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Imagery Rescripting for Patients With Posttraumatic Stress Disorder: A Qualitative Study of Patients' and Therapists' Perspectives About the Elements of Change

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Imagery rescripting (IR) has been proven effective in several studies applied to different disorders. It is unclear, however, what the elements of change are according to patients and therapists and whether they agree on this. In this study, we examined the perspectives of patients and therapists and their degree of agreement regarding the elements of change in IR for posttraumatic stress disorder due to childhood trauma. Patients who showed a substantial decrease in symptoms on the Posttraumatic Stress Disorder Checklist for DSM-5 (PCL-5) after a maximum of 12 sessions of IR, as well as their therapists, were approached. Ten patients and nine therapists provided in-depth interviews about the elements of change in the treatment they had received or conducted. A qualitative analysis of the results was used. One element of change was mentioned by all but one interviewee—namely, caring for the child by the therapist when the therapist rescripts the traumatic event. All except two interviewees mentioned that when the therapist rescripts, speaking up to the perpetrator was important. Both aspects were also important when patients did the rescripting themselves. All patients mentioned the positive connection they had with the therapist and the encouragement they received from him or her was important. There was only moderate agreement between patient and therapist regarding the most important element of change, although overall both patients and therapists believed the same elements were of importance. To our knowledge this is the first study in which the elements of change viewed by patients and therapists are investigated in relationship to one another. Despite the fact that this study does not provide definite answers of what works, the perspective of patients and therapists needs to be taken into account when IR for posttraumatic stress disorder is further developed.

Over the last few years imagery rescripting (IR) has become a popular treatment for several disorders. IR is a technique that was developed as a method not only to activate the traumatic memory and to provide corrective information to a wide range of issues but also to provide the patient with an opportunity to discover and express any trauma-related inhibited emotional responses (Arntz et al., 2007). IR is used to change the meaning of emotional memories and images (Arntz, 2012)—the development of IR has undergone changes over time. Smucker et al. (1995) were one of the first to develop an IR protocol for posttraumatic stress disorder (PTSD). Their protocol consists of two phases—namely, imaginal exposure to the traumatic event and IR. In the rescripting phase, the patient visualizes the traumatic event up to the point of the violence and then the patient intervenes as the adult self. The therapist remains largely nondirective and only facilitates the rescripting. Arntz and Weertman (1999) changed the IR method where the present adult self enters the scene to help the past (child) self by adding an extra phase. Their protocol distinguishes three phases in which the patient shifts perspective. In the first phase, the patient is instructed to imagine the traumatic memory as vividly as possible, as if it is happening in the here and now. In the second phase, the patient, as his or her adult self, enters the image and intervenes in the situation in a way that the sequence of events is changed in a more desirable direction. In the third phase, the patient undergoes the rescripting from Phase 2 from a child perspective. Next to this three-phase protocol there is a two-phase protocol in which the second phase starts with the ther-

Keywords: imagery rescripting; elements of change; posttraumatic stress disorder; qualitative study

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apist rescripting the traumatic event and the patient experiences the rescripting from the perspective of the child. Here the patient does not change perspectives but stays in the former (child) self perspective. The two-phase protocol is especially applied early in treatment and with more severe psychopathology—the three-phase protocol is applied with the patient doing the imagined intervention later in treatment or for those with less severe psychopathology.

IR has been proven effective for several disorders. In their systematic review, Morina et al. (2017) identified 19 trials and found that IR is largely effective in reducing symptoms from pretreatment to posttreatment and follow-up for several disorders, including PTSD (Arntz et al., 2013), social anxiety (Nilsson et al., 2012), obsessive-compulsive disorder (Veale et al., 2015), body dysmorphic disorder (Willson et al., 2016), and major depression (Brewin et al., 2009). However, only seven randomized controlled trials (RCTs) with a small number of participants were included—therefore, findings are still limited. In the present study, IR was used in patients classified with PTSD due to childhood trauma (ch-PTSD). The trauma happened before the age of 16 and the patient agreed that this trauma should be the focus of treatment. For PTSD several treatments are effective (Ehring et al., 2014).

For a long time eye movement desensitization reprocessing (EMDR) and trauma-focused cognitive-behavioral therapy (tf-CBT) were included as first-choice treatments in the national Dutch guideline (Trimbos Instituut, 2013). However, not every patient benefits from these treatments (Cusack et al., 2016), so other treatments were developed and studied for PTSD, like IR. As IR uses a different method, IR may work for patients who do not benefit from other PTSD treatments, such as EMDR or tf-CBT. Several studies have shown that IR is an effective method for PTSD (Alliger-Horn et al., 2015; Arntz et al., 2013; Boterhoven de Haan et al., 2020; Grunert et al., 2007; Jung & Steil, 2012; Kindt et al., 2007; Øktedalen et al., 2015; Raabe et al., 2015; Smucker et al., 1995; Steil et al., 2011). Therefore, in the renewed national Dutch guideline for treatment of PTSD, IR is included as one of the treatments of choice (GGZ Standaarden, 2020). Research shows that there is less dropout compared to imaginal exposure (Arntz et al., 2007) and IR is less distressing (Siegesleitner et al., 2019). Another important issue is that research from Arntz et al. (2007) shows that adding IR to imaginal exposure was more effective for anger control and externalization of anger, hostility, and guilt. Therefore, IR may be indicated for a specific group of patients who experience difficulties in these areas. However, we lack expertise about the elements of change in IR at this point, although there has been some research regarding the elements of change. Several hypotheses have been proposed, but findings are inconclusive. Hypotheses that gained some evidence are listed in Table 1.

Besides the specific role of IR in the reduction of symptoms, common factors also contribute to the reduction of symptoms. For example, Wampold (2015) states three pathways as being important in treatments: (a) engaging in a real relationship, (b) creation of expectation through explanation of the disorder and the treatment, and (c) the enactment of health-promoting actions. Others suggest several common factors in PTSD treatments, including agreement about therapy task (Hoffart et al., 2013), level of hope midway through treatment, and change in tolerability (Gilman et al., 2012).

There has been little research combining patient and therapist perspectives. Monson et al. (2008) assessed the association between clinician and patient ratings of PTSD symptoms. They found that there were significant longitudinal associations between clinicians and patients, indicating that patients and clinicians report PTSD symptoms in the same way. They also found that patients view more improvements relative to clinicians after treatment. Thomas (2006) studied patients and therapists in marriage and family therapy and researched four common factors in therapy that contributed to change (extratherapeutic, model/techniques, therapeutic alliance, and hope/expectancy). Results revealed that patients and therapists have different perceptions on what factors contribute to the most change.

So far little research has been done involving the perspectives of patients with ch-PTSD and therapists regarding the elements of change in IR. The main purpose of this study was to explore what the elements of change are in the view of patients and therapists and to what degree patients and therapists agree about the most important elements of change in IR for ch-PTSD. It is important to gain more knowledge about how these stakeholders view the elements of change in order to possibly improve IR treatment for ch-PTSD. When we investigate the potential elements of change according to patients and therapists, we may be able to better understand the treatment and hone treatment delivery in order to maximize its efficacy and efficiency. In-depth interviews were conducted to explore the view of these stakeholders to gain as much knowledge as possible.

