Journal of Cognitive Psychotherapy: An International Quarterly, Volume 9, Number 1, 1995

Imagery Rescripting: A New Treatment for Survivors of Childhood Sexual Abuse Suffering From Posttraumatic Stress

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Imagery rescripting is presented as a new treatment of posttraumatic stress disorder (PTSD) for adult survivors of childhood sexual abuse. A theoretical discussion illustrates the model's consistency with schema theory and information processing models of PTSD, and suggests that the rescripting process may effect change in pathological schemas associated with interpretation of the traumatic event(s). It is proposed that this combination of imaginal exposure, mastery imagery, and cognitive restructuring goes beyond extinction models to alter recurring images of the trauma and create more adaptive schemas. Hypothesized mechanisms for PTSD symptom reduction are presented, implications for cognitive restructuring are noted, and the model's potential for facilitating personal empowerment and self-nurturance are discussed. Preliminary outcome research data are summarized that support the efficacy of imagery rescripting in significantly reducing PTSD symptomatology with this population.

Over the past decade, a growing body of literature has attested to the alarming

prevalence of childhood sexual abuse and its deleterious effects on the lives of adult survivors (Briere, 1989, 1992; Finkelhor, Hotaling, Lewis, & Smith, 1989; Russell, 1986). Numerous studies have indicated that a history of childhood sexual abuse is associated with psychological difficulties in adulthood, such as increased rates of chronic depression, suicidality and self-destructive behaviors, interpersonal and sexual difficulties, chronic anxiety, and posttraumatic stress disorder. Feelings of guilt, self-blame, self-disgust, self-hatred, low self-esteem, inferiority and powerlessness, and mistrust of others are frequently cited in the clinical literature as long-term effects of sexual abuse (Bagley & Ramsay, 1986; Briere, 1989; Briere & Runtz, 1992; Browne & Finkelhor, 1986; Courtois, 1979; Elliot & Briere, 1992; Herman, 1981, 1992; Janoff-Bulman, 1985; Jehu, 1991; McCann, Sackheim, & Abrahamson, 1988; Tsai & Wagner, 1978).

A number of the above effects may be generated by cognitive distortions and maladaptive beliefs about the self and the interpersonal world that became part of the child's cognitive schemata when the trauma(s) occurred. Indeed, the pathogenic effects of negative core beliefs associated with sexual abuse have been posed as a significant component of posttrauma reactions (Jehu, Gazan, & Klassen, 1984-1985; Jehu, Klassen, & Gazan, 1985-1986). Briere (1989, 1992) has noted that the cognitive effects of negative self-evaluation, guilt, helplessness, hopelessness, and profound distrust may act as contributory factors in producing the affective and interpersonal problems which plague survivors. Jehu, Klassen, and Gazan (1985-1986) report that survivors of childhood sexual abuse often hold distorted beliefs arising from the experience which appear to contribute to disturbances such as low self-esteem, sadness, and guilt. McCann and Pearlman (1990a, 1990b) cite disruption of cognitive schemas as pathogenic factors in postabuse symptomatology, noting that such disturbance occurs in core areas of safety, trust, power, esteem, intimacy, independence, and frame of reference. Factors such as vulnerability, isolation, powerlessness, anger, betrayal, and sadness and loss have been reported by Edwards and Donaldson (1989), who utilize cognitive techniques to restructure the beliefs thought to underlie such effects (Donaldson & Gardner, 1985). Janoff-Bulman (1985) proposes that posttraumatic reactions result, in part, from the "shattering of assumptions" by the onslaught of trauma—assumptions about the benevolence and meaningfulness of the world, self-worth, and personal invulnerability.

Two cognitive processes, assimilation and accommodation, have been proposed as key factors in the interpretation of trauma (McCann, Pearlman, Sakkheim, & Abrahamson, 1988; Resick and Schnicke, 1990). As noted by Hollon and Garber (1988) and Resick and Schnicke (1990), when persons are exposed to schema-discrepant information, either assimilation or accommodation may occur. In the first instance, the information itself may be altered in

order to be assimilated into already-existing schemas. In cases of incest, pathological assimilation could manifest as, "Daddy wouldn't do something like that—maybe it really wasn't so bad." At times the information may actually defy assimilation, existing instead as dissociated material which reemerges as flashbacks, nightmares, flashes of affect, or memory fragments (Horowitz, 1976).

