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# The imagery rescripting protocol for obsessive-compulsive disorder (ImRs-OCD): A decade of iterative refinement in treatment sequencing following ERP

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## ABSTRACT

Obsessive-Compulsive Disorder (OCD) is a debilitating psychological condition that remains resistant to treatment in a significant proportion of clients, even following completion of first-line psychological and pharmacological treatments. This paper describes a sequenced treatment protocol combining Exposure and Response Prevention (ERP) with Imagery Rescripting for OCD (ImRs-OCD) as an adjunctive intervention for individuals with treatment-resistant OCD. The ImRs-OCD protocol has undergone multiple rounds of refinement over the past 10 years through iterative protocol development, based on clinician and client feedback. We describe the evolution of the protocol, key adaptations for OCD, illustrative case examples, and preliminary evidence supporting its efficacy. A standardised 10-step ImRs-OCD protocol is presented, along with guidelines for implementation and a set of standard rescripting questions and handouts. This work aims to provide guidance to clinicians and to encourage further research into imagery rescripting as a comprehensive treatment approach for treatment-resistant OCD.

## 1. Introduction

Obsessive-Compulsive Disorder (OCD) is a chronic and often severely impairing psychological condition affecting 2–3 % of the population worldwide (Ruscio et al., 2010). OCD is characterised by intrusive, unwanted thoughts, images, or urges (obsessions) and repetitive behaviours or mental acts (compulsions). It can significantly impact an individual's quality of life, relationships, and daily functioning (American Psychiatric Association, 2013).

OCD symptoms are resistant to evidence-based treatment in up to 40 % of cases (Pittenger & Bloch, 2014). The gold standard psychological treatment, cognitive-behavioural therapy with Exposure and Response Prevention (ERP), is effective for many, but it can be challenging for some clients to engage with or tolerate (Abramowitz et al., 2019). This underscores the need for new interventions that can complement existing treatments and address the needs of treatment-resistant

individuals.

Intrusive imagery has long been recognised as a core feature of OCD, but it has received considerably less attention than obsessive thoughts, both in standard descriptions of phenomenology and as a focus of treatment. In a recent systematic review of mental imagery in OCD, Zenoni et al. (2025) reported that 89 % of clients with OCD had experienced intrusive images; 70–79 % of these clients reported that these images were related to traumatic or adverse events. This growing recognition of the significance of intrusive imagery in OCD has prompted a recent surge of interest in imagery-rescripting interventions as a therapeutic approach.

Imagery rescripting (Arntz, 2025) differs fundamentally from the imaginal exposure that is often used in ERP. Imaginal exposure aims to achieve safety learning and/or habituation to distressing imagery through repeated exposure. Imagery rescripting, in contrast, seeks to modify the emotional meaning and impact of distressing images or

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memories, and to meet unmet emotional needs and modify associated core beliefs. Imagery rescripting based on the original [Arntz and Weertman \(1999\)](#) protocol has become well established both as a stand-alone intervention and as part of comprehensive treatment packages for a range of psychological disorders, with extensive research demonstrating its effectiveness in conditions such as social anxiety disorder, depression, PTSD, and personality disorders ([Kip et al., 2023](#); [Moreno et al., 2006](#)).

Emerging evidence suggests benefit from imagery rescripting in OCD. Zenoni et al.'s (2025) systematic review identified six studies showing clinically significant improvement in a range of OCD and related symptoms ([Fink et al., 2018](#); [Fink-Lamotte et al., 2022](#); [Maloney et al., 2019](#); [Maloney et al., 2023](#); [Tenore et al., 2020](#); [Veale et al., 2019](#)). A single identified study, [Mpavaenda \(2016\)](#), was less encouraging, finding that only one of five individuals achieved clinically significant improvement. Notably, the ImRs intervention used in this study differed from the original three-phase protocol ([Arntz and Weertman, 2019](#)), and the participant who improved was the only one whose rescripted images were associated with aversive memories. Together, this literature suggests that ImRs has significant potential as a treatment for OCD, but that careful standardisation of the protocol used is needed.

Several studies have examined mechanisms whereby ImRs may impact OCD-relevant intrusive imagery. Cooper and colleagues ([Cooper, Wong, & Grisham, 2024a](#); [Stavropoulos et al., 2024](#); [Cooper, Stavropoulos, & Grisham, 2024b](#)) and [Kühne et al. \(2025\)](#) showed that online-delivered, self-directed imagery rescripting techniques can reduce the distress, vividness, and negative emotional responses associated with intrusive memories and contamination-related imagery.

Three clinical studies identified in the 2025 Zamboni review ([Maloney et al., 2019](#); [Tenore et al., 2020](#); [Veale et al., 2015](#)) applied the imagery rescripting protocol developed by [Arntz and Weertman \(2019\)](#) to OCD clients. [Cooper, Stavropoulos, and Grisham \(2024a\)](#) meta-analysed these studies, finding that 75 % of clients achieved clinically significant Y-BOCS reductions. These studies utilised the original three-phase protocol ([Arntz and Weertman, 2019](#)), which emphasises client-led rescripting. In a subsequent protocol update, [Arntz \(2025\)](#) recommended implementing a two-phase 'therapist-led' rescripting approach prior to three-phase 'client-led rescripting', and a standardised set of questions, to enhance client engagement and clinical outcomes. The updated protocol ([Arntz, 2025](#)) was used in the large international multisite IREM ([Boterhoven et al., 2020](#)) and IREM-Freq ([Wibbelink et al., 2021](#)) studies of PTSD with demonstrated effectiveness. However, this updated approach has not yet been extensively studied in OCD populations. [Arslan et al. \(2025\)](#) recently reported using the updated protocol ([Boterhoven et al., 2020](#)) with 3 therapist-led followed by 3 client-led rescripts in individuals with OCD. 3 of 7 clients achieved clinically significant Y-BOCS reductions (>35 %) and 2 achieved partial reductions (25–35 %). We have also recently completed a case series employing the updated protocol; details are provided below.

The unique characteristics of OCD, including the ego-dystonic nature of obsessions and the persistent, intrusive, recurring experience of mental obsessions and compulsions, necessitate specific modifications to standard ImRs protocol. The adapted protocol must address the potential for compulsive checking and reassurance-seeking during the imagery rescripting process, the challenge of targeting appropriate aversive events and associated core beliefs that may be less clearly linked to specific memories, and the need to integrate ImRs with ongoing ERP work. Particular care must be taken not to rescript or reinforce obsessive or compulsive images, as this contradicts the aims of ERP and can inadvertently strengthen compulsive behaviours.

In this paper, we present a comprehensive adaptation of [Arntz's \(2025\)](#) standard ImRs protocol specifically tailored for OCD treatment. Our protocol incorporates both therapist-led and client-led rescripting sessions, as recommended in [Arntz's](#) updated approach, while introducing extensive OCD-specific modifications. Unlike applications in

PTSD, where ImRs often functions as a standalone treatment, we position this protocol primarily as an adjunctive intervention within the context of comprehensive OCD care, with ERP remaining the gold-standard first-line treatment. This focus on integration reflects our specific target population of clients with treatment-resistant OCD who have had an incomplete response to standard ERP therapies.

The protocol emphasises careful treatment sequencing to ensure optimal integration with existing ERP work, preserving core ERP principles such as habituation and inhibitory learning while incorporating key ImRs elements of meeting unmet emotional needs and schema modification. Although our focus is on a sequenced, comprehensive approach, we note that preliminary research by [Van Verseveld et al. \(2025\)](#) has begun testing ImRs as a standalone intervention for OCD. The ImRs-OCD protocol we developed may have similar potential for non-treatment-resistant populations where compulsions are less likely to interfere with the rescripting process.

The detailed guidelines presented in our ImRs-OCD protocol provide clinicians with specific direction for implementing these specialised OCD adaptations while maintaining fidelity to core ImRs principles. We describe the iterative refinement of the approach based on clinician and client feedback at the first author's speciality OCD clinic over the past decade. We find that an individualised session schedule allowing for flexibility when transitioning from therapist-led to client-led rescripting sessions is needed for OCD, with support and structure for the most severe cases but allowances for fewer rescripting sessions in other clients. This is particularly true given that ImRs often follows ERP treatment in OCD. We provide case examples of the application of the final 10-step ImRs-OCD protocol. It is our hope that this protocol will provide standardisation in the field and encourage ongoing research.

## 2. Methods

### 2.1. Study design/protocol development framework

The ImRs-OCD treatment protocol presented here has undergone systematic development through multiple iterations and comprehensive protocol evaluations over the past decade. Our approach was informed by three established frameworks for developing complex interventions.

1. The Medical Research Council (MRC) framework emphasises the importance of a systematic, phased approach to intervention development, including identifying the evidence base, developing theory, and modelling process and outcomes ([Craig et al., 2008](#)). The MRC framework guided our initial literature review, theoretical foundation development, and systematic approach to protocol refinement based on empirical evidence.
2. The Obesity-Related Behavioral Intervention Trials (ORBIT) model for behavioural treatment development ([Czajkowski et al., 2015](#)): This model provides a stepwise approach to developing behavioural interventions, emphasising the importance of defining and refining the intervention based on theory and empirical evidence before moving to efficacy testing. The ORBIT framework informed our iterative approach to protocol development, ensuring each revision was grounded in both theoretical considerations and clinical feedback.
3. The Treatment Development and Evaluation Research (TDER) framework ([Rounsaville et al., 2001](#)): This framework specifically addresses the development of psychosocial treatments and emphasises the importance of therapist training, treatment fidelity, and systematic evaluation of intervention components. The TDER framework guided our approach to professional development, including the creation of comprehensive training materials, supervision protocols, and fidelity monitoring procedures.

### 2.1.1. Key protocol development components

**Systematic Feedback Integration.** Throughout the development process, we implemented a comprehensive feedback system involving both clinicians who administered the protocol and clients who experienced the ImRs-OCD intervention. This multi-source approach ensured clinical utility and acceptability of core treatment components through collection of diverse data including client feedback, supervision records, expert consultations, training workshop evaluations, and semi-structured interviews. These interviews specifically focused on identifying effective protocol elements, components requiring revision, and essential features to maintain.

