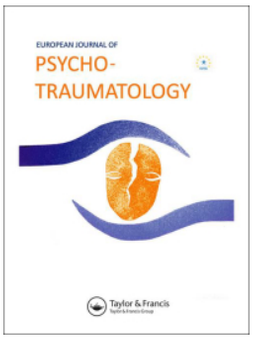

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REVIEW ARTICLE

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Enhancing trauma-focused therapy (EMDR) with Imagery Rescripting for childhood abuse-related PTSD: a case study

Mellony T.C. van Hemert [a], Paula M. de Jong [a], Tessa R. Brouwer [a], Ellen Gunst[b], Laurence Claes [c] and Manuel Morrens[b]

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ABSTRACT

Introduction: Childhood sexual and physical abuse (CSPA) can lead to a heightened risk to develop a posttraumatic stress disorder (PTSD). Cognitive Behavioral Therapy (CBT) and Eye Movement Desensitization and Reprocessing (EMDR) show limited efficacy for CSPA-related PTSD. Highlighting the need for alternative approaches, such as Imagery Rescripting (ImRs), which, when integrated into standard treatment, may improve therapeutic outcomes for these individuals.

Objective: This case report demonstrates the effectiveness of integrating Imagery Rescripting (ImRs) into standard EMDR treatment for PTSD when progress stalls. It focuses on a 25-year-old Dutch male of Indonesian and Surinamese descent with CSPA-related PTSD.

Method: The client completed a total of 30 sessions, which included five psychoeducation sessions, four EMDR sessions, followed by five ImRs sessions and an additional five EMDR sessions. The final sessions focused on evaluating treatment outcomes, enhancing self-esteem, and implementing relapse prevention strategies. Various questionnaires assessing PTSD and psychological symptoms were administered at baseline, during and after treatment.

Results: After following a combination of EMDR and ImRs treatment, symptoms progressively decreased. By the end of treatment, the client had recovered from PTSD, with his Global Severity Index (GSI) score nearing the clinical cut-off score. This treatment success was maintained during a three-month follow-up period.

Conclusions: The integration of ImRs and EMDR seemed crucial for this client's recovery from CSPA-related PTSD. Future research should identify which clients benefit most from EMDR, ImRs, or a combination of both. Long-term studies are needed to assess the sustained efficacy of integrating ImRs into trauma treatment.

ARTICLE HISTORY

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KEYWORDS

Childhood sexual and physical abuse; CSPA; early childhood trauma; Imagery Rescripting; ImRs; EMDR; trauma; PTSD symptoms

PALABRAS CLAVE

Abuso sexual y físico infantil; reescritura de imágenes; ImRs; EMDR; síntomas de TEPT; trauma; trauma infantil temprano; terapia centrada en el trauma

HIGHLIGHTS

- Combined EMDR and ImRs effectively improved symptoms of a patient suffering from CSPA-related PTSD.
- Treatment led to full PTSD recovery, with progress maintained during a three-month follow-up.

Mejora de la terapia centrada en el trauma (EMDR) con reescritura de imágenes para el TEPT relacionado con el abuso infantil: un estudio de caso

Introducción: El abuso sexual y físico infantil (CSPA, por sus siglas en inglés) puede aumentar el riesgo de desarrollar un trastorno por estrés postraumático (TEPT). La terapia cognitivo-conductual (TCC) y la desensibilización y reprocesamiento por movimientos oculares (EMDR) muestran una eficacia limitada para el TEPT relacionado con el CSPA. Se destaca la necesidad de enfoques alternativos, como la reescritura de imágenes (ImRs por sus siglas en ingles), que, cuando se integra en el tratamiento estándar, puede mejorar los resultados terapéuticos para estas personas.

Objetivo: Este informe de caso demuestra la eficacia de integrar la reescritura de imágenes (ImRs) en el tratamiento estándar con EMDR para el TEPT cuando el progreso se estanca. Se centra en un hombre holandés de 25 años, de ascendencia indonesia y surinamesa, con TEPT relacionado con CSPA.

Método: El cliente completó un total de 30 sesiones, que incluyeron cinco sesiones de psicoeducación, cuatro sesiones de EMDR, seguidas de cinco sesiones de ImRs y otras cinco sesiones de EMDR. Las sesiones finales se centraron en evaluar los resultados del tratamiento, mejorar la autoestima e implementar estrategias de prevención de recaídas. Se administraron varios cuestionarios para evaluar el TEPT y los síntomas psicológicos al inicio del tratamiento, durante el mismo y después de este.

Resultados: Después de seguir una combinación de tratamiento con EMDR e ImRs, los síntomas disminuyeron progresivamente. Al final del tratamiento, el cliente se había recuperado del TEPT, con una puntuación en el Índice de Gravedad Global (GSI) cercana al punto de corte clínico. Este éxito del tratamiento se mantuvo durante un periodo de seguimiento de tres meses.

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Conclusiones: La integración de ImRs y EMDR pareció crucial para la recuperación del TEPT de este cliente relacionado con el CSPA. Las investigaciones futuras deberían identificar qué clientes se benefician más del EMDR, las ImRs o una combinación de ambos. Se necesitan estudios a largo plazo para evaluar la eficacia sostenida de la integración de las ImRs en el tratamiento del trauma.

1. Background/Introduction

Childhood sexual and physical abuse (CSPA) is a significant global problem with high societal and financial costs (Peterson et al., 2018; Stoltenborgh et al., 2015). It strongly predicts later mental and physical health issues, particularly posttraumatic stress disorder (PTSD) (Hughes et al., 2017; Kessler et al., 1995). Cognitive Behavioral Therapy with a trauma focus (CBT-T) and Eye Movement Desensitization and Reprocessing (EMDR) are both evidence-based treatments for PTSD, and have been shown to be more effective than wait-list control conditions (Bisson & Andrew, 2013) and non-trauma-focused interventions (Lewis et al., 2020a). CBT-T integrates imaginal and in vivo exposure to reduce avoidance and incorporates cognitive strategies to address maladaptive trauma-related beliefs. EMDR involves recalling traumatic experiences while engaging in bilateral stimulation, such as guided eye movements, to facilitate memory reprocessing and reduce emotional distress (Shapiro, 1989).