For explorative research into the perspectives of patients and therapists, qualitative research is indicated as it provides a method to systematically listen to the points of view of these stakeholders. Thus, rather than

Table 1
Overview of Studies Regarding Elements of Change of Imagery Rescripting

Author	Year	Population	Proposed element of change
Arntz	2011	Personality disorders	Reattribution, emotional processing, receive care, changing meaning on the child level, transforming the rule to the exception
Brewin et al.	2010	None	Adding contextual information and making new representations more likely to win the retrieval competition over the original representation
Çili et al.	2016	Nonclinical	Facilitating the integration with individuals' sense of self and reducing negative impact on the representation of the self
Dibbets & Arntz	2015	Nonclinical	Facilitating the elaboration and integration of the adverse memory within the individual's autobiographical knowledge and life story and allowing the expression of responses that were activated but not expressed during the adverse experiences
Dibbets et al.	2011	Students	Devaluation of the U.S. valence
Germain et al.	2004	Sexual assault survivors	Increased mastery (especially increased social and environmental mastery)
Hagenaars & Arntz	2012	Students	Altering encoding or storage of trauma information
Kunze et al.	2019	Nightmare disorder	Enhanced mastery of the nightmare content
Long et al.	2011	Posttraumatic nightmares	Changing of trauma-related cognitions (maladaptive) beliefs
Mancini & Mancini	2018	None	Less negative self-beliefs and meta-emotional problems
Menninga et al.	2019	ch-PTSD	Focusing on core when patients rescript because of meeting needs the patient had as child
Reimer & Moscovitch	2015	Social anxiety disorder	Altering the meaning of negative autobiographical memories

demonstrating mechanisms of change underlying IR, for which quantitative approaches are indicated, we aimed to understand what the important elements of change are in the views of stakeholders. Qualitative research provides plenty of rich data and is therefore an important and additional research method (Sofaer, 1999). It provides important knowledge about how the stakeholders experience a treatment and therefore can contribute to optimize the treatment. Qualitative analysis was used to examine the interviews verbatim with a focus on the main research questions. In addition to the general research question of to what degree patients and therapists agree on the most important elements of the treatment, we had a number of expectations. We expected that both specific IR elements and nonspecific factors would be mentioned as elements of change (in line with the research of Menninga et al., 2019). However, due to the nature of the treatment (protocol IR), we hypothesized that elements of IR would be mentioned more often. Second, we expected that important elements of change were that there was someone who took care of the patient, that the patient felt that it was not his or her fault, and that the patient was able to express what he or she was unable to do at the time (Smucker et al., 1995).

The research question regarding to what degree patients and therapists agree on the elements is important because nowadays patients are more involved in the decision-making process regarding the treatments they receive. So it is important that the view of therapists and patients are aligned. To our knowledge no article has been published about the (dis)concordance of views of patients and their therapists regarding elements of change in IR for ch-PTSD. Therefore, it is difficult to hypothesize what the agreement will be. Based on the research of Thomas (2006) and our own experience when evaluating treatments, we expect that there will be differences in the view of patients and therapists—namely, that patients more often report common factors as being important in their treatment than their therapists.

Method

Design

This study was part of an international multicenter RCT in which patients with PTSD resulting from a traumatic event before the age of 16 received either EMDR or IR. Both treatments had two frequency conditions: 12 sessions in 6–8 weeks or 12 weekly sessions in 12–16 weeks. Randomization to treatment condition was

based on block randomization per site, to guarantee a balance between conditions per site and over time and stratified for gender, so that the gender distribution was controlled per arm per site. (Trial registration: trial NL6965 [NTR7153]; www.trialregister.nl.)

In this study, patients having received IR and their therapists were asked through a semistructured in-depth interview about their view regarding the elements of change in the treatment. The IR treatment was based on the treatment protocol by Arntz and Weertman (1999) and Arntz (2015). However, after one introduction session in the following five sessions the therapist entered the image, and in the last six sessions the patient as the adult self entered the image (see Boterhoven de Haan et al., 2017, 2020). The treatment protocol used in this study emphasizes rescripting according to the needs and wishes of the patient and requires the therapist to be nondirective regarding the content of the rescripting and directive regarding the process of the rescripting. This means that when the patient expressed his or her needs, the therapist was nondirective in the rescripting. When the patient experienced difficulty expressing his or her needs, the therapist took the lead. Patients were included based on the Posttraumatic Stress Disorder Checklist for DSM-5 (PCL-5). This is a self-report of PTSD symptoms (Weathers et al., 2013). The PCL-5 has been researched in several studies and shows good psychometric evaluation (Blevins et al., 2015). One patient received online IR—due to COVID-19 restrictions, face-to-face treatment was not allowed. These data are not included in an effectiveness study in which only face-to-face treatment is allowed (Wibbelink et al., 2021). Patients were included when they reported a reduction of 10 points on the PCL-5 (on index trauma) on assessment directly after treatment compared to the pretreatment assessment. According to Monson et al. (2008), a change of 10 points on the Posttraumatic Stress Disorder Checklist for DSM-IV (PCL-IV) can be seen as a clinically significant change. Although the PCL-5 is somewhat different from the PCL-IV, it is assumed that the threshold for change is similar (PTSD: National Center for PTSD, 2018). One patient was included despite less than a 10-point reduction. However, the score on the PCL-5 before treatment was already low and the patient was satisfied with the result of the treatment. At posttreatment assessment patients received an information letter about this qualitative study. When patients agreed to participate based on written informed consent, their contact information was sent to M.B. M.B. then approached the patient and corresponding therapist. Patients and therapists were interviewed separately at the local treatment center or when they were at home by telephone/video calling.

Sample

The sample consists of 10 patients and 9 different therapists. The majority of the patients were female (70%), with an average age of 36.1 (*SD* = 11.53, range 21–53). There was a mix in the sample regarding education (lower vocational education 40%, middle vocational education 20%, and higher vocational education 40%), employment (not able to work due to symptoms 40%, working 40%, and student 20%), and marital status (single 20%, married 60%, and living with partner 20%). Half of the patients attended one session a week, the other half two sessions a week. Regarding the nature of the index trauma, 60% were sexually abused, 30% physically abused, and 10% witnessed physical abuse. The average PCL-5 improvement on the index trauma from pre- to posttreatment was 34.11 (*SD* = 13.26, range 19–54) and the average improvement on all traumas was 21.6 (*SD* = 18.53, range 11–51). Improvement on the Clinician-Administered PTSD Scale (CAPS) for all traumas was an average 17.22 (*SD* = 11.45, range 2–33). All but one therapist was female. One therapist was interviewed twice; the rest of the patients were treated by different therapists. In total at five sites, patients agreed to participate (GGZ NHN, GGz Oost-Brabant, PsyQ Beverwijk, PsyQ Amsterdam, and Perth Australia). Patients had a mixed cultural background (Western European, Middle Eastern, and North African, Australian). We planned 10 patient interviews (and hence 10 therapist interviews) given that Guest et al. (2006) found that after six interviews the basic elements for meta themes were present, and after 12 interviews 92% of the total number of codes were developed. Therapists successfully completed basic training in CBT and were trained in the IR protocol used in this study during a 2-day training. Afterward they were peer supervised at the local treatment center by demonstrating IR with pilot patients and only participated in the study after a minimum score on fidelity scales. During the study there was weekly peer supervision. All sessions were videotaped. A fidelity check is part of the IREM-Freq study, of which the present study is a substudy. The fidelity check of the IREM-Freq study is not completed yet, but similar (good) results are expected as in the Boterhoven de Haan et al. (2020) study.

A total of 18 patients did not meet the criteria of this study. They were excluded for several reasons—namely, three patients showed no decrease in complaints after treatment, five patients were not able to be interviewed in Dutch or English (all from German sites), six gave no specific reason for not wanting to participate or did not respond to the invitation, two

patients were not included because there were not enough research assistants to conduct the interviews at that time, and finally, two patients first agreed to the interview, but did not show up at several appointments.

Ethics

The approval for the RCT including the qualitative study was obtained by the Ethics Review Board of the faculty of social and behavioral sciences, University of Amsterdam. Patients received additional information about this study at posttreatment assessment, and after they agreed to participate, they and the corresponding therapist were approached. Patients gave written informed consent by the beginning of the interview. In the study, names and other characteristics of the patients were deleted. The transcripts of the patients were not shared with their therapists and vice versa. This was emphasized at the beginning and the end of the interview.