With accommodation, however, the existing schema is altered in order to "take in" the discrepant information (Hollon & Garber, 1988). Thus, a child's schema related to self-efficacy may become disrupted to the point that a schema of powerlessness becomes dominant, trust may be replaced by mistrust, and a schema of the self as positive may be so distorted that a sense of the self as stigmatized and evil is formed.

Because childhood sexual abuse is, by definition, pathological, it is not surprising that changes in existing schemas are predominately pathogenic. Several basic themes emerge in the thinking of adult abuse survivors which suggest the influence of maladaptive schemas. The presence of degrading self-perceptions, guilt, powerlessness, helplessness, passivity, profound mistrust, and fear of intimacy may indicate that fundamental assumptions were distorted by the trauma of sexual abuse and that maladaptive schema formation occurred.

As the effects of schema disruption in sexual abuse survivors receive increasing attention in the literature, interventions designed to address this aspect of postabuse pathology are becoming more prevalent in clinical work. Cognitive-behavioral techniques such as assertiveness training, stress inoculation training, recording of automatic thoughts and examining the current validity of assumptions, and using imagery to identify core beliefs have recently been integrated into abuse-focused therapy (Blake-White & Kline, 1985; Fallon & Coffman, 1991; Jehu, Gazan, & Klassen, 1988; Jehu, Klassen, & Gazan, 1985-1986; Resick & Schnicke, 1992; Staton, 1990). This cognitive focus is well-expressed by Fallon and Coffman's contention that effective treatment with abuse survivors "must address the cognitions so deeply affected by the abuse experience."

While the restructuring of cognitive distortions and maladaptive schemas thus appears to be a critical component of therapy for childhood abuse survivors, other sequelae of trauma—most notably the clinical syndrome of posttraumatic stress disorder (PTSD)—are also part of the symptom picture. Indeed, the presence of PTSD symptomatology in abuse survivors has been well documented in clinical literature over the past decade, with widespread consensus among clinicians on the appropriateness of the diagnosis (Blake-White & Kline, 1985; Briere & Runtz, 1987; Donaldson & Gardner, 1985; Lindberg & Distad, 1985; van der Kolk, 1987). Some studies indicate that as many as 96% (Donaldson & Gardner, 1985) to 100% (Lindberg & Distad, 1985) of abuse survivors in clinical samples may meet diagnostic criteria for

PTSD. It thus seems critical that treatment of this population encompass an understanding of posttraumatic stress and its deleterious effects.

PTSD AS AN EFFECT OF CHILDHOOD SEXUAL ABUSE

Diagnostic Criteria and Symptom Picture

Posttraumatic stress disorder refers to specific psychological reactions which may occur as a result of disaster, combat, interpersonal violence, or other forms of extreme psychological stress. As defined by the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition (DSM IV, 1994), a combination of features from four core criteria comprise the PTSD syndrome: (a) exposure to a traumatic event; (b) subsequent reexperiencing of the trauma in the form of recurrent and intrusive recollections, dreams, flashbacks, or heightened physiological reactivity; (c) emotional numbing or persistent avoidance of stimuli reminiscent of the event; and (d) symptoms of increased arousal such as hypervigilance, irritability, exaggerated startle response, and sleep disturbance.

Without exception, each of the above symptoms has been reported in the literature as a long-term effect of childhood sexual abuse (Briere, 1989). This evidence strongly suggests that PTSD is part of the clinical picture presented by adult survivors of childhood sexual abuse.

RELEVANT THEORIES OF PTSD

Information-Processing Models of PTSD

As the conceptualization of PTSD has evolved over the past several decades, information-processing models which emphasize the role of emotional networks have gained considerable support as explanations of PTSD symptomatology. Taken together, such models offer explanations for the "state dependent" nature of traumatic memories and for the reexperiencing phenomena which are the hallmark of PTSD, and provide a paradigm for understanding habituation and extinction in therapy (Chemtob et al.,1988; Foa & Kozak, 1986; Foa, Steketee, & Olasov-Rothbaum, 1989; Lang, 1977, 1979, 1986; Rachman, 1980).