Data underwent qualitative analysis using [Braun and Clarke's \(2006\)](#) six-phase framework for thematic analysis, which included: familiarisation with data, generating initial labels, searching for themes, reviewing potential themes, defining and naming themes, and writing up. The analytical process adhered to all essential phases of thematic analysis in qualitative research as described in the 16-item checklist by [Ahmed et al. \(2025\)](#). Recurring themes were initially identified by the first author and subsequently reviewed by experts in both OCD and ImRs fields for consensus development.

The protocol evolved through an iterative consultation process involving multiple stakeholders. Numerous clinicians at the first author's clinic were also encouraged to apply the ImRs protocol with their OCD clients in real-world settings, when clinically appropriate, and provide detailed feedback on their experiences. This implementation feedback proved particularly valuable for identifying practical challenges and necessary adaptations. Throughout this process, we maintained ongoing consultation with recognised experts in ImRs, ensuring all substantive modifications were reviewed by primary authors and field specialists before implementation.

**Iterative Refinement Process.** The protocol underwent nine revisions between 2015 and 2024, with each iteration incorporating empirical feedback, theoretical advances, and clinical observations. This systematic approach ensured that each protocol modification was evidence-based and clinically relevant, with adaptations tested with multiple OCD clients before formal inclusion in the finalised protocol. The

protocol refinement process resulted in four major revisions (outlined in [Table 1](#)) that substantially refined the treatment approach, with the most significant changes implemented in the finalised 10-step 2024 version. The other five revisions involved minor modifications, such as refinements to specific instructions, adjustments to timing parameters, and clarifications of therapist language, that did not fundamentally alter protocol structure. Throughout its development, the protocol incorporated standard imagery rescripting questions used in the IREM-FREQ protocol ([Wibbelink et al., 2021](#)) that were later elaborated upon when Arntz updated his treatment protocol (published in 2025, though available to us earlier) and provided further training. Our approach maintained consistency with core ImRs principles while implementing specific adaptations to address the unique needs of OCD treatment.

**Dissemination and Professional Training Considerations.** The development process incorporated extensive clinician training components, including structured supervision protocols, competency assessments, and ongoing professional development opportunities. Online scalable training programs created for mental health professionals were developed ([Maloney, 2024, 2025](#)) to ensure consistent delivery that can be adapted across different clinical settings and levels of clinician experience, with particular attention to the unique adaptations required for OCD populations.

These frameworks provided a structured approach to systematically refine and preliminarily evaluate the intervention, integrating theoretical foundations, empirical feedback, professional development considerations, and implementation planning. By following these established frameworks, we aimed to ensure a rigorous and comprehensive approach to developing the ImRs-OCD protocol that would be both clinically effective and practically implementable across diverse treatment settings.

### 2.2. Clients/clinicians

The development and evaluation of the ImRs-OCD protocol occurred in distinct phases. First, four separate groups of clients and clinicians provided insights that informed the iterative refinement process. Based

**Table 1**  
ImRs-OCD protocol evaluation timeline.

Phase	Year	Protocol Features	Key Developments	Publication & Dissemination
Initial Implementation	2015–2019	<ul style="list-style-type: none"> <li>• <a href="#">Arntz and Weertman (1999)</a> 3-phase protocol</li> <li>• Client-led rescripting only</li> <li>• ERP + ImRs adjunctive approach</li> <li>• 1–6 sessions</li> <li>• 35 % Y-BOCS reduction threshold</li> </ul>	<ul style="list-style-type: none"> <li>• Demonstrated feasibility of ImRs as ERP adjunct</li> <li>• Significant OCD symptom reductions</li> <li>• Identified potential to address underlying schemas</li> </ul>	<a href="#">Maloney et al. (2019)</a>
Protocol Refinement	2021–2022	<ul style="list-style-type: none"> <li>• Addition of preparatory session</li> <li>• Extended to up to 12 ImRs sessions</li> <li>• Both therapist-led &amp; client-led rescripting</li> <li>• Aligned with IREM-FREQ protocol (<a href="#">Wibbelink et al., 2021</a>) &amp; updated standard ImRs protocol (<a href="#">Arntz, 2025</a>)</li> </ul>	<ul style="list-style-type: none"> <li>• Structured professional development workshops</li> <li>• Training workshop by Arntz (trauma ImRs) and Gayle Maloney (ImRs-OCD)</li> <li>• Systematic clinician/client feedback integration</li> <li>• Telehealth delivery adaptation</li> </ul>	<a href="#">Paulik et al. (2021)</a> - telehealth delivery
Enhancement & Structure	2023	<ul style="list-style-type: none"> <li>• Structured therapist-led rescripting approach</li> <li>• Maintained 35 % Y-BOCS improvement criterion</li> <li>• Advanced professional development</li> <li>• Continued systematic feedback refinement</li> </ul>	<ul style="list-style-type: none"> <li>• Refined therapist-led rescripting methodology</li> <li>• Enhanced clinician training protocols</li> <li>• In-depth case study analysis</li> <li>• Mechanism of change insights</li> </ul>	<a href="#">Maloney et al. (2023)</a> - case study with full transcript
Standardisation & Dissemination	2024–2025	<ul style="list-style-type: none"> <li>• Comprehensive 10-step ImRs-OCD protocol (v1.9)</li> <li>• Standardised training package</li> <li>• Explicit clinical guidelines: Preparatory session; Flexible therapist-to-client transitions; Aversive event identification; Standardised assessments; Explicit 'Healthy Adult Self'-development focus</li> </ul>	<ul style="list-style-type: none"> <li>• Formal evaluation framework</li> <li>• Professional dissemination strategy</li> <li>• Conference presentations</li> <li>• Two-part professional training package (ERP + ImRs-OCD)</li> <li>• Internal and external clinic training programs</li> </ul>	<ul style="list-style-type: none"> <li>• <a href="#">Maloney et al. (2024)</a> - psilocybin synergy exploration</li> <li>• ERP + ImRs Professional training package (<a href="#">Maloney, 2024, 2025</a>)</li> <li>• ImRs-OCD protocol publication</li> <li>• Outcome evaluation publications (in prep)</li> </ul>

on this feedback, we finalised the 10-step ImRs-OCD protocol in 2024. Subsequently, this finalised protocol was evaluated with a fourth group consisting of 10 clients in 2024–2025. The four groups are described below.

The first group comprised 13 clients (Maloney et al., 2019) with treatment-resistant OCD, who participated in our initial application of the original ImRs protocol to OCD. ImRs was administered following ERP by the first author and two other clinicians, under the supervision of the first author. These clients provided crucial data on the efficacy of the initial intervention.

The second group consisted of approximately 60 clients treated by the first author at Perth OCD Clinic ([www.perthocdclinic.com.au](http://www.perthocdclinic.com.au)) as part of their standard clinical care. These clients received ImRs treatment for OCD outside of a formal research study, contributing to over 160 rescripting sessions. Their feedback, experiences, and insights during treatment sessions provided valuable clinical insights that informed the iterative refinement of the protocol. This group was not consented for publication of outcome data.

The third group included a diverse array of clinicians, experts, supervisees, and researchers who provided feedback throughout the development process. In particular, we extend our gratitude to all clinicians from the Perth OCD Clinic; the Yale OCD Research Clinic; the ImRs Perth Consortium; the Special Interest Group for ImRs OCD (SIG-OCD), as well as the supervisees and students of the first author, and participants in workshops that she has led. Their collective expertise and feedback over the past decade were instrumental in shaping the current ImRs-OCD protocol.

The fourth group consisted of 10 clients who participated in our evaluation of the finalised ImRs-OCD protocol with OCD in 2024 and 2025. Data collection from this group was reviewed and approved by the Yale University Institutional Review Board (IRB)/Human Investigations Committee (HIC). Nine met criteria for treatment-resistant OCD, defined as a score of  $\geq 16$  on the Yale-Brown Obsessive-Compulsive Scale (Y-BOCS; Goodman et al., 1989) despite completion of a full ERP program and treatment with an SSRI at the recommended dosage for OCD (if deemed clinically appropriate by referring physicians). One client did not meet the severity criterion for treatment resistance but was included to explore the protocol's potential benefits for individuals with less severe symptoms. This approach ensures that the protocol is primarily tested on clients who have not responded adequately to first-line treatments, while also investigating its potential broader applicability. These ten cases represent the diversity of presentations treated with the finalised protocol, with clients providing explicit consent for their anonymised data to be included in this publication to evaluate the final protocol. We provide data on basic clinical outcomes here, together with detailed descriptions of a subset of the cases, to illustrate key aspects of the protocol. A more detailed description of this case series, including secondary outcomes and process measures, will be provided in a subsequent publication.

### 2.3. Exclusion criteria for cases series

Exclusion criteria included active suicidality, active psychosis, active substance dependence, severe personality disorder that interfered with treatment engagement, severe dissociation, or inability to tolerate exposure therapy. Additionally, we excluded individuals who demonstrated significant difficulty engaging in imagery exercises due to intrusive obsessions and compulsions that persistently interfered with their ability to focus on the rescripting process. Specifically, if clients were unable to participate in the imagery conversation without becoming preoccupied with mental compulsions (such as reviewing the 'correctness' of their wording, revisiting their choice of aversive event, obsessively questioning the use of alternate imagery, etc.), and these compulsions could not be adequately managed through application of ERP and/or mindfulness-based strategies within the therapeutic context, they were deemed unsuitable candidates for this protocol. This criterion

was particularly relevant for the treatment-resistant OCD population targeted in this study, in whom entrenched compulsive patterns often presented significant challenges to engagement in imagery-based work. We note that this exclusion criterion might be less relevant if the ImRs-OCD protocol were to be tested as a standalone treatment for less severe or non-treatment-resistant OCD individuals, where such interference might be less pronounced or more readily manageable. This criterion was established to ensure that participants could meaningfully engage with the core therapeutic components of ImRs without the process being co-opted by the OCD symptoms themselves.

### 2.4. Outcome measures

Yale-Brown Obsessive Compulsive Scale (Y-BOCS; Goodman et al., 1989). The Y-BOCS, widely considered the gold standard for assessing OCD symptom severity, is a clinician-administered rating scale that assesses the severity of obsessive and compulsive symptoms. Clients are scored on a scale of 0–4 on each of 10 items (5 addressing obsessions and 5 addressing compulsions), yielding a total score of 0–40. The Y-BOCS was administered by the first author at baseline, after each ImRs session, and at follow-up.

