Staged dissociative rescripting and reassociation of early memories

Vladimir S Snigur MD, Moscow

info@vladimirsnigur.ru

Originally published here: Collection of scientific articles XVII scientific-practical conference Actual problems of psychosomatics in general medical practice, St. Petersburg, November, 2017. - Vol. XVII.
https://associationcbt.ru/wp-content/uploads/2017/11/sbornik-2017.pdf

Introduction

Working with early traumatic memories has been used in various strands of psychotherapy in the treatment of a wide range of disorders. It has been repeatedly shown in the literature that a history of early psychological trauma is associated with the development of borderline personality organization (Herman et al.,1989), somatized disorders (Saxe et al., 1994), dissociative disorders (Saxe et al., 1993), and other conditions. The effectiveness of techniques aimed at modifying memories in the imagination has been demonstrated by different authors (e.g., Layden et al., 1993; Giesen-Bloo et al., 2006; Smucker, Neiderdee, 1995; Wild et al., 2007, 2011;). In contemporary cognitive behavioral therapy, imagery rescripting techniques are used to work with early maladaptive emotional schemas or underlying emotional beliefs (Arntz, Weertman, 1999; Stopa, 2009). Cooper et al. (2007) showed the effectiveness of a single rescripting session in correcting underlying emotional beliefs in patients with bulimia nervosa. In other words, imagery work is proving to be very useful in the treatment of many severe emotional disorders.

The possibility of combining cognitive-behavioral psychotherapy with hypnosis has been previously discussed in the literature (e.g., Kirsch et al., 1995). Combining CBT with hypnosis has been demonstrated to increase the effectiveness of CBT techniques (e.g., Roy, 2014). A number of authors describe techniques and strategies for combining hypnotic and cognitive interventions in the treatment of various emotional disorders (e.g., Dowd, 2000; Alladin, 2008). Imagery work has traditionally been seen as one of the key approaches in the application of hypnotic interventions.

Many experts have noted that working with early traumatic memories can be very resource-demanding for both the patient and the therapist, and can be associated with significant emotional outbursts. In this paper, the author describes a technique that

provides both the patient and the therapist with additional tools to manage the process and stabilize the patient's emotional state. The principle of dissociating the intellectual and emotional content of memories with examples was described by Erickson and Rossi (1979).

Technique

The following version of rescripting is a technique of staged dissociative rescripting and reassociation, combining the classical version of imagery rescripting with hypnotic dissociation techniques.

The procedure itself consists of five steps and is performed after a specific early traumatic memory has been identified. When the memory has been identified, the circumstances of the actual event, and the cognitive and emotional beliefs associated with the memory have been established, it is usually possible to identify a mismatch between the rational and emotional perception of the event: “I realize that it is illogical, that things have long since changed, but that is how I feel”. In such a case, the use of rescripting or other experiential methods based is justified. This helps to modify the subjective experience associated with the traumatic event.

This technique has several peculiarities. It is performed in stages and may contain several resource elements that the patient brings to the memory one at a time. First, the patient reconstructs the events of the memory in their original form. Then the patient introduces the simplest and most logical change to the memory, which may involve a new character. Next, the patient may introduce another character into the memory that is most emotionally meaningful to the patient. In the third step, the new, more emotionally significant character may replace the old one, or these characters may be present at the same time. The course of the procedure may be determined and regulated jointly by the patient and the therapist, but the therapist may also take a more active position and direct the patient's associations toward predetermined therapeutic goals.

What follows is a step-by-step description of the technique with examples of the therapist's interventions.

1. In the first stage, after the circumstances of the event and the associated beliefs and affective experiences have been clarified, possible options for modifying the memory are discussed with the patient. Typically, rescripting involves introducing a resource

figure into the situation who provides the necessary assistance to the patient and changes the circumstances of the situation. In the case of early memories, this may be an “adult version” of the patient, someone from the patient's close relatives, friends, a therapist, or someone else. Depending on the individual characteristics of the patient, the situation, the therapeutic relationship, or other factors, the degree of detail of this discussion may vary. It is possible to plan in detail the possible variants of the development of events step by step, describing individual interactions, or it is possible to plan the procedure more loosely, specifying the key figures who should participate in the situation and the main changes that should occur.

