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ORIGINAL RESEARCH

Imagery rescripting for somatic flashbacks in post-traumatic stress disorder: a feasibility study

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Abstract

Imagery rescripting (ImRs) is a therapeutic technique that uses mental imagery to update the meanings associated with traumatic memories and reduce re-experiencing and emotional distress (Arntz, 2012). It is commonly used as a therapeutic technique for post-traumatic stress disorder (PTSD). The present study evaluates an ImRs intervention specifically developed to target somatic flashbacks. Somatic flashbacks can be understood as re-experiencing somatosensory sensations, such as touch or physical pain. The study aimed to investigate the feasibility, safety, and acceptability of the intervention. The study also explored if the intervention led to any differences in participants' experiences of somatic flashbacks and their global symptoms of PTSD. A non-randomised feasibility study design was used. Seven participants who reported experiencing somatic flashbacks at assessment were recruited into the study. The ImRs intervention consisted of a pre-intervention session to complete measures, two ImRs intervention sessions, and a 4-week follow-up session. Participants' experience of the intervention was measured at the end of the second ImRs session. Participants' somatic flashbacks and global symptoms of PTSD were measured pre- and post-intervention and at follow-up. ImRs was feasible, safe, and acceptable. Frequency, intensity, and distress of somatic flashbacks reduced, and sense of coping increased following the intervention. A brief ImRs intervention for somatic flashbacks is a promising intervention. Future research should explore the prevalence of somatic flashbacks, underlying mechanisms of ImRs, the optimal timing and content of the intervention, and whether this can be integrated into existing trauma therapies.

Key learning aims

(1) To assess if imagery rescripting is a feasible intervention for somatic flashbacks.
(2) To assess if imagery rescripting is a safe intervention for somatic flashbacks.
(3) To assess if imagery rescripting is an acceptable intervention for somatic flashbacks.
(4) To assess if the imagery rescripting intervention led to any differences in participants' experiences of somatic flashbacks and their global symptoms of PTSD

Keywords: feasibility; imagery rescripting; PTSD; somatic flashbacks

Introduction

Re-experiencing symptoms are a key component of post-traumatic stress disorder (PTSD; Ehlers *et al.*, 2004). Flashbacks are a form of re-experiencing and can be understood as intrusive multi-

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sensory memories (Hellawell and Brewin, 2004; Whalley *et al.*, 2013) which are experienced as uncontrollable and as though they are happening again in the present moment (Ehlers *et al.*, 2004). Flashbacks are thought to exist on a continuum, ranging from a fleeting intrusive memory of a traumatic event to dissociative experiences whereby a person loses orientation to time and place for periods of minutes or more (Brewin, 2015). They have been found to differ from standard autobiographical memories in that flashback memories have been associated with higher levels of arousal, such as increased heart rate (Chou *et al.*, 2018). Whilst it has been proposed that differences are due to traumatic memories being encoded, organised, and retrieved differently from non-traumatic memories (Ehlers and Clark, 2000), research into the underlying mechanisms of flashbacks remains limited. Existing research is also dominated by exploration of the visual component (i.e. what people see) of flashbacks (Brewin *et al.*, 2010; Pearson, 2019).

Somatic flashbacks can be understood as those in which somatosensory sensations, such as touch or physical pain, experienced during the traumatic event are re-experienced in the present. Whilst existing literature recognises that flashbacks are rich in sensory information (Berntsen *et al.*, 2003; Brewin, 2014; Brewin *et al.*, 2010; Crespo & Fernández-Lansac, 2016; Malaktaris and Lynn, 2019), research into somatic flashbacks is in its infancy. Current research is limited to a single prevalence study (Macdonald *et al.*, 2018) and four case reports (Mellman and Davis, 1985; Salomons *et al.*, 2004; Schreiber and Galai-Gat, 1993; Whalley *et al.*, 2007), all of which focus exclusively on the somatic re-experiencing of pain.

Research has found that treatment that specifically addresses flashbacks is associated with better outcomes (Nijdam *et al.*, 2013). Despite this, no empirical research exists which investigates the therapeutic treatment of somatic flashbacks. The present study explores the feasibility of a novel therapeutic treatment for somatic flashbacks, using imagery rescripting (ImRs).