Healthy Adult Mode Scale. This is a subscale of the Schema Mode Inventory (SMI; Lobbestael et al., 2010) assessing the strength of the healthy adult mode. This measure was administered by the first author and used to track the development of the 'healthy adult self'.

Secondary outcome measures will be detailed and analysed in a subsequent publication.

### 2.5. Process measures (refer to appendix A)

- Clients rated the emotional impact of rescripted images on a 0–100 scale. These ratings provided insight into the engagement with and effectiveness of the imagery rescripting process.
- Clients rated their distress and belief in obsessions on a 0–100 scale. These ratings provided an assessment of symptom fluctuations throughout the treatment process.
- Clients were encouraged to complete 'pre' measures at the beginning of each ImRs session. These included briefly describing the aversive event to be rescripted, noting the meaning/belief associated with the aversive event, and completing pre-ratings on the associated emotions.
- 'Post' measures, completed at the end of each ImRs session, included ratings of emotions, beliefs, and new meanings on a 0–100 scale.
- Client and therapist were also asked to note their most important part of the rescript at the end of each ImRs session.

## 3. Results

### 3.1. ImRs-OCD protocol development and evaluation timeline

We iteratively refined the ImRs protocol based on clinician experience and stakeholder feedback between 2015 and 2024. Stages in this process are provided in Table 1.

### 3.2. Clinician and client qualitative feedback

Throughout the development process, systematic feedback was collected from both clinicians and clients to ensure clinical utility and acceptability, with data evaluated using (Braun & Clarke, 2006) six-phase qualitative thematic analysis framework. The first author identified recurring themes from clinicians and experts in the ImRs field (Table 2) and client feedback (see Table 3). These themes were subsequently discussed with an independent expert in experienced in the delivery of both OCD and ImRs treatment, to determine whether these refinements should be incorporated into subsequent protocol revisions. All themes and updates were subsequently discussed between the first

**Table 2**  
Qualitative themes from clinician feedback.

Theme	Description
Flexible session numbers	The number of rescripting sessions needs to be flexible. Clients rarely require all 12 rescripting sessions typically used in the treatment of trauma.
Transition guidance	Clear guidance required on determining when a client is ready to transition from therapist-led to client-led rescripting
ERP importance	For most clients, it appears crucial to administer ERP first, to provide tools to manage OCD symptoms prior to engaging in ImRs
Mindfulness integration	Mindfulness-based strategies incorporated into ERP treatment helped with the management of mental compulsions, facilitating ImRs
Core belief-informed ERP	Highlighting recurrent core beliefs during ERP added depth and prepared clients for ImRs
Therapist and client-led sessions	Both therapist-led and client-led rescripting sessions are important
Therapist modelling	At least one therapist rescripting session should always be provided to model the technique.
Empathetic correction of parenting	A major focus is often empathetic correction of parenting, when relevant in aversive events. Care must be taken not to inadvertently shame clients who may have adopted similar approaches to parenting their own children.
Linking events to OCD	Highlighting links between aversive events and OCD is helpful for reducing shame and increasing insight
Healthy adult development	Explicit focus on healthy adult development is required between sessions
De-stigmatisation	It is important to de-shame & de-stigmatise OCD throughout the process

**Table 3**  
Qualitative themes from client feedback.

Themes	Description
Importance of therapist validation	It is important to hear the therapist tell the client's younger self that it was not their fault; re-attributing blame and shame.
Comfort from therapist modelling	Clients felt more comfortable to try the ImRs session after watching the therapist be the rescripting adult
Permission for creativity	Watching therapists be creative in their use of imagery gave clients 'permission', ideas to try variations in powerful imagery techniques
ERP preparation	Clients felt like they needed to do ERP first so they could focus on the deeper level work. This reduced distraction by other obsessive thoughts and images through understanding how to manage any mental compulsions that arose during ImRs.

and third author to determine whether these refinements should be incorporated into subsequent protocol revisions, with guidance from the second author provided in more recent years to ensure alignment with the updated ImRs standard protocol. Given the longitudinal nature of this work spanning over a decade and the iterative approach to qualitative analysis with multiple refinement cycles, formal calculation of kappa coefficients was not implemented. Instead, we relied on rigorous consensus-building processes among experts, with inter-rater alignment demonstrating excellent concordance throughout the analytical phases, typically achieving approximately 95 % agreement prior to consensus discussions. Agreed-upon adaptations were systematically included and re-tested with multiple OCD clients as part of clinical practice at the Perth OCD Clinic. A total of nine protocol revisions occurred between 2015 and 2024, with the most substantial adaptations implemented during the 2024 refinement phase, resulting in the finalised 10-step ImRs-OCD protocol presented here.

Several key themes emerged from client responses to process questions over the course of ImRs. Clients reported a reduced impact of obsessive thoughts on their self-concept, with many describing a newfound ability to separate their core identity from their intrusive

thoughts. Increased self-worth and resilience were evident across participant narratives, as they developed stronger internal resources to face challenges without resorting to compulsive behaviours. Many clients specifically noted the complementary nature of ERP and ImRs, describing how the combination addressed both their symptomatic behaviours and their underlying emotional vulnerabilities. Improved ability to tolerate uncertainty emerged as a significant therapeutic gain, with clients expressing greater comfort with ambiguity and less need for absolute certainty in their daily lives. Finally, clients consistently reported reduced mental preoccupation with obsessive thoughts, describing a quieter mental landscape and increased cognitive freedom to engage with valued activities and relationships.

### 3.3. The standardised 10-step ImRs-OCD protocol

Following the iterative improvement process described above, we developed a final OCD-ImRs protocol, consisting of 10 steps. The protocol maintains a structured implementation of recommended steps while allowing flexibility specifically in the number and balance of therapist-led versus client-led rescripting sessions, enabling clinicians to tailor this aspect based on individual client needs and capabilities, which may result in fewer than the standard 12 sessions while maintaining therapeutic integrity.

1. Individualised ERP treatment (16–22 session ERP protocol)
2. Identify OCD treatment resistance
3. ImRs-OCD preparatory session (1–2 sessions, as required)
4. Therapist rescripting sessions (1–6 sessions, as required)
5. Determine when to switch roles from 'therapist' to 'client' as the rescripting adult.
6. Client rescripting sessions (1–6 sessions, as required)
7. Ensure explicit encouragement of 'healthy adult (HA) self' behaviours between sessions
8. Final ImRs-OCD session
9. One-month Follow-up Session
10. Maintenance sessions

### 3.4. Detailed protocol step description

Each session lasts 60–90 min; sessions are scheduled once a week. The first 5–10 min of each session is used to check in on ERP progress, to ensure maintenance of ERP skills, and to discuss next steps. All sessions should incorporate guidance regarding the development of the healthy adult self, as outlined below in step 7.

**Step 1: Individualised ERP treatment:** ImRs is generally appropriate when symptoms persist after an adequate course of high-quality ERP, both because ERP is the gold-standard psychological treatment for OCD, supported by extensive controlled data, and because client and clinician report suggest that the skills acquired during ERP are helpful during ImRs (see Tables 2 and 3). ERP should be core belief/schema informed, tailored to the individual, and values-based. Consider integration of ERP hierarchy steps that purposefully trigger core beliefs associated with OCD, such as perfectionism, overdeveloped sense of responsibility, and need for certainty/control (OCCWG, 2003), if endorsed by the client.

**Step 2. Identify treatment resistance:** Treatment resistance is present if a client scores 16 or higher on the Y-BOCS after completing a full ERP program, with an SSRI at the recommended dosage for OCD if this is judged appropriate by a prescriber. The ImRs-OCD protocol may also be beneficial for other clients (e.g. with Y-BOCS <16) who wish to address persisting core beliefs/schemas that affect important areas of their lives (e.g., perfectionism impacting work/life balance or relationships).