2. The second stage is actually a variant of naturalistic hypnotic induction. The aim of this stage is to achieve changes in the patient's current state in which his attention is selectively focused on the immediate subjective reality; he perceives what is happening to him as more or less involuntary; he maintains contact (rapport) with the therapist and demonstrates involuntary responsiveness to the therapist's communication (see e.g. Zeig, 2011).

At this stage, a safe context in which the visualization and modification of the memory will take place is created and elaborated in detail in the imagination. The patient is invited to imagine himself sitting in a movie room with a large screen on which the patient is soon to see a movie “*about this event from his life*.” The patient is encouraged to sit in this movie room in a suitable location where he has a good view and a sense of security. If necessary, it may be suggested to visualize nearby the figure of a therapist who can serve a stabilizing function and accompany the patient. The patient is invited to visualize in detail the place in which he or she finds himself, using all channels of perception (vision, hearing, kinesthetic sensations, smells, etc.). Particular attention should be paid to modeling the patient's emotional state as “*calm and relaxed, with a sense of interest and curiosity about what is about to happen on the screen*”. The therapist should set a frame of reference in which the patient is as detached as possible from the events he will recall through the “movie screen” and perceives them solely as “*objective facts of life, paying attention only to the facts as they appear in a documentary newsree*l”.

It is convenient to conduct such induction in the form of cycles - recursions, where at each new stage the patient is offered additional details of the framework of what is happening, which are interspersed with phrases that describe and accompany his

subjective experience of being in the movie theater chair and strengthen the effect of "*uninvolved observer*". In the first stage, calmness and curiosity about what he will see; in the second stage, a detached observational attitude "*like a documentary*"; in the third stage, the expectation of watching a black-and-white movie without sound as "*in a silent movie*." The therapist then suggests: "*Soon, when the lights go out, the movie screen will flash, and on it you will see the beginning of this movie and watch the facts as they unfold before you, paying attention only to the dry facts and ignoring the other details of what is happenin*g."

Several times during this phase, the patient is asked to describe what he sees, hears, and feels while sitting in the chair of this "movie room" as he or she prepares to watch the "movie".

3. When a stable and calm state has been established and the patient shows signs of relaxation and readiness to continue, the therapist describes what happens next: "*The lights go out, the movie screen lights up, and you see the first frames of the movie. Describe how it begins?*" The patient begins a description of the events that begin this episode of recollection for him or her. The therapist emphasizes several times that the patient sees "*only dry facts, events that are unfolding before his eyes, and can observe them from the outside as something that is happening to someone completely unfamiliar to him*." The therapist accompanies the patient in this description, supporting their narrative and making sure that the description is accurate, as dry and unemotional as possible, and that the patient remains sufficiently dissociated from the events. Signs of this are continued relaxation, calm facial expression, no obvious spontaneous shifts in respiratory and motor rhythms, and verbal feedback. The patient reaches the final frame of the memory, after which the therapist picks up the accompaniment, "*Now that this movie is over, the screen fades, the lights dim, and you can rest a bit and take a few free breaths and exhalations. Intermission. You stay in that chair and wait curiously for the next movie to start*."

4. At this point, during the "intermission" the therapist suggests that the patient tune in to watch the next "movie": "*Soon, when the lights go out, the screen will flash and you will see another movie. It will begin in a very similar way, and it will have similar events until a new character appears in it. And this time you will, like a director, make sure that the character appears at the moment when it is needed, and, like a director, you will be able to direct and control his actions. This movie will be in color*

and the picture quality will be richer, but it will still be just a video sequence. You will be able to control the camera and take a bigger and more general close-up, focusing on the most important moments."