In his theory of emotional processing of fear, Rachman (1980) suggests that PTSD-like symptoms result from inadequate emotional processing of trauma and that such symptoms could be ameliorated by the facilitating of successful emotional processing. Lang (1977, 1979, 1986) proposes a model of emotional processing in which emotion is defined as a specific information structure in memory consisting of *stimuli*, *responses*, and the *meaning* assigned to the stimulus and response data. Lang contends that vivid response imagery is

critical in accessing a fear memory and that affective involvement must be present in order for the memory unit to be altered.

Foa and Kozak (1986), who expanded Lang's theory of emotional processing, contend that the meaning associated with stimuli and responses is most critical in the development of PTSD. Foa and Kozak further assert that in order for the fear network to be modified, the fear memory—and the associated affect—must be activated. Concurrently, "corrective" information, which includes elements incompatible with those in the fear structure, must be provided to the patient and integrated into the memory. The authors conclude that the clinical application of prolonged (imaginal) exposure changes the meaning of the threat memory by facilitating physiological habituation, a process which is incongruent with the belief that anxiety decreases only through escape and avoidance.

While Foa and Kozak's (1986) model may account for a major portion of PTSD symptomatology found in adult rape victims, and its application has shown significant treatment results with that population (Foa, Rothbaum, Riggs, & Murdock, 1991), its circumscribed definition of meaning elements may need to be expanded to account for the "meanings" experienced by survivors of childhood sexual abuse with PTSD. Frequently, the meanings which victims ascribe to their childhood sexual traumas greatly exceed the relationship between perceived danger and physiological reactivity, as evidenced in other postvictimization responses which often accompany intrusive phenomena (e.g., a pervasive sense of helplessness and powerlessness, strong feelings of self-disgust, self-blame and self-denigration, and globalized distrust of others).

Need for an Expanded Information-Processing Model and Treatment Approach

The concurrent presence of PTSD symptomatology and pervasive maladaptive schemata in childhood sexual abuse survivors raises important clinical issues for conceptualization and treatment. Although a number of theories have been offered to explain posttraumatic symptoms in individuals traumatized as adults, an expanded information-processing model which addresses underlying cognitive schemata as well as intrusive aspects of the posttraumatic syndrome could significantly broaden our understanding of adult survivors of childhood sexual abuse and enhance the development of more effective treatment strategies with this "therapy-resistant" population.

If the "meanings" of childhood abuse trauma are reconceptualized to include early-acquired, ingrained schemata which influence subsequent perceptions and behavior (for one such schema-focused approach, see McCann & Pearlman, 1990b), current theories and therapies which focus on early maladaptive schemas might be readily integrated into an information-processing

model similar to that proposed by Foa and Kozak (1986). Broadening the definition of "meaning propositions" to include the victim's core schematic beliefs would allow these maladaptive cognitive structures to be included as a target for intervention when the traumatic network is accessed in therapy. While variations of imaginal exposure could still be used to reduce PTSD symptomatology, schema-focused interventions could simultaneously be employed to effect changes in meaning propositions at the schema level. The goals of treatment thus would be to: (a) decrease physiological arousal, (b) decrease intrusive PTSD symptoms such as recurring flashbacks or nightmares, (c) facilitate cognitive change in the meaning of the event(s), and (d) modify maladaptive abuse-related beliefs and schemas.

According to theories of emotional processing (Foa & Kozak, 1986; Lang, 1979) and state-dependent recall (Bower, 1981), maladaptive schemas associated with childhood abuse could most readily be accessed and modified when the patient is in an emotional state similar to that which occurred during the abuse experience; that is, when the greatest number of "elements" of the experience are included in the imagery. Implementing this in treatment would essentially involve evoking the images and responses experienced by the victim, and offering alternative interpretations with the "network" accessed. It would also be useful for the therapist to have some understanding of the nature of traumatic memories, the early childhood encoding of these memories, and how they might be accessed so that "corrective" information can be effectively integrated into the memory network.

