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# Delivering Imagery Rescripting via Telehealth: Clinical Concerns, Benefits, and Recommendations

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## Abstract

**Purpose of the Review** Delivery of psychological therapies via telehealth has increased with the emergence of the COVID-19 pandemic. Therapists may be hesitant in moving to telehealth when delivering therapies targeting memories of traumatic experiences. This paper collates the clinical experiences of clinicians and clients who have delivered or received imagery rescripting, respectively, via telehealth across a range of clinical presentations, and describes key clinical considerations and recommendations.

**Recent Findings** It is important to consider perceived and real safety; practical and technological issues; therapeutic alliance; depth of emotional processing; and dissociation.

**Summary** There was support for the delivery of imagery rescripting via telehealth being no less effective than face-to-face delivery; however, telehealth delivery was not a viable option for many clients during COVID-19 lockdowns who were living in high density housing, old houses with thin walls, or with some complex disorders.

**Keywords** Remote therapy · Telehealth · Telepsychology · Imagery rescripting · COVID-19 · Mental disorders

## Introduction

Imagery rescripting (ImRs) is a therapeutic technique initially developed to reduce posttraumatic stress disorder (PTSD)–related intrusions (i.e. [1–5]), and has since been applied successfully to reduce intrusive cognitions (i.e. images, nightmares, flashbacks, voices, thoughts) and associated distress in a range of psychological disorders (for literature review

and metanalysis, see [6, 7••, 8•]). Although ImRs is often used as a technique within a broader therapeutic approach, such as schema therapy, it has also been shown effective as a stand-alone treatment. In ImRs, the clinician works with the client's autobiographical memories that are associated with their current psychological problems. The individual first imagines the start of the selected traumatic memory and then imaginably rewrites a new, safer ending. This permits the individual to

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modify the meaning of the representation of the original experience, which subsequently changes the emotions attached to the memory (and thus, reduces associated unwanted intrusions). ImRs has been found to be effective in treating a range of different clinical presentations, including PTSD (i.e. [1–5]), obsessive compulsive disorder (OCD [9, 10, 11]); auditory verbal hallucinations (or “voice hearing” [12, 13]); personality disorders (such as borderline personality disorder, BPD [14]); social anxiety disorder (i.e. [15–20]), paranoia [21, 22], health anxiety [23], nightmare disorder [24, 25], depression [26, 27], bulimia nervosa [28], binge eating disorder [29], and body dysmorphic disorder [30, 31].

The delivery of ImRs via telehealth (rather than face-to-face) has not been studied. The term “telehealth” refers to the delivery of health care services—in this paper, specifically psychological therapy—remotely, via video conferencing facilities. There has been a need for telehealth-delivered psychological interventions, especially in rural and low-income areas, where barriers, such as a lack of local mental health providers, financial constraints, distance to care, and fear of stigma, may be higher [32–34]. The need for remote delivery has increased with the rapid emergence and spread of COVID-19, leading many countries to impose travel restrictions and extended periods of home confinement, making the delivery of therapy face-to-face difficult or impossible. Previous systematic reviews have found the quality, effectiveness, client satisfaction, and dropout rates of telehealth-delivered psychological therapy to be comparable to face-to-face delivery [32, 35, 36, 37, 38, 39].

The aim of this paper is to collate clinicians’ and clients’ (via feedback they provided to their treating clinician) experiences delivering or receiving (respectively) ImRs via telehealth due to COVID-19. Contributing authors have drawn their clinical reflections from a range of clinical presentations, including trauma-affected voice hearers (a transdiagnostic group), OCD, PTSD, BPD and dissociative identity disorder (DID). Authors known to be currently conducting ImRs studies or who had published on ImRs (using this as the key search term) in the years 2019 and 2020 (thus, likely to be administering ImRs via telehealth due to COVID-19) were invited to participate. A series of open-ended clinical questions regarding ImRs delivered via telehealth were completed confidentially to avoid influencing the responses of other clinicians. The first and last authors collated this feedback into themes, which was placed into the following sections: (1) implementing ImRs via telehealth: clinical considerations, (2) therapy progress and outcomes, (3) recommendations to clinicians delivering ImRs via telehealth, and (4) limitations and future research. This paper is limited to reflections specific to ImRs, rather than psychological therapy via telehealth more generally (for broader clinical recommendations, see [40, 41]). Case illustrations and client quotes are provided where possible.