Despite the effectiveness of CBT-T and EMDR, 20%–50% of patients still meet the criteria for PTSD after treatment (Bradley et al., 2005). Additionally, trauma-focused therapies often exhibit higher dropout rates than non-trauma focused approaches, likely due to the intensity of the exposure component (Lewis et al., 2020b). A meta-analysis found no significant differences in dropout rates between EMDR and trauma-focused therapies like CBT-T, suggesting that both types have relatively comparable dropout rates (Bisson & Andrew, 2013). Exposure-based therapies produce particularly high dropout rates among patients with PTSD related to childhood sexual and physical abuse, exceeding those observed in PTSD stemming from other types of trauma (Dorrepaal et al., 2014).

The mechanisms underlying the effectiveness of CBT-T and EMDR for some, but not all, patients with PTSD remain unclear. This case study highlights two symptoms commonly observed in PTSD, namely tonic immobility and shame, to justify the use of Imagery Rescripting as a complement to standard care.

1.1. Tonic immobility

In life-threatening situations or imminent danger, both animals and humans may exhibit a 'freeze' response, also known as tonic immobility (Marx et al., 2008; Porro & Carli, 1988). In humans, this often occurs in fear-inducing situations involving physical restraint, such as during sexual assault (Marx et al., 2008). During tonic immobility, arousal and muscle tone drop significantly, reducing the awareness of pain or emotional distress during a prolonged or inescapable attack. In some cases, individuals may feel detached from their body or lose consciousness entirely. This response is especially common in cases of chronic trauma or childhood trauma, where victims are less able to defend themselves and escape seems impossible (Schauer & Elbert, 2010). Additionally, people with PTSD often experience tonic immobility when recalling traumatic events. Studies indicate that 52% of individuals with CSPA-related PTSD report tonic immobility in response to trauma-related stimuli (Kleine et al., 2018; Volchan et al., 2017). In clinical practice, this may present as an absence of tension and a sudden, unexpected drop in the subjective units of distress (SUD), although minimal or no decrease in SUD is also possible. When this occurs, opportunities for effective processing of the traumatic memory or for inducing fear extinction are significantly reduced, which limits the effectiveness of treatments such as EMDR and other trauma focused therapies such as CBT-T and prolonged exposure.

1.2. Shame

While fear has traditionally constituted the central focus of interventions for PTSD, empirical evidence indicates that shame serves as a more robust predictor of PTSD development and maintenance than fear (Badour et al., 2017). Established evidence-based treatments, including CBT-T and EMDR, recognise that although these methods effectively reduce fear-related responses, their effectiveness can be limited when feelings of shame are activated (Forgash & Knipe, 2012). The intense shame associated with these experiences often makes it difficult for individuals to disclose their painful memories. Shame is a powerful emotion characterised by harsh self-judgment (Tracy et al., 2007) and usually arises from real or perceived violations of social or cultural norms (Tangney & Dearing, 2002). Research has found a moderate yet significant relationship between shame and the severity of PTSD symptoms (López-Castro

et al., 2019), with shame potentially predicting higher levels of PTSD symptoms for up to six months after the trauma (Andrews et al., 2000). In EMDR therapy, the 'blind to therapist' procedure, where the therapist reassures the client that they do not need to share their trauma story but only focus on it, can help bypass shame (Hafkemeijer et al., 2020). However, this approach may make it more challenging for the therapist to identify avoidance behaviours, potentially reducing the effectiveness of treatment for clients who are highly avoidant or those experiencing tonic immobility.

1.3. Imagery Rescripting

Imagery Rescripting (ImRs) is a therapeutic approach in which patients are guided to re-imagine distressing or emotionally charged memories or experiences and modify their content to reduce associated negative emotions and beliefs (Arntz et al., 2007). In ImRs, individuals are guided to revisit traumatic memories and modify them to reduce emotional intensity and change their meaning. This often involves adding adaptive elements, such as envisioning a protective figure or changing the traumatic event's outcome, while providing comfort and validation during the memory. It can be used to target deep-seated childhood maladaptive schemas that often underlie PTSD, replacing them with healthier, adaptive schemas (Arntz et al., 2007). This focus on reshaping traumatic memory content and modifying core schemas makes ImRs particularly well-suited for addressing the complex and pervasive impacts of childhood sexual and physical abuse. Considering the high levels of shame and tonic immobility often observed in clients with CSPA-related PTSD, ImRs may offer potential advantages, as it does not require clients to fully relive traumatic memories and it can reduce feelings of shame by helping clients understand that they were not at fault and that the trauma does not define their self-worth or character.

Layden et al. (1993) were pioneers in introducing ImRs as a method for managing trauma-related memories. Originally developed within schema therapy to treat personality disorders, ImRs has since become recognised for its effectiveness in PTSD treatment (Arntz et al., 2007; Jung & Steil, 2013). A randomised clinical trial by Boterhoven de Haan et al. (2020) demonstrated that both EMDR and ImRs significantly reduced PTSD symptoms in adults with a history of CSPA-related trauma, while also addressing related issues such as depression, dissociation, and trauma-related thoughts. The low dropout rates associated with ImRs suggest that patients found this approach tolerable. Additionally, Raabe et al. (2022) found ImRs beneficial as part of trauma-focused treatment and as a stand-alone option for CSPA-related PTSD. These promising results, however, were derived from a small sample size, underscoring the need for replication. Furthermore, Arntz et al. (2007) showed that integrating ImRs with Prolonged Exposure (PE), a component of CBT, enhanced the management of anger, hostility, and guilt compared to PE alone. This evidence supports the potential of ImRs as a valuable addition to treatment protocols for CSPA-related PTSD.

