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# Treatment of childhood memories: theory and practice

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## Abstract

With the growing interest of cognitive behaviour therapy in early developed psychopathology like personality disorders there is an increased need for therapeutic methods for more directly treating pathogenic schemas. Exploring and reinterpreting memories of early childhood experiences that are assumed to have contributed to the pathogenesis are more and more viewed as a promising way to modify core schemas. Experiential methods seem to be the most effective. This article discusses two main forms of these methods: (i) imagery with rescripting and (ii) role play, both of childhood interactions with key figures. For both, protocols are provided as guidelines for clinicians and to stimulate standardization so that this new field can be opened for experimental research. Theoretical views are discussed as to why these methods might be so effective in treating chronic problems that originated in childhood. © 1999 Elsevier Science Ltd. All rights reserved.

*Keywords:* Cognitive behaviour therapy; Personality disorders; Early memories; Imagery

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## 1. Introduction

There is a growing interest among cognitive behaviour therapists in the treatment of chronic forms of psychopathology which have their roots in (early) childhood. Among them are the sequelae of childhood (sexual) abuse (Jehu et al., 1988; Waller & Smith, 1994; Smucker et al., 1995), personality disorders (Beck et al., 1990; Layden et al., 1993; Arntz, 1994; Young, 1994; Padesky, 1994) and other forms of personality problems like low self-esteem (Fennell, 1997). Attempts to treat these patients with more traditional cognitive behaviour therapy (CBT) methods have generally be found to have limited success, though

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to the best of the present authors' knowledge this conclusion is based on clinical experiences rather than on controlled research. In any event, this clinical impression seems so strong that clinicians and researchers have equally been prompted to develop new methods for these disorders. Among them are, at least for CBT, relatively new methods like imagery with rescripting, psychodrama-like role plays, empathically confronting the patient with feelings elicited in the therapist, schema-dialogues, etc. (Beck et al., 1990; Layden et al., 1993; Arntz, 1994; Padesky, 1994; Young, 1994; McGinn & Young, 1996). Many of these methods are primarily *experiential*, that is use the emotional experience rather than controlled thinking or behaviour to induce change. Not surprisingly, a number of these methods are inspired by, or resemble methods known from experiential and psycho-analytic therapies. Similarly, in these therapies new topics are addressed like the therapeutic relationship and childhood experiences with core figures such as the parents (Beck et al., 1990; Arntz, 1994; Padesky, 1994; Young, 1994; McGinn & Young, 1996). Because these new forms of CBT continue to be based on a theory (in most cases *schema* theories, or variants like interacting cognitive subsystems theory (Teasdale, 1993)), this development has made these new forms of CBT really integrative therapies, in the sense that they use methods and techniques from different orientations, without becoming eclectic in a nontheoretical sense. Some have even proposed new names for these forms of CBT, like schema-based therapy (McGinn & Young, 1996).

During our own work with treating personality disorders we became especially interested in the effects of addressing childhood memories. Clinical observations suggested that chronic problems otherwise difficult to change improved after addressing childhood experiences (or rather, the representations of them in memory), that were affectively linked to the present problems (and on a conceptual level to the schema conceptualization of the casus, for example, see Arntz (1994)). The most effective ways of treating the sequelae of these childhood memories seem to be experiential in nature, inducing new perspectives on what happened by experiencing new views (by taking new roles) and new emotions. The two main methods we use are historical role-plays and imagery with rescripting. The direct effects seem to be mainly affective in nature, i.e. after doing the exercise the patient begins to feel new emotions about the original situation. Of course, this causes confusion for the patient, but in the long run seems to induce change on the level of basic schemas.

Intrigued by these observations and inspired by similar reports by others, we tried to further develop these historical methods. We have now developed more systematic ways of using these methods and have described them in rudimentary 'protocols' which are currently tested in a controlled trial, comparing the effects of treating childhood memories using either role play or imagery methods with the effects of treating present problems (historical versus present focus). This article describes the methods we are currently using for treating childhood memories linked to the problems the patient is experiencing in present life, clinical problems with the application of these methods and their possible theoretical basis.

Before discussing these issues, it should be noted that when the term *experience* is used (in the sense of a childhood experience), not the historical facts are meant, but the memory of the event, i.e. the representation in memory of what was experienced. That is, various processes at different phases have probably influenced what is memorized and the meaning of it. This issue is also important in the context of the discussion on 'recovered memories'. The aim of the methods presented here is not to discover the (repressed) 'true facts', but to change the

meaning of schematic representations that have roots in childhood. In practice, this implies that the therapist must be aware of the (re)constructive processes of memory and restrains from suggesting any historical ‘facts’ during imagery or role plays.

## 2. Choice of method

Two historical methods will be discussed, *imagery with rescripting* and *historical role plays*. Though they have an overlapping domain of problems suitable to address with them, we use the following global rules to decide which to use.

### 2.1. *Historical role plays*

1. An interpersonal interaction with (preferable) one other person which can be easily played by patient and therapist (e.g. a parent verbally abusing the child is suitable, a parent physically abusing is not suitable (at least not the abuse itself)).
2. A specific change of perspective seems indicated, i.e. the therapist thinks it would be helpful when the patient discovers its own contribution as a child to the problematic interaction. Or, the therapist thinks that taking the perspective of the other is indicated (to break through egocentric views common in children).

### 2.2. *Imagery with rescripting*

1. Abuse involving physical contact.
2. The patient has received too little support as a child and it seems unlikely that the other person (as played by the therapist) will provide it when properly asked for.

In addition, some patients, and some therapists, have personal preferences for one of these methods. This should also be an important factor in choice of method. The two methods can also be mixed, e.g. role play to start with, followed by imagery when more than two persons are needed to rescript. These types of historical methods are best known from the treatment of obvious traumas. However, they are also indicated for all sort of experiences that do not impress as traumatic in a strict sense, e.g. the usual way a child felt ignored by the mother, etc. In the following, abuse will sometimes be used as an example, but this does not mean the method cannot be used for other childhood experiences.

## 3. Imagery with rescripting

Previous descriptions of imagery methods have, among others, been provided by Edwards (1990), Layden et al. (1993, pp. 86–92), Young (1994), Smucker et al. (1995) and McGinn and Young (1996). Layden et al. propose to use imagery with rescripting to help the patient deal with traumatic memories and schema’s/beliefs with a significant pictorial component. The major aim is to increase the sense of empowerment. Though their description of the

method is comparable to the one proposed here, there are a number of differences. First, we propose to use the method for all pathogenic early developed schemas and not only for traumatic memories and schema's/beliefs with a significant pictorial component. Second, our aim is broader than increase in empowerment. We hypothesize that the method can lead to fundamental schema change in many aspects. Third, we propose a more structured approach to be used during longer times in therapy, not only during periods when traumatic memories are triggered. Lastly, we tried to develop a more structured protocol, which may be helpful for therapists. We suggest letting the patient stay longer in the different perspectives, so that longer times are available for emotional processing and consolidating new insights.

Smucker et al. (1995) have described a protocol for treating PTSD due to sexual abuse in childhood. Following an information session, eight sessions (1.5–2 h duration) are spent on imagining the original abuse situation (like in imaginal exposure for PTSD; Dancu & Foa, 1993), followed by a rescripting phase, in which the patients imagine themselves as adults intervening (stopping the abuse and nurturing the child). In later sessions only the nurturing scenes are imagined. Homework comprises listening to the taped session twice (!) a day, writing a letter to the perpetrator, filling in a homework journal, etc.