Next, the therapist suggests, as in the previous step, to see how the film begins and to add an additional element: "*As you do this, you may notice that you can sort of begin to recognize some of the details of what is happening as something that resonates with you, that is vaguely familiar to you*." The therapist suggests that the patient watch the movie frame by frame until the moment when he sees that "*something wrong*" begins to happen to his character in the movie, when he begins to "need help." The patient again describes the events up to this stage, after which the therapist suggests seeing a new face appear in this scene: '*Look at who this person is, how he reacts to what is happening and what he does*'. The therapist expects the patient to begin describing the new resource character that he or she has chosen in advance. In the patient's description, this character should show interest in what is happening, empathy for the patient's character, and take an active role in making a difference and helping the patient in this scene feel better. The therapist supports the patient in this description by helping the patient move step by step through the stages of the situation, providing suggestive comments when necessary and suggesting indirectly the possible beneficial development of the situation. As the therapist progresses and modifies the memory, the therapist may suggest that the patient gently "*observe what is happening, beginning to empathize a little more with the character and noticing a response to what is happening, just as we feel a response to a good movie*." The therapist invites the patient to move step by step to the final frame of this movie, asking the patient to describe the ending. At this point, the patient is expected to describe the positive changes and happy ending of the situation in a fairly neutral and constructive manner. After this, the patient is again asked to pause for an "intermission" during which the patient can "taste the aftertaste of the movie".

5. The instructions for the final stage of rescripting imply that the patient will now see the movie again, which begins exactly the same way, but in it a very important person to the patient's character will appear who will provide the necessary help and support. This stage is the most flexible in content and can involve a significant amount of creativity. The therapist needs either to think out in advance the possible variants of what is going to happen, or, flexibly oriented to the patient's feedback, to

offer him possible variants of events that will imply the presence and active participation in the situation of an authoritative and emotionally significant person for the patient. At its simplest, this stage can be a general repetition of the events of the previous stage, simply by introducing a new actor or replacing someone who has already been there. In the preparatory instructions, the therapist suggests that the patient will soon see "*another movie in color and sound in which you will see a familiar beginning but a new development involving someone very important to you. This time you will begin to notice the similarity of the characters to those you know, and you will be able to notice some degree of your own involvement in what is going on, as you would when watching a very good movie*."

At this stage, the therapist's task is to accompany the patient in describing what is happening on the screen, paying more attention to the characters' reactions, facial expressions, words and lines, and their emotional states. The therapist can take a slightly more active position here and model with his or her guidance the possible reactions of a character significant to the patient - his or her emotional reactions, motives, and desires to provide support, help, and protection. The therapist's goal is for the patient to come to a happy conclusion in which the significant person's character provides the patient's character with all the help he or she needs and leads him or her safely out of the situation. The patient may be encouraged to "*find themselves as if they were right next to them and feel the atmosphere change, feel that contact between them and a sense of safety and calm*."

After the "movie" is over, the patient can be encouraged to "*retain and remember this feeling, feel the aftertaste of this event*" and then gently end the session by asking the patient to take a few breaths and exhalations and gradually return to the room.

Clinical example

A woman in her early thirties came in due to alcohol abuse, which helped her to relax, calm down, be more sociable and cheerful. At the initial stage of work, the patient expressed an interest in in-depth psychotherapy. She was married, had two children, lived with her family, and was successfully engaged in business. The work was multimodal, combining elements of a psychoanalytic approach based on the object relations model (Yeomans, Clarkin, Kernberg, 2015) and a schema-oriented approach (Young, Klosko, Weishaar, 2003). The patient's level of personality organization was considered as high-level borderline. In the process of assessing the condition using

Young's schema questionnaire (Kasyanik, Romanova, 2013; Young, 2005), a high (>50%) level of activity of the following schemas was revealed: “unrelenting standards” (100%), ‘approval seeking’ (72%), ‘emotional deprivation’ (60%), ‘mistrust/abuse’ (60%), ‘defectiveness/shame’ (56%). During the course of treatment, narcissistic character traits became evident, including high self-demands, devaluing one's own successes and positive qualities, as well as critical and devaluing attitudes towards others, but, in addition, anxiety-avoidant traits related to avoiding situations involving increased risk and uncertainty, especially in business. Early in the treatment, the patient developed clinical symptoms of depression, which were managed fairly quickly with psychological interventions.