THE NATURE OF TRAUMATIC MEMORY AND IMPLICATIONS FOR THERAPY

In research with traumatized children and adults, van der Kolk and van der Hart (1989, 1991) suggest that, in contrast to narrative memory, traumatic memories lack verbal narrative and context. Second, they are state dependent (i.e., memories are reactivated when a person is exposed to a situation, or is in a somatic state, reminiscent of the one during which the original memory was stored). Third, they are encoded in the form of vivid sensations and images (regardless of the victim's age) and cannot be accessed by linguistic means alone. Fourth, traumatic memories are difficult to assimilate or integrate, which causes them to be stored differently, be dissociated from conscious awareness and voluntary control, and be unavailable for retrieval under ordinary conditions. Fifth, such memories tend to remain "fixed" in their original form and unaltered by the passage of time or subsequent experience. (Thus, traumatic flashbacks or nightmares may be reexperienced over and over without modification, change, or resolution.)

In addition to the characteristics noted above, abuse memories appear to be influenced by the age of the child when the molestation began (Staton, 1990).

According to Bruner (1973), a child's earliest memories are encoded in the sensorimotor system, while visual representation becomes dominant between the ages of 2 and 7. By contrast, linguistic representation develops more slowly, and may not be fully integrated with the kinesthetic and visual modes of representation until adolescence (Bruner, 1973).

Factors specific to sexual abuse further constrain the child's ability to linguistically process the trauma. Because the abuse itself is primarily physical, it is most likely to be encoded in memory through visual or sensorimotor modalities. Moreover, the language spoken during the incident(s) is often minimal, which would lessen the probability of verbal encoding and recall (Staton, 1990).

These characteristics of trauma have profound implications for treatment of survivors. If indeed early abuse memories are encoded primarily in images, utilizing imagery in transforming their meanings would appear essential. This view is supported by Staton (1990) who asserts that without corrective imagery, abusive images may be retained no matter how much "talk" occurs. In a similar vein, Beck, and Freeman, and Associates (1990) conclude:

> Simply talking about a traumatic event may give intellectual insight about why the patient has a negative self-image, for instance, but it does not actually change the image. In order to modify the image, it is necessary to go back in time, as it were, and recreate the situation. When the interactions are brought to life, the misconstruction is activated—along with the affect—and cognitive restructuring can occur. (p.92)

Edwards (1989, 1990) elaborates further on the use of imagery interventions to facilitate the identification and restructuring of maladaptive cognitions, including those related to childhood sexual abuse. (See Anderson, 1980, and Beck, Emery, & Greenberg, 1985 for a review of imagery techniques in cognitive therapy.)

It appears thus from the current literature that therapeutic effectiveness with abuse survivors will be enhanced if (a) both imagery and verbal modalities are employed in recall, desensitization, and cognitive restructuring; and (b) the affect and level of arousal during initial exposure are similar to that which occurred at the time of trauma. The therapeutic approach described below was developed with these conditions in mind.

IMAGERY RESCRIPTING

Imagery rescripting is an imagery-focused treatment designed to alleviate PTSD symptomatology and alter abuse-related beliefs and schemas (e.g.,, powerlessness, victimization, inherent badness, unlovability) of survivors of childhood sexual abuse. The procedure combines *imaginal exposure* (visually recalling and reexperiencing the images/thoughts and associated affect of the traumatic event) with *imaginal rescripting* (changing the abuse imagery to produce a more favorable outcome). The aim of rescripting is to replace

victimization imagery with mastery imagery, thus enabling the abuse victim to experience herself[1] responding to the abuse scene as an empowered individual no longer "frozen" in a state of helplessness. Through this imaginal psychodrama, the recurring victimization imagery is modified and the maladaptive schemas underlying abuse-related cognitions are identified, explored, and challenged. The use of imagery allows these traumagenic schemas to be addressed directly through the eyes of the traumatized child.