**Step 3. ImRs-OCD preparatory session:**

- 3A. Explain the ImRs-OCD Protocol: Provide a clear overview of the ImRs-OCD protocol (e.g. the ImRs handout from Arntz protocol, 2025) and describe its use in treatment; explore other therapeutic options to ensure informed client acceptance of ImRs treatment.
- 3B. Identify aversive memories: Help the client compile a list of approximately 3–4 aversive memories for the upcoming ImRs-OCD sessions. Prioritise memories most closely linked to OCD. Agree on which aversive memory to start with for the first ImRs-OCD session.
- 3C. Introduce Visualization Exercise: Teach and practice the imagery homework exercise focused on soothing the vulnerable child, developed by Paulik et al. (2019).
- 3D. Select a non-OCD-related memory for a pilot ImRs-OCD Session: Choose a non-OCD-related memory with low emotional intensity to practice a mini pilot imagery rescripting session (use therapist rescript standard-questions protocol, Appendix B). This helps the client become familiar with the technique and allows for any questions about the process to be addressed. Instruct the client to identify a mildly negative memory from childhood (ideally before age 12) that is thematically unrelated to OCD and does not involve individuals from the aversive memories selected for the main treatment. This exercise should take approximately 5–10 min. Remind the client to schedule their first ImRs-OCD session at a suitable time, as it may be an emotional experience that requires time for relaxation and processing afterwards (e.g., avoid significant work/social/family events).
- 4. Therapist rescripting (1–6 sessions):** The number of therapist rescripting sessions may vary (ranging from 1 to 6), depending on the client's progress and comfort level with ImRs. The criteria for transitioning from therapist to client rescripting are outlined below.
- 4A. Ask the client to complete the Y-BOCS (Goodman et al., 1989) and the HA subscale of the SMI (Lobbstael et al., 2010) at the beginning of each session (or immediately prior). Ask the client to note any behavioural changes they believe may be associated with the development of their 'healthy adult self' following the previous ImRs session.
- 4B. Collaboratively complete the 'weekly subjective measures handout' (Appendix A) before ImRs-OCD, recording the aversive memory, original meaning, pre-ratings of emotional responses and beliefs, and any behavioural changes attributed to previous ImRs sessions.
- 4C. Follow the 'Standard questions for ImRs-OCD Therapist Rescripting' (Appendix B). In this initial phase, clients access an aversive memory from their child-self perspective, articulating associated thoughts, feelings, and unmet needs with therapeutic guidance. The clinician then facilitates imagining an alternative scenario whereby the clinician enters the imagery as active intervener, addressing both the immediate distress and underlying emotional needs, providing the corrective emotional experience needed. The therapist's presence in the imagery serves multiple therapeutic functions: validating the child's experience, empathetically correcting inappropriate behaviours of others in the scene, establishing safety, and fulfilling developmental needs that were originally unmet.
- 4D. After rescripting, complete the 'weekly subjective measures' (modified meaning/belief; post-emotion ratings). If possible, the therapist can try to note this information during the rescripting session to minimise need for verbal processing after ImRs.
- Step 5. Determining when to switch roles from therapist to client as the rescripting adult:** At least one therapist rescripting session must occur before transitioning to the next ImRs-OCD phase, where the client becomes the rescripting adult. Switching the role from therapist to client as the rescripting adult is appropriate if the client rates their belief in their ability to take on this role at 6+ (with mutual agreement from the therapist) and can generate a sample sentence of what they might say during rescripting (see Appendix A for guidance).
- Step 6. Client rescripting sessions (up to 6):** The client will take on the role of the rescripting adult. Explain to the client that they will now play an active role in the rescripting process. Sessions conclude when the Y-BOCS score has decreased by at least 35 % (indicating a clinically significant reduction) or when their score falls within the healthy range (0–7).
- 6A. Ask the client to complete the Y-BOCS and the HA subscale of the SMI at the beginning of each session (or provide them immediately before the session).
- 6B. Complete the weekly subjective measures handout before ImRs-OCD, recording the aversive memory, original meaning, pre-ratings of emotional responses and beliefs, and any behavioural changes attributed to previous ImRs-OCD sessions.
- 6C. Follow the 'standard questions ImRs-OCD client rescript' (Appendix B). As treatment progresses, clients transition to the second phase where they step into the imagery as their adult self, assuming the intervening role previously modelled by the therapist. Clients are then guided to re-experience the aversive event from their child-self perspective while simultaneously observing their adult-self providing intervention and support, creating a powerful integration of perspectives that fosters emotional processing and schema modification.
- 6D. After re-script complete the weekly subjective measures (modified meaning/belief; post-emotion ratings).
- Step 7. Explicit encouragement of HA-Self behaviours between sessions:**
- 7A. Administer the Y-BOCS and the HA Subscale at the beginning of each ImRs session.
- 7B. Discuss how the imagery rescripting from the previous session impacted the client and ask if they have noted any cognitive, emotional or behavioural changes that they believe are attributable to changes in beliefs or the development of their healthy adult self.
- 7C. Explicitly discuss opportunities for practicing the healthy adult self that might arise in the following week. The healthy adult mode represents an individual's capacity for adaptive functioning, characterised by emotional regulation, appropriate boundary-setting, and self-nurturing behaviours (Young et al., 2003; Arntz and Jacob, 2013). Using a motivational interviewing style approach (e.g., Miller & Rollnik, 2023), clients are explicitly encouraged to create opportunities to develop their healthy adult self through collaborative identification and discussion with the clinician. If clients cannot identify opportunities independently, clinicians employ reflective listening and open-ended questioning techniques to help them identify their lower scoring items on the healthy adult subscale and brainstorm specific actions (e.g., engaging in self-care, expressing emotions appropriately, setting limits) to increase their ratings on these items using probing questions such as "what's one thing that you could do in between the next ImRs session that could increase the rating on the HA subscale item identified by just one point?".
- Step 8. Final ImRs-OCD Session:** Provided that the client has completed at least 1 preparatory session +1 therapist rescript +1 client rescript (totalling 3 ImRs-OCD sessions), and their Y-BOCS score has reduced by at least 35 % (or is 7 or below), the protocol for the final ImRs session can be followed.
- 8A. Discuss the client's progress, feedback on the process, and outcomes of ImRs-OCD treatment. Assist them in reflecting on their experiences during ImRs-OCD.
- 8B. Explore what the client wants to focus on to maintain and continue developing their healthy adult self – encourage development of a written summary of these takeaway points.

- 8C. Emphasise the importance of maintaining previous ERP gains by refreshing skills and planning for times of stress and transition.
- 8D. Discuss future goals related to their recovery and functioning that they will continue to work on outside of therapy.
- 8E. Review their support systems, including mental health resources, assuring them they can reach out if challenges arise.

**Step 9: Schedule follow-up session:** A one-month follow-up session should be scheduled to ensure that gains are maintained and to plan further treatment if needed. In the follow-up session, the therapist will evaluate the client's progress, and any changes observed in their beliefs and the development of their healthy adult self (and monitor further progress/hurdles with ERP). If further treatment is clinically indicated, it should be offered. In the follow-up session, explore:

- 9A. Maintaining ERP progress. Encouraging continued application of ERP skills, assistance with managing hurdles, and predicting/planning for times of stress and transition.
- 9B. Sustaining and developing the healthy adult self to enhance ImRs-OCD treatment. Articulating changes in cognitions, emotions, and behaviours that the client attributes to core schema/belief change and identifying goals to further develop the healthy adult self.

**Step 10. Maintenance sessions:** Schedule 3 and 6 month maintenance sessions; these may be linked to anticipated times of stress or transition.10.

- 10A. Maintaining ERP progress.
- 10B. Sustaining and developing the healthy adult self to enhance ImRs-OCD treatment.

### 3.5. Identifying aversive events in OCD

A crucial aspect of the ImRs-OCD protocol is the careful identification of aversive events suitable for rescripting (step 3). Through our iterative protocol development processes, five strategies were identified to assist clinicians in identifying appropriate aversive events to rescript in OCD (see Table 4). If aversive events were identified through any of the first four methods, the affect bridge technique was not required.

The process of identifying relevant aversive events suitable for rescripting in OCD often involves exploring recurring memories from childhood and adolescence that emerge during treatment, with clinicians asking probing questions such as "when something difficult happened at school, who did you talk to about it?" to uncover both the primary aversive event and any secondary emotional neglect. For example, while bullying might represent a clear aversive event requiring intervention that the client associated with OCD symptoms, if the child had already learned they could not confide in their parents about such experiences, this reveals underlying schemas formed from unmet emotional needs that also require therapeutic attention. In such cases, the rescripting process addresses not only the bullying incident itself but also involves speaking to the parents within the imagery rescript about

**Table 4**  
Methods to identify aversive events suitable for rescripting in OCD.

Method	Description
Direct link	Identify events – often prominent recurring childhood memories – with a direct link to OCD symptom on onset or to the strongest recollection of OCD symptoms.
Collaborative reflection	During ERP, link recurring core beliefs or schemas with aversive events.
Questionnaire analysis	Analyse scores of OBQ-44 (OCCWG, 2003) and Young Schema Questionnaire (YSQ-SF3, Young & Brown, 2005) to identify relevant core belief/schema domains thematically linked to specific life events.
Visualization exercise	Use the 'comforting vulnerable child self' exercise (Paulik, Steele, & Arntz, 2021) to identify needed soothing as a child, and link to relevant events.
Affect bridge technique	Refer to Arntz (2025) for detailed description.

their child's need for validation, care, and guidance regarding how to handle similar situations in the future. This comprehensive approach ensures that both the aversive event and the broader relational context contributing to maladaptive schema development are therapeutically addressed.

This process differs from standard ImRs protocols for trauma in that it seeks to identify events that may have contributed to OCD maintenance or may have become enmeshed in self-narratives of the meaning surrounding OCD and related cognitions. Unlike trauma-focused ImRs, which often targets clearly defined traumatic memories, ImRs-OCD frequently addresses subtler experiences of emotional invalidation, excessive responsibility, or perfectionism that may not initially be recognised by clients as significant. The protocol therefore emphasises thorough exploration of developmental experiences that shaped core beliefs underlying OCD symptomatology, rather than focusing exclusively on discrete traumatic events. Examples of these aversive events are described below in each case study.

Despite evidence supporting the efficacy of transforming aversive imagery in reducing disgust experiences (Schmucker & Köster, 2015; Fink et al., 2018, 2019), our protocol deliberately focuses on rescripting aversive childhood experiences rather than directly modifying current intrusive OCD imagery. This approach initially emerged from clinical considerations with treatment-resistant OCD cases but has broader implications for OCD treatment generally. Many OCD clients already engage in elaborate mental rituals to neutralise or transform unwanted mental imagery into positive images, providing temporary relief but ultimately reinforcing the OCD cycle. While the risk of reinforcing these patterns may be particularly pronounced in treatment-resistant cases, the potential therapeutic considerations exist across various OCD presentations, suggesting a cautious approach when effective alternatives are available. By instead targeting underlying aversive experiences that contribute to beliefs associated with OCD, we address the development and maintenance of OCD while potentially avoiding complications. The protocol incorporates specific procedural safeguards, including clear differentiation between rescripting developmental experiences versus current obsessional content, explicit discussion with clients about the distinction between therapeutic imagery work and mental compulsions, and integration with ERP specifically to prevent engagement in compulsive neutralisation or positive transformation of intrusive imagery. This combined approach ensures exposure to childhood aversive events remains a core component of treatment while actively discouraging maladaptive imagery-based compulsions.

### 3.6. Preliminary outcome evaluation

We have performed ERP followed by OCD-ImRs in a growing number of clinical cases, including a case series of 10 individuals who consented to have their data included in a research study. All clients were treated by the first author at the Perth OCD Clinic ([www.perthocdclinic.com.au](http://www.perthocdclinic.com.au)). We provide a brief overview of this cohort here, followed by a more detailed description of several individual cases with to illustrate some of the specific clinical points that drove protocol development. A detailed description of this case series, including analysis of secondary outcomes and process measures, will be published separately.

These cases included a range of OCD subtypes, including contamination fears, harm obsessions, symmetry/ordering compulsions, visual-Tourette obsessions, and sexual/religious obsessions. Ages ranged from 23 to 67 years, with a mean age of 38.5. The gender distribution was 7 women and 3 men. All clients had a primary diagnosis of OCD, with varying levels of comorbid conditions such as body dysmorphic disorder (BDD), body-focused repetitive behaviours (BFRBs: trichotillomania, excoriation, etc.), panic disorder, major depressive disorder, and generalised anxiety disorder.