Data Collection

Data collection was done using a semistructured in-depth interview. Prior to the study two patients were asked about their experiences with the treatment and in addition several therapists were approached. This resulted in a first topic list. After two trial interviews the topic list was finalized. The topic list consisted of topics that were based on the research questions of this study, the treatment protocol, and previous research, and there was freedom for the participants to add anything that was not captured by the topic list (see Appendix 1 for the topic list). Patients and therapists were interviewed by M.B. or a research assistant who was trained by M.B. in both the IR treatment, as well as conducting interviews. The research assistant viewed the pilot interviews conducted by M.B. and another pilot interview was held with M.B. They also received feedback after the first official interview. The interviews were recorded on a voice recorder and later typed out verbatim. The interview had no fixed duration and was stopped when no new information was brought forward. The interviews varied in length from 30 to 85 minutes. The interviews were held between August 2019 and July 2020. The interviews with patients were mostly held at the local treatment center, except for four interviews (due to COVID-19 restrictions) using videoconferencing and one by telephone because the Internet connection was not stable enough for videoconferencing. The therapist interviews were mostly held by telephone (eight) and two at the local treatment center. The interviewers did not know anything about the patient before the interview.

Quality Procedures

Tong et al. (2007) conducted a 32-item checklist for reporting qualitative research. This was used for comprehensive reporting of the results. All interviews were fully transcribed. After the interviews a member check was made by M.B. and was sent to the patient or therapist. This was done to ensure credibility that the main elements of change were correctly interpreted (Green & Thorogood, 2004). M.B. read and reread the interviews and wrote a summary containing the most important components of the interview. Patients and therapists were given the opportunity to make any adjustments or additions. However, no patient or therapist gave any remarks. Four patients and three therapists did not respond to the member check. During the interview phase a coding frame was set up. The coding frame was based on both concept-driven and data-driven dimensions. After finalizing the coding frame, the coding frame was piloted by coding four interviews by M.B. Every coding unit could be coded by the coding frame, so no adjustments were made.

Data Analysis

The interviews were coded using the program MAXQDA (version 12.3.6 and 2020). After all interviews were fully transcribed, M.B. segmented the material. This means that the responses were divided into units in such a way that each unit fits into one category of the coding frame (Schreier, 2012). Afterward all interviews were first coded by M.B. using qualitative content analysis (QCA). The aim of QCA is to systematically describe the meaning of the material. Later the interviews were also coded by another research assistant. After the coding of three interviews, those interviews were discussed in order to evaluate the coding frame and to make sure that both researchers used the coding frame the same way. No changes were made to the coding frame during this stage. Afterward the remaining interviews were coded. Cohen's kappa (Brennan & Prediger, 1981) was used to calculate intercoder agreement. This resulted initially in a 73.82–91.93% agreement between the two researchers for the 20 interviews and Cohen's kappa between .73 and .92 with a mean for all codes of .82. Items that were coded differently were discussed until agreement was reached between the two researchers. For 16 units coders agreed that both codes could fit the coding unit depending on the interpretation and M.B.'s coding

was used. The 16 codes were scattered throughout the coding frame.

Results

The results of the data analysis can be divided into different categories. First we describe the findings regarding the first research question. We describe what patients responded most frequently as helpful elements of change (see Appendix 2 for an overview of the codes per patient) and then we describe what elements of change were mentioned as most helpful by therapists (see Appendix 3 for an overview of the codes per therapist). Afterward we describe other issues that were mentioned in the interviews, like the most important session, what patients or therapists would change regarding the IR treatment, and other issues worth discussing. All categories are illustrated with quotes of interviewees. Thereafter we get into the main research question about to what degree patients and therapists named the same elements of change in the treatment.

Patients' View

We were interested in what elements patients believed were important in bringing change in the IR treatment for ch-PTSD they received. Several aspects of the treatment were reported by (almost) all patients. First, all but one patient believed that the care they received when the therapist rescripted the traumatic event was helpful to reduce symptoms. Overall, patients responded that it was something that they had not had when they were young, and that they could really experience the support in the rescripting.

> "I'll just explain it briefly. Something happened in the past. That was rescripted, that the therapist stood up for me. When I was a little girl, so to say, that she sat next to me and comforted me. Or it was just that she was there for me. It's so strange to talk about it like that, because it didn't really happen. But it happened that way in my head."

All except two patients also responded that confronting the perpetrator was important. Most responses were accompanied by explanations that it resulted in another view about the traumatic events—for example, that they no longer felt it was their fault.

> "Those traumas that really . . . the abuse and all that. That no one ever stepped in and when she stepped in, the therapist, that was quite intense. But it was nice. There was someone who thought it was not normal and did something about it. Who took action."

When patients did the rescripting themselves, nine mentioned the care they could give to their younger self as important and eight of the patients named confronting the perpetrator as important. Patients mentioned that they felt released because of what they did to the perpetrator in the rescripting and that they could stand up for themselves. Since some patients stood up for themselves in the rescripting, they now apply it more in their daily life.

> "I was sexually abused by my stepfather for years. And for me it was just that at some point I would stick a knife in his stomach to see that . . . yes finally. . .. That I was released from him, you know. Or kick his head 100 times until he was pulpy or something. Yes that helped me to suddenly be like that, that aggressive. Or I don't know what you call it. That was in me that I was actually not fully aware of. Kind of tension, fear and resentment. That all came out."
>
> "I think it's comforting because I was never comforted before. I was always on my own. I could never really talk to my parents, or that they had time for me because they had other things on their mind. So I went and comforted myself. First I didn't know how to do that."

All patients mentioned the positive connection they had with the therapist as helpful and they named specific aspects of the therapist as helpful. More specifically, being straight to the point and confronting were important for patients. Also, as well, the therapist took time for emotions after the rescripting and adapted the sessions to the patient's wishes. For example, the trauma to treat was chosen together, taking into account the feelings of the patient.

> "I think the behaviour of the therapist. That's what appeals to you. And that is different for everyone. It just appealed to me, good explanation, not so exuberant, but just a calm woman. Just take it easy. Don't feel like I have to speed up, time is ticking or something. Then you could get irritated by that too. Well, just that. That also makes you feel safe at that moment."
>
> "Well I think because she was very, very accommodating but also very direct, that it was very good. And not too soft."

All except two patients named the encouragement they received from the therapist during the rescripting as important. Most of the patients mentioned that they needed help in the rescripting to overcome any shame or hesitation they felt and they felt supported when the therapist helped them by advising them on different things or telling them they could do whatever they wanted to do.

> "By giving me suggestions, but also by telling me it was normal what I felt. Encouraging me by telling me that I could do whatever I wanted to do. Nothing would be too weird. It does not mean that you will do it in daily life. I found it really hard in the beginning. But it helped me to really express what I wanted to do."

All patients mentioned specific aspects of the treatment protocol as helpful. For example, several patients believed that because the therapist checked with them whether it was all good or that they wanted to do anything else was important—they could adjust the rescripting in such a way that everything they needed was accomplished. All patients except one also said that breaking through avoidance was important for them in the treatment. Most of the patients mentioned that it was important for them that they could tell somebody about the traumatic event, as well as telling the things they were embarrassed or ashamed about.

> "Yes well . . . that I have given in and that I have stepped over my own shame and when I do that I trusted her that things were going to change and that gave me motivation to continue."

Last, eight patients said that they achieved control over the content of the intrusive images during and after treatment as a result of the treatment.

> "That when I get a memory of my childhood that I can just rescript in my head. I am going to get in the image myself and I say that it is enough or something. That I can solve it myself when it is ever going to be back. Or should something happen that gives me the same feeling again, that I can do it myself in my head. That I know how to do it. And now I know it helps."

Therapists' View

All therapists believed that when they did the rescripting—giving care to the child, bring the child into safety, and speaking up to the perpetrator—it contributed to the reduction of symptoms.

> "Well I think it is important that the patient was supported in what she wanted. And that I emphasized that she didn't had to feel guilty about anything because what she wanted was very normal. I think normalizing what she already knew more or less. But that she could feel it more and more because it was confirmed and normalized in the rescripting by me."

All but one therapist believed that breaking through the avoidance of the patients was important. Most of them believed that it helped patients to express all of the feelings they experienced during and after the traumatic events.

> "Breaking through the avoidance by talking about it. And then in a more detailed way instead of just some angry words and some blanks. But more organized, I think it did her good."

Most of the therapists, mentioned in eight interviews, responded that when the patient rescripted the traumatic events, it was important that their younger self received care and that it was important that the perpetrator was confronted. Patients no longer felt powerless, but could express their feelings both in the rescripting and in daily life now. It resulted in a decrease of symptoms and an increase in a feeling of peace.