## Implementing Imagery Rescripting via Telehealth: Clinical Considerations

One of the strongest overarching themes was that context is paramount. In pandemic times, the contagion and death rate, as well as “wave” of virus proliferation, are important. In countries where lockdowns were imposed, but the rate of contagion was low (such as Australia, where authors GP, GM, and PM are based), the overall anxiety and stress both therapist and client are placed under is considerably lower than countries where the contagion and death rates are higher and they are experiencing their second or third “wave” of the virus (such as the Netherlands, where authors AA, NB, and AK are based). This also impacts the level of restrictions placed on people, such that some clients and therapists were able to voluntarily elect to do telehealth over face-to-face therapy, rather than this being the only option, and whether family members (or housemates) would have been at home during their therapy session (i.e. if schools were still open, or if family could vacate the house by going to a public park during the therapy session). Similarly, the type of living environments was of importance. People living in large houses or with thick walls, who could find a private space to conduct the session even if family/housemates were home, generally had a more positive experience than those who lived in small houses with thin walls.

## Perceived and Real Safety

All clinicians agreed that it was imperative that the client only proceed with ImRs via telehealth if they had a space where they were safe (both perceived and real safety) [42]. ImRs is not recommended for clients who are still experiencing trauma, regardless of delivery mode. However, a client may be physically safe, but living with people who they do not want (or *feel safe*) overhearing them discuss their trauma, which can create a barrier for remote delivery. Several clients in the Netherlands chose not to commence—or continue, if they had already commenced face-to-face—ImRs via telehealth due to a perceived lack of privacy, increased distractions, and feelings of anxiety and shame. One client who lives in a small apartment, where her parents (who were not the perpetrators) may have been able to hear some of her session, reported that she may have rescripted differently (e.g. had the parents reprimanded for not protecting the client) had they been in the therapist’s office or home alone (“I felt a little more self-conscious about the rescripts in case they [my parents] could over hear, even though I don’t think they could. In a couple of the rescripts I may have rescripted the memory differently if they had not been home”).

Some clients living in home environments where they had real and perceived safety, and thus proceeded with telehealth, still expressed initial reluctance (“Well, I’d obviously feel

more comfortable if I could try this out with you in person, but I know that's just not an option right now and I don't want to wait either"). However, at the end of the first ImRs session, clients generally reported much stronger positive associations with the process. Other clients reported feeling *more* comfort and safety, and being able to concentrate *better*, during ImRs in their own home environment than in the clinical setting ("It [telehealth] also meant I didn't get anxious before or after with the commute and I felt safer at home", "while I felt safe in your office when I saw you there, I feel even safer at home").

### Practical Considerations

Some clients noted that it was more convenient to attend sessions from the comfort of their own homes as they did not need to drive or catch public transport, find parking, or interact with other people in the waiting room, and could wear more comfortable clothes and immediately access soothing objects/people (e.g. blankets, soft toys, cushions, and pets; "I loved being able to wear my comfortable 'house-clothes' to sessions – I knew you wouldn't care"; "it was convenient as it's one hour to get to the clinic, which is also stressful and makes therapy seem like a chore."). All trauma-affected voice hearing clients cited these reasons for declining face-to-face once lockdowns eased. Two clinicians in the Netherlands (AA, AK) reported that the majority of their clients did not share these sentiments and found that telehealth from home was less convenient for a variety of reasons reflecting individual differences and contextual influences.

Benefits noted by some clinicians were increased structure and efficiency (e.g. greater focus during telehealth sessions) and flexibility. Three clinicians said it shortened the sessions (by 5–20 min), and one said this allowed for more frequent but shorter sessions, which is advantageous as increased frequency of sessions has been shown to increase positive client outcomes [43]. It was noted that the preparation session was often longer when delivered via telehealth as there were more potential obstacles to problem-solve with the client. It was also mentioned that ImRs can be more easily adapted to telehealth delivery than other trauma-focused methods (such as eye movement desensitization and reprocessing [EMDR] where the client's eyes must follow the clinicians moving finger), as during the rescript, the client has their eyes closed and is not focused on the therapist regardless of delivery mode.