All clients completed a full course of ERP ( $\geq 16$  weeks). 8 were on stable doses of medication; 2 were unmedicated. 9 of 10 were judged to be treatment-refractory (Y-BOCS  $\geq 16$  despite treatment); the 10th had a

good response to ERP but opted to continue to ImRs to address core maladaptive schemas that continued to give them difficulty in various aspects of life. All clients completed the full ImRs protocol outlined above, with 1–2 therapist-guided rescripting sessions before switching to client-guided rescripting sessions. 9 clients completed 1–2 client-guided rescripting sessions; one, our sole non-responder, completed 6 sessions. 9 of 10 clients (90 %) achieved clinically significant reduction on Y-BOCS (>35 % reduction) following ImRs-OCD.

### 3.6.1. Example cases

**Case example 1:** A woman in her twenties with severe OCD and comorbid panic attacks presented with checking compulsions, “not just right” experiences, magical thinking, and harm-related intrusive thoughts about home invasion. Her obsessions focused on perfectionism, alignment concerns, and contamination fears, driven by the belief that imperfection would harm her parents. Compulsions included placing window blockers, repetitive washing and aligning objects, mentally reviewing door alignment photos while at work, and seeking reassurance from family members. Assessment revealed severe OCD symptoms (Y-BOCS = 27), elevated scores on the OBQ-44 perfectionism and responsibility/harm domains, and underlying schemas of abandonment, self-sacrifice, mistrust, unrelenting standards, and vulnerability to harm. Following ERP treatment that included panic attack management and hierarchy steps targeting tolerance of asymmetrical items and prevention of checking behaviours, her Y-BOCS declined to 16. Subsequent imagery rescripting targeting childhood aversive events (Table 5) achieved remarkable results, with Y-BOCS scores decreasing to 3 (81 % reduction) following the first therapist-led rescripting session, decreasing to 1 after the second therapist-led session (the client did not feel confident to be the rescripting adult after a single therapist-led session, despite the dramatic drop in Y-BOCS). Gains were maintained at one-month follow-up (Y-BOCS = 1) and three-month follow-up (Y-BOCS = 2).

**Case example 2:** A woman in her twenties presented with multiple OCD symptoms involving intrusive thoughts about health, sexual orientation, breathing, food safety, and inappropriate interactions with her dog and children. Core beliefs centred on fears of death from food inhalation and personal defectiveness. Compulsions included checking food expiration dates, repetitive chewing, restricted dog interactions, and mental reviewing of bodily reactions. She sought reassurance through parental validation about her character and food safety, and indirectly through OCD podcasts and conversations about sexual orientation. Assessment revealed severe OCD symptoms (Y-BOCS = 25), elevated scores on the OBQ-44 responsibility/harm, perfectionism, and importance/control of thoughts domains, and underlying schemas of abandonment, enmeshment, dependence, insufficient self-control, and subjugation. Following ERP treatment that included panic attack management and hierarchy steps targeting dog-patting with averted gaze, school exposure, food challenges, and social media engagement, her Y-BOCS reduced to 19 (moderate range). Subsequent imagery rescripting targeting childhood aversive events (Table 6) achieved significant additional improvements, with Y-BOCS scores decreasing to 11 (42.6 % reduction) following a single therapist-led rescripting session and further reducing to 9 (52.6 % reduction) after a single client-led rescripting session, with gains maintained at one-month follow-up (Y-BOCS = 9) and continuing to improve at three month follow-up (Y-BOCS = 6). Symptom reduction was accompanied by substantial improvements in healthy adult behaviours including self-soothing, boundary-setting, emotional regulation, and relationship functioning.

**Case Example 3:** A man in his thirties presented with severe OCD featuring intrusive thoughts about inappropriate looking at children and relationship doubts. Core beliefs centred on being a “monster” for having such thoughts and fears that relationship uncertainty would lead to abandonment. Compulsions included reviewing ex-partner photos, analysing feelings, monitoring reactions to women on social media, and mentally reviewing conversations. He sought reassurance from his

**Table 5**  
Aversive events (AE) rescripted in case example 1.

AE Rescripted (Age when AE occurred)	Original Meaning associated with AE	Modified Meaning associated with AE	Most Important Part of Rescript Noted by Client
Therapist-Led Rescript (1): Assumed emotional caretaking role for mother following parental separation announcement (Age 10).	We are now going to be at home alone. The day to day is now uncertain. I don't know what's going to happen or if we'll be OK. I have to be strong for mum and put on a brave face for her otherwise she'll be devastated.	We are all going to be OK. Our family will be OK and may look different. The kids are going to be kids. The adults can take responsibility for their emotions and the safety of the house going forward	Visualised appropriate parental responsibility assumption, enabling recognition of the connection between childhood role reversal and current OCD symptoms while establishing responsibility boundaries.
Therapist-Led Rescript (2): Suffered complications requiring emergency care after cosmetic procedure with physician denying accountability (Age 18).	Others should take responsibility for their actions. I can't stand up for myself, I'm not strong enough	I've gone through a lot of shitty things and I'm still able to be open-hearted and kind. I'm resilient and determined. I don't need the protective blanket of OCD anymore because I know that I can do this myself	Experienced emotional validation while assertively confronting the doctor, visualising him inhaling critical statements and offering an apology.
Client-Led Rescript (1): Isolated in bathroom to process emotional response to father's remarriage announcement (Age 13).	Dad didn't consider us, neglected us, we are not a priority in the forefront of his life. We aren't important. He doesn't love us as much as he loves her	My dad leaving isn't about my worth. I don't have to take on the bad in imperfect situations, I don't need to protect my mum from my dad's hurtful behaviour. We don't need a solution and even though we don't like that feeling of not knowing, we're going to be OK.	Visualised protective boundary while processing emotions, externalised OCD behaviours, and experienced integration of life experiences symbolised as colourful puzzle pieces fitting together with profound relief.

fiancée about their compatibility, consumed relationship OCD podcasts, took online compatibility tests, and sought validation from friends. Assessment revealed severe OCD symptoms (Y-BOCS = 25), elevated scores on the OBQ-44 responsibility/harm, perfectionism, and importance/control of thoughts domains, and underlying schemas of defectiveness, mistrust, unrelenting standards, pessimism, and self-punitiveness. Following ERP treatment, with hierarchy steps targeting social media engagement, female friendships, gym attendance, relationship uncertainty, media exposure, school environments, and wedding decision-making, his Y-BOCS declined to 20. Subsequent imagery rescripting targeting childhood aversive events (Table 7) achieved progressive improvements, with Y-BOCS scores decreasing to 14 (30 % reduction) following a single therapist-led rescripting, fluctuating to 15 after the first client-led session, then improving further to 11 (45 % reduction) after the second client-led rescripting. Gains were maintained at one-month follow-up (Y-BOCS = 11) and dramatically improved to 3 (85 % reduction) at three-month follow-up, accompanied by substantial improvements in healthy adult behaviours including reduced personalisation of OCD triggers, increased comfort with uncertainty and

**Table 6**  
Aversive events (AE) rescripted in case example 2.

AE Rescripted (Age when AE occurred)	Original Meaning associated with AE	Modified Meaning associated with AE	Most Important Part of Rescript Noted by Client
Therapist-led Rescript (1): Prevented mother from securing bathroom door due to separation anxiety in public setting (Age 7).	I need to look after my parents to make sure they won't die	I was a child. It's not my responsibility to make sure my parents are not going to die. They are responsible for taking care of their own health. It's OK not to be OK. Anxiety is something I can sit with and don't need to push to the side.	Received emotional validation while modelling gradual anxiety management strategies for mother rather than reinforcing maladaptive coping patterns.
Client-Led Rescript (1): Inhaling a candy. Felt like she was dying. Lack of parental empathy (age 9)	I'm going to die if I inhale food incorrectly	My feelings and sense of panic was not an over-reaction. It was understandable. It's OK to sit with panic. It has a beginning, middle and an end. It's OK to be human.	Validated panic experiences while normalising legitimate needs for comfort and reassurance.

wedding decisions, and improved workplace functioning.

**Case Example 4:** A man in his thirties with severe OCD and body dysmorphic disorder presented with checking compulsions and body comparison behaviours. His obsessions focused on perceived thinness of arms/thighs, bodily imperfections, dating concerns, and social embarrassment. Core beliefs included that being skinny indicated weakness and that dating without attraction meant seeking validation. Compulsions included checking dating apps, mirrors, and photos; weighing; body scanning; mental comparing; and analysing others' comments. He sought reassurance from friends about messages and photos and engaged in covert behaviours like sending texts to prompt responses. Assessment revealed severe OCD symptoms (Y-BOCS = 28), elevated scores on the OBQ-44 responsibility/harm, perfectionism, and importance/control of thoughts domains, and underlying schemas of unrelenting standards, social isolation, defectiveness/shame, abandonment, and punitiveness. Following ERP treatment that included cognitive restructuring for BDD symptoms and hierarchy steps targeting gym attendance without body comparisons, dating app use, mirror checking prevention, and anti-perfectionist tasks, his Y-BOCS declined to 21. Subsequent imagery rescripting targeting childhood aversive events (Table 8) achieved progressive improvements, with Y-BOCS scores decreasing to 15 (28 % reduction) following therapist-led rescripting, further reducing to 14 (33 % reduction) after the first client-led session, then dramatically improving to 8 (62 % reduction) after the second client-led rescripting, with gains maintained at one-month follow-up (Y-BOCS = 8) and continuing to improve to 3 (85 % reduction) at six-month follow-up, accompanied by substantial improvements in healthy adult behaviours including increased dating comfort, vulnerability in relationships, self-care through clothing purchases, and appropriate boundary-setting in his new relationship.