1.4. Cultural sensitivity

This case study examines a Dutch male of Indonesian and Surinamese descent. Cultural background is a critical consideration, as it can shape both engagement in therapy and responsiveness to trauma-focused interventions. Schnyder et al. (2016) emphasise that trauma symptomatology, coping strategies, and the therapeutic alliance are profoundly influenced by cultural context. In individuals of Surinamese/Indonesian heritage, culturally normative patterns of emotional expression, deference to authority, and family role expectations may substantially impact both participation in therapy and outcomes of interventions such as EMDR or Imagery Rescripting (Anjara et al., 2021). These considerations are particularly salient when addressing shame and trauma-related responses such as tonic immobility, as culturally mediated expectations regarding emotional restraint or submission may exacerbate feelings of guilt, embarrassment, and involuntary motor inhibition during traumatic recall, thereby influencing symptom presentation and therapeutic engagement.

2. Objective

The objective of this case report is to examine the potential benefits of incorporating ImRs into standard EMDR treatment for patients with CSPA-related PTSD who show limited progress with traditional trauma-focused interventions.

3. Case report

3.1. Case introduction

Willem, a 25-year-old Dutch male of Indonesian and Surinamese descent, was referred to our practice by a psychiatrist for the assessment of an autism spectrum disorder. Subsequent evaluation revealed that he did not meet DSM-5 criteria for autism spectrum disorder, but did meet criteria for PTSD. Diagnosis was established using the Structured Clinical Interview for DSM-5 (SCID-5-CV; First et al., 2016), complemented by the PTSD Symptom Scale (PSS) interview (Foa et al., 1993).

He experienced nightmares and flashbacks related to physical and emotional abuse by his father from the age of seven, and later disclosed sexual abuse by his father. To avoid flashback triggers, he avoided criticism, conflicts, older men, and Surinamese music. Other symptoms included chronic tension, persistent depressive mood, disrupted sleep, a 6-kilo weight loss over six months, low concentration, low self-esteem, feelings of inferiority, and a sense of disconnection from others. He also exhibited dissociation in response to criticism and during conflicts. Symptoms had been relatively manageable until two years ago, but worsened following the birth of his first child and increased relational stress.

Given the chronicity, severity, and broad range of symptoms, including affective dysregulation, self-perception disturbances, and relational difficulties, complex PTSD was considered and confirmed in line with ICD-11 criteria (WHO, 2022).

4. Method

4.1. Assessment

Table 1 displays the measures used from intake through session 30 and three months after treatment. The Structured Clinical Interview for DSM-5 Clinician Version and Personality Disorders version diagnostic tools were applied to assess Willem's diagnosis. Outcome measures, including the PTSD Symptom Scale, Symptom Checklist-90, Young Schema Questionnaire and Schema Mode Inventory were used to evaluate treatment effects and track progress.

4.2. Clinical measures

The Dutch versions of these instruments were used to assess treatment outcomes.

4.2.1. PTSD Symptom Scale

The PTSD Symptom Scale (PSS) interview consists of 17-items designed to assess core PTSD symptoms based on DSM-IV criteria (Foa et al., 1993). Items are rated on a 4-point rating scale, ranging from 1 (no distress) to 4 (extreme distress). The total score was used. A cut-off score of 14 is set to indicate clinically significant symptoms (Wohlfarth et al., 2003). The scale demonstrated good internal consistency and adequate reliability (Foa et al., 1993).

4.2.2. Symptom Checklist-90

The Symptom Checklist-90 (SCL-90) is a 90-item tool that assesses various psychological symptoms. Items are rated on a 5-point scale ranging from 0 (no distress) to 4 (extreme distress) (Derogatis, 1977). The Global Severity Index (GSI) is an average score of the SCL-90 that reflects overall psychological distress. The SCL-90 total shows excellent psychometric properties, with high internal consistency ($\alpha = .98$) and strong test-retest reliability ($r > 0.80$) (Arrindell & Ettema, 1986). In the average Dutch male population, a GSI cut-off score of 0.85–1.0 indicates clinically significant distress (Smits et al., 2015).

4.2.3. Young Schema Questionnaire – Long Form

The Young Schema Questionnaire – Long Form (YSQ-L3) was administered to assess clients' maladaptive schemas. The YSQ-L3 identifies 18 schemas based on 116 items rated on a 6-point scale ranging from 1 (not at all true of me) to 6 (very true of me). In this study, mean schema scores are used. The YSQ-L3 shows good to excellent reliability (α's ranging from.74 to .86) for most schemas, except for Enmeshment ($\alpha = .57$), and demonstrates good construct validity (Yalcin et al., 2023). Significant correlations exist between maladaptive schemas and post-traumatic symptoms (Dutra et al., 2008).

4.2.4. Schema mode inventory

The Schema Mode Inventory (SMI) (Young et al., 2007) assesses the intensity of various 'schema modes' or personality states. The SMI consists of 112 items rated on a 6-point scale ranging from 1 (not at all true of me) to 6 (very true of me), providing both total scores and average scores across 14 modes (e.g. Healthy Adult Mode, Vulnerable Child Mode). In this study, average mode scores are used. The SMI shows acceptable internal consistency (α's ranging from .79 to .96), adequate test-retest reliability, and moderate construct validity (Lobbestael et al., 2010).

Table 1. Diagnostic and Outcome Measures Administered from Intake to 3 months post-treatment.

	Measurement method	T0 Intake	T1 Session 5	T2 Session 12	T3 Session 21	T4 Session 30	T5 3 months past T4
Diagnostic measures	The Structured Clinical Interview for DSM-5 Clinician Version (*SCID-5-CV;* First et al., 2016)	X					
	The Structured Clinical Interview for DSM-5 Personality Disorders Version (*SCID-5-PD;* First et al., 2015)	X					
Outcome measures	PTSD Symptom Scale (*PSS;* Foa et al., 1993)	X	X	X	X	X	X
	Symptom Checklist-90 (*SCL-90;* Derogatis, 1977)	X	X	X	X	X	X
	Young Schema Questionnaire (*YSQ-L3; Young et al., 2003*).	X					X
	Schema Mode Inventory (*SMI;* Young et al., 2007)	X					X

4.3. Ethics statement

Written informed consent was obtained from the patient for the publication of this case report.