The present authors have tried to use the protocol of Smucker et al. (1995) protocol with personality disordered patients, in some cases slightly adapting the method to treat other interpersonal issues of the child than sexual abuse<sup>1</sup>. The main problem encountered was that some patients had great difficulties with integrating the new views they experienced from the perspective of themselves as an adult. Briefly, they commented “as an adult I saw that it was wrong what (for example) the parents did and that the child was not to blame, *but I do not feel it*”. We therefore added a third phase, in which the rescripting was again imagined, but now the patients again taking the perspective of the little child, receiving the interventions of themselves as adult. Moreover, the patient (as a little child) was stimulated to ask the intervening adult for anything (s)he needed. Usually, the adult patient intervenes by stopping the abuse and protecting the child, but forgets to comfort the child, or does not adapt its communications to the level of a little child, or forgets to correct actively dysfunctional interpretations. In the perspective of the child, the patient generally experiences after the abuse is stopped the need for consolation (usually on an experiential level, e.g. the child wants to be hugged and protected more by bodily communications than by words). The patient is therefore stimulated to express any need until (s)he feels fine. Thus, the third phase functions (i) to help to integrate the new perspectives and (ii) to further rescript and process by letting the patient as a child experience and express anything (s)he needs.

On a theoretical level, the addition of this third phase has advantages above using only the first two phases. First, the new information is feed more directly into the schematic representations of the (class of) experiences compared to when only the adult perspective is available, because it is experienced from the same perspective and, so to say, on the same developmental level as the original experience was. Second, we generally have experienced

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<sup>1</sup> Note that identifying a memory to treat with imagery or historical roleplays is more complicated in the average personality disorder compared to PTSD (in which the childhood trauma is known). Methods to find important childhood memories in personality disorders are described later.

much higher levels of affect and new forms of affect (e.g. sadness and anger instead of fear), in the third phase compared to the second phase. Thus, emotional processing (Rachman, 1980) is taken place in a much more intensive form, fostering the change of self- and other schemas. Third, the perspective of the child receiving the interventions by the adult patient triggers new needs that have generally be suppressed in childhood (i.e. the family in which abuse takes place without correction is generally also punitive as to emotional expression of the child's needs). In that way, the patient learns to feel and acknowledge emotional needs and to ask others for help, support, consolation, etc. which forms new basic self and other schemas. Thus, better integration of new information in basic schemas, more intensive emotional processing and the growth of underdeveloped areas central to self and other schemas seem more facilitated with this third phase.

The various forms of the imagery with rescripting method are now described. Some of the problems we encountered will be discussed and solutions offered. It will also be discussed which form seems most appropriate given the individual characteristics of the patient. The basic model will be treated first and other forms of imagery with rescripting will be discussed as variants from this model.

#### 4. Imagery with rescripting: basic model

As said, this model is a direct extension from the method of Smucker et al. (1995). It comprises three phases (Table 1). In phase 1, the patient is asked to close the eyes and imagine the concrete childhood experience as lively as possible. There is no need for prolonged exposure and in the case of very severe traumas it is not necessary (certainly not in the beginning) that the patient imagines and tells the whole experience. The reason for this is that the method is not based on extinction, but on processing new, corrective information about the meaning of the event for self and others. In phase 2, the patient is asked to imagine the scene (with eyes closed) as an adult (thus, the patient sees the abuse, etc., as a bystander), to realize what (s)he feels, thinks and is inclined to do and to intervene and do whatever (s)he thinks is right. In phase 3, the patient is asked to imagine the whole situation again as a child, to view the interventions of him/herself as an adult, to feel what it means for him/her and to ask for anything (s)he needs from the intervening adult. The whole session is audiotaped and the

Table 1  
Three phases of the basic rescripting model

1	Patient = child	original scene as experienced by the patient as a child
2	Patient = adult	rescription: scene viewed by the patient as an adult intervention by the patient as an adult
3	Patient = child	rescription: intervention by the adult patient experienced by the patient as a child patient as a child asks for and receives further interventions from patient as an adult

patient takes the tape home to listen to it as homework. The three phases are now discussed in more detail.

#### 4.1. Phase 1

First, a lively memory of a childhood experience related to the origins of the dysfunctional schemas of the patient has to be found. There are several options. Sometimes it is known from previous information (e.g. anamnestic interview, etc.) which (traumatic) experiences in childhood happened. The patient can then be directly asked to close the eyes and remember the experience. In other cases, there is not such a direct recollection of childhood memories. Associative procedures are often helpful. The therapist can, for instance, ask the patient to describe a problematic recent experience. When feelings, thoughts or behaviour are clear, the therapist can ask to hold the central feeling (etc.) and to imagine him/herself as a child having the same feeling (etc.). Usually, a clear image from childhood comes. Another possibility (Young, personal communication) is to start with the imagination of a situation the patient feels good in (as an adult). After the patient has described the situation, the therapist asks to let out the image and to imagine him/herself as a child. Usually, a memory of opposite affective valence and meaning is triggered, which can be used for the procedure. Letting patients read the Young and Klosko (1994) self-help book *Reinventing your life* can also be very helpful in triggering early memories.

It is not necessary that the remembered experience is traumatic in a restricted sense. We have successfully used the method with memories of interactions with parents in which the child experienced emotional neglect, miscommunication, etc. It is also not necessary that the memory is the earliest, because usually the typical events were repeated over and over again during childhood. Concrete traumas that were not (often) repeated are exceptions to this rule. It is also not necessary that the patient is absolutely certain that the remembered experience really took place in all aspects as remembered, because it is aimed to change the meaning of generalized, schematic representations of prototypic childhood experiences. The patient can be explained, if this seems helpful, what the ideas of the method are. If the therapist has a good case conceptualization and has done an anamnestic interview, (s)he can decide whether or not the memorized experience has been important for the formation of central dysfunctional schemas.

The second step is to let the patient imagine the concrete memory. The patient is asked to close the eyes and to get a clear image of what happened. The patient is stimulated to tell what happens, and what (s)he experiences in the present tense (e.g. “I see my mother yelling and crying on the bed and she scares me”). It can be helpful to ask the type of questions familiar to CBT therapists who use imagery exposure: ask for sensory experiences (what do you see, smell, hear, feel, etc.), for emotions (what do you feel?), for thoughts (what is going through your mind?), for behaviour, for what is happening, etc. Strong emotions are a good indication that an important memory has been triggered. If the event is a clear enough, and the memory has been triggered enough (affective activation), the second phase can be started. Sometimes it seems helpful to discuss the memory and the feelings and ideas the memory evoked, but the therapist may also start phase 2 immediately.

#### 4.2. Phase 2

Eyes (still) closed, the patient is instructed to view the scene just imagined as an adult bystander. When the patient has the image, the therapist asks what the patient (as an adult) sees, feels and thinks, what inclinations (s)he has to do and to intervene (that is to do what (s)he is inclined to do). It can be helpful to lead the patients attention to certain persons or acts (e.g. look at the face of little Hans, what does he think of what happens?). The basic questions are summarized in Table 2 and can be repeated until all interventions are done and the patient says it is OK now. It is suggested not to direct the patient as an adult to any specific feeling, opinion or intervention (unless, perhaps, the patient asks for help), because the force of the method is that the new views on what happened are *experienced* by the patient by taking the perspective of a bystander. It is hypothesized that self-generated ideas are much more believable than ideas suggested by others (as the therapist) (Nisbett & Ross, 1980). Thus, by letting patients concentrate on what they feel and think looking at how the little child is treated helps to develop new meanings about the event.

