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Imagery Rescripting as stand-alone treatment for posttraumatic stress disorder related to childhood abuse

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ABSTRACT

Objective: This case series tested the feasibility and explored the efficacy of Imagery Rescripting (ImRs) as a stand-alone treatment for PTSD related to childhood physical and/or sexual abuse (CA).
Method: Participants (6 women and 2 men) were patients with PTSD related to CA who entered an 8 week treatment program with 16 twice-weekly ImRs sessions. Blind assessments took place at pre- and post-treatment and at 3 month follow-up.
Results: Participants showed improvement in both self-reported and clinician-rated PTSD symptoms. Gains were maintained at 3-month follow-up. At post-treatment, 50% of participants no longer met criteria for PTSD, and this number increased to 75% at 3 month follow-up.
Limitations: The main limitation is the small sample size and the selective nature of the sample, which limits the generalizability of the findings.
Conclusions: This pilot study suggests that Imagery Rescripting as stand-alone treatment is feasible and effective without prior stabilization in an outpatient population with CA-related PTSD. Further replication is needed in form of a randomized controlled trial.

1. Introduction

Exposure to childhood sexual and/or physical abuse (CA) is strongly associated with the occurrence of mental disorders throughout the course of life (Gilbert et al., 2009). Adults with a past of CA are three times more likely to have contact with mental health services than the general population. The highest odds ratios (OR) for DSM-IV Axis I and Axis II disorders are found for post-traumatic stress disorder (PTSD; OR = 5.56), alcohol abuse (OR = 5.88), drug abuse (OR = 5.94) and borderline personality disorder (OR = 6.07) (Cutajar et al., 2010). This shows that CA-related trauma often results in complex presentations of severe psychopathology.

Trauma-focused cognitive-behavioral therapies, particularly those including prolonged exposure (PE), have been shown to be successful in the treatment of PTSD (Bisson et al., 2007; Powers, Halpern, Ferenschak, Gillihan, & Foa, 2010). While these treatments have been extensively studied among samples with PTSD following single trauma in adulthood, empirical evidence for the applicability and efficacy of these treatments in a population with CA-related PTSD is lagging behind (Cloitre, 2009). In addition, despite endorsement by professional guidelines, clinicians are often hesitant to use exposure therapy in this population due to concerns of alleged problems patients may have in managing emotions arising from trauma processing and subsequent adverse effects of PE (van Minnen, Harned, Zoellner, & Mills, 2012; van Minnen, Hendriks, & Olff, 2010). Some clinicians are more inclined to use stabilizing treatments (e.g. Dorrepaal et al., 2013), while the debate on the efficacy of such interventions is ongoing (de Jongh & Ten Broeke, 2014).

Until now, it remains unknown whether the concerns about how well patients with PTSD due to CA tolerate exposure-based interventions are justified. To our knowledge, there are only two published studies, in which PE was systematically tested in samples with CA-related PTSD (Cloitre et al., 2010; McDonagh et al., 2005). In both studies intent-to treat analyses showed effect sizes for PE that are comparable to the effect sizes reported for single- and mixed-

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trauma samples (Bradley, Greene, Russ, Dutra, & Westen, 2005). On the other hand, in both studies PE appeared to be associated with significantly higher dropout-rates (39% resp. 41%) in comparison with active control conditions (ranging from 9% to 26%; Cloitre et al., 2010; McDonagh et al., 2005). This indicates that PE may be too aversive for a considerable proportion of patients with CA-related PTSD. Two factors are proposed to cause the high dropout rates. First, direct comparisons between survivors of chronic childhood interpersonal trauma vs. those of adult-onset trauma revealed that the former group has a higher probability to experience problems in the domains of affect modulation, anger management, self-concept, and interpersonal functioning (Cloitre, Garvert, Brewin, Bryant, & Maercker, 2013). This might indicate that a considerable proportion of patients with childhood abuse-related PTSD are lacking skills to effectively handle the emotions that are triggered by PE sessions. Second, some authors criticize that PE limits itself to the extinction of fear, and does not cover other emotions and cognitions often associated with CA-related PTSD, such as anger, irrational guilt, shame, disgust and self-contempt (Grunert, Weis, Smucker, & Christianson, 2007; Jung & Steil, 2013). Indeed, there is preliminary evidence that PE is less effective in changing trauma-related emotions of anger (Foa, Riggs, Massie, & Yarczower, 1995), guilt and shame (Arntz, Tiesema, & Kindt, 2007; Grunert et al., 2007).