**Case Study 5:** A woman in her forties with severe OCD, skin picking, and depression presented with work-related checking compulsions and perfectionism. Obsessions included concerns about skin imperfections, hair-pulling urges, appliance safety, work quality, and social monitoring, driven by beliefs of inadequacy and needing to "get the bad out." Compulsions involved reviewing conversations, monitoring others' reactions, ruminating about alternatives, and skin-picking. She sought reassurance about social appropriateness and covertly checked for social exclusion by monitoring friends' activities and online presence. Assessment revealed moderate OCD symptoms (Y-BOCS = 20), elevated scores on the OBQ-44 responsibility/harm and perfectionism domains, and underlying schemas of emotional deprivation, social isolation,

**Table 7**  
Aversive events (AE) rescripted in case example 3.

AE Rescripted (Age when AE occurred)	Original Meaning associated with AE	Modified Meaning associated with AE	Most Important Part of Rescript Noted by Client
Therapist-Led Rescript (1): Met with parental anger and therapy threats after disclosing intrusive thoughts about sexual orientation (Age 8)	If I need to see a therapist, I'm not normal and there is something wrong with me and I won't be accepted. I'm not right and I need to be fixed	There isn't anything wrong with me. Everyone has these kinds of thoughts, even adults have these kinds of thoughts	Applied current understanding of OCD to reimagine father responding with calm psychoeducation, reducing shame and promoting emotional disclosure.
Client-Led Rescript (1): Shamed by mother's inappropriate exposure of body part during reassurance-seeking about intrusive thoughts (Age 9).	There is definitely something wrong with me. I'm sick. I shouldn't be thinking of Mum in this way. I'm not a good person	I am OK. I'm normal. I just needed a bit more attention and chance to learn how to reassure myself that I am a good person when the thoughts came in.	Incorporated mother's recovery-driven relational improvements, contrasting current supportive capacity with impaired responses during intoxicated periods of his childhood.
Client-Led Rescript (2): Abandoned roadside after confronting intoxicated parent about unsafe driving (Age 13).	I can't trust mum to be honest. She is unreliable and no trustworthy. She has betrayed us and does not care about me. I'm not worthy of Mum's love and care. I have to be responsible for controlling situations.	I don't need to be perfect and in control of the situation. I don't have to be the adult around her. She will step up and you are her world. I am a worthy person. I am a loveable person. I'm a good person who means to do well. Everyone who knows me, knows me to be a kind person. I don't need to second guess anyone's motives. I am good enough as I am. I can go forward being genuinely myself and people will love me for who I am	Recognised origins of perfectionism and excessive responsibility-taking as maladaptive control strategies.

failure to achieve, defectiveness, and insufficient self-control. Following ERP treatment that included habit reversal training for BFRB and hierarchy steps targeting work stress exposures, social situations with unknown guests, work performance evaluations, makeup-free appearance, and mirror exposure, her Y-BOCS declined to 18. Subsequent imagery rescripting targeting childhood aversive events (Table 9) achieved progressive improvements, with Y-BOCS scores decreasing to 13 (27 % reduction) following therapist-led rescripting, temporarily increasing to 15 (16 % reduction) after the first client-led session (during a time of work stress), then dramatically improving to 7 (61 % reduction) after

**Table 8**  
Aversive events (AE) rescripted in case example 4.

AE Rescripted (Age when AE occurred)	Original Meaning associated with AE	Modified Meaning associated with AE	Most Important Part of Rescript Noted by Client
Therapist-Led Rescript (1): Following sudden death of grandmother and experienced magical thinking on maths test (age 10/11)	If I finish all of these math's problems in the next minute, my grandad will be OK. If it doesn't feel right – someone will die. If something happens to others it will be my fault because I don't do things perfectly and on time	I feel sorry for myself as a child during these compulsions. It was not my responsibility to control future events	Recognised connection between bereavement and magical thinking as attempt to regain control.
Client Led Rescript (1): Bullied by peers for being sexually inexperienced (age 13)	I am ugly, unattractive and won't get girls. I won't fit in.	Its kids being immature. I didn't mean I'm ugly or unattractive	Acknowledged previously invalidated bullying-related emotions while projecting future positive outcomes to reassure younger self of eventual improvement.
Client-Led Rescript (2): Confronted former school bullies at nightclub with supportive intervention from new friend (Age 18)	I'm weak if I let them win. Others will think I needed someone stronger to back me up and I would have folded if it was just me	If it comes down to it, I can handle myself. I don't need a big brother type to protect me. I don't need a protector	Recognised self-sufficiency and capacity for autonomous functioning without external protection.

the second client-led rescripting, with gains maintained at one-month follow-up (Y-BOCS = 6) and three-month follow-up (Y-BOCS = 6), accompanied by substantial improvements in healthy adult behaviours including increased enjoyable activities, completion of long-avoided creative projects, enhanced social functioning, reduced co-dependency with siblings, markedly reduced skin-picking with decreased shame, and cessation of taking responsibility for others.

**Case example 6:** A woman in her sixties with moderate OCD presented with email verification and organizational checking compulsions. Her obsessions centred on perfectionism and fears of disappointing others or missing appointments. Driven by “just right” beliefs, she repetitively checked calendars and emails, maintained duplicate record systems, and aligned objects until they felt correct. She sought reassurance from her partner about potential oversights and others’ reactions, while avoiding social planning and email deletion. Assessment revealed moderate OCD symptoms (Y-BOCS = 22), elevated scores on the OBQ-44 responsibility/harm, perfectionism, and insufficient control/uncertainty domains, and underlying schemas of failure to achieve, social isolation/alienation, practical incompetence/dependence, subjugation, and unrelenting standards. Following ERP treatment that included panic attack management and hierarchy steps targeting tolerance of asymmetrical items, limiting calendaring system use to single email reads before diary entry and deletion, organizing social events, and preventing re-checking behaviours, her Y-BOCS declined to 20. Subsequent imagery rescripting targeting childhood aversive events (Table 10) achieved significant improvements, with Y-BOCS scores decreasing to 14 (36 % reduction) following therapist-led rescripting and to 9 (55 % reduction) after client-led rescripting, with gains largely maintained at one-month follow-up

**Table 9**  
Aversive events (AE) rescripted in case example 5.

AE Rescripted (Age when AE occurred)	Original Meaning associated with AE	Modified Meaning associated with AE	Most Important Part of Rescript Noted by Client
Therapist-Led Rescript: Grandma highly critical of artwork on family vacation - (age 10)	No matter what I do or how hard I try, the outcome is never good enough and I'll never get a pat on the back. I need to be tentative. Cautious and weigh all my options otherwise I might get disapproved of.	The actions of grandma aren't a reflection of what I can and can't do; it's a reflection of her.	Experienced timely provision of needed validation and reassurance.
Client-Led Rescript (1): Breaking a camera and father yelling at her (age 10)	I should never do things wrong. I'll get yelled at/ reprimanded. I do things wrong all the time. I'm a bad person.	I've grown and I'm able to achieve things. I feel valued and achieved. I'm valuable.	Reattributed emotional invalidation to father's deficits rather than personal inadequacy while normalising behaviours, removing shame, and offering healthier coping alternatives.
Client-Led Rescript (2): Sister falling downstairs and feeling responsible (age 13)	I'm responsible for my sister's safety. If I don't keep her safe, I'm irresponsible. You are always at risk of something going wrong and I should always stay protected.	I can still be there emotionally for others without taking responsibility for them	Required autonomy in receiving physical affection without disciplinary associations.

**Table 10**  
Aversive events (AE) rescripted in case example 6.

AE Rescripted (Age when AE occurred)	Original Meaning associated with AE	Modified Meaning associated with AE	Most Important Part of Rescript Noted by Client
Therapist-Led Rescript (1): Told parents she received 95 % in test. They said next time you'll do better and get 100 % (Age 9)	It was not good enough. In order to be good enough, I need to do more.	I did well and that was good enough	Gained insight into developmental origins of perfectionism as internalised paternal beliefs rather than authentic personal values.
Client-Led Rescript (1): Rushed clothing preparation due to father's rigid timeframe despite available alternatives, resulting in unnecessary daylong separation (Age 12).	Spending time with me is less important. I'm not important enough. It's more important for Dad to be on time than to spend time with me	I've got a voice and my voice matters. I might be little, but I'm smart. I understand the value of spending time with my family. I am different to my dad. I have different priorities. I don't need to speed and rush. I just need to enjoy it and connect.	Developed self-expression while recognising distinct personal family values separate from parental models.

(Y-BOCS = 10, 55 % reduction) and three-month follow-up (Y-BOCS = 8, 60 % reduction), accompanied by substantial improvements in healthy adult behaviours including enhanced organisational skills, reduced over-responsibility in her family, increased socialising and self-nurturing, and improved assertion of personal feelings and needs.

### 3.7. Qualitative evaluation

When participants were queried about the most important aspects of the ImRs-OCD protocol, several key themes emerged; these are illustrated here using client quotes.

#### 3.7.1. Reduced impact of obsessive thoughts on self-concept and validation of self

Case example 2: “I feel like I have a different relationship with my anxiety now – I can step back from my OCD thoughts and just be mindful and sleep easy. If I wasn’t due to leave the country next week, I’m sure the questionnaire (Y-BOCS) would be even lower. The rescripting has been like a light-bulb moment and it’s like it all makes sense. It really helped me to know there is nothing wrong with my emotions”.

#### 3.7.2. Increased self-worth and resilience; feelings of empowerment

Case example 4: “The epiphany moment was when I realised I don’t need a protector. When I think about the rescripting event I have a more positive feeling. I know it didn’t happen, but it feels like it sort of did. I feel empowered when I think about it. The OCD and BDD symptoms just don’t bother me in the same way. So, if there were a few things about my body that I needed reassurance about, I’d just ask (myself) about it and let the rest go. I bought some new clothes – I haven’t bought anything for myself in a really long time”.

#### 3.7.3. The complementary nature of ERP and ImRs

Case example 3: “Now when I come to the obsessive thoughts - it doesn’t attack the core of me like it used to. It’s like I’ve got a better armour to protect myself ... The obsessive thoughts are so far back in my head, and because my self-worth is higher, the thoughts are quieter now and barely audible ... I know that doing the imagery rescripting work earlier on, I wouldn’t have been able to go to the same depth .... I was so much more equipped to do it after ERP. There’s a massive freedom that comes from being able to lean into the uncertainty you feel like your brain capacity is now freed up and you can just focus on what’s happening now instead of constantly analysing whether the obsessive thoughts I just had mean I’m not a worthwhile person.”

#### 3.7.4. Insight into the potential functionality of OCD, improved self-concept and desire to reduce OCD behaviours

Case example 1: (Speaking to the OCD) – “Thank you for protecting me while I needed you. I don’t need you anymore as I can deal with anything that comes up by myself [imagined the OCD blanket coming off her and floating away]. I feel happy and accomplished. With all of the hard work I’ve put in, I know I can get through anything”.