Generally, the patient as an adult first addresses the parent, or other abusive figures, and intervenes. Sometimes it is indicated to actively direct the patient's attention to the little child, using the same questions and stimulating interventions, usually resulting in actions towards the child like telling the child it is safe now and that the abuse was not its fault (cf. Smucker et al., 1995). Following this, the new views and correcting actions are discussed, paying special attention to the implications for the meaning of the event. Sometimes patients are not satisfied with their actions. They can then be invited to try alternative actions in imagery. It should be stressed that patients are free to try and find various actions, until they are satisfied. As an example, a patient might initially want to kill an abusive brother, but on second thoughts does not like this action and tries another action, like threatening the brother with legal actions if he does not stop the abuse.

#### 4.3. Phase 3

After discussing phase 2, patients are again invited to take the imaginary role of the child and to view and undergo the actions of themselves as an adult. Patients are asked to describe what happens and what they feel and think. When the actions of the adult are finished, the therapist instructs the patient to focus on feelings and thoughts about the intervention, and to

Table 2

Main questions in phases 2 and 3 of the basic model of imagery with rescripting

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What happens? What do you see?  
 What are you feeling?  
 What are your thoughts about this?  
 What are you inclined to do?  
 OK do it ....  
 (repeat sequence until it is OK)

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explore any wishes they have for further actions of the adult. When it is clear what the child wants, the patient is stimulated to ask the adult for this. The patient is then asked what the adult does, how that does feel and to explore and express additional wishes, etc., until the child feels fine. Thus, in this phase the patient learns to receive protection and care, to acknowledge what (s)he needs, and to ask for these needs to be met.

#### 4.4. Case example

After phase 1 the therapist continues as follows:

T: Good, I would like to ask you now to imagine the whole event again, but now as an adult, as if you are witnessing what happens, looking to your father and little Tanja. Imagine that you are standing in the same room looking to what happens... OK... could you close your eyes? You are in the same room as little Tanja, seeing Tanja lying in her bed...

P: Uh hm...

T: What is happening?

P: She is lying there restlessly... and her father enters the room...

T: Look to her. What do you see on her face?

P: She is scared... scared to death...

T: ...what is happening?

P: He walks to her bed, starts to fondle her and tells her to keep quiet because otherwise mother will hear her...

T: Look to the girl... what are you feeling?

P: I'm outraged. (*Note: in phase 1 fear and guilt were the dominant emotions.*)

T: Is there anything you would like to do?

P: I would like to pull him off the little girl, to curse him and throw him out of the room!

T: OK, do that...

P: I pull him off the girl, curse him, say he is a bastard, and I throw him out of the room and I lock the door.

T: OK (...) and how are you feeling now? Is there anything you would like to do?

P: Satisfied. It is OK so.

T: Good (...) Look to the girl now...what are you seeing?

P: She is lying on the bed... still afraid...

T: What are you feeling now?

P: Pity...

T: What would you like to do?

P: I would like to tell her that she is safe now...

T: OK tell her.

P: You are safe now. You do not have to be afraid anymore.

T: Look to her... how is she reacting?

P: She seems OK now.

T: Good. What are you feeling now? (etc. until P says it is fine).



After phase 2, the therapist continues as follows:

T: I would like to ask you to imagine the whole event again, with the adult Tanja in the room and throwing out father and talking to little Tanja, but now as little Tanja. Can you close your eyes? So you are little Tanja, lying on her bed. Papa is sneaking into the room... how are you feeling?

P: I was already waiting for him... I'm so afraid...

T: What is happening?

P: He comes to my bed and starts to fondle me and says I should be quiet otherwise mama will hear us and she will find me a naughty child doing this and perhaps send me away...

T: Big Tanja is also in the room... what is she doing?

P: She walks to us, pulls papa from me, she curses him, saying he is an idiot and that he shouldn't do things like that, and she throws him out of the room... she locks the door...

T: How are you feeling now?

P: I'm glad she has done something, but I'm also afraid that papa will be very angry and that mama has heard it...

T: What is big Tanja doing now?

P: She comes to me and tells me that I'm safe now, that I do not need to be afraid anymore...

T: How do you feel now?

P: Still afraid...

T: Is there anything you need from big Tanja, that she could do?

P: I'm afraid that papa will return and punish me, beat me for letting big Tanja help me.

T: Can you tell her that?

P: Yes... I'm afraid papa will punish me for you helping me.

T: And what is she doing?

P: She says that she will not allow that to happen.

T: Is that enough?

P: I want her to stay with me forever, to protect me...

T: Ask her! What is happening?

P: Will you stay with me to protect me?

T: What is she saying?

P: She says that's OK.

T: How are you feeling now? Is there anything you need?

P: I want to feel it, I want she comforts me, I want to sit on her lap and that she hugs me...

T: OK, ask her!

P: May I sit on your lap? Can you hold me and let me feel I'm safe and it is OK now?

T: What is she saying, what is she doing?

P: She says that's OK and takes me on her lap and hugs me... (patient starts to cry and feels relief).

T: (... after some time...) What is happening now? Is there anything more you need? (etc. until it is fine for patient).

#### 4.5. Variations

In some cases it might be helpful, or even necessary, to use variations on the basic imagery model. With very severe psychopathology, e.g. borderline personality disorder, the patient is in phase 2 unable to experience any new and healthy view in the role of adult on what happens with the child. Correction should then come from others. In other cases, the patient remains mainly in an autonomic, quasi-adult like role, unable to experience what the needs of the child are in phase 3 (this phenomenon is generally strongly related to the basic schema's of the patient, i.e. also clear from the case conceptualization; for instance: when autonomy is overdeveloped and dependency underdeveloped). In still other cases, the patient is too anxious or feels too powerless in the adult role to undertake any corrective action. In these cases one of the following variants may be used. It should be noted, however, that we sometimes found that the patient more easily discards the new views and corrective actions of others (including the therapist) in the imagery, compared to when the patient is the intervening adult. Apparently, at least for some patients experiencing the new view by taking the adult perspective is more convincing than having someone else bringing in this view. Globally, there are three variations on the method described above.

##### 4.5.1. Patient uses helpers

When the patient does not feel powerful enough to intervene (e.g. stop the abuse) in phase 2, or is too afraid of the 'perpetrator(s)', the patient can imagine others and/or tools as helpers. There seem to be cultural differences here: American patients seem often to use weapons like guns (Young, personal communication), whereas Dutch patients seem to generally prefer powerful others (like friends, the police). Others may be persons trusted in childhood, real persons like family members, neighbours, the teacher, etc., or fantasy figures (e.g. batman); but they can also be persons from the patient's present life. The therapist can also assist the patient. In this variant of phase 2 the patient remains the central actor: the patient directs the helpers.