At an early stage of the treatment, the patient's rigid and demanding attitude towards herself was revealed in the course of the study of her extremely critical and devaluing internal representation, the interactions with which kept the patient in tension and caused a feeling of hopelessness and powerlessness. This manifested itself in self-deprecating and criticizing thoughts, insecurity, pickiness about the results of her work, in the expectation of criticism from others, which the patient hid under a mask of detachment, emotional coldness. She tried to distance herself from strangers and had difficulty making contact with new people. Role-play exploration of the dyad of object relations associated with this criticizing representation revealed a representation of a helpless and powerless Self that was unable to counteract the criticizing figure. The patient described significant fusion with the weak and powerless representation and had difficulty detaching from these feelings. Associated with this representation were thoughts such as “You won't succeed,” “You're not capable of anything,” “You don't deserve anything good,” and others. The study of this figure revealed two episodes from the patient's childhood and adolescence in which she felt extremely helpless and suffered pain, physical abuse, and the insensitive and even cynical attitude of others.

In the first flashback, the patient, aged ~6 years old, was in a hospital where she was undergoing a medical manipulation involving gastroscopy. At this time, she was held by several people, tried to resist, but eventually had to surrender. None of her relatives were around at the time and there was no one to support her.

The second recollection also concerned a medical manipulation when the patient was about 15 years old: a girl underwent an operation to remove her appendix under local

anesthesia. This was the surgeon's know-how, who justified this choice of anesthetic aid by the poor quality and danger of the available anesthetic drugs. The patient felt complete helplessness and intense pain throughout the procedure and was again confronted with the callous and cynical attitude of the medical staff. She described how, after the operation was completed, a woman, whom she thought was a cleaner, came to the operating table, took the removed appendix from the tray and shook it in her face, telling her that everything had gone well.

Recalling these episodes, the patient described feeling powerless, helpless, hopeless, and emotionally convinced that she could be treated in such a heartless and cruel manner. The patient was offered to perform imagery work to modify the subjective experience associated with these memories.

First session

To begin, the first, earlier memory was selected. During the discussion phase of the rescripting session, the patient decided to include her mother in this memory, who had to come and take the girl out of the room, preventing the doctors from performing the procedure because she felt she did not need the procedure - she had probably been confused with another child. The patient was also asked to imagine an adult version of herself in this memory and to do the same - to take the girl out of the room and fight back against the staff who had treated her so callously.

In the second stage, no formal hypnotic guidance was conducted; the patient was asked in a naturalistic way to imagine that she was in a movie theater. The patient, accompanied and guided by the psychotherapist, easily focused on her inner reality and visualized a cinema hall with a movie screen, herself sitting in a chair in the middle of the hall, and the psychotherapist in the next chair who could support her. She was able to easily develop this image in auditory and kinesthetic modality. While focusing attention, the patient exhibited typical signs of trance: relaxation of facial muscles, slower breathing rhythm, immobility, and saccades of closed eyes. Verbal contact with the patient was maintained throughout the procedure.

The third phase of the rescripting procedure proceeded calmly. The patient presented a black-and-white video without sound on a movie screen and described the events occurring there from the observer's point of view in the same way as she had described them earlier.

In the fourth stage of the rescripting, the patient imagined that in the manipulation room, when the doctors were trying to start probing the girl, her mother appeared, took the girl with her, calmed her down, and told the doctors that they had made a mistake.

In the fifth stage, the patient imagined herself in her current age appearing in the room, reprimanding the medical staff for mistreating the girl, comforting her, taking her in her arms, and hugging her. At this time, tears came to the patient's eyes, but she remained steadily focused on her inner reality and maintained contact with the therapist. After the technique was completed, as the patient reoriented herself in the room, she described the distinct feeling of hugging this little girl that she had after the rescripting. The patient described her experience very emotionally and reported a deep sense of relief.