The treatment program consists of nine sessions ranging in length from 90 minutes to 2 hours each, as shown in Table 1. Patients are deemed appropriate if they meet criteria for PTSD and are currently experiencing intrusive images, flashbacks, or nightmares of the abuse. Prior to treatment, patients are fully informed of the affective distress which may be temporarily evoked during imagery.

The first session is devoted to information gathering in a semistructured interview format. In the second session, the therapist presents the treatment rationale and begins the exposure and rescripting procedure. The exposure phase involves an imaginal reenactment of the traumatic event in its entirety, as experienced by the patient in recurring flashbacks or nightmares. The individual is asked to reexperience the images of the abuse scene and verbalize aloud what she is experiencing, in the present tense (e.g.,, "He's walking toward me now".) The therapist's role is to provide a supportive, safe environment in which the patient can visualize and verbalize the traumatic imagery while reprocessing the associated painful affect. The therapist helps the patient "stay with" the affectively charged imagery as the patient determines the level of detail included in the description. The following instructions are given to the patient:

> I'm going to ask you to recall the memories of the abuse. It is best if you close your eyes so you won't be distracted. I will ask you to recall these painful memories as vividly as possible. It is important that you describe the abuse in the present tense, as if it were happening now, right here. We will work together on this. If you start to feel too uncomfortable and want to run away and avoid it by leaving the image, I will help you to stay with it. Every so often, I'll ask you to rate your discomfort level on a scale from '0' to '100'. Please answer quickly and do not leave the image. Do you have any questions before we start?....I'd like you now to close your eyes, visualize the beginning of the abuse scene, and describe what you see and feel as well as the thoughts you are having about what is happening. (Smucker, Dancu, & Foa, 1991, p. 8)

Following imaginal exposure to the abuse scene, the rescripting phase begins. During rescripting, the patient again visualizes the beginning of the abuse memory. This time, however, when the molestation begins, she develops mastery imagery by creating a new scenario in which she visualizes her "adult" self today entering the abuse scene to assist the "child." The therapist may facilitate this through such questions as: "Can you now visualize your ADULT self today entering the scene?" "Does he (the perpetrator) see you?" "How does he respond to your presence in the room?" "What would you, the ADULT, like to do at this point?...Can you see yourself doing that?" "And how does he (the

TABLE 1. Summary Treatment Outline

Session 1: (1.5 hrs)	Information gathering (initial interview)
Session 2: (2.0 hrs)	Explain treatment rationale Reexperience in imagery the sexual abuse scene (reexperience in the present what actually happened) Develop mastery imagery: Rescript abuse scene to include coping strategies to drive out the perpetrator After completion of mastery imagery, facilitate "adult-nurturing-child" imagery
Session 3: (1.5 hrs)	Review homework Repeat abuse scene Repeat mastery scene Repeat "adult-nurtuing-child" imagery Explain letter rationale and homework assignment
Session 4: (2.0 hrs)	Review homework and discuss letter Repeat abuse scene Repeat mastery scene (include any new information from the letter if appropriate) Repeat "adult-nurturing-child" imagery
Session 5: (1.5 hrs)	Review homework Repeat abuse scene Repeat mastery scene Repeat "adult-nurtuing-child" imagery
Session 6: (1.5 hrs)	Review homework Repeat abuse scene Repeat mastery scene Repeat "adult-nurturing-child" imagery
Session 7: (1.5 hrs)	Review homework Adult "check in" with child Repeat "adult-nurtuing-child" imagery Assign homework
Session 8: (1.5 hrs)	Review homework Adult "check in" with child Repeat "adult-nurturing-child" imagery Discuss termination issues
Session 9: (1.5 hrs)	Review homework Adult "check in" with child Repeat "adult-nurturing-child" imagery
Follow-up:	3 months posttreatment 6 months posttreatment

perpetrator) respond?" "And what's happening now?"