Several clinicians felt less attuned to their client's experiences and emotions when working solely with the client's narrative self-report and facial expressions, as the camera was often positioned so that the client's body was not visible. One client reported: "I think that if you [therapist] were able to see my full body you would have been better able to read how I was feeling". In instances where the client sat back so that their upper body was included in the video frame, the clarity of facial expressions was often reduced. Both client facial

expressions and body language (e.g. clenched fists) can facilitate additional feedback from the clinician (i.e. helping them to relax bodily tension in the final, soothing stage of the rescript). One clinician overcame this issue by asking the client to set up two cameras simultaneously: one focused on their whole body and another zoomed into their face. Two clinicians commented that this was less of an issue with clients who had experienced a face-to-face ImRs session before switching to telehealth, as both the clinician and client felt more comfortable with the process and how the client was responding.

Clinicians reported that seeing clients back-to-back for therapy via telehealth is more mentally exhausting than face-to-face delivery [44, 45]. The theorized reasons behind this are that more mental energy is required to compensate for lags in communication, off-set eye contact, and the reduction of visual social cues. This exhaustion may be more pronounced in ImRs as the clinician relies more heavily on facial expressions and body language to guide therapy choices (i.e. determining in an image where to commence the rescript or what the client needs next).

Other practical considerations included the client setting up a private and comfortable area at home. One clinician suggested that the use of headphones and competing sounds (i.e. music) in the other parts of the house to muffle the client's speech for others was beneficial. This however was not adequate for all clients during COVID-19 lockdowns, where families/housemates were home together, living space was small, and walls were thin. It was also recommended that the "therapy space" be inside the home; however, instances were noted where the client could only find a suitable space outside, and both client and therapist reported these rescripts going smoothly. There was one instance reported where a client did not disclose that their partner was also in the room during ImRs, which highlights that there are potentially more unknowns when conducting therapy via telehealth.

A few clinicians were also concerned that the traumatic memories would be triggered when the client re-entered the home space in which therapy was completed. Steps taken to reduce the likelihood of this being an issue included packing away all therapy-related items and leaving the room after therapy or sitting on a blanket in session that was only brought out for use in therapy. Feedback from some clients suggested that this was not a concern ("I was easily able to wind down after therapy by moving rooms and engaging in other activities"). Despite all the strategies that can be suggested to "contain" the association of traumas with the client's home, some clients chose to postpone the ImRs work until the strict lockdown measures were discontinued. One DID client refused to do telehealth ImRs because she did not want her home to become associated with trauma processing, while she was able to engage in ImRs of severe trauma memories in the clinic. In contrast, the clinician working with clients with treatment-

resistant OCD had encouraged her clients, where clinically appropriate, to try to not distract themselves from any resulting emotions that accompanied the image after session to allow for further scope for habituation and/or inhibitory learning. This opportunity was viewed by the clinician as one of the benefits of telehealth.

### Technical Considerations

Technological issues included some clients needing assistance to initially set up the telehealth software (which delayed the commencement of therapy), not having access to necessary equipment, their device not being fit for purpose (i.e. a small handheld phone where the image of the therapist was small and screen sharing of written materials, such as weekly measures, was difficult), and device batteries going flat or internet connection failing mid-rescript. Most clinicians preemptively problem-solved these issues by ensuring clients had their devices plugged into a power source and agreeing they would attempt to reconnect and continue the rescript from where they left off or continue via the phone if this were not possible. In instances where this occurred, clinicians and clients reported that the rescript was promptly recommenced and the client was still able to end the rescript feeling safe and calm; however, these clients did report a large spike in anxiety at the point when the connection cut out. For additional commentary and recommendations regarding technological considerations, see [40].

Two clinicians compared their experience of remote delivery of ImRs to other therapy modalities, including CBT (for voices) and exposure and response prevention treatment (for OCD). It was agreed that ImRs translated more seamlessly to telehealth delivery than the comparison modality, due to ImRs not requiring any movement or provision of materials within sessions (e.g. completion of homework via handouts), which telehealth can hinder.

