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CASE STUDY

The application of imagery rescripting to intrusive autobiographical memories in depression

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Abstract

Intrusive autobiographical memories are a prominent feature of depression implicated in the onset and course of the disorder. Current cognitive behavioural treatment of depression does not specify techniques to address intrusive memories. Imagery rescripting has been demonstrated to be effective in the treatment of trauma-related intrusive memories. This paper illustrates the application of imagery rescripting as a stand-alone treatment for two patients experiencing a current major depressive episode. The two cases are described in detail and follow-up data are reported. Both patients experienced clinically significant and reliable change in their depression scores and no longer met criteria for a current major depressive episode at post-assessment, with gains maintained at 3-month follow-up. Implications are discussed for the theoretical mechanisms of change of this intervention as well as methods to overcome common treatment obstacles that arise in depression.

Key learning aims

(1) To learn how intrusive autobiographical memories are implicated in the onset and maintenance of depression.
(2) To learn the limitations that may present clinically when applying verbal-linguistic techniques such as cognitive restructuring to intrusive memories.
(3) To learn when imagery rescripting may be required to treat intrusive memories and how to implement this technique to overcome traditional treatment obstacles in depression.

Keywords: depression; intrusive memory; imagery rescripting

Introduction

Intrusive memories, otherwise known as intrusions, are a common feature of depression (Patel *et al.*, 2007). The events featuring in intrusive memories are often self-defining moments which precipitated the onset of depression symptoms (Patel *et al.*, 2007). The experience of intrusive memories triggers a range of distressing emotions, unhelpful cognitions and maladaptive behavioural responses which are perpetual depression symptoms (Williams and Moulds, 2007). The prominent role of intrusions in the onset and course of depression suggests that they also represent an ideal therapeutic target in the disorder.

Intrusive memories are targeted in post-traumatic stress disorder (PTSD) through imagery based techniques such as imaginal exposure or imagery rescripting (Clark and Mackay, 2015). Treatment of intrusions via imagery rescripting has gained momentum in recent years, due to

findings that this technique has the capacity to modify non-fear-related emotions such as shame, guilt or anger (Dibbets and Arntz, 2016). Additionally, imagery rescripting has been found to have significantly greater therapist and patient acceptability in comparison with imaginal exposure (Arntz *et al.*, 2007).

In contrast, imagery approaches are not currently recommended in depression, as traditional techniques of cognitive restructuring and behavioural modification are more commonly used (National Institute for Health and Care Excellence, 2022). Yet evidence suggests that as intrusive memories are encoded perceptually, effective treatment of these memories will require their activation in sensory form (Foa and Kozak, 1986). Therefore some cognitive behavioural therapy (CBT) techniques, such as cognitive restructuring, may be ineffective at times in treating intrusive memories. This is due to the promotion of verbal-linguistic processing, which may have the unintended effect of blocking the sensory processing needed to access and modify emotional memories in their perceptual form.

It is proposed that imagery rescripting works through challenging cognitive-affective memory representations on both a verbal and cognitive level, as well as a sensory emotional and behavioural level (Arntz, 2012). A recent meta-analysis examining the results of 19 clinical trials of imagery rescripting on a range of mental disorders related to aversive memories including PTSD by Morina *et al.* (2017) found that this treatment was largely effective in reducing symptoms from pre-treatment to post-treatment resulting in large effect sizes, and was also effective in reducing co-morbid depression, aversive imagery, and encapsulated beliefs.

While the results for imagery rescripting PTSD are promising, evidence for the efficacy of this technique for intrusive memories in depression is limited. Moreover, intrusions in depression differ in key features to those in PTSD, namely their content and conditions of encoding (Krans *et al.*, 2016). The preliminary effectiveness of imagery rescripting in depression has been demonstrated via a single case series (Brewin *et al.*, 2009), with online self-help imagery as well as when applied as an adjunct to CBT (Moritz *et al.*, 2018; Yamada *et al.*, 2018). Therefore, there is a need to extend these findings to explore the modification and application of imagery based techniques to treat the unique intrusive memories found in depression.