> "Well, by really lying next to her child self, by being physically very close. This was difficult for the child at first to go along with that. But after one rescripting the child could also relax when that happened, the tension really disappeared. By allowing that closeness and trusting that it was good."

> "And he addressed the parent and the other perpetrator. And I was not allowed to do that. So that has changed."

In 7 of the 10 interviews, therapists believed that it was important that patients recognized their emotions and thoughts regarding the traumatic events and that they were more aware of their feelings. It was believed that this helped patients to express their feelings both in the rescripting, as well as being strengthened by it in daily life.

> "He was very furious about that period. And that was actually not allowed at all by him. So the anger could exist. He has been validated, in his sense that things weren't right."

> "I don't think he realized how important that good-bye was to him. And that he was able to experience this in the rescripting . . . in one way or another. That it enabled him to reach some closure."

In 8 of the 10 interviews with therapists, the encouragement of the therapist was believed to be important. Some therapists believed that it was necessary to encourage the patient in order to do the things in the rescripting that he or she thought needed to be done. Some therapists mentioned that the encouragement helped patients to overcome their fear and break through avoidance. Others experienced the importance of repeatedly telling the patient that he or she was not alone.

> "And that I gave her very much encouragement: I'm going to help you, I'm going to pull you through, I'm going to help you, you will succeed."

Most therapists also mentioned several consequences of the rescripting—namely, that a new meaning was given to the traumatic events by the patients (9 out of 10 interviews) and that patients created a more integrated self-image during treatment (8 out of 10 interviews).

> "Well he actually realized he wasn't doing that bad as a dad. And that it really doesn't have to be repeated. So that he actually did quite well as a father. And that reacting agitated once really does not mean that you immediately become a perpetrator."
>
> "And that she has also noticed through the rescripting that it was not unwillingness on the part of mother, but maybe sometimes ignorance. And that that made it easier in contact with mother now."

Most Important Session

Patients and therapists were asked what they believed was the most important session. Patients and therapists only agreed on the most important session in 4 out of 10 interview couples. Three patients were persistent in that several sessions were important for them and they could not make a distinction. Three patients found that rescripting of another traumatic event than the index trauma was the most important. Surprisingly for only half of the patients the rescripting of the index trauma was the most important session. Most patients responded that the most important session resulted in a big change in the way they felt about the traumatic events they went through and that they immediately felt a reduction in symptoms.

> "Well what I said. They used to tell my mom's family it was my fault that my grandfather died. And on the death bed, I was not there myself. But the rescripting made sure I was there and that I could say good-bye. That the therapist could tell grandpa what was going on. She made it completely different from the image I have in my head. That was really . . . at least I could say goodbye. Because I couldn't do that then. That was, that was really intense."
>
> "I used to be abused by my stepfather. With the rescripting, I really liked that. I had to go back as who I am now. I always said that when I run into that man . . . he's just mine. In the rescripting I punched him so hard in the face that he was knocked out. I just came out of that session laughing. I thought that was a very nice session."

Proposed Changes in the IR Treatment

All patients received 12 sessions (or fewer sessions when they completed treatment early) and 11 sessions contained IR. Two patients wanted to change something in the treatment. Both patients would have found it helpful that besides the sessions with IR there was another session in which other things in life and responses to the IR could have been discussed. All patients who were asked whether or not they were satisfied with the frequency condition were positive about their treatment condition—this was the case for both the once- and twice-a-week conditions.

Therapists were also asked whether or not they would change something in the treatment. Two therapists said that adding more psychoeducation about the role of schemas and modes could be beneficial for the patients, to get more insight into how the previous events might have influenced them in daily life now. One therapist advised to delete the last step of the rescripting in which the patient experiences the rescripting they did before as an adult. One therapist would have preferred to have more time for psychoeducation about emotional responses to traumatic events and ways to stabilize emotions during the treatment period. Last, one therapist would have preferred to have more time to discuss other life events of the patient during treatment. In the other five therapist interviews, therapists would not change anything in the treatment.

Other Important Issues

Due to the nature of this study in which interviewees were able to mention anything they believed was important, there are other important aspects that were mentioned by patients and therapists during the interviews that are worth discussing. First, in 6 out of 10 interviews, therapists said that the imagery ability of the patient was helpful to gain more out of this treatment.

> "Well it is very nice when someone can imagine it very well. Because then rescripting just works much better. When someone is really good at imagining. She was also sometimes completely gone. Then she was rubbing her eyes. . .. Then you can really stand up for someone. So then the intervention works much better than when someone is not good at it at all."

Also the motivation of the patients was believed to contribute to the effectiveness of the therapy. Therapists named things, like patients showed up despite feeling sick, they were used to more no-shows in regular treatments, and the willingness of patients to speak about their most important issues throughout treatment, even in the last session.

Surprisingly, the step in which the patients experienced the rescripting they did as an adult from the child perspective was mentioned less than the other steps of the IR. Only six patients and seven therapists mentioned a part of this step as important, and nobody believed this was the most important element of change of the treatment.

Agreement Between Patient and Therapist

To answer the main research question of what degree patients and therapists agreed on the elements of change, we looked into the responses of the patients and therapists per couple. All responses were coded and checked whether or not the responses of the patient and therapist matched. All couples matched on at least one element of change (see Table 2 for an overview of the coded units). The two most important elements mentioned by patients and therapists are listed first, and in Columns 5 and 7 other elements mentioned by therapist and patient, respectively, are listed. In the columns between it is stated whether or not patient and therapist agreed about the mechanism—this is done separately for the elements that were mentioned as most important, and whether or not the elements were agreed upon at all (partial agreement).

Only one couple agreed about the most important element of change (Couple 1). Most of the couples agreed partially (Couples 2, 4, 5, 6, and 7) and four couples reached no agreement at all (Couples 3, 8, 9, and 10). However, when looking at what patients and therapists believed were important elements regardless of whether they mentioned it as the most important, agreement was much higher. Looking at the first four responses of patients and therapists, most of the couples—7 out of 10 (Couples 1, 2, 3, 5, 6, 7, and 10)—agreed about the therapist rescript that receiving care was an important element of change. Five out of 10 couples (Couples 1, 2, 3, 4, and 7) believed that the therapist rescript of speaking up to the perpetrator was important. Other elements that reached agreement between patient and therapist were (a) therapist rescript of making sure it is safe (Couples 5 and 6), (b) patient rescript of receiving care (Couples 5 and 6), and (c) patient rescripts of speaking up to the perpetrator (Couple 4) and (d) telling about the trauma (Couple 4). When taking into account every element that was mentioned by the patient or therapist, therapist rescript of receiving care was also agreed to by Couple 4; therapist rescript of speaking up to the perpetrator was mentioned by Couple 6; patient rescript of speaking up to the perpetrator by Couples 3 and 5; therapist rescript of making sure it is safe by Couple 7; patient rescript of receiving care by Couple 4; and finally, therapist rescript of expressing emotions by Couple 7 were also mentioned by both patients and therapists.

Facilitating factors that some couples agreed on had to do with the support that was given by the therapist during treatment (Couples 1, 3, 7, and 10), the connection between the patient and the therapist (Couple 1), experiencing progress throughout treatment because of questionnaires that were filled in prior to a treatment session (Couple 2), and having time to talk about daily experiences and adapting treatment to it (Couples 1 and 10).

Discussion

Despite that there are several effective treatments for PTSD today (e.g., EMDR, tf-CBT), IR might also be an attractive treatment for PTSD. This study explored the perspectives of two important stakeholders—namely, patients and therapists regarding the elements of change in IR for ch-PTSD.