### Therapeutic Alliance

Developing strong therapeutic alliance is critical, as it helps the client trust the process and therapist's ability to guide them through the process. Therapeutic alliance can be developed in psychotherapy over videoconference, with clients rating bond and presence at least as strongly as face-to-face settings across a range of diagnostic groups [46, 47]. However, there was a spread of client-reported experiences with regard to strength of therapeutic alliance during ImRs via telehealth. Once face-to-face therapy resumed, several clients reported the therapeutic relationship during telehealth had been "suboptimal" and "less real" (i.e. "I think I would have felt closer to you [therapist] if we had done therapy face-to-face"). Another client said they felt it may have developed more slowly ("I felt both our therapeutic connection and the strength of the imagery

was just as strong as it would have been with you in person, though perhaps the connection would have built a little faster"), and others reported strong rapport (i.e. "actually, I have not felt closer to another therapist than I have with you").

Clinicians varied with regard to the perceived strength and development of therapeutic alliance. Clinicians who felt that the relationship may have been negatively impacted by telehealth cited the reduction in direct eye contact (to make direct eye contact with the client, the therapist must stare directly into the camera, which breaks the connection for the therapist) and absence of body language as the key impediments. Other clinicians felt the alliance was just as strong, and one felt it was stronger, explaining that the clients were less activated, less concerned with how the therapist would perceive them (less shame), more at ease in their own environment, and more able to open up [46]. Clinicians agreed that alliance may be less compromised during ImRs compared to other therapy approaches, given that ImRs clients have their eyes closed and are only focusing on the sound of the therapist's voice. Clinicians reflected that they felt therapeutic alliance was less compromised if the assessment or earlier sessions had been face-to-face. Telehealth may have an advantage with regard to therapeutic rapport if the client and therapist are required to wear face masks in face-to-face sessions due to COVID-19 regulations.

### Depth of Emotional Processing

For ImRs to be effective, the client must be able to visualize and emotionally connect to the image/memory. Thus, it is essential that this process is not diminished when ImRs is delivered via telehealth. Several clients who chose to proceed with ImRs via telehealth reported that they were able to emotionally engage well with the image ("the imagining of the memory and the fantasy ending were very strong, as though I was actually there"), including those who had previously experienced ImRs via face-to-face ("I was surprised that the image was just as powerful and emotional for me when we did the rescript at home as when we did it together [in face-to-face therapy]"). Another client said "I liked doing it this way [telehealth] – If I don't have to worry about seeing other people afterwards, I feel like I can just 'really go for it' and not have to worry". Others reported difficulties with imagery work because they did not feel safe enough to fully engage.

### Dissociation

Dissociation encompasses a range of experiences regarded as psychological reactions to trauma or extreme stress, leading the individual to emotionally and/or mentally detach from events that are experienced as too distressing to endure or process [48]. Clients are prone to dissociate during ImRs because they revisit these traumatic memories and



accompanying fear (though less likely than in many other trauma-focused therapies given that the rescript does not necessitate the prolonged reliving of the emotionally “hot” part of the trauma). Clinicians commented that some strategies to stop dissociation used in face-to-face therapy could not be used or were more difficult in telehealth, such as having the therapist and client hold one end of a scarf, which the therapist can tug if they suspect the client is starting to dissociate to help bring them back to the rescript. One clinician used this virtually with some success by asking the client to hold one end of a scarf and the clinician clapped (instead of tugged) when needed. There was one dissociation incident reported where a clinician reported that being face-to-face would likely have been beneficial: “In a very severe dissociative patient (with DID), I needed her partner to get her out of a dissociation episode during a telehealth ImRs session. After this the partner needed to be present in subsequent sessions to help manage dissociation. This increased her shame and unwillingness to engage in ImRs and we could not find a solution so stopped ImRs until we were able to resume face-to-face ImRs, which had good outcomes for this client.” Overall, however, clinicians reported that they were able to develop and implement a plan on how to reduce and manage dissociation if it did occur during a rescript.