In this article, the treatment of depression using imagery rescripting as a stand-alone treatment will be illustrated using two case examples. These cases were derived from a single case series of imagery rescripting on 15 patients with major depressive disorder (MDD), which is described in an adjunctive paper and provides a quantitative overview of symptom outcomes. The present focus on two cases provides greater opportunity to describe the application of the intervention in the context of particular client presentations. Of particular interest was whether the distinct content and features of intrusive memories found in depression would be amenable to imagery rescripting. Furthermore, we were interested in patients' experience of this treatment, and the impact on their depressive symptoms.

Method

The two cases discussed were patients who completed a trial of imagery rescripting for MDD. The trial was registered on the Australian and New Zealand Clinical Trials Registry (ACTRN12619001713189). The full trial methodology is described elsewhere (article available on request). Both patients were assessed using the Diagnostic Interview for Anxiety, Mood, and OCD and Related Neuropsychiatric Disorders (DIAMOND; Tolin *et al.*, 2018) before and after treatment, and met the *DSM-V* criteria for a current major depressive episode at pre-treatment, as well as reporting at least one distressing intrusive memory in the past week. The DIAMOND has been found to have very good to excellent inter-rater reliability with κ coefficients ranging from very good (κ=.62) to excellent (κ=1.00) for all subscales, and very

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Table 1. Demographics and outcome data of total sample ($N = 15$)

	Total sample	Case 1	Case 2
Age (years)	29 (6.3)	41	39
University education	10 (63%)	Y	Y
Previous mental disorder diagnosis	13 (81%)	Y	N
Sought treatment for mental health in the past	12 (75%)	Y	Y
PHQ-9 (pre-treatment)	16 (4.66)	17	14
PHQ-9 (post-treatment)	7.6 (5.30)	6	9

Total sample age and PHQ-9 score represents mean and standard deviation. Clinical cut-off score for PHQ-9 is 10.

good (κ=.62) for MDD. Additionally, test–retest coefficients have been found to range from good (κ=.59) to excellent (κ=1.00) for all subscales, and very good (κ=.72) for MDD.

We note that the two participants were not selected on the basis of any particular characteristics or outcomes and are broadly representative of the larger sample (see Table 1). They did not meet criteria for PTSD. The patient's symptoms were assessed with daily administrations of the Patient Health Questionnaire-9 (PHQ-9; Kroenke *et al.*, 2001) which patients completed on their smartphone over a baseline period of 2 weeks and throughout the 12 weeks of treatment. The PHQ-9 has been found to have good criterion validity, construct validity, external validity and internal reliability with a Cronbach's alpha of 0.89 (Kroenke *et al.*, 2001).

The treatment followed the protocol used by Boterhoven de Haan *et al.* (2017) in their trial of imagery rescripting for adults with childhood trauma-related PTSD. While the procedure of imagery rescripting followed that of Boterhoven de Haan's study, certain modifications to the intervention the therapist would provide within the rescripting phase are included in the discussion.

The rationale provided to clients is summarised below:

> It is very common to experience intrusive memories of unpleasant events from our past. If we have not been helped to deal with these experiences, we can take unhelpful meanings from these memories, which can have a powerful impact on how we perceive ourselves, others, and how we behave. We cannot change what happened or erase the memory, but we can modify the memory in imagery rescripting which can help you to develop a different view on what happened and experience that so that the meaning of what happened changes and the painful feelings reduce. This technique will also help you to feel safer in emotions and express the feelings, needs and actions that you may have had to suppress at the time. It will also help you to experience that the needs you had at the time of the event are met, and although this is in fantasy, the brain responds to this as a healing experience. This treatment may trigger all kinds of feelings and new insights, and this is a natural part of the recovery process.

In the current study, the patient and therapist then collaboratively created a list of distressing experiences or themes, and used these memories as the basis for a formulation of the patient's depression symptoms. In subsequent sessions, patients would select a memory theme and were guided by the therapist to find a concrete memory, which they then vividly imagined and described in the present tense. The patient was then asked to rate their feelings and thoughts in the image on a scale of 0–100. They were also asked to describe what they needed to change in the image in order to feel better. In sessions 2–6, the therapist would then enter and intervene in the image to meet the needs of the patient. Affect, belief and needs were then re-rated, and the intervention continued until the patient stated that their past self was OK, and the ratings significantly reduced.