The main finding of the present study about the elements of change in the IR treatment that patients with ch-PTSD received partially matched our expectations. All interviewees believed that when the therapist rescripted the traumatic event, receiving care was an important element of change. Patients mentioned that they had lacked this in their childhood and they experienced the feeling that someone was there for them. All except one patient believed that confronting the perpetrator by the therapist was also an important element of change. Patients stated that this helped them to feel that what had happened was not their fault. This is in line with the proposed elements of change by Arntz (2011) in which emotional processing and receiving care were mentioned as important in the treatment, and by Long et al. (2011), who mentioned that changing beliefs about the traumatic event is important. When patients rescripted the traumatic events themselves, confronting the perpetrator and receiving care were also mostly mentioned as being important elements of change. Patients believed that this helped them to stand up for themselves in daily life and they felt released afterward. This is in line with research of Dibbets and Arntz (2015), who found that expressing responses that were felt at the time but could not be expressed is important. Overall the results suggest that it is important that the rescripting is adapted to the needs of the patient, both in the here and now and as when they were young.

Consequences of the IR were mostly having more control over intrusive images, giving new meaning to the traumatic event and more integration of self-image. This is in line with the research of Kunze et al. (2019) and Germain et al. (2004) in which they found that enhanced mastery over nightmare content is proposed as an element of change. Brewin et al. (2010) also believed that by adding contextual information and making new representations it is more likely that this will win the retrieval competition over the original representation. In the present study, patients mentioned that they remembered the

Table 2
Agreement Between Patients and Therapists Regarding Elements of Change

	Most important element according to patient	Most important element according to therapist	Agreement	Important element according to therapist	Partial agreed	Important element according to patient	Partial agreed
Participant 1	Therapist rescript—receiving care	Therapist rescript—receiving care	Yes			Patient rescript—speaking up to perpetrator	No
	Therapist rescript—speaking up to perpetrator	Therapist rescript—speaking up to perpetrator	Yes				
Participant 2	Telling of the trauma	Therapist rescript—receiving care	No	Therapist rescript—making sure it is safe	No	Therapist rescript—receiving care	Yes
	Therapist rescript—stopping perpetrator	Therapist rescript—stopping perpetrator	Yes				
Participant 3	Patient rescript—speaking up to perpetrator	Therapist rescript—focus on emotions	No	Therapist rescript—making sure it is safe	No	Therapist rescript—receiving care	Yes
	Therapist rescript—awareness emotions	Therapist rescript—speaking up to perpetrator	No	Therapist rescript—receiving care	Yes	Therapist rescript—speaking up to perpetrator	Yes
Participant 4	Therapist rescript—receiving care	Therapist rescript—shift in responsibility	No	Telling about trauma in detail	Yes	Therapist rescript—speaking up to perpetrator	Yes
	Patient rescript—speaking up to perpetrator	Patient and therapist rescript—speaking up to perpetrator	Yes	Psychoeducation	No	Telling about trauma in detail	Yes
Participant 5	Therapist rescript—receiving care	Therapist rescript—receiving care	Yes	Therapist rescript—making sure it is safe	Yes	Therapist rescript—checking if it is okay	No
	Therapist rescript—making sure it is safe	Patient rescript—receiving care	No	Therapist rescript—speaking up to perpetrator	No	Patient rescript—receiving care	Yes
Participant 6	Patient rescript—understanding how child is feeling	Patient rescript—making sure it is safe	No	Therapist rescript—receiving care	Yes	Patient rescript—making sure it is safe	Yes
	Patient rescript—receiving care	Patient rescript—receiving care	Yes	Therapist rescript—making sure it is safe	No	Able to feel as a child	No

(continued on next page)

Table 2 (*continued*)

	Most important element according to patient	Most important element according to therapist	Agreement	Important element according to therapist	Partial agreed	Important element according to patient	Partial agreed
Participant 7	Therapist rescript—receiving care	Therapist rescript—receiving care	Yes	Therapist rescript—speaking up to perpetrator	Yes	Therapist rescript—speaking up to perpetrator	Yes
	Patient rescript—speaking up to perpetrator	Therapist rescript—making sure it is safe	No	Therapist rescript—express emotions	No	Telling of trauma	No
Participant 8	Calming himself	Therapist rescript—receiving care	No	Therapist rescript—speaking up to perpetrator	No	Rescripting	Yes
	Calming by therapist	Therapist rescript—making sure it is safe	No	Patient rescript—receiving care	No		
Participant 9	Patient rescript—making sure it is safe	Therapist rescript—receiving care	No	Patient rescript—experience feelings of the child	Yes	Psychoeducation	No
	Child perspective—receiving care	Patient rescript—receiving care	No	Therapist rescript—speaking up to perpetrator	No	Patient rescript—experience feelings of adult self	No
Participant 10	Patient rescript—speaking up to perpetrator	Therapist rescript—speaking up to perpetrator	No	Therapist rescript—experience feelings of the child	No	Talking about daily events	Yes
	Patient rescript—making sure it is safe	Therapist rescript—receiving care	No	Patient rescript—experience feelings of the child	No	Therapist rescript—receiving care	Yes
Total Yes			7		6		11
Total No			13		11		6

rescripted version of the traumatic events after treatment instead of the original events. The results regarding the self-image support research by Çili et al. (2016) and Mancini and Mancini (2018). The results indicate that the treatment not only reduces PTSD symptoms but also has a more general impact in daily life. These results might imply that having more control over intrusive images, giving new meaning to the traumatic event, and a change in self-image might be the mechanisms of change that are facilitated by IR. Furthermore, all patients believed that the positive connection they experienced with the therapist was important. They felt supported and encouraged throughout treatment. This more common factor was also mentioned by most of the therapists. This partially supports the viewpoint of Wampold (2015) because he

stated that having a real relationship is an important element of change, although in this study, patients and therapists named this as a facilitating factor and not the most important element of change in the treatment.

Regarding the most important session, two results are interesting. First, patients and therapists believed different sessions were the most important. This is in line with another result of this study that agreement between patient and therapist regarding the most important element of change is only moderate. This shows that it is important that both patients and therapists are approached in studies, because they are two different sources of information that can yield different findings. The next interesting result is that after treatment several patients believed that the session regarding the index trauma did not result in the most reduction of symptoms. This shows that what was thought was needed to be the focus of treatment, afterward did not always account for the greatest reduction of symptoms. This implies that up front it is difficult to predict what should be addressed in the treatment, and that adaptation during treatment is advised.

The second research question regarding to what degree patients and therapists reached agreement about the elements of change is more difficult to answer. It could be said that agreement about the most important elements of change was less than we expected. However, when looking at what patients and therapists believed to be the elements of change not taking into account what was most helpful, agreement was much higher. Elements that reached most agreement were therapist rescript: receiving care, speaking up to the perpetrator, making sure it is safe. This was followed by patient rescript: receiving care and speaking up to the perpetrator. Suggesting that both patients and therapists found the phase in which the therapist enters the traumatic event is most important followed by the phase in which the patient rescripts him- or herself. Since patients and therapists mostly disagreed about the most important elements of change, it is important that both stakeholders are approached when revising treatment protocols. What might not seem to be important to therapists could be important for patients, and vice versa. Taking into account the patients' view is important for reaching good collaboration in treatments and therefore contributes to the therapy.

Remarkably, the third phase in which the patient experienced the rescripting that they did as his or her adult self from the viewpoint of the patient as a child was mentioned less often as important, and even mentioned as redundant by some patients. However, 8 out of 10 patients mentioned that this phase in which they experienced the caring of the adult self, seeing that the perpetrator was punished and recognizing their feelings as a child, resulted in a further and important reduction of symptoms.

This study has several strengths and limitations. To our knowledge, this is the first qualitative study in which patients and therapists were interviewed and compared on what they believed are the most important elements of change in a specific treatment. Nevertheless, this study has several limitations that need to be addressed. For one, the results are based on a small number of interviewees. Despite research by Guest et al. (2006) that found that after six interviews the most important elements came up, others stated that it varies on how many interviews are recommended among others things, depending on the research question (e.g., Baker & Edwards, 2012). Generalizability is limited as saturation of elements of change might not have been reached and more interviews might result in additional elements of change. Next we interviewed only patients who benefited from the treatment due to the nature of the primary research question in which we were interested to what degree patients and therapists agreed on the most important elements of change. Although interviewees were asked about things they would change in the treatment, interviewing patients who dropped out might have resulted in a broader picture of the helpful and less helpful elements. Furthermore, we tried to reach maximum variance in participants when the research was conducted. However, due to inclusion problems, there was no luxury to choose participants and all participants who met the inclusion criteria were asked to participate. This resulted in a mix regarding gender, age, and index trauma, but almost half of the participants came from one site. This could have resulted in a bias, because of the site's weekly peer supervision, which may have had an impact on how the treatment was conducted. Moreover, this study was conducted by a researcher who also participated as a therapist in the study, which on the one hand enabled her to properly understand the subject matter. However, on the other hand, this might have also had an impact on the process of data collection and analyses by the way the topic list was set up and interviews were conducted. However, to rule out any bias—interviewees were questioned in an open manner during the interview and they could make any additions they wanted—a member check was done and the analysis was double checked by a second researcher. Altogether we believe that the possible influence on the results is minor.