One clinician was able to compare a small sample of clients (trauma-affected voice hearers) who completed ImRs via telehealth ( $N=5$ ) versus face-to-face ( $N=7$ ), and found that there were lower incidences of dissociation reported by clients during rescripts completed via telehealth than face-to-face (telehealth:  $M=1$  (out of 7 rescripts),  $SD=0.71$ , face-to-face:  $M=2.86$  (out of 7 rescripts),  $SD=1.95$ ). This may be because these clients who completed ImRs remotely said they felt safer in their own home and reported lower levels of anxiety prior to therapy, given that heightened anxiety is a common trigger for dissociation.

## Therapy Progress and Outcomes

Most clinicians did not observe a significant difference in outcomes between clients being delivered ImRs via telehealth versus face-to-face. However, again, it needs to be noted that several clients (particularly those based in countries that were more severely impacted by COVID-19 and where high-density housing is common) did not proceed with—or stopped—their ImRs therapy, and thus, their outcomes are assumed to have been worse than face-to-face clients.

The clinician working with OCD clients noted no difference on standardized test outcome measures (Yale-Brown Obsessive Compulsive Scale, YBOCS [49]) between the two delivery mode groups. This clinician also collected two ratings from clients at the beginning and end of each ImRs session: (1) “distress caused by the aversive memory”, and (2)

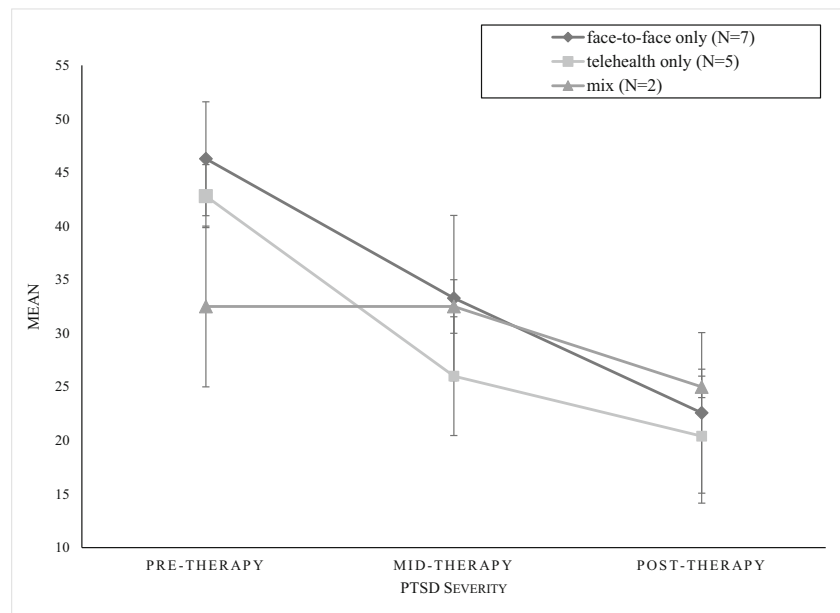
“vividness of the memory”, and found continual improvements (reductions) in both for all clients over the course of treatment regardless of delivery mode. She also reported enhanced generalizability to clients’ homes due to visual memory cues. For example, one client noted “Each time I walk into the study, it takes me back to our session. It’s like I get to re-experience the session again. It’s a good reminder for me”. Clinicians working with clients with BPD commented that their clients who had previously worked with them face-to-face benefited from ImRs via telehealth and had good outcomes on routine outcomes measures; however, there seemed to be more variability for clients who had not previously engaged with the clinician face-to-face. Even when contextual factors were fine (e.g. privacy guaranteed), some of these clients could not engage in ImRs, and detached from emotional activation. When face-to-face treatment was possible again, they mostly attributed this to not sufficiently experiencing the presence and support of the therapist.

The clinician working with trauma-affected voice hearers reported no clear differences in clinical outcome for clients who were delivered ImRs via face-to-face, telehealth, or a mix of the two (the data presented here from the Perth Voices Clinic has ethics approval from Murdoch University Human Research Ethics Committee; approval number: 2016/089). As seen in Fig. 1, the pattern of change in PTSD symptoms was similar regardless of mode of therapy delivery. There were 3 dropouts (not included in the figures below), and these were all from the face-to-face group. As reported above, there were also fewer episodes of dissociation during a rescript reported in the telehealth group.