Essentially, the role of the ADULT during rescripting is to: (a) "rescue" the CHILD and protect her from any further abuse, (b) "drive out" the perpetrator (or take the CHILD away to a safe place) so that the CHILD is no longer in the presence of the perpetrator, and (c) "nurture" the CHILD. During the initial phase of rescripting, the ADULT uses whatever means necessary to rescue the CHILD from the abuser and provide protection for her. If the ADULT is unable

to visualize herself "driving out" the perpetrator, she may bring additional support people (e.g.,, a spouse, police officer, therapist) into the abuse scene to help her accomplish this task.

Throughout the rescripting phase, the therapist remains largely nondirective and is careful *not* to tell the patient what to do, or suggest what should be happening, or push her beyond that which she is able or willing to do. The therapist's role is thus primarily facilitative, as the patient is encouraged to decide for herself what coping strategies to use in the mastery imagery.

Following completion of the mastery imagery, the therapist fosters "adult-nurturing-child" imagery, in which the ADULT is encouraged to interact directly with the traumatized CHILD. The therapist facilitates this by asking the ADULT such questions as: "What would you the ADULT like to say to the CHILD?.... Can you see yourself saying that to the CHILD?" "How does the CHILD respond?" "What does the CHILD need at this point?" In many instances, the ADULT will begin to hold or hug the CHILD, reassure the CHILD that the abuse will not happen again, and promise not to abandon the CHILD.

If the ADULT has difficulty nurturing the CHILD, or blames the CHILD for the abuse and wants to abandon or hurt the CHILD, it is sometimes helpful to ask the ADULT: "How far away are you from the CHILD?... When you look directly into the CHILD's eyes from up close, what do you see?" "Might you be able to go up close to the CHILD and tell her how she is to blame for the abuse?" "And how does the CHILD respond?" Generally, as the adult moves closer to the CHILD, she becomes more affected by the CHILD's pain and finds it more difficult to continue blaming, hurting, or abandoning her.

When the therapist senses that the patient may be ready to bring the "adult-nurturing-child" imagery to a close, the therapist asks: "Is there anything more you, the ADULT, would like to do or say to the CHILD before coming out of the imagery?" Once the patient has indicated her readiness to terminate the imagery session, the therapist concludes with, "When you are ready, you may let the imagery fade away and open your eyes."

When the imagery has ended, the therapist asks the patient to rate on a 0-100 scale (a) how difficult it was to drive away the perpetrator, (b) how difficult it was for the ADULT to nurture the CHILD, and (c) how vivid the imagery was for the patient. The remainder of the session (the last 15 minutes or so) is spent processing the patient's reactions to the imagery session and discussing homework. An audiotape of the entire imagery session is given to the patient for review twice daily as a homework assignment. The patient is asked to record on a standardized homework sheet her subjective units of discomfort (SUDS) each day, prior to and after listening to the imagery tape. The patient also records in a journal any PTSD reactions (e.g., nightmares, flashbacks) she may experience during the week, and brings her journal for review at the beginning of the next session. It is important to allow the patient sufficient time

to gain control over her emotions prior to leaving the session. Arrangements are also made for the patient to call the therapist between sessions if difficulties arise.

In sessions 3 through 6, the first 15 minutes are devoted to reviewing the patient's general mood, shifts in mood since last session, and homework assignment (including sharing from her journal). Next, the abuse imagery followed by the mastery imagery and the "adult-nurturing-child" imagery are carried out for approximately one hour. In the remaining 15 minutes of the session, the patient's reactions to the session are discussed and homework is assigned, which involves reviewing the audiotape of the imagery session twice daily. In all of the imagery sessions throughout treatment, the therapist records the patient's discomfort level (SUDS) every 10 minutes during the abuse imagery, the mastery imagery, and the "adult-nurturing-child" imagery.

Between sessions 3 and 4 the patient is asked, as part of her homework assignment, to write a letter to the perpetrator (which she does not mail) in which she expresses her thoughts and feelings about the abuse. The rationale behind writing such a letter is explained to the patient in the following manner:

> One of the ways we have found helpful to express your feelings and thoughts is to write a letter to the perpetrator or family member. This is a coping strategy to help you digest the painful memories and current intense emotions that must be assimilated as part of your life. I am going to ask you to write a letter this week as a homework assignment. Do you have any questions? [Provide sufficient time to discuss feelings and concerns about the assignment.] In the beginning of the next session, you will have the opportunity to read your letter and discuss your feelings (Smucker, Dancu, & Foa, 1991, p. 11).