##### 4.5.2. Therapist assists patient in the imagery

If, despite help, the patient still feels too powerless, is unable to imagine helpers or is unable to develop new views on what is happening, the therapist might actively instruct the patient to imagine the therapist assisting the patient as an adult. The therapist then asks the patients what needs to be done, proposes actions, etc. In other words, the therapist takes a more active role in intervening (what the therapist is doing in the image is said clearly by the therapist). However, the therapist still tries to have the patient as an adult involved in the rescripting and let the patient direct the intervention as much as possible. It is important that the therapist is self-confident, assertive and inventive in intervening. Very abusive others are not easily stopped in the patient's image, but the therapist must win. Therapists can also propose to get helpers or to use tools. Sometimes it is needed to be verbally very aggressive to defeat the abusive person (as in case of images of punitive parents in borderline patients, cf. McGinn & Young, 1996). In other cases, a calm but decisive tone of voice is more helpful. In one of our cases, the therapist spoke in a rather soft voice to a humiliating mother, explaining to her what she did to the child, asking her to correct her behaviour or otherwise leave the child. The patient said to be

astonished because nobody had ever dared to say such things to her mother and because the therapist was not aggressive, in her image her mother had therefore no defence nor excuse to neglect or oppose what the therapist said.

#### 4.5.3. *Therapist intervenes*

As a last possibility, when the patient is completely unable to play an active role in phase 2, or is even unable to view the situation as an adult, the therapist plays the role of the correcting adult. In that case, the patient imagines the interventions by the therapist from the perspective of the child, thus phase 2 and phase 3 are fused. The therapist has to set his own course, but can check with the patient in the later part of the imagination (when the child is safe and is invited to explore and express what it needs more) whether the interventions were right. Though this variant is helpful with severe pathology (in our experience it is the only possibility to start with in case of Borderline Personality Disorder), it can have the disadvantage that the patient dismisses the intervention and starts an argument with the therapist (using rationalizations like that the intervention would have been impossible, that the method is useless because the past cannot be redone, etc.). Because the patient did not experience the new views as a bystander and did not intervene him/herself, it is more easy to dismiss them and to continue the old view.

Another indication to use this variant is when the patient cannot experience the child perspective in phase 3. By talking to the child in a warm emotional tone, using language appropriate for children of that age, the therapist might succeed in letting the patient experience the child's perspective in receiving the corrections.

#### 4.6. *Example of therapist intervening*

The patient (paranoid personality disorder, dependent and borderline traits) has imagined a scene in which he as a young child is ridiculed in front of the whole family by his mother for having made a mistake and crying. His mother has commanded the whole family to attend this 'meeting'. In attempting to intervene as an adult in the second phase, he gets inhibited.

P: I cannot do anything. I'm too afraid. I'm little Peter now, I cannot be large and strong in front of my mother.

T: OK, be little Peter. Is it OK when I join you? Can you imagine me standing alongside you?

P: Yes, I can see you beside me.

T: Good. I'm talking to little Peter now... what is it what you need? Is there anything I can do?

P: ... (does not say anything, seems very afraid...).

T: OK, listen to what I say to your mother then... Madam, you are Peter's mother, aren't you? I have to tell you that you are doing terrible things to your son. He has made a mistake and feels sad about that. That is normal, everybody makes mistakes and everybody feels sad now and then. But you are humiliating him in front of the rest of the family. You are saying that he is ridiculous, a fool, inferior. But that is not true, Peter is a good boy and it is good that he tries to get sympathy and consolation from you. Because you are his

mother. And if you are not able to give him what he needs, and what every other child needs, that is a problem enough. But in any case you shouldn't humiliate him, because you have a problem in handling emotions and being a parent. So, stop humiliating him!... Peter, look to mamma now, what is she doing? What is she saying?

P: She looks a bit surprised... she is not used to be talked to like that... she does not know what to say... well, she says that I should be taught a lesson because I should have known beforehand that it would be wrong what I did...

T: Listen to me, madam. That's nonsense, Peter didn't know that beforehand and he feels sad about that, and if you cannot comfort him, stop talking like this or leave the room... What is she doing now, Peter?

P: She stops talking and just sits in her armchair...

T: How do you feel, little Peter?

P: I'm afraid that she will punish me when you go away...

T: Is there anything that I can do to help you? Ask me!

P: I want you to stay and care for me.

T: That is OK, Peter, I'll stay and take care of you... what do you need now?

P: That everybody stops looking at me and continues with what he was doing...

T: OK, everybody can continue with what he was doing. This was the last meeting during which one of the children was ridiculed. Everybody can go now, we want to be alone now.

P: I'm feeling sad now (starts to cry).

T: That's OK, do you want me to comfort you? Let me take you in my arms... can you feel that?

P: (cries even harder).

(etc.)

Note that the therapist takes several roles, intervening and protecting the child, correcting dysfunctional ideas about guilt and badness and comforting the child so that the experience can be emotionally processed. The therapist acts, in other words, as a good parent would have done.

#### 4.7. *Practical problems*

In practice, several problems can be encountered. The most common problems our group has experienced are now addressed.

##### 4.7.1. *What memory to choose?*

It is suggested to try and find memories that are highly affect laden, are related to the basic schema's and are early. It is not uncommon that rescripting is more complicated with memories of events experienced during puberty, than with earlier childhood. The patient tends to expect more adult behaviour from the adolescent than from the young child, so that correcting views and actions are more easily elicited in phases 2 and 3 with a young child compared to an adolescent. It is therefore suggested to choose the earlier memories.

#### 4.7.2. *Cannot find a memory*

There are roughly three reasons for this. First, the patient resists finding, telling or getting involved in a memory. Second, the patient might dissociate (getting blank) or show micro psychotic symptoms (e.g. seeing the therapist as the abuser). For both holds that fear of the presumed consequences is usually the cause. Exploring the fears and using techniques like providing disconfirming information, giving the patient control over the process (e.g. let the patient practice a nonverbal signal, like lifting a finger, to indicate that the therapist has to stop the imagery exercise), gradual approach of memories, gradual use of techniques, post-session contact (e.g. a telephone call) to help the patient deal with the elicited emotions, etc. may be helpful. With severe psychopathology, it cannot be expected that these imagery techniques can be applied immediately. It is not uncommon that it takes many sessions before the fearful patient is able to engage fully in the imagery exercises.

Third, the memory is not available by controlled processes. As said, associative procedures can be helpful. Experiencing any emotion, including those elicited during the therapy session, and using this feeling to get an associated memory from childhood is the method we usually employ in this circumstance.

#### 4.7.3. *The patient does not close the eyes*

It is not necessary to close the eyes, but we believe it is helpful because of greater concentration on the image. Exploration of the reasons is indicated, but the patient should not be forced to close the eyes. When reasons are known, it is sometimes possible to solve the problem. The first author once treated a paranoid (axis-2) patient who refused to close the eyes out of suspicion: he thought that the therapist would look for any signs of weakness and jeer at him. The therapist and patient agreed that the therapist would sit beside the patient and also close the eyes and the patient would be free to either close the eyes or not. After some sessions the patient reported to be able to close the eyes, but the therapist remained seated beside the patient and also engaged in the imagery while closing his eyes.

#### 4.7.4. *The patient dissociates*

This is not uncommon among the more severely abused patients. We have learned that with enough safety and with repeating the imagination the tendency to dissociate gradually reduces. A number of techniques can increase safety:

- (i) Giving the patient control over the process (e.g. rehearse a signal (like lifting a finger) which the patient can give when (s)he starts to dissociate: the therapist then stops the imagery exercise and helps the patient to concentrate on present reality (the patient can for instance be asked to direct attention to an object in the room and to describe it), cf. Arntz, 1994).
- (ii) Gradual approach of fearful memories.
- (iii) Allowing the patient to do the imagination with eyes open.
- (iv) Not letting the patient imagine the whole abusive memory, only the start of it and quickly going to phase 2.