4.4. Course of treatment and assessment of progress

The client completed a total of 30 sessions, which included five psychoeducation sessions, four EMDR sessions, followed by five ImRs sessions and an additional five EMDR sessions. The final sessions focused on evaluating treatment outcomes, enhancing self-esteem, and implementing relapse prevention strategies.

4.4.1. Session 1–5

The initial five sessions focused on establishing a therapeutic alliance, developing a case conceptualisation, and preparing the patient for trauma-focused therapy through psychoeducation and the creation of a trauma hierarchy. The latter involved identifying and ranking traumatic events on a distress scale ranging from 0 to 10. As therapy progressed, the patient became increasingly open about his childhood traumas, including instances of sexual abuse.

To illustrate how the client began to develop an understanding of the connection between his current symptoms and his traumatic childhood, as well as how he started to access and articulate these experiences, a verbatim excerpt from session 5 is presented below (translated from Dutch).

T1: How does it feel inside right now?
C1: Empty … and kind of scary.
T2: In what way does it feel empty and scary?
C2: I feel anxious … and dark inside.
T3: Dark and anxious. What's it like inside when it's like that?
C3: Tight. Suffocating, like there's no way out. Like I'm trapped in a closed room.
T4: Where are you in that closed room?
C4: I'm searching along the walls, trying to find a way out.
T5: Looking for an opening, huh?
T6: That suffocating feeling – where do you feel it in your body?
T7: Here … in my throat, like my breath is being taken away.
C5: Yeah.
T8: Can you describe more precisely how it feels in your throat?
C6: It's like my throat is being squeezed shut.
T9: By something? What's doing the squeezing?
C7: I think … my father.
T10: Your father is squeezing your throat shut?

4.4.2. Session 6–9

The second phase of treatment focused on addressing the various traumas the client had experienced. EMDR therapy was initiated, specifically targeting the A-criterion traumas (e.g. multiple instances of sexual and physical abuse during the client's childhood). In addition, in vivo exposure and response prevention interventions were introduced (e.g. listening to Surinamese music that triggered traumatic memories and intense fear, without turning it off as he would normally do) (see Table 2).

In the first EMDR session, Willem reported a significant reduction in emotional intensity; within the first 15 min of EMDR, he was able to listen to Surinamese music without distress. However, the therapist expressed concern about the rapid drop in the client's SUD score, questioning whether dissociation or emotional avoidance might be contributing factors. In the subsequent session, this issue was addressed, and the client acknowledged feeling overwhelmed by the emotions elicited during EMDR, fearing that they might intensify his depression. He also reported that expressing emotions had historically led to punishment from his father, leading to deeply ingrained patterns of emotional suppression. He admitted that he had likely suppressed his emotions during EMDR, which may have contributed to the rapid decline in SUD scores.

Through psychoeducation, the client learned how his avoidance strategies reinforced his symptoms and the importance of confronting his emotions. Despite resuming EMDR with a new target, he continued to struggle with connecting to the emotions tied to the traumatic images. After the third and fourth EMDR sessions, this difficulty persisted. The client explained that feelings of shame and guilt were preventing him from fully engaging; he continued to feel that he was a bad person and experienced it as very dangerous to let his emotions surface.

Table 2. Summary of EMDR sessions 6–9.

Session	Trigger/memory	Negative cognition	SUD (start – mid – end)	Intervention/sentences	Goal
6	Surinamese music	'I'm dirty.'	8 → 5 → 0	'It's not your fault.'	Reinterpret music as harmless
7	Physical abuse	'I'm bad.'	8 → 4 → 0	'You didn't do anything wrong.'	Reduce feelings of guilt
8	Physical abuse	'I'm not good enough.'	3 → 0	'You are good enough. You are deserving of love.'	Work on self-esteem
9	Sexual abuse	'I'm dirty.'	6 → 2 → 0	'You are safe now.'	Emotion regulation

Note: SUD = Subjective Units of Distress.

Due to these ongoing difficulties, the decision was made to incorporate ImRs into the treatment. It was hypothesised that ImRs could help the client process emotions related to punishment for emotional expression and reduce feelings of shame and guilt, thereby enabling him to engage more fully in EMDR.

To illustrate how EMDR therapy was applied and how the client processed distressing memories triggered by Surinamese music, a verbatim excerpt from session 6 is provided below (translated from Dutch).

T1:	Think about the moment with the Surinamese music. Feel that angry feeling pressing in your heart and say to yourself, "I'm disgusting." Do you feel that? Follow my finger. [eye movements] What comes up now?
C1:	My body betrays me and doesn't do what I want it to.
T2:	Just focus on that. [eye movements] What comes up now?
C2:	I feel really ashamed.
T3:	Okay, notice that. [eye movements] And now?
C3:	That it's my own fault.
T4:	Focus on that. [eye movements] What comes up now?
C4:	I feel my heart pounding less.
T5:	Notice that. [eye movements] And now?
C5:	I'm starting to feel calmer.
T6:	Notice that. [eye movements]
T7:	What comes up now?
C6:	I want this feeling to stay.
T8:	(back to target) Now, if you focus again on the Surinamese music, how unpleasant does it feel on a scale from 0 to 10?
C7:	A 5.
T9:	What affects you the most when you think of it now? What makes it a 5?
C8:	That I'm angry at my body for getting aroused by the touches.
T10:	Focus on that. [eye movements] And now?
C9:	Shame … and sadness. (Tears roll down his cheeks)
T11:	Okay, focus on that. [eye movements] What comes up now?
C10:	I feel calm.
T12:	Focus on that. [eye movements] And now?
C10:	I don't want to think about it anymore. It's okay now.
T13:	Hold onto that. [eye movements] What comes up now?
C11:	Yeah, very positive. I feel calm.
T14:	Hold onto that. [eye movements] And now?
C12:	Very calm … peaceful.
T15:	Okay, focus on that. [eye movements] And now?
Back to target:	And on that scale from 0 to 10, how unpleasant does it feel now?
C13:	Not unpleasant … a 0, actually. I can handle it!