## Recommendations to Clinicians Delivering ImRs via Telehealth

When moving to telehealth delivery, flexibility with clinical protocols is needed, and adherence to our recommendations need to be exercised with caution, as there is no one-size-fits all as clients’ personal situations will differ (e.g. home environment, engagement style). Recommendations have been provided in Table 1. There may be different or additional recommendations specific to other clinical populations not treated by the current authors. For instance, Clark’s group provided clinical recommendations in the remote delivery of ImRs of socially traumatic memories [41]. They recommended that the clinician provide more empathy and encouragement during the rescript (i.e. “you are doing really well”), more verbal checks on affect, and utilize objects available at home (i.e. photos of happy social events) to facilitate the ideas and strength of a happier and safer ending.

**Fig. 1** Group means on the primary outcome of PTSD severity as measured by the Posttraumatic Diagnostic Scale for the DSM-5 (PDS-5) [50] pre-, mid-, and post-ImRs in trauma-affected voice hearers (standard error presented as error bars)



## Limitations and Future Research

The clinical considerations and recommendations raised here are based on subjective clinician’ experiences and their clients’ experiences as reported to them. We especially note the contrast of experiences reported by clinicians and their clients based in Australia versus the Netherlands, where both housing situations and the spread of COVID-19 and imposed restrictions are different. This highlights that caution regarding the generalizability of these findings needs to be exercised. More robust clinical trials, such as randomized controlled trials comparing face-to-face, telehealth, and mixed (where clients commence face-to-face and then move to telehealth after the first rescript) delivery of ImRs are required (measuring clinical outcomes, along with therapy satisfaction, rapport, core schemas, physiological responses, vividness of imagery), along with more structured ways of aggregating clinician feedback (e.g. Delphi approaches; qualitative research). However, a critical note is needed here. RCTs require informed consent of participants. This includes consenting to the possibility of being randomized to telehealth. Thus, patients who do not want this will refuse participation, as long as there is a “usual” face-to-face treatment available. This probably explains why we found a substantial number of patients not doing well with telehealth ImRs: the COVID-19 lockdown created a natural experiment that is (for ethical reasons) impossible in times without a lockdown. From this uncontrolled natural experiment, we learn that the findings of clinical trials on telehealth can only be generalized to the subgroup of patients who are willing on a voluntary basis (and able) to engage in telehealth. Another interesting observation is that some patients seem to do better with telehealth than

with face-to-face ImRs, feeling more at ease, while others reported the opposite, feeling less at ease and more disconnected to their feelings. The subgroup of patients who seems to need more “real” contact to be able to engage seems to be particularly prevalent in those with BPD and DID; whereas those who did well or even better with telehealth might be more prevalent in OCD, PTSD, and voice hearing. This probably points to fundamental differences in the need of proximity of a caring and supportive other in states of emotional distress, opening an interesting area for further research. Other possible avenues of research in this area include investigating the impact on clinical outcomes of clinicians’ and clients’ beliefs and confidence in telehealth, and the use of single camera angle (on facial expression) versus dual camera angle (one of face, one on body). Future research should also examine the experiences and outcomes in a larger range of clinical populations.

## Conclusion

This paper summarized the clinical experiences of clinicians and their clients who have experienced ImRs as delivered via telehealth with the aim to raise awareness of potential clinical considerations and provide clinical recommendations for clinicians working in this area. ImRs can be delivered well through telehealth. Some consistent themes emerged across a number of clinical populations (namely trauma-affected voice hearers, OCD, PTSD, BPD, and DID), although the real and perceived safety of doing ImRs remotely from one’s home—and thus the decision to proceed or not—depended heavily on context and client characteristics.

**Table 1** Clinical recommendations to improve outcomes and reduce shortcomings in the delivery of imagery rescripting via telehealth**1. When not to proceed****a. Compromised real or perceived safety**

A client is living with people who can overhear them or if there is a sense of real or perceived lack of safety.