Future research should include dismantling studies of IR, because these studies might result in more information about what results in which reduction of symp-

toms—for example, a dismantling study in which a specific element of the rescripting is systematically left out of treatment or a dismantling study in which the phase that the patient experiences when rescripting as the child self is only included in one condition. As a result of knowing more about the specific elements and phases of IR and the consequences of symptoms on daily life, treatments may become more effective when treatments can be adapted to the specific symptoms and needs of each patient. Another area of future research should be comparing different strategies of rescripting. For example, Rijkeboer et al. (2020) studied rescripting through writing in healthy adults and found that it was as effective as imaginal rescripting. When different strategies of rescripting appear to be effective, we might also study what method works best for whom. Indication could then possibly be made on specific markers or preferences of the patient.

In conclusion, this study revealed several elements of change in IR for ch-PTSD, according to patients and therapists. Both caring for the child and speaking up to the perpetrator were important elements of change. This accounts for both rescripting by the therapist, as well as rescripting by the patient. Furthermore, all patients believed that the positive connection they felt with the therapist was important for them as a facilitating factor. Although patients and therapists, overall, believed the same elements were of importance, there was only moderate agreement between patient and therapist regarding the most important element of change for that specific treatment. In future research, both stakeholders should be involved, as it appears that they gain different knowledge.

Appendix 1. Topic List

Most important elements

1. Which element of the treatment has helped you the most?
   - Why was this so important for you?
   - What changed because of this?
   - What else in the treatment has been important for you?

Specific session

2. What was the most important session?
   - What happened in this session?
   - Why was this the most helpful for you?
   - What changed because of this?
   - What else happened in this session that was important for you?
   - Was this session pointed at the index trauma?

Specific imagery rescripting

3. Which element of the imagery rescripting helped you the most?
   - How did this help you the most?
   - What changed because of this?
   - And what else?

Ask about the specific elements

- Telling the traumatic event
- Therapist in the picture and rescripts
- Patient as adult in the picture and rescripts
- Perspective of the child and experiencing the rescripting patient did as adult
- Pay attention to sensory information, emotions, cognitions, needs
- Also pay attention to confronting the perpetrator/stopping the perpetrator, bringing the child in safety, explaining the situation to the child
- Frequency of the sessions

General

4. Did any other factors have an affect for you?
   - Like intake procedure, assessments, the therapist, hope of the patient/therapist, level of motivation for the treatment, accessibility of therapist/treatment center, connection with the therapist, breaking through avoidance, frequency of the sessions?
5. Is there anything that was important for you that we have not talked about so far?
6. What is missing in the treatment/what needs to be added?

Appendix 2. Codes Mentioned by Patients

	Participant									
	1	2	3	4	5	6	7	8	9	10
General	0	0	0	0	0	1	0	1	0	1
New representation that wins	1	0	0	0	1	1	0	1	0	1
Retrieval										
Less fear when exposed to stimuli	1	1	0	0	0	0	0	0	0	0
New meaning of traumatic event	0	1	1	0	1	1	1	0	1	1
Control over memories	0	1	1	0	1	1	1	1	1	1
Integration of self-image	0	0	0	0	1	1	0	0	1	1
Therapist rescript										

Codes Mentioned by Patients (*continued*)

	Participant									
	1	2	3	4	5	6	7	8	9	10
General	1	1	1	1	1	0	1	1	1	1
Experience feelings of the child	0	1	1	1	1	1	1	0	0	0
Receiving care	1	1	1	1	1	1	1	1	0	1
Making sure it is safe	0	0	1	1	1	0	1	1	1	0
Speaking up to perpetrator	1	1	1	1	1	1	1	0	0	1
Patient rescript										
General	0	0	1	1	1	1	1	1	1	1
Experience feelings of the child from adult perspective	0	0	1	0	0	1	1	0	0	0
Receiving care	1	0	1	0	1	1	1	0	0	0
Experience feeling of the child	0	0	1	0	0	1	1	0	0	0
Making sure it is safe	0	0	0	1	0	1	0	0	1	1
Speaking up to perpetrator	1	1	1	1	1	0	1	0	1	1
Experience feelings of adult self	0	0	1	1	0	0	0	0	1	0
Child perspective										
General	0	1	1	0	1	1	0	0	1	1
Express feelings from child perspective	0	0	0	0	0	1	0	0	0	0
Receiving care	0	1	0	0	0	0	0	0	1	1
Making sure it is safe	0	0	0	0	0	0	0	0	1	0
Therapist factors										
General	1	1	1	1	1	0	0	1	1	1
Encouragement	1	1	1	1	1	0	1	1	0	1
Connection between patient and therapist	1	1	1	1	1	1	1	1	1	1
Specific aspect of therapist	1	1	1	1	1	1	1	1	0	1
General										
Investigation core	0	1	0	0	0	0	1	0	1	0
Psychoeducation	1	0	0	1	1	0	1	1	1	1
Talk after rescripting	0	1	1	0	1	0	0	0	0	1
Treatment protocol	1	1	1	1	1	1	1	1	1	1
Breaking through avoidance	1	1	1	1	0	1	1	1	1	1
Too general	1	1	1	1	1	1	1	1	1	1
Awareness of feelings and thoughts	0	0	1	1	1	1	1	0	0	0
Acknowledgment	0	1	1	0	0	1	0	0	0	0
Facilitating factors										
Talk about daily events	1	1	1	0	0	0	1	0	0	1
Questionnaire before session	1	1	0	0	1	0	0	0	0	0
Ability of imagination	1	0	0	0	0	1	0	1	0	0
Consequences										
Decrease in symptoms	1	1	1	0	1	1	1	1	1	1
Behavioral change	0	1	1	0	1	1	1	0	0	1
Other										
Most important session	1	1	1	1	1	1	1	1	1	1
Change about treatment	0	0	0	1	0	1	1	1	1	1
Irrelevant	1	1	1	1	1	1	1	1	1	1
Interviewer	1	1	1	1	1	1	1	1	1	1

Note. 0 = never mentioned; 1 = mentioned at least once.

Appendix 3. Codes Mentioned by Therapists

	Therapist									
	1	2	3	4	5	6	7	8	9	10
Theoretical										
General	0	0	0	0	0	0	0	0	0	1
New representation that wins	1	0	0	0	0	1	0	1	0	0
Retrieval										
Less fear when exposed to stimuli	0	1	0	0	0	0	0	0	0	0
New meaning of traumatic event	0	1	1	1	1	1	1	1	1	1
Control over memories	0	0	0	1	1	1	0	1	0	0
Integration of self-image	1	0	1	1	1	1	1	0	1	1
Therapist rescript										
General	1	1	1	1	0	0	1	1	1	1
Experience feelings of the child	0	0	1	1	0	1	1	1	0	1
Receiving care	1	1	1	1	1	1	1	1	1	1
Making sure it is safe	1	1	1	1	1	1	1	1	1	0
Speaking up to perpetrator	1	1	1	1	1	1	1	1	1	1
Patient rescript										
General	0	1	1	1	1	1	0	1	1	1
Experience feelings of the child from adult perspective	0	0	0	1	0	1	0	1	1	1
Receiving care	0	1	1	1	1	1	0	1	1	1
Experience feeling of the child	0	0	0	0	1	1	0	0	0	0
Making sure it is safe	0	0	1	0	1	1	0	0	1	1
Speaking up to perpetrator	1	0	1	1	1	1	0	1	1	1
Experience feelings of adult self	0	0	1	1	1	0	0	0	1	0
Child perspective										
General	0	0	1	1	1	0	0	0	1	1
Express feelings from child perspective	0	0	0	0	0	0	0	1	1	0