In sessions 7–12, the patient was directed to enter the image as their adult self and provide the intervention to their past self. An additional phase was then added in which the patient would

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re-experience the intervention as their child self, asking their adult self for any further needs that arose in the image. This would continue until the belief and affect ratings significantly reduced, and the patient reported that they were satisfied with the new image, and there was nothing else they needed in the image in order to feel better. Additionally, patients at this stage could choose to use future pattern breaking imagery whereby they would imagine a future event in which they may be likely to engage in old coping behaviours. They would then imagine their adult self entering the image and engaging in a new adaptive form of coping. Afterwards, each rescript would be evaluated and the patient would be provided with feedback on the activity and application of the intervention towards current functioning and symptoms.

Case 1 formulation

'Linda', aged 46, had a history of recurrent depressive episodes throughout her adult life. At the beginning of treatment, she reported daily intrusive memories of mistakes and failures in her life, triggered by minor mishaps that would occur throughout the day. This would trigger rumination about her defectiveness as a person, accompanied by intense feelings of shame. Linda would in turn cope with these feelings through self-sacrificing in her relationships, and overworking in a range of domains in her life. Unfortunately, these behaviours served to reinforce her feelings of defectiveness in the long term as she would inevitably feel taken advantage of by others and fail to meet her own unrelenting standards.

Linda met full criteria for a current major depressive episode, with over 10 previous episodes, and did not meet criteria for any other mental disorders including PTSD.

Course of therapy

Sessions 1–6 focused on accessing and rescripting intrusive memories related to past mistakes and poor decisions. In the second session, Linda identified an intrusive memory of being chastised by her father after dropping a birthday cake on the floor as a 6-year-old girl. Linda reported her appraisal of this memory was 'I am so stupid' 90%, her affect was shame and guilt 70%, and she reported a need for acceptance, approval and love from her father. During the rescripting, the therapist confronted Linda's father for chastising her, and took Linda away to console her and reassure her that her father's response was related to his own emotions, and was not her fault. The therapist also praised Linda for her positive attributes, and explained to her that everyone makes mistakes and it does not make her stupid or worthless. This intervention resulted in a drop in her affect of shame and defectiveness from 70 to 30%, and her belief that she was stupid from 90 to 30%. After the rescripting, Linda reported that her overall view on the memory had shifted, as she was able to reflect on her father's response as an adult and as a parent herself. She stated that she could now see that her father did not handle the situation well, and she had done nothing wrong in that instance.

Linda reported that following the initial rescripting session, she realised her feelings of shame had in many instances been related to experiences of criticism or emotional neglect. She also realised this was not due to anything inherently wrong or lacking in her, but rather the way she had been treated by others. The intrusive memories that Linda subsequently reported experiencing had also shifted from experiences of mistakes or failure on her behalf, to themes of emotional neglect or maltreatment. The subsequent memories which were rescripted in session consisted of being left alone in her room to cry as a child, being yelled at and criticised as a child, being ignored by her boss, and a friend not coming to her childhood party.

In the latter half of treatment (sessions 7–12), Linda reported more memories from childhood and later in life that shared similar themes of being emotionally neglected or maltreated. For example, she remembered being bullied in high school, receiving a poor performance review from work and an ex-partner having an affair. The original meaning of these memories were

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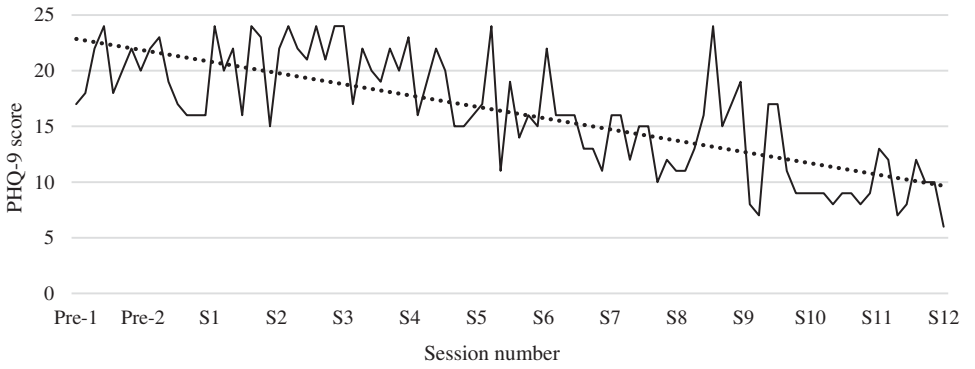

Figure 1. Linda's daily PHQ-9 scores throughout treatment. The dotted line depicts the trendline of the data.

that it was her fault, she had made a mistake, and she was not good enough. Linda was able to intervene in these images by consoling her past self, reassuring her that it is not her fault and supporting her to assertively communicate her needs or leave toxic situations where her needs are not being met. These interventions resulted in a significant reduction or elimination of feelings of defectiveness and shame, which were replaced by feelings of pride and accomplishment. Linda also reported a new-held belief that she was capable and worthy.

