would you need the most in this situation as a little boy?
George: I need somebody who stands up for me, protects me…
Therapist: You knew somebody in your life who could protect you. Someone who could protect you from your angry father? A protector can be someone from that time, but from any time in your life…. I can come too if you don't remember anybody other now…
George: My grandfather. My father always had respect for him - he respected him very much - and my grandfather loved me; I was his favourite grandson….
Therapist: Perfect. What should your grandfather do to protect you?
George: He would only say calmly, but clearly: Johnny, what are you doing?
Therapist: And what would happen?
George: Dad would stop immediately and start controlling himself. When grandpa said something, a dad pays attention.
Therapist: Do you need anything else?
George: Grandpa tells dad: Are you not ashamed? Look, he is your son, and he is afraid of you, he needs to be protected. Take him in your hands now and calm him. Then treat his mouth, because he is scared and it must be painful.
Therapist: And what is next?
George: Dad is aware of what is happening. He takes me on his arms. He blows on my mouth. Then he says. Don't worry, George, now we'll treat it, so it doesn't pain anymore.
Therapist: And how does little George feel?
George: I'm fine. It doesn't even hurt anymore. I stopped crying. Dad is big, and as he holds me in his arms, I'm not afraid of anything anymore.
Therapist: Do you need anything else?
George: Grandpa comes to us and blows my hair. He says: You're such a brave boy, George. You don't even cry anymore though it hurts. I'm proud of my grandson.
Therapist: And, how are you?
George: I am very proud. I'm not crying anymore. Dad treats my mouth, but it doesn't hurt anymore, it just stings a little, and I don't mind. I feel brave and big. Moreover, they love me—both grandpa and dad.
Therapist: So, enjoy the feeling for a while.

Return to the safe place

At the end of the imagery, the therapist returns the patient from the imagery to the present and lets them

open the eyes. Then they discuss the experience they had in imagery. They discuss the emotions, how they changed, and needs of the child, how they were satisfied. If the patient is restless at the end of the imagery, it is good to return with them to the safe place. It is essential to give the patient enough time to calm down and be sure that they are leaving the session in a balanced emotional state.

Later in the therapy, they also discuss a schema related to the imagery situation.

For instance, in the imagery in the case shown above, there was the Abandonment schema. The therapist with the patient can discuss the impact of this schema on current situations - how the Abandonment schema contributes to the patient's problems with his wife and other close persons.

Dialogues in imagery

The therapist gives the patient an idea to engage in dialogue with those who participated in the development of their maladaptive schemes in childhood, or those who strengthened their schemas in adulthood (Young *et al.* 2003).

The first essential people in most patients in childhood are their parents. So, working with dialogues in the imagery usually begins with them. The therapist asked the patient to close his eyes and imagine themself with their parents in a painful, upsetting or difficult situation. This is similar to the examples already given. However, then they ask the patient to express to the parent as clearly as possible how they feel to them at that moment, especially stenotic emotions such as anger. The therapist helps the patient to be aware of their child's needs and to express anger to the parent for not fulfilling these legitimate needs of the child. The reason is not only the cleansing effect of expressing anger but mainly the fighting with one's schema, which is connected with parent´s behaviour. Fighting one's schema allows the patient to distance themselves from the schema and accommodate it. When the patient says, "I don't want her to criticize me anymore! I don't want you to continue to control me, curse me, or blame me! I need love, and you don't give it to me! I need you to notice me, to praise me, to take me on my lap!", they feel cleansed, no longer subject to parental pressure, but leaning on themselves. Sometimes obedience to authority is so strong (Subjugation schema) that the patient doubts that they could be critical of the parent at all. In that case, a rational interview on the universal needs and fundamental rights of the child is appropriate (Young *et al.* 2003).

Some patients say they feel guilty about the imagery dialogue. They believe that expressing anger at their own parents is something wrong or immoral. They can believe that the parents don't deserve it, and either always did everything well or good intentions guided their behaviour. The therapist must make it clear that they do not consider the parents to be wrong, but that it is necessary to distinguish between the parent´s behaviour that led the patient to create their maladaptive schema and other behaviours, which could be appropriate.

We will return to the story of George. This time we will show his conversation in imagery with his mother. Sometimes in his childhood, the mother was proud of George and predicted him a great future. Other times she was excessively critical and dismissive to him. She had high demands on him - he had to be good at everything he did; otherwise, she told him that he was useless, and no one would like him. If the father behaviour is linked to the Abandonment schema during George´s development ("I will leave you because you are not worth it."), with the mother, there the scheme of Perfectionism / Hypercriticalness ("You must be perfect to be loved."). In his imagery, George described the upsetting situation with the mother:

Patient: I remember the situation, I was older, but it was typical. In the sixth grade, my school results got a little worse; before that, I had only the best marks. The mother came from the meeting with my teacher and looked like a Sphinx.

Therapist: Try to remember the details.

