



We cannot change the past, but we can change its meaning. A randomized controlled trial on the effects of self-help imagery rescripting on depression

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ABSTRACT

Background: Imagery rescripting is a psychotherapeutic technique that aims to ameliorate negative emotions by altering (i.e., rescripting) inner representations of negative memories and images. Although the treatment was initially developed for traumatized individuals, face-to-face interventions have yielded promising results for patients with other diagnoses as well. The present study explored the feasibility and efficacy of the approach when used as a self-help intervention for depression.

Method: A total of 127 individuals with diagnosed depression were randomly allocated to either a wait-list control condition or received a brief or long version of a manual teaching imagery rescripting. Six weeks after inclusion, patients were invited to participate in the post assessment. The Beck Depression Inventory (BDI-II) served as the primary outcome (registered at ClinicalTrials.gov (NCT03299127)).

Results: The long version was superior to the wait-list control condition on the BDI-II, self-esteem, and quality of life at a medium effect size. No effects emerged for anxiety. No significant between-group differences were found for the brief version. Moderation analyses indicated that the self-help approach seems particularly beneficial for those scoring high on symptoms, willingness to change, and expectancy (baseline). Most patients indicated they would use the technique in the future.

Discussion: The efficacy of imagery rescripting was confirmed when applied via self-help. Use of the long form of the manual is recommended. Future studies are needed to ascertain whether treatment effects are sustained over time.

“What matters in life is not what happens to you but what you remember and how you remember it.”

Gabriel García Márquez, 2002

1. Introduction

In the 1991 science fiction movie *Terminator II*, a friendly robot, played by Arnold Schwarzenegger, is sent by John Connor, the leader of the survivors of an epic battle between robots and humans, on a time-traveling mission to defend his teenage alter ego, whose life has been just threatened by another robot. Numerous other movies (e.g., *Back to the Future*, *The Butterfly Effect*) and books (*A Yankee in King Arthur's Court* by Mark Twain or *11/22/63* by Stephen King) with similar plots have been published before and since that express the human desire to

change the past for the sake of a better future.

Psychotherapists may help their patients to reinterpret past events that trouble them and to attenuate the impact of haunting memories. However, they cannot eradicate or alter the past. A technique developed by Smucker (Smucker, Dancu, Foa, & Niederee, 1995), called imagery rescripting (IR), is certainly no exception. This approach aims to edit negative memories via imagination and lead them to a “happy ending” by various techniques reminiscent of the introductory example (e.g., sending one's adult ego into the past in order to comfort or defend oneself as a child). Although the original negative memory is presumed to remain, its rival rescripted representation is hoped to weaken the influence of the traumatic memory. Positive mental imagery strategies are superior to mere verbalization (Holmes, Mathews, Dagleish, & Mackintosh, 2006) and may hold negative mental images in check and impart to the patient a feeling of self-efficacy, thereby decreasing

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helplessness and despair. A rather consistent body of evidence suggests that the technique ameliorates symptoms in patients with PTSD (Arntz, Sofi, & van Breukelen, 2013; Long et al., 2011; Raabe, Ehring, Marquenie, Olff, & Kindt, 2015; Smucker & Niederee, 1995) and other anxiety disorders, particularly those with a specific phobia (Hunt & Fenton, 2007) and social anxiety (Lee & Kwon, 2013; Nilsson, Lundh, & Viborg, 2012; Wild & Clark, 2011). More recently, its scope has been extended (Holmes, Arntz, & Smucker, 2007; Stopa, 2011) to depression (Brewin et al., 2009; Rahnema, Tarkhan, & Khalatbari, 2013; Wheatley & Hackmann, 2011), personality disorders (Arntz, 2011), and body dysmorphic disorders (Ritter & Stangier, 2016). Although the technique does not seem advisable in patients with psychosis, who may further lose contact with reality, there is initial evidence that IR may work even for this group (Ison, Medoro, Keen, & Kuipers, 2014). A new meta-analysis shows that IR yields large effects on anxiety and depressive symptoms across a range of disorders (Morina, Lancee, & Arntz, 2017).

Imagery has been predominantly used to reduce the distress and lack of control elicited by negative memories, but may also be adopted to change negative images of future events. Instead of ruminating about catastrophes, the patient is encouraged to contemplate positive outcomes of prospective events (Blackwell et al., 2013; Holmes et al., 2006; Ji, Holmes, & Blackwell, 2017; Morina, Deeproose, Pusowski, Schmid, & Holmes, 2011; Murphy et al., 2015).

The technique builds upon the fact that human memories are often vivid and perceptual. Studies show that the negative thoughts (e.g., intrusions, obsessions, ruminations) of patients with depression, obsessive-compulsive disorder (OCD), and other disorders are often accompanied by very vivid images and sounds that increase the impact of the patients' thoughts and negatively affect their well-being and behavior (Holmes, Blackwell, Burnett Heyes, Renner, & Raes, 2016; Moritz, Hörmann, et al., 2014; Moritz, Claussen, Hauschildt, & Kellner, 2014; Röhlinger, Wulf, Fieker, & Moritz, 2015).