4.4.3. Session 10–15

Over the course of six ImRs sessions, the client practiced rescripting memories of being punished for expressing emotions and protecting himself from physical and sexual abuse. While the therapist was highly involved in guiding the rescripting process at the beginning, by the last session the client actively took a central role in rescripting, successfully protecting his younger self from his father.

Table 3 summarises the ImRs sessions, including the targeted triggers or memories, therapeutic focus, interventions, and goals:

The verbatim excerpt below highlights how the client began to articulate and process feelings of guilt, shame, and helplessness, and how the therapist guided him in validating and comforting the younger self:

T8:	What is it that you can't handle, Willem?
C8:	The memories … I can't bear them. I can't help it when they come back, but it takes so much out of me …
T9:	But Willem, it *is* a lot, what you've been through, isn't it?
C9:	Sometimes it felt truly unbearable. The beatings on my buttocks and my penis, having to satisfy him … it hurt so much, and sometimes it just felt so disgusting.

Table 3. Overview of ImRs sessions 10–15.

Session	Trigger/memory	Focus	Intervention/sentences	Goal
10	Physical abuse	Emotional validation and protection	'It is not your fault, you did nothing wrong. I am here to protect you now.'	Protecting and reassuring the younger self
11	Physical abuse	Emotional validation and protection	Same as session 10.	Strengthening safety and self-protection
12	Punishment after showing emotions	Safety in expressing emotions	'It is safe to show how you feel. I am here to listen.'	Reducing avoidance, enhancing emotional connection
13	Punishment after showing emotions	Safety in expressing emotions	Same as session 12.	Further strengthening the sense of safety and acceptance
14	Sexual abuse	Protection, removing child from situation	'This is not a safe place for a child, come, let me take you away from here.'	Visualizing removal from traumatic situation in a safe context
15	Sexual and physical abuse	Strengthening the healthy adult; experiencing control	'Now you are safe; I protect you. You are allowed to feel what you feel.'	Active rescripting by adult self, emotional regulation, and self-protection

Table 4. Overview of EMDR sessions 16–21.

Session	Trigger/memory	Negative cognition	SUD (start – mid – end)	Intervention/sentences	Goal
16	Surinamese music	'I'm dirty.'	5 → 0	Reinforce previous sense of safety	Consolidate progress achieved
17–21	Several instances of Sexual/ Physical abuse	'I am worthless,' 'I am not safe'	Highest: 8 Lowest: 0	'You are safe now; there is nothing to fear.'	Enhance emotional connection; reduce avoidance

Note: SUD = Subjective Units of Distress.

T10 Yes … but Willem, hearing you say this, I already feel a knot in my stomach. I think, my God, what a heavy burden you carried as such a little boy. I feel so sad for you – it's just terrible.
T11: (Short silence)
C10: Yeah … (the client starts crying) and I thought, *that's the worst part* … my mother just went on with other things … and I kept thinking, *why? why?*
T12: (Short silence) … Why?
C12: I'll never get an answer to that, unfortunately.
T13: (Long silence) Have you ever been comforted, Willem?
C13: No …
T13: But how can we comfort that little boy, Willem? Because that little boy went through so much – things no eight-year-old should ever experience. That child must have been terrified at times. How can we best comfort him?
C14: By telling him it wasn't his fault … and by listening. I'm so full of these memories. They have to come out. I feel so dirty.
T14: I'm here to listen, Willem. It's a lot, I know. I'd like to suggest we take it slowly – we have time. Let's work through the memories step by step. Is that okay with you?
C15: Very much so. Thank you for being here for me.

4.4.4. Session 16–21

This process laid the foundation for the subsequent five EMDR sessions (see Table 4), during which the client was able to engage more fully with the traumatic material, experienced reduced feelings of shame and guilt, and felt an increased sense of control while reflecting on and processing his traumatic experiences.

4.4.5. Session 21–30

The final sessions focused on evaluating the treatment and applying the client's new insights to his daily life. He began reassessing his social contacts, distancing himself from some significant others while growing closer to others, and showing vulnerability to those he trusted. Attention was also paid to relapse prevention, particularly for depressive symptoms.

5. Results

The client's symptoms improved substantially after treatment. After treatment, the client no longer met a PTSD diagnosis and all scores on the PSS and the SCL-90, were below cut-off for clinical significance. This progress remained stable after three months.

Significant reductions in PTSD symptoms were observed on the PSS following treatment. The client's score decreased from an initial 24 to a final score of 3, which remained stable at three-month follow-up, reflecting a 21-point improvement (see Figure 1). Symptom reduction began gradually, with a slow and steady decrease evident by Session 5 after the initiation of EMDR. Following the introduction of Imagery Rescripting (ImRs), symptoms decreased further, and by Session 12 the client's score fell below 16, indicating remission of PTSD. A second round of EMDR (Sessions 16–21) contributed to additional reductions in PTSD symptoms (see Figure 1).

Assessment of general psychological distress using the SCL-90 revealed an initial GSI of 2.3 (see Figure 2), reflecting severe distress relative to the average Dutch male population, in which a GSI of 0.85–1.0 indicates clinically significant distress (Smits et al., 2015). After the first five sessions, the client reported some relief, although scores briefly increased during initial work on traumatic memories. Notably, distress increased from Session 5 to Session 12, coinciding with the first EMDR sessions (6–9) and the introduction of ImRs at Session 10. Following Session 12, a clear reduction in distress emerged, corresponding with the rescripting of memories in which the client had been punished by his father for expressing emotions. Between Sessions 12 and 21, GSI scores declined from 2.4 to 1.4, likely reflecting the combined effects of ImRs sessions and the second round of EMDR. By Session 30, the GSI had decreased further to 1.1, approaching the clinical cut-off for distress (see Figure 2).

The YSQ revealed high scores (>3.0) pretreatment on the schemas Seeking approval/recognition, Emotional deficiency, Strict standards/being overcritical, Distrust/abuse, Social isolation/alienation & Punitive. After treatment, scores decreased substantially for all schemas, with decreases of 27.0% to 75.5% and all but two mean scores falling below 3.2. Only the schemas 'Seeking approval/recognition' and 'Strict standards/being overcritical,' were still above 3.0 after treatment (both scored 3.2) (see Figure 3).