With a successfully completed sequence of imagination with rescripting dissociative tendencies generally reduce.

#### *4.7.5. Loyalty to parents*

When parents have to be corrected in imagery, there is often resistance from the patient because of loyalty to the parent. It is generally believed that children of parents who treat them badly are loyal children (Cohen, 1984), some even say ‘the most loyal’ children. However, loyalty may have many faces. For instance, it is important to distinguish positively motivated loyalty from negatively motivated loyalty: in the first case something positive is earned from being with the other(s); in the second case something negative may happen when the obligations are discarded (Cohen, 1984). From our own work, we get the impression that ‘negative loyalty’ is the most common source of resistance against rescripting. In most cases this seems motivated by fear of being punished or abandoned when the child revolts against the maltreatment of the parent. Perhaps this type of loyalty is a sort of survival mechanism, motivating the child to keep the bonds with the parents despite maltreatment. In any case, we disagree with the view of some family therapists that loyalty should not be challenged. Thus, the patient is stimulated to engage in the imagery process and not to avoid the acknowledgement of the feelings, views and actions that are elicited. Realizing that your parent has treated you badly is, of course, a difficult process and elicits mourning. However this can help to leave old schema’s and to build new ones. Loyalty should therefore not cause avoidance of what should be addressed. Discussing this issue and repeatedly explaining that loyalty feelings were necessary to survive as a child, but do not have this function any more (as the patient is now an adult), can be helpful. Lastly, at end of therapy patients can make a new, and more balanced decision, as to what degree they will be loyal to their parents: the therapy does not require that the patient breaks with the parents, it only requires that this fear does not interfere with treatment.

#### *4.7.6. Guilt about chosen intervention*

Patients sometimes feel guilty about the intervention they chose during imagination. The first solution is that the therapist helps the patient to find alternative interventions that are also helpful, but do not have the disadvantage of inducing guilt. The alternatives are then tried, until the patient feels satisfied. A second possibility, especially in the case of exaggerated guilt, is to use cognitive methods to challenge the reasoning that leads to the guilty feelings (e.g. Kubany and Manke, 1995). It can also be helpful to explain that the method is ‘fantasy’, helpful to process the early experiences and not meant to be put in real action.

#### *4.7.7. Guilt about not having intervened as a child*

Patients sometimes complain that they feel guilty (or that the therapist let them feel guilty) because of not having intervened as a child in the way the adult patient does in imagery. The therapist can then explore with the patient to what degree it is realistic to expect from a child in the given circumstances to intervene like an adult. A second option is to address the issue in imagery: the patient as an adult (or the therapist) makes clear to the child why (s)he is not guilty of not having intervened.

#### 4.7.8. *The intervention is discarded as being unrealistic*

This is one of the most problematic forms of ‘resistance’. The dismissal is usually expressed after one of the first attempts to rescript. The therapist can explain the rationale and the method again, try to convince the patient to first try the treatment before discussing it, or explore what is avoided (e.g. becoming emotional). Sometimes patients are afraid of being guilty of not having invented the intervention themselves as a child (see above). The patient can also be invited to try alternative interventions.

#### 4.7.9. *Patient is too fearful/too powerless to intervene*

The patient can use whatever method to become stronger (e.g. becoming larger in the image, using weapons, getting help from others, etc.). In the most severe cases, the therapist should take the corrective role (see above variants).

#### 4.7.10. *Patient cannot take the child perspective*

There may be several reasons for this difficulty. Parentified patients might find it especially difficult to experience in the child perspective what they need and to receive comfort and nurturance from others. There are several things that can help. First, to choose an earlier memory: the younger the child, the more obvious it is it needs help. Second, the therapist can enter the picture and take care of the parent (or other children) so that the child is liberated from its quasi-parent role and can safely experience what it needs self. Third, if the therapist has entered the scene, (s)he can talk to the child as a child and behave in ways appropriate to the child’s age.

#### 4.7.11. *Fear of future consequences*

In the image, the patient can fear the future consequences of the intervention (e.g. the abusive parent punishing the patient when the correcting adult has left the child). Therapists should be aware of this fear and actively ask the patient about it because patients do not always express it. We have developed several options with patients: the adult stays forever with the child; the child gets a ‘beeper’ and signals the adult when in danger; the adult takes the child with him/her and raises the child; the adult will regularly return to check with the child, etc.

## 5. Historical role plays

Role playing interactions as remembered from childhood may be as effective as imagery techniques. Historical role play in the context of treatment of personality disorders has been mentioned, among others, by Beck et al. (1990), Arntz (1994) and Padesky (1994). However, as far is known to the present authors, a formal description of the method has not yet been provided. In the following an attempt is made. The presented method is currently be tested in a controlled study (Weertman, in preparation). As with the imagery method, many role plays, often of different situations, can be needed.

First, a memory of an interaction in childhood should be elicited. The same methods can be used as with the imagery technique (see Section 4). The therapist then proposes to replay the

Table 3

Three phases of the historical role play

1	Patient = child; therapist = other	original interaction
2	Patient = other; therapist = child	original interaction, patient experiences perspective of the other
3	Patient = child; therapist = other	patient (child) behaves in new ways

interaction in a role play, the patient playing him/herself as a child, the therapist playing the other person (often a parent). When more persons are needed, a stand-in can be used (a colleague therapist, a friend of the patient). A stand-in can also be used when there are certain problems as to the sex of the therapist, or professional limits (see Arntz (1994), for an example of a role play with a female friend of the (female) patient playing the role of the mother, so that the mother could caress the patient (playing herself as a child)). The method has three phases (Table 3): the ‘original’ interaction, change of perspective and rescripting.

### 5.1. Phase 1: the original interaction

Based on information given by the patient, the therapist plays the role of the other (usually a parent). It is recommended to make the role play as realistic as possible (e.g. when the child tried in vain to get the attention of her mother washing the dishes, the therapist plays mother standing before the sink and washing the dishes). Because the role play can have very powerful effects, the patient absorbing in a re-experience of the original situation, it is further recommended not to use the chairs on which patient and therapist are usually seated (or at least to put them on other places), to prevent confusion between the roles and the real persons. Otherwise the patient may continue, for instance, to hold the therapist as the dangerous, abusive parent.

After the role play, emotions and thoughts elicited by the interaction are discussed and the central meaning is clarified (usually much clearer now than before the role play). This can be related to the basic schema’s of the patient and to events in the present, but this more controlled mental activity is not necessary, because of the primary experiential nature of the method. The therapist also asks whether (s)he played the other person adequately enough. If not, the patient gives directions and the interaction is played again.

### 5.2. Phase 2: role reversal

The therapist then proposes that the patient takes the role of the other person, the therapist playing the child. The therapist instructs the patient to try to identify as much as possible with the other person’s objective situation (e.g. a mother mourning over a child recently passed away, having to work in a hotel and to take care of 5 other children) and to experience the situation from that perspective.



After the role reversal, again emotions and thoughts experienced by the patient are discussed. The therapist is especially interested in any cues of new perspectives on the intentions of the other person and on how the child's behaviour was perceived by the other person. The therapist and the patient, now using his insight as an adult, then try to formulate an alternative interpretation, which the patient can test in the next phase (e.g. my mother did not react not because she didn't love me, but because she was overburdened and depressed and the child was very cautious in asking attention). It is necessary that the therapist emphasizes that the patient uses now his adult insight and that any ideas and new behaviours could not be expected of the child, dependent for survival of his parents (etc.), in the given situation.