Second session

The following day, rescripting was performed for the second episode. Prior to this, the patient reported that her family had always been extremely respectful of doctors, as her immediate family included many physicians and her grandfather was a respected and well-known professor. Therefore, two new elements were proposed in the development of the second episode. First, the patient suggested that an anesthesiologist should be available in this operating room at the right moment to provide adequate pain relief. Then, the therapist also suggested that the image of her grandfather, who could be an emotionally significant figure for her and provide her with important support, be brought into the memory. This idea was readily accepted by the patient.

The second and third stages of rescripting were generally the same as in the previous session, but the image of the movie room was slightly different - this time it was a small home theater. In the fourth stage of rescripting, the patient imagined that at the moment of the beginning of the operation, an anesthesiologist appeared in the operating room, who quickly assessed the situation, saw the girl's suffering, and quickly introduced general anesthesia, after which she fell asleep and woke up after the operation was completed without feeling any pain. In the fifth stage of rescripting, the patient, in addition to the figure of the anesthesiologist, using the therapist's cues, also presented her grandfather in a medical gown who was standing in the next room watching the surgery through the glass. To the girl in the operating room, the

anesthesiologist informed her that her grandfather was nearby looking out for her. Events then unfolded in a similar fashion - the girl was given anesthesia and fell asleep, waking up in the room to find her grandfather nearby, hugging and comforting her. After completing the procedure and reorienting herself in the room, the patient described her deep emotional experience and sense of relief. In addition, some time later she reported feeling a spontaneous lightness in her hands and spontaneous movements of her fingers during the sessions. This can be explained by the development of a dissociated trance-like state with spontaneous ideomotor phenomena.

Therapeutic Elements

In addition to the central element of modifying memories in the imagination, this technique contains several other elements that may have additional therapeutic value:

1.The staged structure of the procedure ensures a gradual deepening of the emotional experience and the patient's habituation to the new experience, and allows for the addition of new elements in turn, thus developing the process in the desired direction. Theoretically, the number of stages can vary according to clinical necessity.

2.The dissociative technique of projecting memories onto a “movie screen” allows for interaction with the traumatic material with minimal emotional involvement, developing a stable observational stance, modulating the perception of the traumatic material, allowing the patient to adapt to the process and maintain a resourceful state during the procedure, and facilitating contact with the therapist.

3.Gradual reduction of the degree of dissociation at each stage (reassociation), theoretically, allows to deepen the patient's emotional experience and make it the most intense exactly at the stage of the most significant resource experience.

4.The patient is implicitly invited to develop an active subjective position in himself, metaphorically becoming the “director” of what happens to him during rescripting.

Additional remarks

The therapist should continually monitor verbal or nonverbal feedback from the patient during the course of the work. In the event of a significant and uncontrollable increase in emotional distress, the therapist may return to the third, maximally dissociated stage of rescripting, or interrupt the session and use interventions aimed at developing emotional regulation skills, then return to the rescripting session.

This technique relies heavily on the construction of a hypnotic responsiveness and the use of dissociation techniques. It is useful for the therapist to have a basic knowledge of hypnosis in order to maximize flexibility in constructing and tailoring the technique to the individual patient. There is evidence that an individualized hypnotic support procedure is more effective than a standardized approach (Barabasz, 2007). Any deviations from the trajectory of the procedure can be utilized by the psychotherapist to achieve the main therapeutic goal of reducing the intensity of the traumatic emotional experience, restructuring the associated beliefs, and reassociating it with the involvement of resource states and emotionally significant figures. The principle of utilization in hypnosis and psychotherapy has been described in the literature (e.g., Zeig, 1999).

References

Alladin, A. *Cognitive Hypnotherapy: An Integrated Approach to the Treatment of Emotional Disorders*. Chichester, West Sussex: John Wiley & Sons: 2008.

Arntz A., Weertman A. Treatment of childhood memories: Theory and practice. Behaviour Research and Therapy. 1999;37:715–740.