(*continued on next page*)

Codes Mentioned by Therapists (*continued*)

	Therapist									
	1	2	3	4	5	6	7	8	9	10
Receiving care	0	1	0	0	0	1	0	0	0	1
Making sure it is safe	0	0	0	0	0	0	0	0	0	0
Therapist factors										
General	1	0	1	1	0	1	1	0	1	0
Encouragement	1	0	1	1	1	0	1	1	1	1
Connection between patient and therapist	1	0	0	1	1	1	1	0	1	1
Specific aspect of therapist	1	0	1	0	0	0	0	0	1	1
General										
Investigation core	0	0	0	1	0	0	0	0	0	0
Psychoeducation	0	0	1	1	0	0	1	0	1	1
Talk after rescripting	0	0	1	1	0	0	0	0	0	0
Treatment protocol	0	1	0	1	1	1	0	1	1	1
Breaking through avoidance	1	1	1	1	1	0	1	1	1	1
Too general	1	1	1	1	1	1	1	1	1	1
Awareness of feelings and thoughts	0	0	1	1	1	1	1	1	1	1
Acknowledgment	0	1	1	1	1	0	1	1	1	0
Facilitating factors										
Talk about daily events	1	1	0	0	0	0	0	0	1	0
Questionnaire before session	0	1	0	0	0	0	0	0	0	0
Ability of imagination	1	0	1	0	1	1	0	1	1	0
Consequences										
Decrease in symptoms	1	1	1	1	1	1	1	0	1	0
Behavioral change	1	1	1	1	1	1	1	0	0	1
Other										
Most important session	1	1	1	1	1	1	1	1	1	1
Change about treatment	1	1	0	1	1	1	0	1	1	1
Irrelevant	1	1	1	1	1	1	1	1	1	1
Interviewer	1	1	1	1	1	1	1	1	1	1

Note. 0 = never mentioned; 1 = mentioned at least once.

References

Alliger-Horn, C., Zimmermann, P., & Mitte, K. (2015). Comparative effectiveness of IRRT and EMDR in war-traumatized German soldiers. *Vergleichende wirksamkeit von IRRT und EMDR bei kriegstraumatisierten deutschen Soldaten. Trauma und Gewalt, 9*(3), 204–215.

Arntz, A. (2011). Imagery rescripting for personality disorders. *Cognitive and Behavioral Practice, 18*, 466–481. https://doi.org/10.1016/j.cbpra.2011.04.006.

Arntz, A. (2012). Imagery rescripting as a therapeutic technique: Review of clinical trials, basic studies, and research agenda. *Journal of Experimental Psychopathology, 3*, 189–208. https://doi.org/10.5127/jep.024211.

Arntz, A. (2015). Imagery rescripting for post traumatic stress disorder. In N. C. Thoma & D. McKay (Eds.), *Working with emotion in cognitive behavioral therapy: Techniques for clinical practice* (pp. 203–215). Guilford Press.

Arntz, A., Sofi, D., & van Breukelen, G. (2013). Imagery rescripting as treatment for complicated PTSD in refugees: A multiple baseline case series study. *Behaviour Research and Therapy, 51*, 274–283.

Arntz, A., Tiesema, M., & Kindt, M. (2007). Treatment of PTSD: A comparison of imaginal exposure with and without imagery rescripting. *Journal of Behavior Therapy and Experimental Psychiatry, 38*, 345–370. https://doi.org/10.1013/j.jbtep.2007.10.006.

Arntz, A., & Weertman, A. (1999). Treatment of childhood memories: Theory and practice. *Behaviour Research and Therapy, 37*, 715–740. https://doi.org/10.1016/S0005-7967(98)00173-9.

Baker, S. E., & Edwards, R. (2012). How many qualitative interviews is enough? Expert voices and early career reflections on sampling and cases in qualitative research. *National Centre for Research Methods* https://eprints.ncrm.ac.uk/id/eprint/2273/4/how_many_interviews.pdf.

Blevins, C. A., Weathers, F. W., Davis, M. T., Witte, T. K., & Domino, J. L. (2015). The Posttraumatic Stress Disorder Checklist for DSM-5 (PCL-5): Development and initial psychometric evaluation. *Journal of Traumatic Stress, 28*, 489–498.

Boterhoven de Haan, K. L., Lee, C. W., Fassbinder, E., Van Es, S. M., Menninga, S., Meewisse, M. L., Rijkeboer, M., Kousemaker, M., & Arntz, A. (2020). Imagery rescripting and eye movement desensitisation and reprocessing as treatment for adults with post-traumatic stress disorder from childhood trauma: Randomised clinical trial. *British Journal of Psychiatry, 217*(5), 609–615.

Boterhoven de Haan, K. L., Lee, C. W., Fassbinder, E., Voncken, M. J., Meewisse, M., Van Es, S. M., Menninga, S., Kousemaker, M., & Arntz, A. (2017). Imagery rescripting and eye movement desensitisation and reprocessing for treatment of adults with childhood trauma-related post-traumatic stress disorder: IREM study design. *BMC Psychiatry, 17*(1), 165.

Brennan, R. L., & Prediger, D. J. (1981). Coefficient kappa: Some uses, misuses, and alternatives. *Educational and Psychological Measurement, 41*(3), 687–699.

Brewin, C. R., Gregory, J. D., Lipton, M., & Burgess, N. (2010). Intrusive images in psychological disorders: Characteristics, neural mechanisms, and treatment implications. *Psychological Review, 117*, 210–232. https://doi.org/10.1037/a0018113.

Brewin, C. R., Wheatley, J., Patel, T., Fearon, P., Hackmann, A., Wells, A., Fisher, P., & Myers, S. (2009). Imagery rescripting as a brief stand-alone treatment for depressed patients with intrusive memories. *Behaviour Research and Therapy, 47*(7), 569–576.

Çili, S., Pettitt, S., & Stopa, L. (2016). Impact of imagery rescripting on adverse self-defining memories and post-recall working selves in a non-clinical sample: A pilot study. *Cognitive Behaviour Therapy, 46*(1), 75–89.

Cusack, K., Jonas, D. E., Forneris, C. A., Wines, C., Sonis, J., Middleton, J. C., Feltner, C., Brownley, K. A., Olmsted, K. R., Greenblatt, A., Weil, A., & Gaynes, B. N. (2016). Psychological treatments for adults with posttraumatic stress disorder: A systematic review and meta-analysis. *Clinical Psychology Review, 43*, 128–141.

Dibbets, P., & Arntz, A. (2015). Imagery rescripting: Is incorporation of the most aversive scenes necessary? *Memory, 24*, 683–695.

Dibbets, P., Poort, H., & Arntz, A. (2011). Adding imagery rescripting during extinction leads to less ABA renewal. *Journal of Behavior Therapy and Experimental Psychiatry, 43*, 614–624.

Ehring, T., Welboren, R., Morina, N., Wicherts, J. M., Freitag, J., & Emmelkamp, P. M. G. (2014). Meta-analysis of psychological

treatments for posttraumatic stress disorder in adult survivors of childhood abuse. *Clinical Psychology Review, 34*, 645–657.

Germain, A., Krakow, B., Faucher, B., Zadra, A., Nielsen, T., Hollifield, M., Warner, T. D., & Koss, M. (2004). Increased mastery elements associated with imagery rehearsal treatment for nightmares in sexual assault survivors with PTSD. *Dreaming, 14*, 195–206.

GGZ Standaarden. (2020). *Zorgstandaard psychotrauma—en stressorgerelateerde-stoornissen*. https://www.ggzstandaarden.nl/zorgstandaarden/psychotrauma-en-stressorgerelateerde-stoornissen.