### *5.3. Phase 3: rescripting*

Based on experiences in both roles, the patient is invited to play the child and to try new behaviours in the interaction. Because the child's behaviour is completely new now, the therapist has to improvise the reactions of the other, in such a way that they are still convincing for the patient, but are also appropriate with respect to the child's new behaviour. If the therapist does not respond in a convincing way, the patient should give instructions and the role play is repeated. Because the new behaviour can be very difficult for the patient (at least playing him/herself as a child in front of a key figure like a parent), the therapist can play gradually more difficult reactions.

Following the last phase, the therapist again lets the patient explore the emotional and cognitive reactions. If satisfying new feelings and ideas have been formed, the role play can be finished. If not, new variants should be tried. In practice, several rounds can be necessary. The division in three phases has a formal function, and is not meant as a straitjacket.

### *5.4. Case example*

#### *5.4.1. Phase 1: original interaction*

The patient with an avoidant and obsessive–compulsive personality disorder feels often neglected by other people. On the basis of a recent experience with her husband, she gets an early memory standing in the kitchen, wanting to have attention from her mother because of being teased at school. However mother does not react and she concluded that she was unlovable. Therapist and patient play the interaction. Mother is preparing the meal for the children. She is very tired, tense and sighs a lot. The child enters the kitchen, greets mother and waits behind mother until mother reacts. Relevant contextual information is that at the time of the event, mother had just lost her youngest child, had to take care of five young children and had to run a hotel together with her alcoholic husband.

Therapist and patient play the interaction. The therapist in the role of mother does not feel a clear need in the child for attention, but does not yet tell this to the patient, because the patient may discover this in phase 2 (role-reversal). Following the interaction, therapist and patient return to their seats:

T: By and large, was this the way it happened?

P: Yes.

T: And did I play your mother well enough?

P: Yes, this is how it happened.

T: Good. What did you experience as little Maria? Can you tell me what you felt and thought?

P: I felt neglected, not worth any attention, as if I could better disappear for ever...

T: So this was like the experiences you have so often in your present life, that nobody is interested in your feelings and that you may as well vanish, were it not that you have to take care of the practical things of your household?

P: Yes.

T: It seems that this type of experience with your mother has given you this feeling that nobody is really interested in you...

P: Uh hm.

T: I would like you to play now your mother's role. I'll play you as a child. Try to play your mother in the same situation. She has lost her baby Natalie three months ago, she is very sad and tired, her husband drinks a lot and she has to take care of five children and has to help to run the hotel. Her husband does not support her, neither practically, nor emotionally. Could you try to do that? Remember, the dinner has to be prepared in time, because next you have to cook for the guests in the hotel...

#### 5.4.2. Phase 2

The therapist now plays little Maria, the patient mother. Following the role-play, both return to their original chairs and discuss the role play.

T: What did you experience, playing your mother?

P: Well, I was very tense and busy, worrying about all the things I had to do. As my mother always was.

T: Was it clear for you, as a mother, what the child wanted?

P: Not that clear. But as a mother I would ask the child...

T: Even when tired, depressed because of losing a child, at that moment, having to cook for the children?

P: I do not know... but I am still angry at my mother for neglecting me.

T: Would you, in the role of mother, punish the child if it would be more assertive in asking attention?

P: No. I mean, it may have been problematic to pay attention at that moment, but I would not think that the child was bad for asking attention.

T: So what we have here is a child being very cautious in asking attention and an overburdened mother trying to cook the meal. The mother does not react to the child, the child thinks she is neglected and not loved by her mother. But, that was not what you felt playing the mother. You experienced the worries and the stress, but not that little Maria was bad and unlovable?

P: Uh hm.

T: So, looking as an adult to this situation, what would you do if you could do it all over again? If you could advice and support little Maria, what would you suggest to her?

P: Well, maybe she could be more assertive in asking attention... and not so easily conclude that she is not worth any attention...

T: OK, why wouldn't we try that? If you play little Maria again, but now more assertively asking for attention and finding out what the reason is why mother does not pay attention to you when you are standing in the kitchen; then I'll play mother again.

#### 5.4.3. Phase 3: *rescripting*

Therapist and patient play the new interaction. The patient plays the child now trying to ask more actively for attention by standing next to mother and telling her about being teased at school. The therapist improvises mother's reactions. Mother listens and reacts to what the child says but also tells she is in a hurry to get the dinner finished. She therefore proposes to talk about it later. After the role play therapist and patient return to their original chairs and discuss the role play.

T: Good. What did you experience, playing your new role?

P: Well, in the beginning I felt very nervous about her reaction, telling my mother about the harassment out of myself. But she listened to me and that was fine.

T: Uh hm. Do you think that your mother could have reacted in this way?

P: Yes, I think so, because I made it clear that I needed the attention. I did not dare to ask her attention for this, I was too much ashamed...

T: OK. You were also clear that you needed her attention by standing next to her instead of behind her. Very good. Can you tell me what you felt and what you thought?

P: I felt like I was worth her attention. I think she was very busy, but that she did understand that I needed her.

T: Did you feel rejected, not loved by your mother, during the play?

P: No...not longer.

T: Uh hm, fine. How do you feel now?

P: Confused. I mean, I have always viewed my mother as rejecting me when I felt ashamed. I did not feel that way now, that's strange... I guess I was too afraid of telling her...

#### 5.5. *Problems with historical role plays*

Most of the problems that can interfere with the role play technique are similar to those we encountered with the imagery technique and were already addressed. We therefore now discuss only specific problems.

##### 5.5.1. *Rescripting is impossible with role play*

The therapist can change to the imagination method, e.g. when physical contact to nurture the child is indicated in the last phase and the therapist feels uncomfortable with that.