#### 3.7.5. Improved ability to tolerate distress and uncertainty; reduced mental preoccupation with obsessive thoughts

Case example 5: “I went away on a trip, and this is the first time I just went with physical baggage and not mental baggage. By leaning into the feeling and just feeling it out, I know I can sit with the emotion and be mindful or go for a run and just notice the increases and decreases of my physiological heart rate. I love being able to “healthy-adult” myself and draw from the toolbox of skills based on what I need, and I can give that to myself. I’m still putting myself in situations that trigger myself. I am good enough. I can back myself up. I am worthy of people’s time without needing to be liked by everyone. Perfection is boring”.

## 4. Discussion

Our observations during the development of the ImRs-OCD protocol and our early clinical experience, reviewed here, suggest that ImRs-OCD is a promising adjunctive intervention for treatment-resistant OCD. The high rate of clinically significant improvement here (90 %) and in our earlier published work (92 %; Maloney et al., 2019) is particularly noteworthy given the treatment-resistant nature of the sample. The qualitative feedback suggests that ImRs-OCD may work by modifying core beliefs and self-concepts that underlie OCD symptoms.

### 4.1. Adaptations for OCD

The ImRs-OCD protocol adapts standard imagery rescripting to address the unique characteristics of OCD. The protocol functions as a complementary intervention rather than a replacement for ERP. This synergistic approach allows ERP to reduce symptom severity and build distress tolerance before ImRs-OCD addresses the underlying beliefs maintaining OCD symptoms. The protocol targets core beliefs related to perfectionism, responsibility, and control through a flexible approach to identifying rescripting targets, as OCD-related beliefs may not connect to discrete memories. Given OCD’s ego-dystonic nature, the intervention emphasises reducing shame and self-stigma while featuring empathetic correction of parental responses. Therapists model understanding of parental anxiety while providing psychoeducation about developmentally appropriate responses. A key distinguishing feature is the explicit focus on developing the “healthy adult” mode between sessions, helping clients generalise rescripting insights to daily functioning and maintain treatment gains over time. The integration of schema-informed ERP using a trauma-informed lens represents a promising direction for future investigation. This approach conceptually parallels the innovative SCHerp protocol developed by Peeters et al. (2025), which successfully integrated schema mode work with exposure and response prevention techniques for individuals with obsessive-compulsive personality disorder. Both approaches recognise the potential synergistic effects of combining symptom-focused behavioural interventions with deeper schema-level work, suggesting that comprehensive treatment models addressing both symptomatic behaviours and underlying maladaptive schemas may yield enhanced outcomes for complex presentations of obsessive-compulsive psychopathology.

The systematic development process we employed yielded important insights across all three key protocol development pillars. Our systematic integration of feedback from both clinicians and clients revealed the necessity for specialised training in OCD phenomenology alongside technical ImRs skills. The iterative refinement process, which led to the finalised 10-step protocol, highlighted critical adaptations needed for the OCD population, particularly regarding case conceptualisation, integration with ERP techniques, and management of compulsive imagery symptomatology. These refinements directly informed our understanding that comprehensive training and ongoing clinical supervision are essential for effective implementation. Clinicians required not only technical proficiency in standard imagery rescripting but also specialised knowledge of OCD maintenance factors, as consistently emphasised in feedback throughout the development cycle. The interplay between trauma-focused ImRs interventions and OCD-specific considerations emerged as a central theme across multiple protocol iterations. This comprehensive understanding from both systematic feedback and iterative refinement is precisely why we developed professional development training workshops in both ERP and ImRs-OCD (Maloney, 2024, 2025) to complement the protocol implementation. These training initiatives were designed to address the dual competency requirements identified through our development process. Future research should evaluate whether different training modalities and supervision intensities affect treatment outcomes and therapist competence with this specialised protocol.

#### 4.2. Clinical implications, limitations and future directions

While our preliminary findings suggest the ImRs-OCD protocol may offer a promising approach for clients with incomplete response to standard OCD treatments, we acknowledge that clinical implementation should proceed cautiously given our limited sample size and the absence of randomised controlled data. The protocol's focus on addressing underlying schemas and beliefs maintaining OCD symptoms presents a theoretical mechanism that might contribute to improvements in overall functioning, though larger controlled studies are needed to establish its efficacy and durability. The authors are currently recruiting for a study including both treatment-resistant clients and those with Y-BOCS scores in the mild range (10–16) to better understand the protocol's efficacy across varying OCD severity levels, potentially expanding its clinical applications and refining implementation strategies. This study also aims to address a limitation of the current case series design by including multiple clinicians to administer ImRs-OCD to enhance generalisability. A methodological limitation was that the treating clinician, rather than independent assessors, administered the Y-BOCS and Healthy Adult subscale measurements, potentially introducing bias; however, this approach reflects the practical constraints of implementation within routine clinical settings where independent assessment resources are often unavailable.

Future research on ImRs-OCD should prioritise several key directions to advance our understanding of this promising intervention. Large-scale randomised controlled trials are essential to establish efficacy compared to other treatments and control for non-specific factors. We have published this protocol to facilitate such research across diverse settings, acknowledging ethical and practical constraints in private clinics. Investigation into specific mechanisms of change should examine how ImRs-OCD affects beliefs, self-concept, and emotional processing to elucidate the underlying processes of therapeutic change. Studies examining differential efficacy across OCD subtypes could help refine the protocol and identify which clients are most likely to benefit, enhancing treatment outcomes and resource allocation. Long-term follow-up research is crucial to determine the durability of treatment gains and potential need for booster sessions. Critical evaluation of treatment sequencing is needed—while clinical feedback strongly supports using ERP prior to ImRs, this assumption requires empirical validation through studies comparing ImRs-OCD as a stand-alone treatment, evaluating different sequencing approaches, and exploring potential adaptations for automated online delivery to enhance accessibility. While the current protocol positions ImRs-OCD as a sequenced treatment following ERP for individuals with treatment-resistant OCD, it is worth noting that preliminary research investigating ImRs as a stand-alone treatment for OCD is currently being undertaken (Van Verseveld et al., 2025), which may soon provide valuable insights into alternative implementation approaches. Therefore, the optimal configuration (standalone versus adjunctive) and client selection criteria for standard OCD presentations remain important clinical considerations. Future research should evaluate whether our comprehensive ImRs-OCD protocol targeting childhood aversive events, with its emphasis on fulfilling unmet emotional needs and modifying core beliefs, produces enhanced long-term outcomes compared to approaches that focus primarily on neutralising or transforming intrusive imagery. Such comparative studies would be particularly valuable in determining optimal treatment pathways for both treatment-resistant and less severe standard OCD presentations. Finally, exploring integration with emerging treatment modalities, such as psychedelic-assisted therapy (Maloney et al., 2024), could open new avenues for treating refractory OCD and potentially enhance efficacy for clients who have not responded to traditional interventions.

#### 4.3. Conclusion

The ImRs-OCD protocol represents a promising adjunctive treatment

for OCD that has been systematically developed and refined over a decade. By addressing underlying schemas and beliefs, it offers a complementary approach to standard ERP treatment. While further research is needed to establish its efficacy, the preliminary results are encouraging. We hope that by providing open access to the ImRs-OCD protocol and associated training materials, we can stimulate further research and clinical application of this approach, ultimately improving outcomes for individuals struggling with treatment-resistant OCD.

#### CRediT authorship contribution statement

**Gayle Maloney:** Writing – review & editing, Writing – original draft, Visualization, Validation, Supervision, Resources, Project administration, Methodology, Investigation, Formal analysis, Data curation, Conceptualization. **Arnoud Arntz:** Writing – review & editing, Supervision, Conceptualization. **Christopher Pittenger:** Writing – review & editing, Writing – original draft, Visualization, Validation, Supervision, Project administration, Methodology, Investigation, Formal analysis, Conceptualization.

#### Declaration of generative AI and AI-assisted technologies in the writing process

During the preparation of this work the author(s) used 'Claude Version 4' in order to improve language and grammar. After using this tool/service, the author(s) reviewed and edited the content as needed and take full responsibility for the content of the publication.

#### Declaration of competing interest

The authors declare the following financial interests/personal relationships which may be considered as potential competing interests: Christopher Pittenger reports financial support was provided by Funded in part by the State of Connecticut Department of Mental Health and Addiction Services through its support of the Ribicoff Research Facilities at the Connecticut Mental Health Center. Arnoud Arntz reports financial support was provided by I provide training in ImRs and that the remuneration goes to the University of Amsterdam to support research. Gayle Maloney reports a relationship with I provide training in ImRs and that remuneration goes to the Perth OCD Clinic to support research that includes: speaking and lecture fees. If there are other authors, they declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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#### Appendix A. Supplementary data

Supplementary data to this article can be found online at <https://doi.org/10.1016/j.brat.2025.104878>.

#### Data availability

The data that has been used is confidential.

#### References

Abramowitz, J. S., Deacon, B. J., & Whiteside, S. P. H. (2019). *Exposure therapy for anxiety: Principles and practice* (2nd ed.). The Guilford Press.