Outcome

Figure 1 presents the client's raw daily depression scores. Linda's PHQ-9 scores reflect an overall decrease of 10 points, reflecting clinically significant and reliable change (McMillan *et al.*, 2010). This is also reflected in Linda's clinical assessment scores at pre- and post- treatment, which revealed she no longer met criteria for a current depressive episode at post-assessment or 3-month follow-up.

Case 1 discussion

Linda engaged very well in the treatment, and reported that she had enjoyed the rescripting exercises. Furthermore, despite the therapist not specifically challenging Linda's cognitions or modifying her behaviours, spontaneous changes in both these domains were reported by Linda in the latter half of treatment. For example, Linda reported taking more time for self, asking for help from family and friends, being more vulnerable in her relationships by communicating her emotions and needs, as well as reduced perfectionistic behaviours.

Below is a quote from Linda about her experience of treatment:

> 'I am less self-critical and that has resulted in being less critical of others. I am more relaxed, and have let go of those expectations on myself. Also, I am comparing myself less to others and no longer feel the need to keep up to others' standards. I think that without this treatment, I would have coped with recent stressors much less effectively. I really believe and feel the change.'

Case 2 formulation

Sophie, aged 34 years, had experienced depression recurringly for 3–4 years. She also reported two recurring intrusive memories which she would experience multiple times per week. The first intrusive memory was from when Sophie was 3 years of age where she remembered seeing

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her parents walk out of the gate as they dropped her off for her first day at day-care. Sophie reported that this memory was accompanied by feelings of loneliness 90%, and the belief that nobody wanted her 70%. This memory would be triggered at times when Sophie felt lonely, and she would respond to the memory by pushing it away and distracting herself. Additionally, Sophie reported that she would avoid getting into relationships to prevent triggering this memory and the associated fear of abandonment.

The second intrusive memory Sophie experienced was of being told by a client at work that she had not met their expectations of her. This memory evoked feelings of shame 90% and defectiveness 80%, as well as the belief that she was not capable 90%. Sophie would cope with this memory through overworking and perfectionism in her job.

Unfortunately, Sophie's coping responses functioned to maintaining her fear of abandonment, perceived defectiveness and depressive symptoms through the lack of social reinforcement from relationships, as well as perpetual burn-out at work. Sophie met full criteria for a current major depressive episode, with four previous depressive episodes, and she did not meet criteria for any other mental disorders including PTSD.

Course of therapy

In sessions 1–6, treatment initially focused on rescripting Sophie's memory from childhood. The first time she relived this memory, Sophie found it very difficult to identify and take the perspective of her child self, as well as to identify what her needs were in the image. Additionally, Sophie reported that she felt a lot of shame in the image which was surprising to her. This was discussed in session and it was suggested that because she was so young when the memory occurred, if she had never had the experience of having her needs for attachment and emotional nurturance met, this may explain why she had trouble identifying this as a need. The therapist then rescripted the image to provide comfort and support, and explain that this is a need that all children have, and it is natural to feel lonely when it is not met. This resulted in a significant shift in affect as loneliness reduced from 90 to 20%. Additionally, the meaning of the belief shifted, as Sophie was able to see from an adult perspective that her parents did not want to leave her, but rather had to for financial reasons. The original belief that she was unwanted reduced from 70 to 20%.

In subsequent sessions, Sophie reported that she had recalled additional memories of emotional neglect from childhood. These memories consisted of being left to cry alone at 7 years of age, her mother forgetting to pick her up from primary school aged 8, and receiving a lack of praise or acknowledgement for her school report. These memories were all linked in affect to the original memory, as Sophie reported they triggered feelings of loneliness and shame, as well as the belief that she was not wanted or cared about. The therapist rescripted these memories by providing comfort, care and support, as well as reassuring that her feelings were normal and that all children have the same needs that she does. Sophie reported that she found the normalisation and psychoeducation around emotions to be very transformative for her, as she had not previously realised that it was normal to feel the way that she had as a child. She reported reduced feelings of shame both in the memories, as well as in response to emotions that she was having in her daily life.