**b. Client or therapist reluctance**

Clients (or therapists!) who are not agreeable to remote delivery. Preference and ownership are important components to any therapy.

**c. Technological failings**

Telehealth via telephone (audio-only) may be a suitable delivery mode for low-risk clients, especially if they have done ImRs face-to-face with the therapist previously. However, before proceeding, it is strongly recommended that videoconferencing facilities be set up with a strong Internet connection and a device with a camera.

**2. Assessment****a. Building rapport**

It is recommended that, where possible, the assessment session be completed face-to-face before transitioning to telehealth. When engaging via telehealth, sit more than 1 m from the camera to reduce eye gaze angle [51]. Consider having the client set up two cameras simultaneously, one capturing their face and the other capturing their full body, to ensure both facial expressions and body language are seen by therapist. The therapist may need to verbally validate facial, social, and emotional cues more often to assist rapport building to compensate for body language cues being absent.

**b. Assessing conditions (i.e. comorbid disorders) that may impede progress**

Undertake a thorough psychological assessment to identify any comorbid disorders/issues that might make telehealth more difficult and problem-solve if electing to proceed with telehealth. For example, a comorbid attentional disorder might make it harder for the client to sustain focus during ImRs via telehealth. Here it would be worth taking extra time to discuss ways to reduce competing distractors and strategies to hold attention (i.e. holding a stimulating object such as a fidget cube).

**b. Assessing real and perceived safety**

Ensure the client is able to conduct the telehealth sessions in a space that is safe, private, and comfortable. Ensure that no one can overhear the session, and if they may be able to, that this would not be an issue. If they are in a small, shared space, recommend they use headphones and play music in the space others are residing to drown out the client's voice. Suggest they put a "do not disturb" sign up during session if they are not home alone. At the start of each session, again, check in with client on their privacy.

**c. Discussing pros and cons of telehealth**

It is advised to discuss the pros and cons (raised in the *Clinical Considerations* section) of delivering ImRs via telehealth so that the client can make an informed decision. We also encourage clinicians to identify their own beliefs about the use of telehealth and to examine evidence for and against any negative beliefs during telehealth (like a behavioural experiment!).

**3. Adaptations to ImRs protocols****a. Preparing the therapeutic space**

Once safety has been established, discuss with the client the space they will use for therapy. Request the client to notify others in the house not to disturb them during session. Ensure the client has comforting and grounding items available to hold during rescripts, and also that all distractors are put away. To help the client separate their therapy session from the rest of their day, have them pack up all therapy-related items (i.e. close laptop, put away grounding object) after the session and then do an activity in another room or outside. You can also suggest they sit on a blanket that is only used during therapy and packed away afterwards.

**b. Navigating technological issues**

Ensure both client and clinician have a strong Internet connection, a suitable device that is plugged into a charger to avoid a power failure mid-rescript, all other notifications are disabled, and any necessary software has been installed to conduct the telehealth session. Problem-solve with the client what you will do if the Internet connection fails or battery fails mid-rescript (i.e. try to refresh once, and if this fails, therapist should call the client and finish the rescript via the phone). Ensure the client is not holding the device (the client's body needs to be able to relax in the final rescript phase) and that the therapist can see the client's face and upper body and vice versa. Where possible, the clinician and client should use a device with a large screen (i.e. desktop computer) to allow for more detailed facial expressions, which will likely assist with monitoring the progress of the rescript as well as rapport development. The client and clinician should ideally not be able to see themselves, so are advised to close or reduce the screen displaying their own face. Post-it notes can be placed over images if required. If the clinician needs to wear headphones, try to use high-quality earbuds, as these appear less obvious to clients and more akin to face-to-face sessions.

**c. Developing a safety plan**

Ensure you have discussed with the client how they will unwind after session. Recommend that they do not plan any emotionally taxing events for later that day, and that they know which social supports they can enlist and soothing or distracting activities they can engage in if emotions are heightened after session. For clients prone to dissociation, it is important to prepare with the client ahead of time how you will reduce this risk and respond to it if they do dissociate (see section below and [52•]).