- Ahmed, S. K., Arsalan, R., Abdulqadir, M. J., Radhwan, N., Ibrahim, H., Abdalla, A. Q., Mohammed, B. M., Renas, A., & Khdir, M. (2025). Using thematic analysis in qualitative research. *Journal of Medicine, Surgery and Public Health*, 6. <https://doi.org/10.1016/j.gmedi.2025.100198>
- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). <https://doi.org/10.1176/appi.books.9780890425596>
- Arntz, A. (2025). Imagery rescripting: An update of the treatment protocol. Special issue on imagery rescripting. *Behaviour Research and Therapy*. Submitted for publication.
- Arntz, A., & Jacob, G. (2013). *Schema therapy in practice: An introductory guide to the schema mode approach*. Wiley Blackwell.
- Arntz, A., & Weertman, A. (1999). Treatment of childhood memories; theory and practice. *Behaviour Research and Therapy*, 37(8), 715–740. [https://doi.org/10.1016/S0005-7967\(98\)00173-9](https://doi.org/10.1016/S0005-7967(98)00173-9)
- Arslan, F., Krans, J., Hendriks, G. J., Mobach, L., & Kampman, M. (2025). Imagery rescripting for clients with obsessive-compulsive disorder not responding to outlier cognitive behavioral therapy. *Behaviour Research and Therapy*, 193. <https://doi.org/10.1016/j.brat.2025.104823>
- Botelho de Haan, K., Lee, C., Fassbinder, E., Van Es, S., Menninga, S., Meewisse, 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. <https://doi.org/10.1101/2021.101699>. <https://doi.org/10.1192/bjp.2020.158>
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77–101. <https://doi.org/10.1191/1478088706qp0630a>
- Cooper, D. D. J., Stavropoulos, L., & Grisham, J. R. (2024a). Variants in imagery rescripting for OCD: Memories versus future, attachment versus mastery. *Journal of Cognitive Therapy*, 17, 578–597. <https://doi.org/10.1007/s41811-024-00212-5>
- Cooper, D. D. J., Wong, S. F., & Grisham, J. R. (2024b). Testing an imagery rescripting exercise targeting fear of self. *Journal of Cognitive Psychotherapy*, 38(3), 243–254. <https://doi.org/10.1891/JCP-2023-0023>
- Craig, P., Dieppe, P., Macintyre, S., Michie, S., Nazareth, L., & Petticrew, M. (2008). Medical research council guidance. Developing and evaluating complex interventions: The new medical research council guidance. *British Medical Journal*, 337, Article a1655. <https://doi.org/10.1136/bmj.a1655>
- Czajkowski, S. M., Powell, L. H., Adler, N., Naar-King, S., Reynolds, K. D., Hunter, C. M., Laraia, B., Olster, D. H., Perna, F. M., Peterson, J. C., Epel, E., Boyington, J. E., & Charlson, M. E. (2015). From ideas to efficacy: The ORBIT model for developing behavioural treatments for chronic diseases. *Health Psychology*, 34(10), 971–982. <https://doi.org/10.1037/hea0000161>
- Fink, J., Pflugradt, E., Stierle, C., & Exner, C. (2018). Changing disgust through imagery rescripting and cognitive reappraisal in contamination-based obsessive-compulsive disorder. *Journal of Anxiety Disorders*, 54, 36–43. <https://doi.org/10.1016/j.janxdis.2018.01.002>
- Fink-Lamotte, J., Platter, P., Stierle, C., & Exner, C. (2022). Mechanisms and effectiveness of imagery strategies in reducing disgust in contamination related obsessive-compulsive disorder: Comparing imagery rescripting, imagery self compassion and mood-focused imagery. *Cognitive Therapy and Research*, 46(4), 747–763. <https://doi.org/10.1007/s10608-021-10275-9>
- Goodman, W. K., Price, L. H., Rasmussen, S. A., Mazure, C., Fleischmann, R. L., Hill, C. L., Heninger, G. R., & Charney, D. S. (1989). The Yale-Brown obsessive compulsive scale. I. Development, use, and reliability. *Archives of General Psychiatry*, 46(11), 1006–1011. <https://doi.org/10.1001/archpsyc.1989.01810110048007>
- Kip, A., Schoppe, L., Arntz, A., & Morina, N. (2023). Efficacy of imagery rescripting in treating mental disorders associated with aversive memories—an updated meta-analysis. *Journal of Anxiety Disorders*, 10, 2772. <https://doi.org/10.1016/j.janxdis.2023.102772>
- Kühne, F., Hobrecker, L. K., Fink-Lamotte, J., et al. (2025). The Spit-face scenario: Inducing contamination-based disgust and anxiety and investigating the effects of imagery rescripting in an online experiment. *Cogn Ther Res*. <https://doi.org/10.1007/s10608-025-10597-y>
- Lobbstaal, J., van Vreeswijk, M., Spinhoven, P., Schouten, E., & Arntz, A. (2010). Reliability and validity of the short schema mode inventory (SMI). *Behavioural and Cognitive Psychotherapy*, 38(4), 437–458. <https://doi.org/10.1017/S1352465810000226>. Epub 2010 May 21. PMID: 20487590.
- Maloney, G., Kelmendi, B., & Pittenger, C. (2023). Imagery rescripting (ImRs) as an adjunctive treatment to exposure and response prevention (ERP)-resistant obsessive-compulsive disorder: A case study. *Clinical Case Studies*, 22, 174–191. <https://doi.org/10.1177/15346501221123797>
- Maloney, G. (2024). Exposure and response prevention (ERP) for OCD treatment in adults – Training for mental health professionals. <http://www.perthocclinic.com.au>. Retrieved from, Accessed November, 2024.
- Maloney, G. (2025). Imagery-rescripting for OCD – Training for mental health professionals. <http://www.perthocclinic.com.au>. Retrieved from, Accessed June, 2025.
- Maloney, G., Ching, T., Kichuk, S. A., Pittenger, C., & Kelmendi, B. (2024). Mechanisms of therapeutic change after psychedelic treatment in OCD. *Psychiatry Research*, 336, Article 115907. <https://doi.org/10.1016/j.psychres.2024.115907>
- Maloney, G., Koh, G., Roberts, S., & Pittenger, C. (2019). Imagery rescripting as an adjunct clinical intervention for obsessive compulsive disorder. *Journal of Anxiety Disorders*, 66, Article 102110. <https://doi.org/10.1016/j.janxdis.2019.102110>. Epub 2019 Jul 18.
- Miller, W. R., & Rollnik, S. (2023). *Motivational interviewing. Helping people change and grow* (4th ed.). The Guildford Press.
- Moreno, F. A., Wiegand, C. B., Taitano, E. K., & Delgado, P. L. (2006). Safety, tolerability, and efficacy of psilocybin in 9 clients with obsessive-compulsive disorder. *Journal of Clinical Psychiatry*, 67(11), 1735–1740. <https://doi.org/10.4088/jcp.v67n1110>
- Mpavaenda, D. N. (2016). *Imagery rescripting therapy, a pilot study: Reducing shame and cognitive inflexibility in obsessive compulsive disorder [unpublished doctoral dissertation]*. University of Surrey.
- Obsessive Compulsive Cognitions Working Group. Behaviour Research & Therapy. (OCCWG). (2003). Psychometric validation of the Obsessive Beliefs Questionnaire and the Interpretation of Intrusions Inventory. *Part I*, 41(8), 863–878. [https://doi.org/10.1016/s0005-7967\(02\)00099-2](https://doi.org/10.1016/s0005-7967(02)00099-2)
- Paulik, G., Maloney, G., Arntz, A., et al. (2021). Delivering imagery rescripting via telehealth: Clinical concerns, benefits, and recommendations. *Current Psychiatry Reports*, 23, 24. <https://doi.org/10.1007/s11920-021-01238-8>
- Paulik, G., Steel, C., & Arntz, A. (2019). Imagery rescripting for the treatment of trauma in voice hearers: A case series. *Behavioural and Cognitive Psychotherapy*, 47(6), 709–725. <https://doi.org/10.1017/S1352465819000237>
- Peeters, N., van Passel, B., Hendriks, G. J., Becker, E., & Krans, J. (2025). Schema-therapeutic exposure for treatment resistant anxiety and obsessive-compulsive disorders: A multiple baseline case series design study. *Psychiatry Research Case Reports*, 4(1), Article 100241. <https://doi.org/10.1016/j.psycr.2024.100241>
- Pittenger, C., & Bloch, M. H. (2014). Pharmacological treatment of obsessive-compulsive disorder. *Psychiatric Clinics of North America*, 237(3), 375–391. <https://doi.org/10.1016/j.psc.2014.05.006>
- Rounsaville, B., Carroll, K., & Onken, L. (2001). A stage model of behavioral therapies research: Getting started and moving on from stage I. *Clinical Psychology: Science and Practice*, 8, 133–142. <https://doi.org/10.1093/clipsy.8.2.133>
- Ruscio, A. M., Stein, D. J., Chiu, W. T., & Kessler, R. C. (2010). The epidemiology of obsessive-compulsive disorder in the national comorbidity survey replication. *Molecular Psychiatry*, 15(1), 53–63. <https://doi.org/10.1038/mp.2008.94>
- Stavropoulos, L., Cooper, D. D. J., Champion, S. M., Keevers, L., Newby, J. M., & Grisham, J. R. (2024). Basic processes and clinical applications of mental imagery in worry: A systematic review. *Clinical Psychology Review*, 110, Article 102427. <https://doi.org/10.1016/j.cpr.2024.102427>
- Tenore, K., Basile, B., Cosentino, T., De Sanctis, B., Fadda, S., Femia, G., Gagnani, A., Luppino, O. I., Pellegrini, V., Perdighe, C., Romano, G., Saliari, A. M., & Mancini, F. (2020). Imagery rescripting on guilt-inducing memories in OCD: A single case series study. *Frontiers in Psychiatry*, 30(11), Article 543806. <https://doi.org/10.3389/fpsy.2020.543806>. eCollection 2020.
- Van Verseveld, T., Arntz, A., Denys, D., & Luigjes, J. (2025). Imagery rescripting as a stand-alone treatment for obsessive-compulsive disorder: A multiple-baseline study. *Conference presentation at EABCT. Glasgow, Scotland*.
- 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 Behaviour Therapy & Experimental Psychiatry*, 49(Pt B), 230–236. <https://doi.org/10.1016/j.jbtep.2015.03.003>. (Accessed 11 March 2015)
- Wibbelink, C. J., Lee, C. W., Bachrach, N., Dominguez, S. K., Ehring, T., van Es, S. M., ... 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*, 22, 848. <https://doi.org/10.1186/s13063-021-05712-9>
- Young, J. E., & Brown, G. (2005). *Young Schema Questionnaire-Short Form; Version 3 (YSQ-S3, YSQ) [Database record]*. APA PsycTests. <https://doi.org/10.1037/t67023-000>
- Young, J. E., Klosko, J. S., & Weishaar, M. E. (2003). *Schema therapy: A practitioner's guide*. New York, NY: Guilford Press.
- Zenoni, M., Badaoui, A., Brewin, C., Milton, A. L., Archer, S., Bloomfield, M. A., & Bisby, J. (2025). Mental imagery and its role in the psychopathology and treatment of obsessive-compulsive disorder: A systematic review and narrative synthesis. *PsyArXiv*. [https://doi.org/10.31234/osf.io/6yxbs\\_v1](https://doi.org/10.31234/osf.io/6yxbs_v1)