The latter half of treatment (sessions 7–12) focused on rescripting memories related to Sophie's work and adult life. The memory of being told by her client that she had not done a good job was rescripted by Sophie herself, who provided her past self with reassurance that she was capable, and that her client's comments were inappropriate and unfounded. She also coached her past self in the image to assertively communicate her needs for support to her boss, which resulted in her being encouraged and supported in her tasks. Sophie reported her feelings of shame reduced from 90 to 10%, while her belief that she was not defective capable reduced from 90 to 30%. This rescript promoted a discussion of other occurrences in which her boss had acted in an

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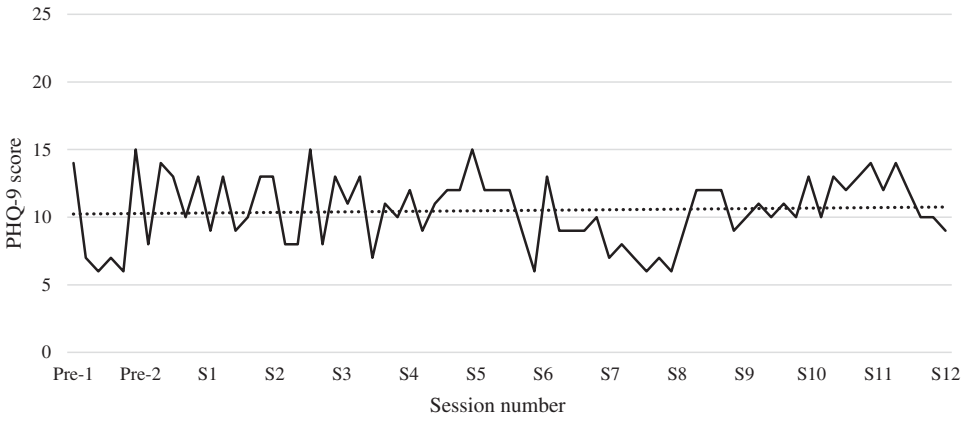

Figure 2. Sophie's daily PHQ-9 scores throughout treatment. The dotted line depicts the trendline of the data.

inappropriate way, which she reported had helped to shift her shame towards herself to criticism of her boss. Other intrusive memories subsequently emerged in later sessions which were categorised under the theme of lacking support in relationships. Sophie recalled intrusive memories of being disappointed in her 20s by an ex-partner who wouldn't listen to her, having colleagues take credit for her work, and her family not taking an interest in her life. Sophie rescripted these memories herself by reassuring her past self that her needs were valid, and encouraging her to communicate these needs to others assertively rather than taking sole responsibility.

Outcome

Figure 2 present the client's raw daily depression scores. Sophie's PHQ-9 scores reflect an overall decrease of 5 points from pre–post treatment, reflecting clinically significant and reliable change (McMillan *et al.*, 2010). This is also reflected in Sophie's clinical assessment scores at pre- and post-treatment, which revealed she no longer met criteria for a current depressive episode at post-assessment or 3-month follow-up.

Sophie's engagement in treatment progressed slowly. As previously noted, she initially found the rescripting to be difficult, which was found to be due to lack of understanding and discomfort in expressing emotions. This was observed by the therapist to improve significantly over the course of treatment, however, and by the last three sessions, Sophie engaged in the imagery in a very detailed and expressive manner.

Without specifically setting behavioural targets, Sophie reported that the actions she had taken in the imagery had translated to her current life. She reported that she was more confident in asserting herself and communicating needs in relationships. She also reported that she had reduced her self-criticism and unrelenting standards, and was taking more time out for self-care to prevent burn-out and stress at work. Additionally, she stated that she felt more connected to herself, her emotions and her needs, and that the view of herself as needy or weak for feeling emotions had drastically reduced.

Below is a quite from Sophie about her experience of treatment:

> 'I found the rescripting helpful, particularly when the therapist entered the image. Now when I have memories of the events, I remember the therapist there with me and that makes me feel less lonely'.