Barabasz A, Christensen C. (2006) Age regression: tailored versus scripted inductions. *Am J Clin Hypn* 2006;48(4):251-261.

Cooper, M. J., Todd, G., & Turner, H. The effects of using imagery to modify core emotional beliefs in bulimia nervosa: An experimental pilot study. *Journal of Cognitive Psychotherapy.* 2007, 21(2), 117-122.

Dowd, E. T. Cognitive hypnotherapy. Livingston, NJ: Jason Aronson: 2000.

Erickson, M. H., Rossi, E. L. *Hypnotherapy: an exploratory casebook*. Irvington Publishers, New York: 1979.

Giesen-Bloo J., van Dyck R., Spinhoven P., van Tilburg W., Dirksen C., van Asselt T. Outpatient psychotherapy for borderline personality disorder: A randomized clinical trial of schema focused therapy versus transference focused psychotherapy. *Archives of General Psychiatry.* 2006;63:649–658.

Herman, J.L., Perry, J.C., van der Kolk, B.A. Childhood trauma in borderline personality disorder. *Am J Psychiatry*. 1989 Apr;146(4):490-5.

Kirsch, I., Montgomery, G., Sapirstein, G. Hypnosis as an Adjunct to Cognitive-Behavioral Psychotherapy: A Meta-Analysis. *Journal of Consulting and Clinical Psychology* 1995;63(2):214-220.

Layden, M.A., Newman, C.F., Freeman, A., Morse, S.B. *Cognitive therapy of borderline personality disorder*. Needham Heights, Massachusetts: Allyn & Bacon: 1993.

Roy PK. Efficacy of combined cognitive-behavior therapy and hypnotherapy in anorexia nervosa: a case study. *Int J Clin Exp Hypn.* 2014;62(2):224-30.

Saxe GN, Chinman G, Berkowitz R, Hall K, Lieberg G, Schwartz J, van der Kolk BA. Somatization in patients with dissociative disorders. *Am J Psychiatry*. 1994;151(9):1329-34.

Saxe GN, van der Kolk BA, Berkowitz R, Chinman G, Hall K, Lieberg G, Schwartz J. Dissociative disorders in psychiatric inpatients. *Am J Psychiatry*. 1993 Jul;150(7):1037-42.

Smucker M.R., Neiderdee J. Treating incest-related PTSD and pathogenic schemas through imaginal exposure and rescripting. *Cognitive and Behavioral Practice* 1995;2:63–93.

Stopa L. How to use imagery in cognitive-behavioural therapy. In: Stopa L., (Ed.). *Imagery and the threatened self.* Routledge; New York: 2009.

Transference-Focused Psychotherapy for Borderline Personality Disorder A Clinical Guide. Edited by Frank E. Yeomans, M.D., Ph.D.; John F. Clarkin, Ph.D.Otto F. Kernberg, M.D. American Psychiatric Publishing, Washington, 2015; 411 pp.

Wild, J., Clark, D.M. Imagery Rescripting of Early Traumatic Memories in Social Phobia. *Cogn Behav Pract.* 2011, 18(4), 433–443.

Wild J., Hackmann A., Clark D.M. When the present visits the past: Updating traumatic memories in social phobia. *Journal of Behavior Therapy and Experimental Psychiatry.* 2007;38:386–401.

Young, J. E. (2005). *Young Schema Questionnaire – Short Form 3 (YSQ-S3)*. New York, NY: Cognitive Therapy Center

Young, J.E., Klosko, J.S., & Weishaar, M. (2003). *Schema Therapy: A Practitioner's Guide*. Guilford Publications: New York.

Zeig, J. (2011) Hypnotic induction. In C. Loriedo, J. Zeig, & G. Nardone (Eds.), *Tranceforming Ericksonian methods* (pp.43–58). Phoenix, AZ: The Milton H. Erickson Foundation Press.

Zeig, J. The Virtues of Our Faults: A Key Concept of Ericksonian Therapy. *Sleep and Hypnosis.* 1999;1:129-138.