Patient: I was afraid of what she would say when she came. She opened the door to my room and said coldly, "You let me down." I see her face like now. Tight lips and a voice like ice. Then she spoke slowly, adding that she would tell the father right away and he would beat me. At that moment, I felt that she hated me. (pause)

Therapist: How did you feel at that moment?

Patient: I don't know ... yeah ... like I can't breathe. I was sorry, but I couldn't cry. That was as if her coldness had got through me and paralyzed me. I feel it in me now, I can't even breathe, such tension, and at the same time, I feel like someone stabbed me.

Therapist: How do you feel about her now?

Patient: Hate and cold too. Like her to me...

Therapist: Could you tell her?

Patient: Chuuu... That is disgusting ..... Mom, if you speak with me so hatefully, I hate you. I hated you for all the humiliation when something went wrong. For bragging to me in front of others, and then I felt embarrassed. For telling my father to beat me when you didn't like something. For the falsity with which you said something to my eyes and something else behind my back. For abusing my feelings when you knew I needed you so much because I didn't have anyone else for strengthening Dad's disapproval of me. You favoured me ostentatiously over him. Ugh, that was disgusting. You created a distance between us. At the same time, I longed for him to like me too. I'm so angry with you that I would kill you .... no, no…. (cries) ....

Therapist: What does the mother say?

Patient: How dare you! I always wanted only good for you. That's gratitude!? You let me down. You didn't finish university! You don't care about me!

Therapist: Maybe ... Let's try to go back to childhood ... To the situation when she came from the school meeting ... What you needed to tell her then?

Patient: Mom, I can't stand it. I really need you to love me. However, I got worse at school. I only have you; Dad doesn't care about me. Mom, you can't leave me (crying)...

Therapist: And something else you need after her...
Patient: Mom, I love you, and I want you to love me, even if I'm not doing well. I want you to support me. I want to improve at school. Nevertheless, I need to know that you stand behind me.
Therapist: What would your mother say...?
Patient: I don't know... Maybe ... I would probably like that ... "You let me down now, but I know you can do it again. I love you—the most in the world." I'll love you, even if you don't learn for the best marks. I will always love you, George. Sometimes I'm upset when you let me down, and then I overreact. I'm such a person. Nevertheless, I'll be glad if you can do it at school. Moreover, dad likes you too, but he can't say it (cries) ...

Imagery connecting the past with the present

After discussing the images from childhood related to the schemas, the therapist leads the patient to visualize current situations in which they feel similar. That can help to create a connection between childhood memories and adult life. The example of the continuation of imagery work with:

Therapist: Close your eyes. Breathe in ..... With each breath, peace enters in your lungs and with each breathe out the peace passes into the whole your body... Now that we return to the feelings of the last imagery with your mother, you can try to recall a situation with similar feelings in adulthood?
Patient: Uhm… I don't know.
Therapist: You don't have to try; let the memories come freely. Let me know when something comes up...
Patient: I don't know if that's it... I remembered coming from the United States. I brought presents to the family. The children were delighted. But Elisabeth, my wife, not at all. At first, she was shocked, and then she began to blame me for spending money on bullshit.
Therapist: Can you go back to that memory as a movie? Do you see the situation?
Patient: Wait ... I see Betty, that's how she looks. So stony. That scares me. I want to make the situation right somehow, but at the same time, I'm disappointed. So, I was looking forward to everyone being happy. Nevertheless, the situation with Betty is the opposite.
Therapist: Can you describe how you feel?
Patient: I feel disappointed, so helpless, I can't do anything about it. I want her to be kind to me, to be happy. It's my fault, and I should have been more in control of those gifts. However, I feel like a kicked dusty dog. I was disappointed again; I don't stand a chance. I want to cry, but I'm ashamed. I try convulsively to ask what happened here during the time I was away.
Nevertheless, I don't really concentrate on that. I'm still scalded. At the same time, I'm starting to get angry at Elisabeth. I'm also angry with myself for that anger. It's all my fault. I do nonsense, so no one likes me. Nobody cares about me.
Therapist: (pause, let the affect, continues after calming down) You can now try to tell Elisabeth something like the last time your mother did. What do you want most from your wife?
Patient: I don't know, I don't really know what I want from her. To make me happier...
Therapist: Try to recall it in your imagination and tell it to her ... right in the eye.
Patient: (long pause) You annoy me, Elisabeth. I was looking forward to you being happy, and you freeze me like many times. It bothers me. And a lot. Furthermore, I'm even more sorry ... I love you. I really want you to be happy. I need it ... I want you to like me more ..... not despise me if I made a mistake because I'm not wrong. Even if I make a mistake sometimes, I'm not wrong. I'm pretty good. And I want you to know (firmly).

Almost everything what George told his wife, Elisabeth, he could tell his mother or father. The topic is very similar. It's an Abandonment schema. George feels that his loved ones are not able to show him warm feelings, closeness, because they are emotionally unstable, they explode into anger or they disproportionately criticize him in situations where he needs to be accepted the most.

After the imagery, the therapist helps the patient to express what happened during the imagery. This allows the integration of the intense emotional states that the patient experienced during the imagery.