The SMI demonstrated reductions in dysfunctional modes such as the Vulnerable Child (reduction of 3.4), Angry Child (reduction of 3.3), Punishing Parent

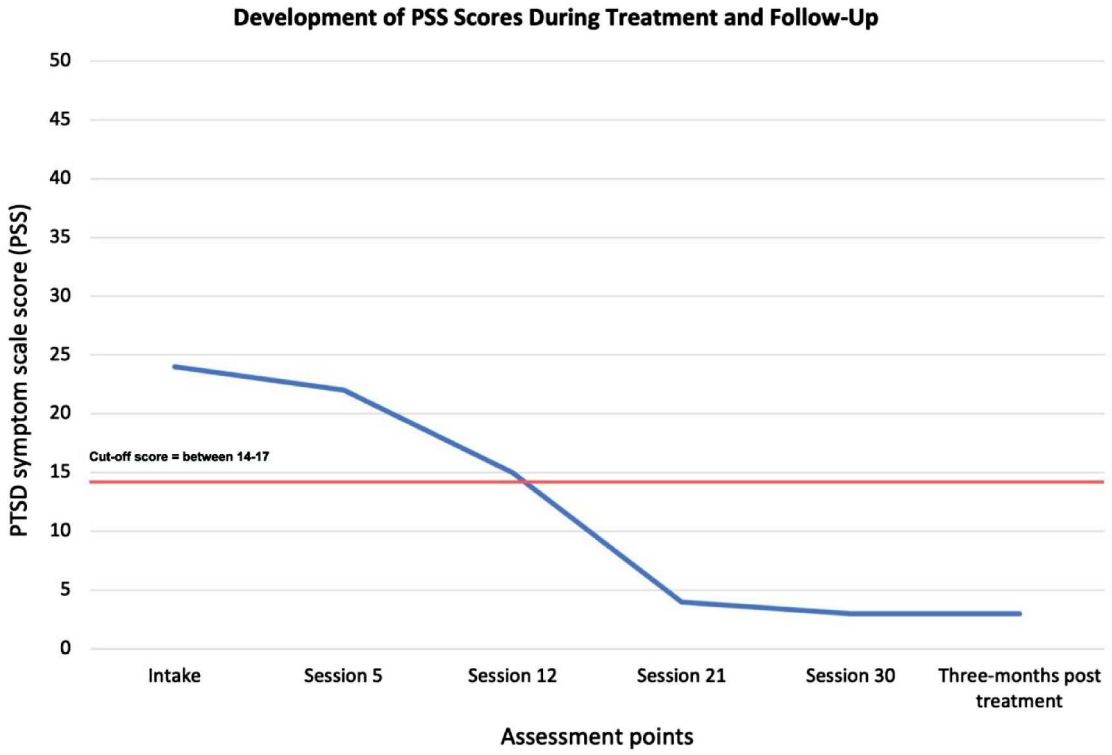

Figure 1. Posttraumatic Symptom Scale (PSS) scores at intake, during treatment, after treatment, and at the 3-month follow-up. Total scores range from 0 to 51, with a cut-off score of 14–17 typically indicating clinically significant symptoms consistent with a diagnosis of posttraumatic stress disorder (Wohlfarth et al., 2003).

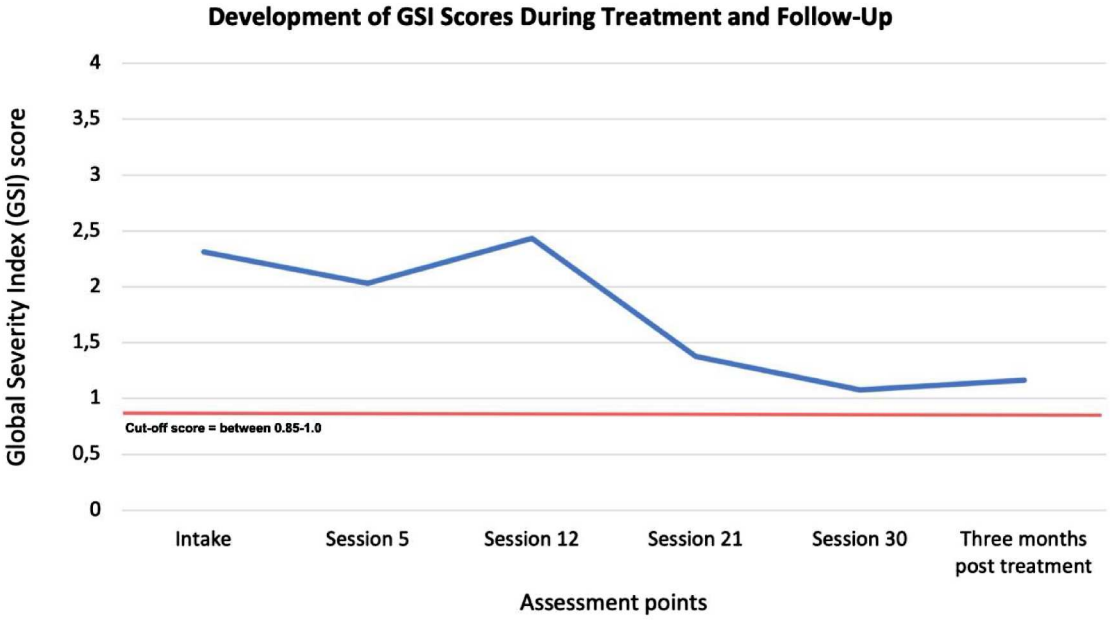

Figure 2. Scores on the Symptom Checklist-90 (SCL-90) at intake, during treatment, after treatment, and at the 3-month follow-up (Derogatis, 1977). The Global Severity Index (GSI), derived from the SCL-90, reflects overall psychological distress, with scores ranging from 0 to 4. A GSI cut-off score between 0.85 and 1.0 indicates clinically significant distress (Smits et al., 2015).