**d. Looking after yourself (clinician)**

Mental fatigue is increased when seeing clients back-to-back via telehealth. It is important that the clinician is monitoring the effects of this on their own wellbeing and taking steps to manage this, such as taking breaks and engaging in self-care activities (see [45] for more tips).

**4. Managing intense emotions during ImRs****a. Monitoring emotions**

In the absence of body language, the clinician will need to ask how the client is feeling more frequently before, during and after the rescript to help guide clinical decisions (i.e. if they require slow breathing or grounding beforehand, the pace to set during the rescript, what their next need is, and how to best help them sooth and ground at the end of and after the rescript).

**b. Reducing and responding to dissociation**

Discuss ahead of time what you will do to prevent dissociation (e.g. slow breathing beforehand, hold a grounding object, enter the image or start the rescript earlier, discuss the first few steps of the rescript beforehand, move faster through the initial phase of the rescript) and what the therapist will do



**Table 1** (continued)

during the rescript if they suspect the client has started to dissociate (e.g. verbally reassure the client they are safe and do not need to dissociate and guide their attention back to the image or to their grounding object). If a client is disconnecting from their emotions, try using an emotional bridge prior to commencing the rescript, move more slowly in the initial phase of the rescript, and ask them more questions about how they feel and where they feel it in their body. See [52•] for more clinical recommendations around managing dissociation during ImRs.

### c. Managing emotions after session

Discuss what the client plans to do after the session to help switch between the session and the next part of the day (e.g. pack away the laptop, splash face with cold water, do an activity in another room or outside). The client may not want to do this immediately, however, to allow them time to reflect on and process the session. Clients who have other people home during the rescript may need to communicate ahead of time with their family members/housemates what their needs will likely be post-rescript (e.g. some clients value having their family members support and company after session, while others need time to themselves).

## 5. Monitor the impact of ImRs

### a. Checking in

Regularly check in with the client about how they are finding telehealth. This may also serve to reassure the therapist and provide evidence against some of their negative expectations. Administer outcome evaluations measures as usual, although these may need to be completed via an online questionnaire program.

While the clinical considerations and outcomes discussed here were described with specific reference to ImRs, some may generalize to other trauma-focused therapies delivered using telehealth. Studies of other trauma-focused therapies (predominantly cognitive behavioural therapy-oriented), delivered via telehealth, have largely found that clients report high levels of satisfaction, therapeutic rapport, and PTSD symptom improvement, which is in most part consistent with our findings [35–39]. However, several of the clinical considerations raised in our paper (and the diversity of client experiences within these) are likely somewhat specific to pandemic times. For instance, client and clinician stress are likely increased; telehealth may be the only viable option (rather than this being elected); and during lockdowns, clients living with others may find it difficult to find confidential space to conduct the telehealth session. These factors likely led to an increase in the number of clients who elected not to proceed with telehealth. It was noted however that clients with DID (and to a lesser extent, BPD) were less open to proceeding with ImRs via telehealth regardless of their individual circumstances, and thus less likely to be pandemic-specific. It would be informative for future research to identify factors that influence engagement and outcomes with telehealth across clinical problems, with alternative trauma-focused treatments, and both during and outside of pandemic restrictions.

The case series data and commentary on clinical progress and outcomes show preliminary support that the delivery of imagery rescripting via telehealth is no less effective than face-to-face delivery among those who volunteer for a telehealth option. This paper is particularly timely, with the need for remote delivery of psychological therapy in high demand in times of COVID-19 lockdowns.

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**Availability of Data and Material (Data Transparency)** Service evaluation data from the Perth Voices Clinic will be available for five years.

**Code Availability (Software Application or Custom Code)** Not applicable.

## Compliance with Ethical Standards

**Conflict of Interest** Arnoud Arntz, Annemieke Koppeschaar, and Georgie Paulik give workshops/trainings in imagery rescripting, with fees going to the University of Amsterdam to support research, as part of salary, and for private fee (respectively).

**Ethics Approval (Include Appropriate Approvals or Waivers)** The only data presented here needing ethics approval was from the Perth Voices Clinic which has approval from Murdoch University Human Research Ethics Committee (approval number: 2016/089), where clients gave consent for their outcome measures to be published for service evaluation purposes.

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