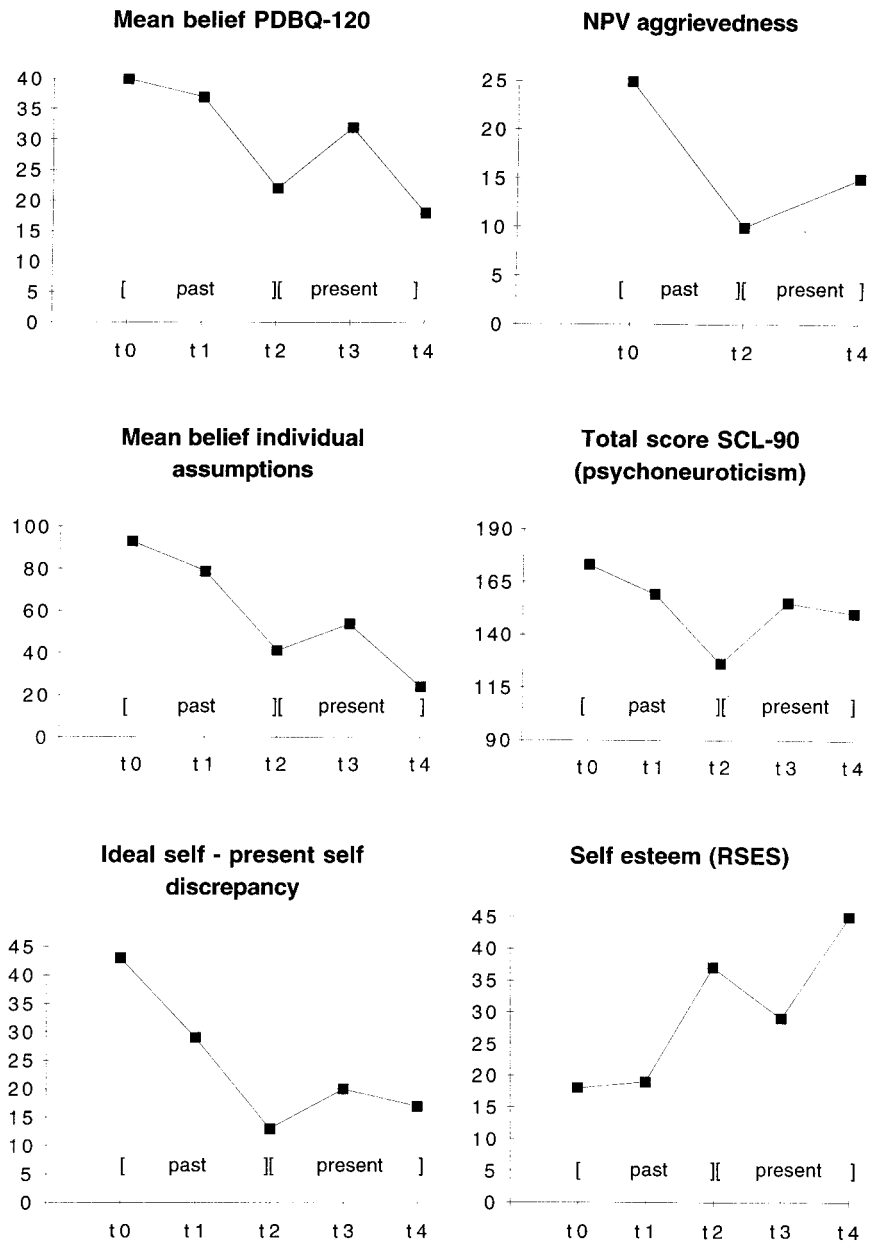


Fig. 1. (caption overleaf)

### 5.5.2. *The patient cannot or refuses to take the other person's perspective*

The patient has sometimes great difficulties in getting absorbed in the other's perspective. It can be helpful to repeat the instruction and role play. In still other cases, there is a tremendous resistance against taking the other role. Underlying motives should be explored and addressed. If this does not help, the therapist can consider to go directly to phase 3, or to give the patient the role as bystander instead of the other, or to change to the imagery method. This may be particularly helpful if there is too much antipathy of the patient to the other to play the other's role.

### 5.5.3. *Patient feels guilty of not having behaved in the new way as a child*

The therapist empathizes with the patient, making clear that it would be irrational to expect this behaviour of the child in the given situation. Only an adult could generate the alternative view. The therapist can also stress that it was functional of the child to not explore other behaviours, because of the dependency of the child of the caregivers. The therapist then explains that the patient is no longer dependent of the caregivers, though (s)he may still feel the anxiety, and is thus free now to experiment with new options.

### 5.5.4. *Therapist is afraid of attributing responsibility to the child*

Sometimes therapists have resistance with this method because they are afraid of attributing responsibility to the child. First, there is a reasoning error here. How can people be guilty for not having done something because they did not know the possibility? An excellent text on this issue is provided by Kubany and Manke (1995). Second, there *may* be positive aspects of making an internal unstable attribution (“as a child I was too afraid to be assertive, but now I'm adult and it is safe to assert myself”) that may outweigh the benefits of external stable attributions (“my mother always hated me”). Third, what was stated just above about how to deal with feelings of guilt in the patient might be helpful for the therapist as well.

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Fig. 1. Scores of a patient with paranoid PD on 6 main outcome measures at pretest (t0), after 12 sessions focussing on the past (t1), after 24 sessions focussing on the past (t2), after 12 sessions focussing on the present (t3) and after 24 sessions focussing on the present (t4). As is shown, most progress was achieved during the phase in which treatment focussed on childhood memories ('past'). PDBQ-120: mean score on the 120 item version of the Personality Belief Questionnaire, assessing strength of belief in 6 groups of assumptions, hypothesized to relate to avoidant, dependent, obsessive-compulsive, paranoid, histrionic and borderline personality disorder (Dreessen & Arntz, 1995; Arntz et al., 1999b). The scales have excellent reliabilities (Cronbach  $\alpha$ 's > 0.88). Range 0–100. High scores are dysfunctional. NPV aggrievedness: score on the aggrievedness subscale of the Dutch Personality Inventory (Luteijn et al., 1985; range 0–38; Cronbach  $\alpha$  range 0.74–0.85). High scores are dysfunctional. Mean belief individual assumptions: mean belief score on 11 idiosyncratic assumptions formulated before start of therapy (range 0–100). Total score SCL-90: total score on the Dutch version of the SCL-90 (Arrindell & Ettema, 1986; range 90–450; Cronbach  $\alpha$  range 0.95–0.97). Ideal self, present self discrepancy: mean difference between ideal self and present self ratings on Miskimins Self-Goal-Other Discrepancy Scale (Miskimins et al., 1971; Miskimins & Baker, 1973; range 0–100). In a patient sample, Cronbach  $\alpha$  of this discrepancy score of the Dutch version was 0.89 (Arntz et al., 1999a). High scores are dysfunctional. Self esteem: score on a Dutch version of Rosenberg's self esteem scale (Rosenberg, 1965; van den Hout et al., 1995). Cronbach  $\alpha$  in a patient sample was 0.91 (Arntz et al., 1999a). Low scores are dysfunctional.

## 6. Case example

Fig. 1 displays the mean scores of the first patient treated in our experimental study comparing present versus past focus of therapy for treatment of personality disorders. She was (by random allocation) assigned to the condition in which childhood memories had to be treated first (24 sessions) and present functioning next (also 24 sessions). These 48 treatment sessions were preceded by 12 sessions needed for case formulation and formulation of idiosyncratic assumptions. Assessment took place before treatment proper (t0) and after 12 (t1), 24 (t2), 36 (t3) and 48 (t4) sessions, between the two conditions and after the last condition. As is shown by Fig. 1, the patient (paranoid personality disorder with dependent and borderline traits as assessed with the SCID-II) made most progress during the phase in which historical techniques were used, despite enormous problems with dissociation when imagination was tried (the patient refused to do role plays). The focus on the present seemed less effective. This case suggests that it is possible to achieve great progress with purely historical techniques, even when used in an early phase of treatment with severe psychopathology.

## 7. Theoretical considerations

If it is true that addressing childhood memories with highly affective methods as described above are much more effective than addressing present problems in the treatment of characterological problems, the issue raises how this can be theoretically understood. The reason might be evident for PTSD caused by childhood trauma's (e.g. activation of the traumatic memories to process them, like in all cases of PTSD, cf. Smucker et al., 1995), but is not that clear for non-PTSD cases (like most of the personality disorders). The explanation that is most often proposed is that it is necessary to return to the level of the original experiences, both as to content as to information processing characteristics (i.e. Layden et al., 1993; Smucker et al., 1995). The explanation is further elaborated mainly on the process characteristics, e.g. it is hypothesized that children process information and form memories primarily on senso-motoric levels (0–2 yr) and visual levels (2–7 yr). Thus, it is concluded, corrective methods should use nonverbal strategies.