(reduction of 2.5), Detached Self-Soother (reduction of 3.0), Willing Compliant (reduction of 1.86), and Demanding Parent (reduction of 1.86), after treatment. Additionally, there were increases in healthy modes, with the Happy Child showing an increase of 2.0 and the Healthy Adult an increase of 1.2 (See Figure 4). These changes indicate improved emotional resilience and a greater ability to meet emotional needs.

6. Discussion

The client showed substantial and sustained improvement following combined ImRs and EMDR treatment.

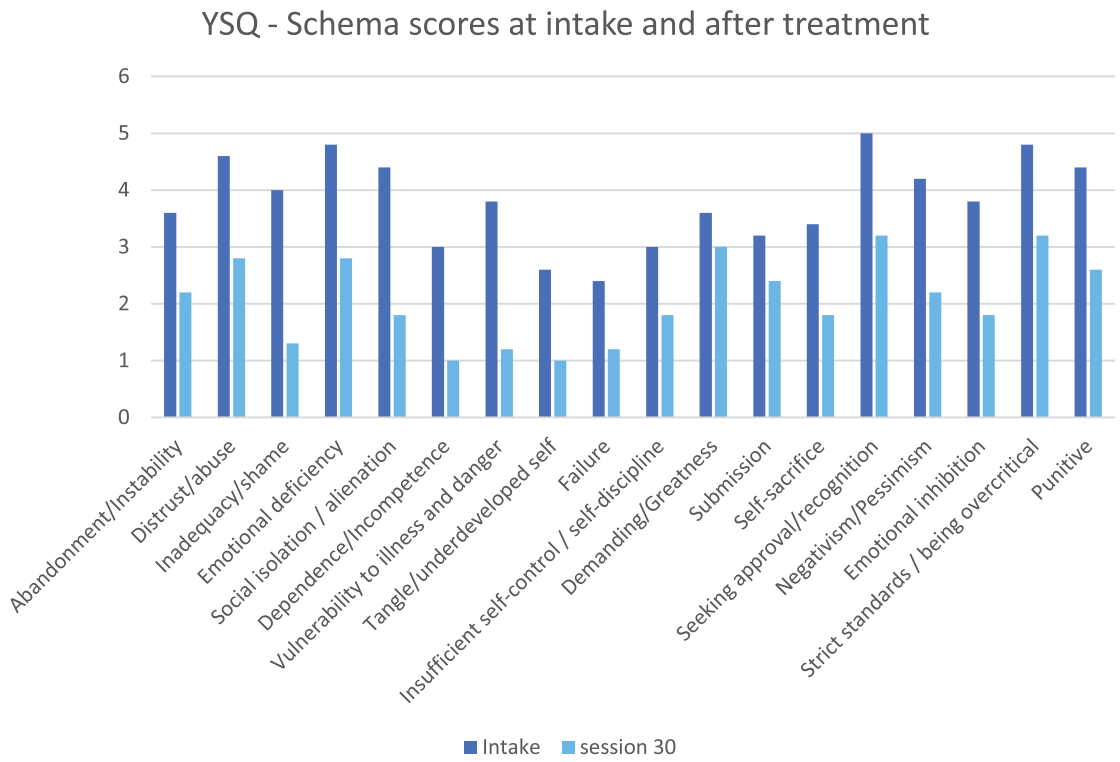

Figure 3. The Young Schema Questionnaire – Long Form (YSQ-L3) was administered at intake and post-treatment (Session 30). The YSQ-L3 assesses 18 schemas through 116 items rated on a six-point scale ranging from 1 ('not at all true of me') to 6 ('very true of me'). The figure displays the mean scores for each schema. Higher total and subscale scores indicate a greater presence of maladaptive schemas, with scores of 5 or 6 reflecting clinically significant schema endorsement (Young et al., 2003).

PTSD symptoms decreased steadily, with initial reductions during EMDR and further improvement following ImRs and a second round of EMDR. In contrast, general distress initially increased during early EMDR sessions but began to decline once ImRs was introduced, particularly during sessions addressing punishment for emotional expression. These sessions appeared to mark a turning point, after which distress rapidly decreased. Maladaptive schemas and dysfunctional modes had decreased by the end of therapy, while healthy modes increased, reflecting improved emotional regulation, resilience, and self-support.

These improvements appear to result from complementary mechanisms of ImRs and EMDR. Early EMDR sessions were limited by avoidance, dissociation, and tonic immobility (Marx et al., 2008),