For example, in one study, we found that patients with OCD suffering from vivid obsessions show lower insight (Moritz, Claussen, et al., 2014), and in a recent study the severity of sensory-laden obsessions predicted less control over compulsions (Röhlinger et al., 2015). IR seems to turn a vulnerability into a virtue by using imagination to create a positive representation of the past, present, and future (Holmes, James, Blackwell, & Hales, 2011). Again, the technique is not intended to change the memory itself – only its representation in consciousness and its impact on well-being.

To the best of our knowledge, IR has never been tested as a self-help intervention. For the present study, we recruited a large sample of patients with depression and randomly allocated them to either an IR group or a wait-list control group. The IR group consisted of two subgroups that received a long or a brief manual (the brief version had similar content but in less detail) teaching them how to practice IR. While we expected that the intervention group would have a better outcome than the wait-list control group, we had no directed hypotheses related to which subgroup (long vs. brief manual) would yield a better result.²

As patients with depression often have cognitive deficits, especially a short attention span (Lee, Hermens, Porter, & Redoblado-Hodge, 2012; Rock, Roiser, Riedel, & Blackwell, 2014), one might expect that the abbreviated version of the manual would be more beneficial. Indeed, a review and meta-analysis of computer-based psychological treatments for depression found that shorter interventions (here defined as fewer sessions) yielded better effects (Richards & Richardson, 2012). Yet, some studies have shown that longer versions are superior to shorter versions, even shorter versions that are tailored to patients'

needs and demands (Moritz et al., 2016). In another meta-analysis, within-group effects were significantly larger for shorter interventions than for longer interventions, but the reverse picture emerged for between-group effects (Păsărelu, Andersson, Bergman Nordgren, & Dobrea, 2017). The interventions may have differed on unmeasured key variables (e.g., content, how the interventions were deployed), so it is unclear whether the differences were due to the length of the intervention alone (see also Richards & Richardson, 2012). Finally, we also wanted to elucidate the subjective acceptance and effectiveness of the manual and determine which baseline variables moderate the results.

2. Methods

2.1. Recruitment

The study was conducted at the Department of Psychiatry and Psychotherapy of University Medical Center Hamburg-Eppendorf (Germany). We invited via email a total of $N = 920$ patients who had been seen for diagnostic purposes at the Medical Treatment Center Falkenried (Germany) to participate in an online study (recruitment: January to April 2017). All participants had provided explicit informed consent to be recontacted for future research. All patients had been diagnosed at the facility according to the ICD-10 and fulfilled the criteria for a mild, moderate, or severe unipolar major depressive disorder. We included patients with primary or secondary diagnoses of depression. A prior diagnosis of schizophrenia represented an exclusion criterion.

Participation in an anonymous (internet-based) assessment at baseline and six weeks later was mandatory. A weblink directed potential participants to the baseline assessment, which was implemented with EFS Survey* (www.unipark.info). Multiple logins from the same computer were prevented by means of “cookies”. Participants were instructed on how to create anonymous email accounts at no cost. Participants were automatically excluded during the baseline (pre) assessment if they affirmed acute suicidal thoughts; high scores (a score of 2 or 3) on the BDI-II suicidality item led to immediate exclusion by means of a “trap door” in the survey that cancelled the assessment by informing participants of the reason for their exclusion and how they could get help (i.e., telephone numbers and addresses of specific organizations were provided). One hundred fifty-seven people accessed the first page of our online survey. Of these, 25 patients started but did not complete the baseline assessment. Two participants were excluded during the baseline assessment due to acute suicidality. Three other participants were excluded after completion of the survey because of age > 70 or stereotype responses (the same score was entered throughout), leaving $n = 127$ for randomization (intention-to-treat-sample). The study's flow chart is presented in Fig. 3.

The study was approved by the local ethics committee of the Medical School Hamburg (Germany) and was registered at ClinicalTrials.gov (NCT03299127). In the invitation email, participants were informed about the procedures as well as the inclusion and exclusion criteria (the inclusion criteria were a prior diagnosis of depression, age between 18 and 70 years, and no suicidality). Participants were promised free access to the self-help application, either immediately or after a six-week delay. When the study was completed, all participants received a manual with mindfulness-based exercises along with the long version of the manual.

On the first page of the baseline internet survey, the rationale of the study was repeated. We then asked for the electronic informed consent (mandatory). After that, the baseline survey asked for demographic information (e.g., age, gender, education) and medical history details (e.g., previous and current treatments, medications, diagnoses). The assessment proceeded with a number of questionnaires tapping depression (e.g., Beck Depression Inventory-II, which was the primary outcome; PHQ-9), quality of life (World Health Organization Quality of Life global item), self-esteem (Rosenberg Self-Esteem Scale), and

² In this context, one needs to distinguish between similar interventions that differ in length but not in active elements (e.g., in our case, the long manual was simply more detailed and repetitive than the brief manual) and those that also differ in content (e.g., a treatment is augmented by additional sessions that teach new techniques).

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