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Discussion

A prominent theme that can be taken from both cases is the significance of unmet interpersonal and attachment needs in childhood to the origin of both clients' depression. It has been noted that individuals with depression often report childhood experiences in which caregivers were inconsistently available (Cassidy *et al.*, 2013). Moreover, individuals with depression are more likely to display dysfunctional attachment styles in adulthood (Shaver *et al.*, 2005). Imagery rescripting is ideally suited to address these concerns, as it enables individuals to experience having their emotional needs met in their memory, which provides emotional healing from their experiences (Mancini and Mancini, 2018).

In both cases, exploration of the content of intrusive memories led to basic psychoeducation about emotional needs. Both clients remarked that through the discussion of this information and the experience of having their needs met in the imagery, this assisted them to understand their emotional experiences better in their current lives without the need to avoid these experiences. These findings add to the increasing evidence that satisfaction of emotional needs is important for recovery from depression (Rouse *et al.*, 2020) and highlight the need to emphasise this element in theoretical models and treatment approaches of depression.

Despite not employing cognitive or behavioural modification techniques, both patients achieved substantive cognitive and behavioural change that generalised beyond the intrusive images targeted. Both clients reported that the experience of revisiting their childhood memory as an adult led to a spontaneous shift in the way they viewed the causes of the situation from self-blame to a more balanced view on the range of external causal factors. They also both reported that as a result of this, they now view their emotions and needs as valid rather than wrong or shameful. Moreover, both clients achieve similar behavioural change in their current lives from increasing self-care, improved interpersonal functioning, and reduced maladaptive coping behaviours. It is conceivable that through the therapist modelling and the patient practising the application of adaptive behavioural responses in imagery, this enabled the patients to then apply these behaviours in the present in the face of new triggers that emerged.

Additionally, it is likely that the high levels of affect elicited through the imagery rescripting may have been responsible for the observed cognitive and behavioural changes. Imagery techniques have been found to elicit substantially greater affect than verbal processing of the same material (Holmes and Bourne, 2008). It was observed that both patients became much more emotional during the imagery rescripting exercises than at other points in treatment. Furthermore, the emotion elicited by the exercise peaked early-to-mid treatment, and the imagery was observed to be less distressing in later sessions, which is likely to indicate that successful emotional processing had occurred (Foa and Kozak, 1986).

Due to the high levels of emotion evoked through the treatment, caution is required when applying this technique to individuals who experience suicidality. This can be addressed by discussing with the client the likelihood of a temporary increase in depression symptoms at the start of treatment, and how to manage any increases in suicide risk that accompany this. Yet as suicidal patients have been found to experience a high frequency of intrusive memories that may maintain their depressed mood (Wheatley *et al.*, 2007), these patients should not be automatically excluded from imagery rescripting if their suicide risk can be appropriately managed.

While these cases highlight the effectiveness of imagery rescripting as a stand-alone intervention, this technique is a core experiential component of schema therapy, a psychological treatment designed to treat chronic psychological disorders (Jacob and Arntz, 2012). A central concept in Young's schema mode model from which this therapy is derived is early maladaptive schemas (EMS) which are developed in response to unhelpful autobiographical experiences. Depressed samples have been shown to have elevated rates of

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childhood adversity and EMSs, which both predict up to 53% of the variance in depression severity (Renner *et al*., 2013).

Memories are central to EMSs, as they often represent formative situations in which EMSs developed (Young *et al*., 2006). The themes of both clients' intrusions consisted of emotional neglect/deprivation, defectiveness/shame, and abandonment, which represent core vulnerability schemas in Young's mode model (Young *et al*., 2006). Therefore, it is plausible that the recollection of an intrusive memory could represent the EMS activation. Moreover, both clients' reduction in the frequency of intrusive memories may also demonstrate that meaningful schema change can be made within a short time frame without employing the full schema therapy package.

There are a number differences in the application of imagery rescripting between trauma and depressed samples. While trauma intrusions feature themes of threat, abuse and danger, those in depression are more often related to the absence or deprivation of an emotional or attachment need from being met (Patel *et al*., 2007). Consequentially, while the trauma memories will often involve a sense of fear and threat, emotions such as sadness, loneliness and grief may be more characteristic of the memories found in depression. This may require changes in the intervention that the therapist provides. For example, rather than providing safety to trauma presentations, rescripting in depression may emphasise the provision of emotional care, validation and connection. Other authors have noted that the ability to gain a sense of mastery over the memory, as well as provide compassion towards oneself which is enabled through imagery rescripting may be particularly useful in depressed populations where confidence or compassion towards oneself may be lacking (Wheatley *et al*., 2007). It is also important to note, however, that in many cases there is overlap in the content of intrusions both samples. Thus it is essential that intervention is based on a case formulation rather than diagnosis which can be arbitrary in some instances.