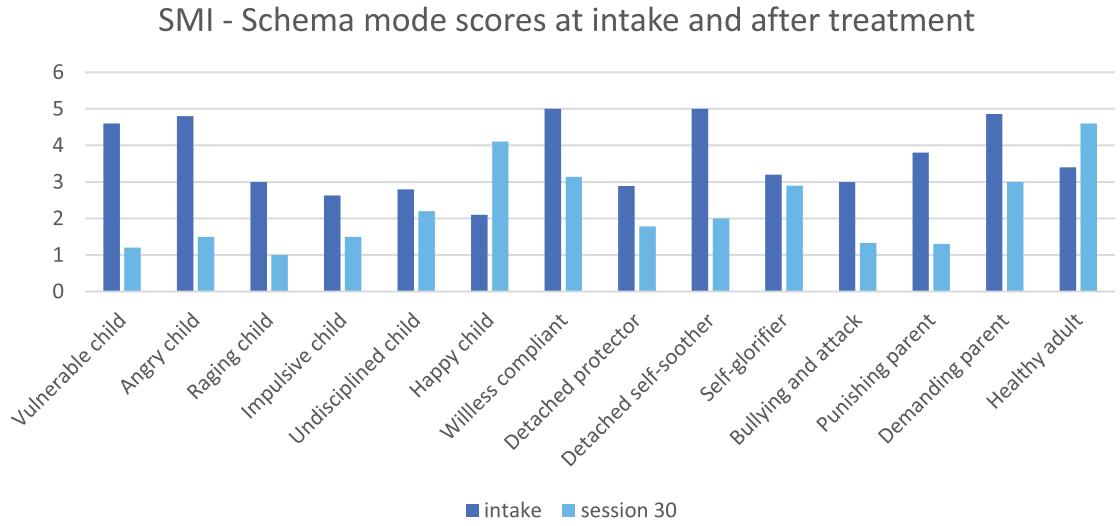

Figure 4. The Schema Mode Inventory (SMI; Young et al., 2007) was administered at intake and post-treatment (Session 30). The SMI consists of 112 items rated on a 6-point Likert scale ranging from 1 (not at all true of me) to 6 (very true of me), generating total and subscale scores across 14 schema modes (e.g. Healthy Adult, Vulnerable Child). Average scores for each mode are presented. Higher scores indicate greater intensity of the corresponding schema mode, with mean subscale scores above 4 considered clinically significant (Young et al., 2007).

which hindered full engagement with traumatic material. Like EMDR, ImRs requires a certain degree of confrontation with traumatic material, which can evoke intense emotions, shame, or even a freeze response when traumatic experiences are activated. Critics might argue that ImRs could be more shame-evoking than EMDR, given the therapist's active presence in the imagery, making the trauma more 'visible' to another person. In this case, however, ImRs facilitated emotional processing by providing a structured and supportive context in which the therapist initially modelled and guided rescripting of distressing memories, particularly those involving emotional suppression and fear of punishment (Arntz et al., 2007). Over time, the client gradually adopted a more active role in rescripting and self-protection. A marked reduction in general distress followed the session in which the client was validated for expressing emotions and protected from imagined punishment. The therapist's empathic presence and real-time guidance appeared to help the client tolerate and integrate intense emotions such as shame, guilt, sadness, and fear. Beyond its role in schema modification and mastery, ImRs may also reduce tonic immobility by restoring agency and defensive capacity (Schauer & Elbert, 2010). This shift likely enabled more effective engagement during the second EMDR phase, when avoidance diminished and both PTSD symptoms and distress scores decreased.

From an EMDR perspective, Imagery Rescripting can also be conceptualised as an elaborated cognitive intervention (CI): by actively rescripting traumatic memories, previously inaccessible emotional or cognitive material becomes available for processing (Shapiro, 2001). Unlike brief psychoeducational or cognitive interventions sometimes used in EMDR, ImRs provides a structured, imaginal, and interactive format, allowing the therapist to model responses and guide the client through the rescripting process.

ImRs may be particularly beneficial when cultural factors influence emotional expression or relational dynamics with authority figures (Schnyder et al., 2016). In this case, the intervention provided a culturally sensitive framework in which the client could guide the therapist in what felt safe and appropriate, enhancing trust, reducing shame, and supporting emotional processing within his Surinamese – Indonesian context. These findings are consistent with previous research demonstrating that both ImRs and EMDR are effective for complex PTSD (Boterhoven de Haan et al., 2020) and highlight the potential benefit of flexible, personalised treatment approaches that are tailored to the client's emotional and cognitive readiness. Optimal arousal, neither too high to provoke overwhelm nor too low to prevent emotional engagement, appears critical for effective trauma processing (Greenberg, 2015; Pascual-Leone, 2018).

Clinically, this case emphasises the importance of flexible, client-centered treatment planning. Therapists should observe signs of avoidance, dissociation, or tonic immobility and adjust pacing, validation, and protective interventions accordingly. Active therapist involvement combined with client-guided rescripting enhances mastery, self-protection, and emotional regulation. These strategies may benefit other individuals with complex PTSD, particularly those struggling with entrenched maladaptive schemas, shame, or culturally influenced patterns of emotional suppression.

A key strength of this study is its detailed, session-by-session tracking, which illustrates how therapy can be adapted to the client's needs in real time. The interactive nature of ImRs is highlighted, showing how therapist modelling initially supports rescripting, gradually enabling independent client engagement. This demonstrates the value of personalised, flexible intervention, particularly in cases where avoidance, dissociation, or tonic immobility might otherwise limit progress.

Several limitations should be noted. First, the use of the PSS rather than the DSM-5–aligned PCL-5 limits comparability with current research (Weathers et al., 2013) and may not have fully captured symptoms such as guilt, negative self-beliefs, and negative emotions. This may explain why PSS scores decreased from Session 5, while overall distress initially increased. Second, no pre-specified session plan was established, limiting experimental control and making it difficult to disentangle the specific contributions of ImRs versus EMDR. Third, the single-case design and small sample size reduce generalizability, and cultural or therapist-specific factors may have influenced outcomes. Finally, the relative influence of therapist factors versus the intervention itself cannot be fully determined.

Despite these limitations, the case illustrates the advantages of flexible, real-world therapeutic adaptation. Future research should employ randomised controlled designs to clarify causal effects, compare multiple trauma-focused interventions including EMDR, ImRs, Imaginal Exposure, and Emotion Focused Therapy for Complex Trauma, and examine moderators and mediators of treatment response. While stricter experimental designs improve internal validity, they may reduce the capacity for personalised intervention, highlighting the ongoing value of case studies for understanding therapy in practice.

7. Conclusions

The combination of ImRs and EMDR appears to have contributed to this client's recovery from PTSD related to childhood trauma. While initial EMDR sessions were limited by avoidance, dissociation, and

intense emotions, ImRs may have facilitated the client's ability to reframe traumatic experiences, reduce maladaptive schemas, and build emotional regulation and self-protection. Personalised, flexible treatment appears particularly important for individuals with complex PTSD, as interventions need to be adapted to the client's emotional readiness, cultural context, and response patterns. This integrated approach was associated with substantial reductions in PTSD symptoms and improvements in overall well-being. Future research should examine the comparative and combined efficacy of ImRs and EMDR and investigate which client characteristics predict optimal outcomes with these interventions.

Disclosure statement

No potential conflict of interest was reported by the author(s).

Ethics approval and consent to participate

Client signed informed consent and gave permission for publication. All identifiable details have been altered.

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