During the last three sessions, the entire focus of the imagery work is on "adult-nurturing-child" imagery. The patient no longer repeats the abuse imagery, but instead closes her eyes and uses her own imagery to "check in" with the child. The therapist facilitates the self-nurturing imagery by asking such questions as: "Where is the CHILD now?" "What is she doing?" "Is she alone?" "How is she feeling?" "What are her needs?" "Where are you, the ADULT?" "How far are you, the ADULT, from the CHILD?" "When you look directly into the CHILD'S eyes, what do you see?" "What would you like to say to the CHILD?" "How does the CHILD respond to you, the ADULT?"

For homework during this phase of treatment, the patient is asked to: (a) listen twice daily to the audiotape of the "adult-nurturing-child" imagery session, (b) "check in" each day with the CHILD on her own, followed by self-initiated "adult-nurturing-child" imagery, and (c) continue with daily entries in her journal, recording her experience with and reactions to the self-nurturing imagery.

Throughout the rescripting sessions, interactions between the ADULT and CHILD provide an opportunity for both the patient and therapist to identify, confront, and modify abuse-related cognitions and underlying schemata at a child's level of representation and understanding. The early origins of the

traumagenic beliefs are clarified, and through the dialogue between the ADULT and CHILD, the patient is encouraged to construct new, more adaptive meanings.

In the last 20 minutes or so of sessions 8 and 9, the therapist and patient review progress made during treatment and prepare for termination. This includes discussion of ways to cope with future stressful situations.

Although the nine-session format is standard, it is open to adjustment according to patient need. Additionally, the patient has ready access to the therapist between sessions, and provision is made for additional therapy sessions if required.

SUMMARY

The theoretical rationale for the use of imagery rescripting in the treatment of adult survivors of childhood sexual abuse is presented and the procedure briefly described. When the technique was first developed, the primary goal was alleviation of intrusive PTSD symptoms, with cognitive change a secondary goal. Preliminary outcome data from a pilot study conducted at the Medical College of Pennsylvania and the Medical College of Wisconsin (Dancu, Foa, & Smucker, 1993) have supported the efficacy of the treatment in alleviating PTSD symptoms with this population. At posttreatment and follow-up (3 months and 6 months), none of the subjects met criteria for PTSD. (The results of these findings will be described in more detail in a separate article.)

Analyses of patient "mastery" imagery protocols further suggested notable changes in their maladaptive abuse-related beliefs. Not only did a number of abuse survivors' statements reveal an enhanced sense of control and empowerment following mastery imagery, they also showed less self-blame and a greater capacity to assign responsibility for the abuse to the perpetrator. Also noteworthy were the changes observed during the "adult-nurturing-child" imagery. Initially, negative self-perceptions, self-hatred, worthlessness, and shame were revealed in the statements of a number of the subjects when they attempted to nurture the abused CHILD. Across the sessions, however, their perceptions of the CHILD appeared to undergo profound changes (e.g., "It wasn't her fault." "She's not evil." "She's really a strong kid." "She's so tiny, there was nothing she could have done." "She's just a beautiful kid."). Likewise, their ability to self-nurture and self-soothe appeared to be enhanced, both in and out of the imagery sessions.

Although the indicators of the above cognitive changes are subjective patient statements and excerpts of recorded sessions rather than objective test data from controlled studies, they are nonetheless encouraging. To be sure, additional outcome research is needed to empirically evaluate the efficacy of magery rescripting, both in alleviating PTSD symptomatology and in facilitating the restructuring of core maladaptive schemas (e.g., powerlessness, inher-

ent badness, unlovability) over a relatively short period of time. Such research is presently being undertaken by several of the authors.

NOTES

[1] The feminine pronoun is used throughout the treatment protocol. This is done for the sake of clarity and because of the prevalence of women in this population.

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