Because of these shortcomings, there have been calls for the adaptation of the existing treatment protocols for patients with CA-related PTSD. One option that has been put forward is a phase-based approach starting with a phase in which emotion-regulation and interpersonal difficulties are targeted prior to the application of PE in order to enhance skills to more effectively handle trauma treatment. (e.g. Cloitre, Cohen, & Koenen, 2006). Another approach is to modify existing trauma-focused components in such a way that they not only reduce fear responses but also deal with trauma-related cognitions and schemas. Recently, the use of Imagery Rescripting (ImRs) has attracted growing attention as a technique that targets the meanings and schemas resulting from traumatic childhood memories (Arntz, 2012). In ImRs, the patient imagines the (onset of a) traumatic experience and subsequently changes the original course of events by imagining different interventions and outcomes, thereby allowing for the change of original schematic representations and cognitions (Arntz, 2012; Hackmann, 2011). Smucker and colleagues were the first to develop a systematic approach to the use of ImRs with survivors of CA-related PTSD (Smucker & Dancu, 1999; Smucker & Niederee, 1995). In their protocol, ImRs was applied as an add-on to standard PE, based on the assumption that it would be ineffective to avoid exposure to the complete trauma memory. Until now, this protocol has not systematically been tested in a population with CA-related PTSD, but ImRs has been shown to improve standard exposure therapy (Arntz et al., 2007; Jung & Steil, 2013; Steil, Jung, & Stangier, 2011), and also to be effective in a sample with previous treatment failures (Grunert, Smucker, Weis, & Rusch, 2003). In addition, ImRs has been found to be effective in targeting intrusive images and memories within other disorders, such as social phobia (Wild, Hackmann, & Clark, 2007; Wild, Hackmann, & Clark, 2008), specific phobia (Hunt & Fenton, 2007), and depression (Brewin et al., 2009; Wheatly et al., 2007).

Arntz and Weertman (1999) adapted the Smucker protocol for the treatment of traumatic childhood memories, using a three-phase ImRs-procedure. This procedure differs from the Smucker protocol in two ways. First, reliving of the memory is only used up to the moment when the patient realizes that something terrible is going to happen; from that point on, rescripting commences. In that way, patients do not have to remember all the horrid details of the trauma and the accompanying feelings of helplessness, shame and guilt. Second, in the third phase the new course of events is viewed from the child's perspective, rather than the adult's, eliciting different emotions stemming from the developmental level at which the trauma occurred. A recent case series has shown a good effectiveness of ImRs for refugees with war-related PTSD (Arntz, Sofi, & van Breukelen, 2013). ImRs has also been found to be effective in the treatment of borderline personality disorder (Weertman & Arntz, 2007). However, ImRs has not been investigated in a population with CA-related PTSD, yet.

The aim of this pilot study is to investigate the feasibility and explore the efficacy of the treatment protocol as described by Arntz and Weertman (1999) for patients with CA-related PTSD. To achieve this we conducted a cases series in an outpatient setting.

2. Method

2.1. Sample and procedure

Participants were outpatients of two mental health institutions in Amsterdam (the Netherlands) with a primary diagnosis of PTSD according to the DSM-IV, whereby the disorder had to be related to a history of childhood sexual and/or childhood physical abuse before the age of 15. Childhood sexual abuse was defined as repeated episodes of sexual contact, initiated by a caregiver or figure of authority, starting under the age of 15. The perpetrator had to have been at least 5 years older than the participant, unless the participant experienced the sexual contact as against his/her will. Childhood physical abuse was defined as repeated actions of a person in charge of the participant who intentionally hit, choked, punched or cut the participant, leaving bruises, broken bones or bleeding wounds, also before the age of 15.

Exclusion criteria were psychotic symptoms in the present or past, substance dependence not in full remission for at least 6 months, significant cognitive impairment, psychotic of bipolar disorder, use of benzodiazepines, high risk of life-threatening self-harm or suicide in the previous 6 months, current assaults and threats causing current physical or emotional harm, unstable living circumstances that prevent meeting daily needs (e.g. having no shelter), a full diagnosis of antisocial personality disorder, and having received trauma-focused therapy within 6 months prior to entering the study. Candidates who received antidepressant medication were allowed to maintain treatment as long as the dosage was stable for at least 6 weeks.

All participants provided informed consent, using forms approved by the ethics board of the University of Amsterdam.

During a 24-month time period, 46 patients were scheduled for an initial evaluation of eligibility (13 men, 32 women). Seven patients canceled or did not show up for their assessments, and 39 patients completed the initial assessment. After completion of the assessment, 12 patients were excluded. Reasons for exclusion were not meeting criteria for full PTSD ($n = 10$), presence of a psychotic disorder ($n = 1$), and acute suicidal risk ($n = 1$). Of the 27 patients found eligible for treatment, three withdrew from participation before the first treatment session. One participant did not show up for the first session and did not respond to rescheduling attempts, one could not meet the time-schedule requirements and one participant declined treatment because of a misunderstanding at the reception desk of the treatment facility.

Of the 20 participants who were found eligible for treatment, 10 were assigned to receive ImRs (three men, seven women). (The remaining 10 participants received another treatment that was conducted within the same institution during the same period of time. Allocation to one of the two case studies was non-randomized and depended on the availability of a suitable therapist.)

Of the 10 participants receiving ImRs, two participants (1 woman, 1 man) dropped out of treatment after two and five