Imagery of future

Reviewing or shifting negative images can bring about emotional or symptomatic relief. At times, this imagery could be focused on past events (and on changing its meaning); at other times, the imagery can be of present-day or even future-time images. Also, positive imagery can be used to access adaptive emotional states (Ji *et al.* 2016).

Test anxiety, a condition which affects as many as 20 % of students (Holm-Hadulla *et al.* 2009), involves excessive negative thoughts about poor performance or failure in exams or other situations considered by the examination, as well as about the possible consequences of such performance. Test anxiety is manifested in phenomenological, physiological, and behavioural responses (Zeidner & Matthews 2010). Phenomenologically, it often involves intense fear and can be accompanied by panic attacks, feelings of hopelessness, inferiority, and desperation (Fehm & Fydrich 2011). Physiologically, test anxiety involves a stress response which includes hyper-activation of the hypothalamic-pituitary-adrenal axis (Morris & Liebert 1970). Behaviorally, test anxiety often culminates in procrastination, sleep disturbances, and loss of appetite before the exam, and sweating, shaking, disturbed concentration, and blackouts during the exam (Fehm & Fydrich 2011; Zeidner 2014). A recent review (Ji *et al.* 2016) have noted that mental imagery gets to the core of individuals' distress straightforwardly. The images of aversive experiences activate memories and associated emotions and do so more intensively than verbal prompts (Holmes & Mathews 2010). The imagery work provides a more powerful means of intervening with it than do purely verbal techniques (Rafaeli *et al.* 2016). Reiss *et al.* (2017) shown that a group intervention

combining CBT and imagery rescripting as a treatment for students with test anxiety led to a significant decrease of the symptoms, with the main benefits ascribed to the imagery rescripting component. These results show that the addition of imagery rescripting alone improves outcome compared to stand-alone CBT treatment.

Typical steps of imagery work with test anxiety are following (Prinz *et al.* 2019):

(1) psychoeducation regarding test anxiety, beginning to socialize the client to the use of imagery in a non-threatening way, safe place imagery only;
(2) understanding of test anxiety and its phenomenological elements (body sensations, emotions, cognitions, and behavioural tendencies), and preparing the client to be able to monitor these; clients were asked to imagine upsetting circumstances tied to the exam and again focus on all four phenomenological elements;
(3) imagery component introduced the possibility of rescripting (past) distressing test- or studying-related conditions; put on the insights gained thus to the future situation. The imagery component concentrated on a future learning-related situation that calls for behavioural change. The rescripting process involved finding the anticipated blocks to such behaviour, e.g. dialogue between the procrastinating or perfectionistic inner voice vs the healthy voice), and finally, rehearsal of the behaviour in imagery. The post-session homework involved practice in monitoring test-taking situations, again identifying alternative behaviours and cognitions.
(4) The imagery work was followed by a review of the entire treatment protocol's materials, with particular focus on both emotional and behavioural insights from the imagery exercises as well as the homework assignments. The post-session homework involved encouragement in continuing practising those behaviour changes that proved to be most promising during the intervention.

Training in the imagination

When planning homework, it is sometimes appropriate for the patient to go through the planned task in the imagery during the session, because it can help in preparation for possible problems and plan how to solve them (e.g. an interview with a supervisor). This preparation in the imagery usually increases the motivation to embark on the task, because during the repeated imagery of the task, the intensity of their anxiety gradually decreases. Wilson (1987) recommends practising the imagery of the future task in two successive steps:

In the first phase, the patient imagines themselves after having effectively completed the task. It is easier for the patient to imagine that they have already completed the task successfully and to use the feelings of relief and pride evoked by this imagery to strengthen their motivation to embark on this task. This notion of self-success weakens the usual thought patterns, focused on expectations of failure. The patient should practice this imagery first in a session, while the therapist must ensure that the patient not only images their situation after completing the task but also experiences it emotionally and that they imagine the praise of other people. In the second step, the patient images themselves performing the task. At the same time, they occupy the position of an observer - as if watching themselves in a film, how they perform the respective task. If they begin to feel anxious, they may interrupt the imagery and evoke calming imagery (e.g. safe place). When they succeed in completing the task in the imagery, the patient should experience the enjoyment of being able to do so. Gradually, the patient can imagine their bodily reactions and thoughts while performing the task, including soothing self-talk. At the end of the exercise, the patient can imagine the possible problems that could arise in the performance of the task and how they could manage them. The patient needs to finish the exercise with a pleasant feeling that they completed the task.

Conclusion

Experiential methods such as using imagery are used to process negative memories from the past or prepare for the worrying situations in the future. The goal is to teach the patient to handle strong emotions that are part of aversive memories or worries in a safe atmosphere. The purpose of experiential techniques is to experience a new emotional (corrective) experience and to enable the connection of cognitive understanding with emotional states (Young *et al.* 2003). Without the use of experimental approaches, such as imagery rescripting, it is often not possible to change early maladaptive schemas because they are not available to conscious control.

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