This explanation can be criticised on several grounds (see also Arntz, 1996). First, many of the central pathogenic meaning elements of the childhood memories are verbal and often already known to patient and therapist (e.g. "I'm worthless", "feelings have no value", etc.). Second, treating memories of experiences after 7 yr (when the verbal mode becomes the most important) with the 'experiential' methods described are also very effective. Third, in many cases the abusive experiences happened after 7 years (e.g. the majority of borderline patients were sexually abused between 6–12 yr, Arntz, 1994). Thus, memories of the phase where verbal processing becomes dominant are central to most of the pathology for which these methods are indicated.

If it is not that the core meaning elements of the schema's to be addressed in therapy were formed in a preverbal stage, what is the explanation of the effectiveness of addressing childhood memories with these experiential methods? First, it is attempted to explain why it is

so effective to address childhood memories. Second, it is discussed why experiential methods could be the most effective.

### 7.1. Focus on childhood memories

One possible explanation as to why this focus is so helpful, if not necessary, for fundamental change to occur, is based on modern learning theory. According to this class of theories, unlearning often (or always) consists of learning exceptions to what was originally learned (Holyoak et al., 1989). Strong primarily learned rules are maintained, and exception rules are learned. This is especially the case when the subject is not exposed to the original conditioned stimuli, but to generalized stimuli. What was learned first forms the general rule, and this rule is not easily erased, but it can be learned under what circumstances the original rule does not apply. In case of early learning without immediate correction, the acquired knowledge (the 'rules') are probably strongly generalized and often the only available knowledge<sup>2</sup>. Applying methods directed at the present will then be cumbersome and time consuming, because for every new situation the patient has to learn that it is an exception to the primary rule. Moreover, the original rule remains the basic schema and is not changed by the exceptions.

An example may clarify this. A borderline patient, for instance, may have learned that intimacy leads to abuse or abandonment, by abusive experiences as a child with caregivers and the punitive actions of other caregivers when trying to elicit help for emotional problems from the abuse (see Arntz et al. (1999b), for an empirical test of the hypothesized content of borderline schema's). It may be possible for the borderline patient to learn that some individuals are the exception to the rule, i.e. they do not abuse or abandon the patient. However, to find this out, the patient must go through a difficult process for each new individual (including the therapist). Various exceptions to the basic rule do not change the rule: the distrust schema continues to dominate the patient's thinking, feeling and behaviour.

The optimal thing to learn in therapy is the very opposite of finding out that there are exceptions to the original schema: *the original experience is the exception*. Thus, the borderline patient can hopefully experience that not the therapist and some other individuals are the exception to the rule, but that the early caregivers are the exception<sup>3</sup>. The best way to learn this is to address the prototypical situations that gave rise to these generalized rules and reappraise them as atypical (instead of typical). Thus, it is hypothesized that by addressing and reappraising the representation of the original experiences that led to the schematic self and

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<sup>2</sup> Cognitive theories of personality disorders have hypothesized that the pathogenic schema's are the only schema's available for the patient, in contrast to axis-I problems, where alternative, healthy schema's are assumed to be potentially available. Thus, in case of axis-I problems, therapy consists mainly of activating healthy schema's; whereas in personality disorders completely new schema's have to be formed (e.g. Padesky, 1994).

<sup>3</sup> Sometimes it is possible to reevaluate the original experience (to change the meaning of it rather than to reduce the scope of application of the rule that was formed on basis of it). It is hypothesized that addressing childhood experiences is in that case still an efficient method, for the same reason: the patient does not have to learn exceptions, but has learned that the old meaning is, so to say, an exception: it was a meaning of former times, but not valid in the present. Though the implicative meaning of experiences can be changed, experiences cannot be completely changed (e.g. the 'facts' of sexual and physical abuse, a non-available parent, etc.) and these should be acknowledged. It cannot be the goal of treatment to 'erase' these facts.

other representations, new meanings of them are formed which will lead to new schema's and reduction of the scope of the old schematic representations. (In terms of learning theory this would be called 'UCS/UCR revaluation', cf. Davey, 1989.)

The revaluation of the original rules can take two main forms. First, there may be disconfirmation, e.g. by testing the parent's reactions to assertive behaviour in a role play and finding out that the parent (in the role play) does not react as expected. Second, there may be no disconfirmation of the parent's (etc.) reactions, e.g. when the parent was too 'sick' to react in a healthy way. In that case, re-interpretative processes and experiencing that the parent's reaction were the exception (as to how people in general are), and not the rule, may be central to change. Thus, in the first case a change of the CS -> UCS predictive relationship takes place (i.e. the CS does no longer predict the UCS). In the second case, the UCS gets another meaning and/or only the original CS<sub>1</sub> (-configuration) remains predictive of the UCS, but the generalized CS<sub>i</sub> no longer predict the UCS.

### *7.2. The efficacy of experiential methods*

Though this theoretical analysis is helpful to understand why a historical focus might be so effective (or even necessary), it does not explain why the more experiential methods would be more effective than the traditional cognitive methods (based on reasoning). Perhaps, indeed, we need developmental theories to understand this. If the meanings of the original experiences, as represented in the pathogenic schema's, are still represented on an informational level characteristic of the child, it may be indicated to use methods that are the most informing for a young child. This is not to say that verbal content is not important, as has been suggested by some writers (e.g. Layden et al., 1993; Smucker et al., 1995). Rather, the young child does not reason on the formal-operational level that fit with more traditional cognitive techniques and the reasoning level associated with the early developed schema's is probably stagnated at an early developmental level (e.g. borderline patients evaluate dichotomous when confronted with schema-specific material, but not when confronted with nonspecific material (Veen & Arntz, 1999)). In addition, another developmental argument can be put forward. If it is necessary for the child to get through preprogrammed channels certain experiences in order to form healthy views of self and others (e.g. bodily contact is needed to convey safety and love), it may be possible to let the patient have corrective experiences, but only (or far more effectively) through these same channels (apparently, imagining this is as helpful as really experiencing it). Lastly, activation of the affective memories is probably more effectively done with such experiential methods than with talking about experiences. This would nicely fit with the Interacting Cognitive Subsystem theory (Teasdale, 1993), from which it follows that using as many (sensory) channels as possible results in better activation of implicational meaning representations, necessary to change them.



## 8. Conclusion

To summarize, on a theoretical level it is more easily understood why addressing childhood experiences (as represented in memory) is so helpful in the treatment of chronic psychopathology with early origins, than why this would be the most effective with experiential methods. Nevertheless, several reasons are proposed why experiential methods are so effective. We do not expect that all experiential methods are effective, however. From the current analysis it follows that especially those methods are the most effective that focus on the forming of new adaptive meanings and reducing the scope of the old experiences. Letting the patient experience different perspectives on what happened and letting the patient experience all feelings and needs in the imagined childhood situation may be among the most effective ingredients. However, before research addresses these issues, it should first be tested whether using these methods is more helpful than methods focusing on the present. Our group has just started a controlled study contrasting these focuses in the treatment of personality disorders (Weertman, in progress). So far, historical methods have mainly played a subordinate role in the treatment of personality disorders, though some have claimed that the opposite should be the rule (e.g. Arntz, 1994; McGinn & Young, 1996). Research may demonstrate that they are necessary for deep and long-lasting change to occur in characterological problems.

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