There were a number of obstacles that arose throughout the course of treatment which needed to be overcome. Firstly, both cases had a strong propensity to ruminate when distressed, which can prevent successful emotional processing from occurring (Williams and Moulds, 2007). Imagery rescripting was able to effectively bypass rumination, however, as the rescripting exercise enabled the emotions the client was experiencing to be the focus, rather than the content of rumination.

Additionally, both clients reported an urge to avoid completing the rescripting at times to prevent experiencing aversive emotions. Avoidance was addressed by giving clients a choice about the memory that they would like to target, so that they had a degree of control over the emotional content. This choice allowed the client to pick a memory that they felt would be pertinent to them in that moment, and was achievable with the amount of emotional capacity they had at the time, making it less aversive and therefore less appealing to avoid. Additionally, within the imagery modifications could be made to the duration of the rescripting, the number of probing questions the therapist asked regarding affect, as well as excluding questions about the client's somatic responses during the imagery. Moreover, if a client became very distressed at a particular point in the memory, the memory could be rewound and the intervention initiated earlier before the most distressing aspects took place.

Hopelessness is a core characteristic of the depressive cognitive style (Beck *et al*., 1979), and has been found to represent a key risk factor for chronic course of depression and suicide (Brown *et al*., 2000). Hopelessness was observed in both patients within the context of not getting their emotional needs fulfilled, and would present as a resignation that this would always be the case for them. One method used to combat this symptom was the use of future pattern breaking imagery, a technique in which a future triggering event was imagined and the patient was guided to adopt healthier coping in order to mitigate potentially harmful consequences and experience the fulfilment of their emotional needs (Holmes *et al*., 2007).

Finally, it was observed that both patients had very self-critical thoughts that would induce feelings of shame and guilt. In both cases, these self-critical thoughts were formulated to be

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central to the maintenance of the patient's symptoms. Often the autobiographical memories that were associated with these thoughts were experiences of being criticised or emotionally neglected. Through the rescripting, this could be addressed through bypassing the self-critical thoughts and meeting the emotional need in the rescripting. Furthermore, within the imagery the patient would be supported to build a healthy counter-perspective to their inner critic, which would enable the patient to experience hearing more positive and healthy messages in place of toxic critical messages.

Despite being initially developed for the treatment of trauma memories, imagery rescripting has been found to be successfully modified and applied to the distinct intrusive memories found in depression. Following 12 sessions, both patients were found to experience significant emotional, cognitive and behavioural change, as well as no longer meeting diagnostic criteria for depression. Furthermore, various features of imagery rescripting, particularly its uniquely emotional and experiential components, make this treatment ideally suited to overcome treatment barriers which have been observed in traditional treatments for depression. While there are important considerations when applying this treatment, it was well tolerated by clients, and treatment effects were obtained within a short period of 12 sessions, making this treatment accessible and applicable to a variety of clinical settings.

Key practice points

(1) Intrusive autobiographical memories are a common feature of depression found to maintain the disorder.
(2) Cognitive behavioural treatment may not be effective at treating intrusive memories as they promote verbal-linguistic processing which may block sensory processing needed to access and modify emotional memories in their perceptual form.
(3) Twelve sessions of imagery rescripting were found to be effective at producing clinically significant and reliable change in two patients depression symptoms.
(4) Treatment was well tolerated by clients and ideal to overcome traditional treatment obstacles in depression.

Further reading

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Data availability statement. The data that support the findings of this study are available on request from the corresponding author, D.B. The data are not publicly available as they contain information that could compromise the privacy of research participants.

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Conflicts of interest. The authors declare none.

Ethical standards. The authors have abided by the Ethical Principles of Psychologists and Code of Conduct set out by the BABCP and BPS. All participants provided written informed consent to participate, and the study was approved by the University of Technology Sydney Human Research Ethics Committee (UTS HREC ETH19-3967). Participants were not reimbursed for their participation. The authors confirm that both individuals described in this paper have seen the final version of the manuscript and provided written consent for the paper to be published.

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