Gilman, R., Schumm, J. A., & Chard, K. M. (2012). Hope as a change mechanism in the treatment of posttraumatic stress disorder. *Psychological Trauma: Theory, Research, Practice, and Policy, 4*, 270–277.

Green, J., & Thorogood, N. (2004). Qualitative methods for health research. *London School of Hygiene and Topical Medicine*.

Grunert, B. K., Weis, J. M., Smucker, M. R., & Christianson, H. F. (2007). Imagery rescripting and reprocessing therapy after failed prolonged exposure for posttraumatic stress disorder following industrial injury. *Journal of Behavior Therapy and Experimental Psychiatry, 38*(4), 317–328.

Guest, G., Bunce, A., & Johnson, L. (2006). How many interviews are enough? An experiment with data saturation and variability. *Field Methods, 18*(1), 59–82.

Hagenaars, M. A., & Arntz, A. (2012). Reduced intrusion development after post-trauma imagery rescripting; An experimental study. *Journal of Behavior Therapy and Experimental Psychiatry, 43*(2), 808–814. https://doi.org/10.1016/j.jbtep.2011.09.005.

Hoffart, A., Øktedalen, T., Wampold, B. E., & Langkaas, T. F. (2013). Alliance and outcome in varying imagery procedures for PTSD: A study of within-person processes. *Journal of Counseling Psychology, 60*(4), 471–482.

Jung, K., & Steil, R. (2012). The feeling of being contaminated in adult survivors of childhood sexual abuse and its treatment via a two-session program of cognitive restructuring and imagery modification: A case study. *Behavior Modification, 36*(1), 67–86.

Kindt, M., Buck, N., Arntz, A., & Soeter, M. (2007). Perceptual and conceptual processing as predictors of treatment outcome in PTSD. *Journal of Behavior Therapy and Experimental Psychiatry, 38*(4), 491–506. https://doi.org/10.1016/j.jbtep.2007.10.002.

Kunze, A. E., Lancee, J., Morina, N., Kindt, M., & Arntz, A. (2019). Mediators of change in imagery rescripting and imaginal exposure for nightmares: Evidence from a randomized wait-list controlled trial. *Behavior Therapy, 50*, 978–993.

Long, M. E., Davis, J. L., Springer, J. R., Elhai, J. D., Rhudy, J. L., Teng, E. J., & Frueh, C. (2011). The role of cognitions in imagery rescripting for posttraumatic nightmares. *Journal of Clinical Psychology, 67*(10), 1008–1016.

Mancini, A., & Mancini, F. (2018). Rescripting memory, redefining the self: A meta-emotional perspective on the hypothesized mechanism(s) of imagery rescripting. *Frontiers in Psychology, 9*, 581.

Menninga, S. M., van Es, S. M., Boterhoven de Haan, K. L., Lee, C. W., Fassbinder, E., Koehne, S., Vermeulen, F. H., & Arntz, A. (2019). Patients' perspective on the effective working mechanisms in ImRs and EMDR treating childhood-trauma related PTSD; A qualitative study. *[conference presentation] ESTSS 2019 Conference, Rotterdam, Netherlands*. ESTSS 2019 Conference, Rotterdam: conference presentation.

Monson, C. M., Gradus, J. L., Young-Xu, Y., Schnurr, P. P., & Price, J. L. (2008). Change in posttraumatic stress disorder symptoms: Do clinicians and patients agree? *Psychological Assessment, 20*(2), 131–138.

Morina, N., Lancee, J., & Arntz, A. (2017). Imagery rescripting as a clinical intervention for aversive memories: A meta-analysis. *Journal of Behavior Therapy and Experimental Psychiatry, 55*, 6–15.

Nilsson, J. E., Lundh, L. G., & Viborg, G. (2012). Imagery rescripting of early memories in social anxiety disorder: An experimental study. *Behaviour Research and Therapy, 50*(6), 387–392.

Øktedalen, T., Hoffart, A., & Langkaas, T. F. (2015). Trauma-related shame and guilt as time-varying predictors of posttraumatic stress disorder symptoms during imagery exposure and imagery rescripting—a randomized controlled trial. *Psychotherapy Research, 25*(5), 518–532.

PTSD: National Center for PTSD (2018). *PTSD Checklist for DSM-5 (PCL-5)*. https://www.ptsd.va.gov/professional/assessment/adult-sr/ptsd-checklist.asp.

Raabe, S., Ehring, T., Marquenie, L., Olff, M., & Kindt, M. (2015). Imagery rescripting as stand-alone treatment for posttraumatic stress disorder related to childhood abuse. *Journal of Behavior Therapy and Experimental Psychiatry, 48*, 170–176.

Reimer, S. G., & Moscovitch, D. A. (2015). The impact of imagery rescripting on memory appraisals and core beliefs in social anxiety disorder. *Behaviour Research and Therapy, 75*, 48–59.

Rijkeboer, M. M., Daemen, J. J., Flipse, A., Bouwman, V., & Hagenaars, M. A. (2020). Rescripting experimental trauma: Effects of imagery and writing as a way to reduce the development of intrusive memories. *Journal of Behavior Therapy and Experimental Psychiatry, 67* 101478.

Schreier, M. (2012). *Qualitative content analysis in practice*. Sage.

Siegesleitner, M., Strohm, M., Wittekind, C. E., Ehring, T., & Kunze, A. E. (2019). Effects of imagery rescripting on consolidated memories of an aversive film. *Journal of Behavior Therapy and Experimental Psychiatry, 62*, 22–29.

Smucker, M. R., Dancu, C., Foa, E. B., & Niederee, J. L. (1995). Imagery rescripting: A new treatment for survivors of childhood sexual abuse suffering from posttraumatic stress. *Journal of Cognitive Psychotherapy: An International Quarterly, 9*(1), 3–17.

Sofaer, S. (1999). Qualitative methods: What are they and why use them? *Health Services Research, 34*, 1101–1118.

Steil, R., Jung, K., & Stangier, U. (2011). Efficacy of a two-session program of cognitive restructuring and imagery modification to reduce the feeling of being contaminated in adult survivors of childhood sexual abuse: A pilot study. *Journal of Behavior Therapy and Experimental Psychiatry, 42*(3), 325–329.

Thomas, M. L. (2006). The contributing factors of change in a therapeutic process. *Contemporary Family Therapy, 28*, 201–210.

Tong, A., Sainsbury, P., & Craig, J. (2007). Consolidated criteria for reporting qualitative research (COREQ): A 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care, 19*(6), 349–357.

Trimbos Instituut (2013). *Multidisciplinaire richtlijn angststoornissen* (3rd ed.). https://assets-sites.trimbos.nl/docs/cc5b0f4e-9398-452d-8792-1453a38bf0a8.pdf.

Veale, D., Page, N., Woodward, E., & Salkovskis, P. (2015). Imagery rescripting for obsessive compulsive disorder: A single case experimental design in 12 cases. *Journal of Behavior Therapy and Experimental Psychiatry, 49*, 230–236.

Wampold, B. E. (2015). How important are the common factors in psychotherapy? An update. *World Psychiatry, 14*(3), 270–277.

Weathers, F. W., Litz, B. T., Keane, T. M., Palmieri, P. A., Marx, B. P., & Schnurr, P. P. (2013). *The PTSD Checklist for* DSM-5 *(PCL-5)*. www.ptsd.va.gov.

Willson, R., Veale, D., & Freeston, M. (2016). Imagery rescripting for body dysmorphic disorder: A multiple-baseline single-case experimental design. *Behavior Therapy, 47*(2), 248–261.

Wibbelink, C. J. M., Lee, C. W., Bachrach, N., Dominguez, S., Ehring, T., van Es, S., Fassbinder, E., Köhne, S., Mascini, M.,

Meewisse, M. L., Menninga, S., Morina, N., Rameckers, S. A., Thomaes, K., Walton, C. J., Wigard, I., & Arntz , A. (2021). *The effect of twice-weekly versus once-weekly sessions of either Imagery Rescripting or Eye Movement Desensitization and Reprocessing for adults with PTSD from childhood trauma (IREM-Freq): A study protocol for an international randomized clinical trial. Trials, accepted for publication. (accepted for publication)*

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