ImRs is a therapeutic technique that uses mental imagery to update the meanings associated with traumatic memories and reduce re-experiencing and emotional distress (Arntz, 2012). The term 'mental image' is used to describe imagery that can contain one or more of the five senses (Kosslyn *et al.*, 2001). Although ImRs is not explicitly named within the current UK clinical guidelines for the treatment of PTSD (National Institute for Health and Care Excellence, 2018), it is often integrated into the recommended trauma-focused therapies, cognitive therapy for PTSD (CT-PTSD) and eye movement desensitisation and reprocessing (EMDR) therapy (Arntz, 2011; Ehlers *et al.*, 2004). Over the last 30 years, ImRs has been used successfully as an intervention for PTSD amongst veterans *(Alliger-Horn et al.*, 2016), asylum seekers and refugees (Arntz *et al.*, 2013; Steel *et al.*, 2023), survivors of childhood abuse (Boterhoven de Haan *et al.*, 2020; Jung and Steil, 2012; Jung and Steil, 2013; Raabe *et al.*, 2015; Raabe *et al.*, 2022; Smucker and Niederee, 1995; Steil *et al.*, 2011), survivors of workplace injuries (Grunert *et al.*, 2007), people experiencing survivor guilt (Murray *et al.*, 2021), people with a co-morbid eating disorder (Napel-Schutz *et al.*, 2022), and people with co-morbid symptoms of psychosis (Clarke *et al.*, 2022; Paulik *et al.*, 2019). A recent meta-analysis of 17 randomised control trials (Kip *et al.*, 2023) demonstrated ImRs can effectively treat a variety of mental health difficulties, and produced similar treatment effects to other evidence-based interventions; potentially in fewer sessions.

ImRs protocols fall into two categories: those in which the client relives a traumatic memory and is invited to change the ending of it, to meet their needs, e.g. for a child in danger to be rescued by a valued adult (Arntz and Weertman, 1999; Smucker *et al.*, 1995); and those in which a new mental image is constructed to capture the 'antidote' cognitions, emotions, and meanings needed to counteract the distress associated with a 'toxic' image (Holmes *et al.*, 2019; Steil *et al.*, 2011). An example of the latter would be creating a mental image in which someone can see all of their skin cells regenerating to reduce the feeling of being contaminated following a sexual assault (Steil *et al.*, 2011).

The current study aims to contribute to the existing evidence base for ImRs in PTSD by developing an ImRs intervention to specifically target somatic flashbacks. It addresses the gap in knowledge around the feasibility of using ImRs in the treatment and management of somatic

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flashbacks in PTSD. An effective ImRs intervention for somatic flashbacks could complement existing therapies and lead to more effective treatment protocols for a specific symptom that has been overlooked in the existing literature. As the majority of existing research focuses on imagery re-scripting for visual flashbacks, the current study aims to provide guidance to an adaptation to imagery re-scripting for somatic flashbacks, which may be less intuitive to clinicians.

The primary aim of the present study is to investigate the feasibility, safety, and acceptability of the intervention. Given that research suggests that re-experiencing symptoms reduce following successful PTSD treatment (Ehlers *et al*., 2004), the secondary aim of this study is to explore if the intervention leads to any differences in participants' experience of somatic flashbacks and their global symptoms of PTSD. It was hypothesised that ratings of somatic flashbacks and global PTSD symptoms would reduce following the intervention.

Method

Participants

Seven participants were recruited from two National Health Service (NHS) out-patient specialist PTSD services between October 2023 and April 2024. Inclusion criteria were: (1) age 18 and above, (2) DSM-5 (American Psychiatric Association, 2013) diagnosis of PTSD or ICD-11 (World Health Organization, 2022) diagnosis of complex PTSD. PTSD and complex PTSD were diagnosed during participants' assessments into their respective services. The Clinician-Administered PTSD Scale for DSM-5 (CAPS-5) (Weathers *et al*., 2018) and the Posttraumatic Stress Disorder Checklist for DSM-5 (PCL-5; Weathers *et al*., 2013) were administered at this stage to assess for PTSD symptoms, (3) currently experiencing somatic flashbacks, and (4) to have completed the first phase of those services' phase-based model of treatment for PTSD (Robertson *et al*., 2013). Phase 1 involves providing psychoeducation about common symptoms of PTSD and techniques on how to manage re-experiencing symptoms, including flashbacks, nightmares, and dissociation.

Exclusion criteria were: (1) currently receiving another trauma-focused intervention, (2) active suicidal intent or recent (past 8 weeks) suicide attempt, (3) currently abusing substances (substance abuse was not clinically measured; if substance use was disclosed by a participant, clinical judgement, supervision, and discussion with the participant was used to understand if current substance use was impacting the participant's ability to engage and benefit from the intervention), (4) participation in the study is not considered in the best interest of the prospective participant by the clinical team responsible for the participant's care, (5) participants who do not consent to the intervention sessions being recorded, and (6) participants who do not consent to their assessment information being made available to the trainee clinical psychologist carrying out the intervention.

One of the NHS services was unable to provide funding for interpreters, and therefore, eligible clients who did not speak English could not be recruited. See Table 1 for sample demographics. Due to the small sample size, nationality was recorded in place of ethnicity to protect participants' anonymity. No participants shared the same racial or ethnic identity, and all non-British participants had refugee status.

Design

A non-randomised feasibility study design was used.

Instruments

Primary outcome measures

Feasibility. Feasibility was assessed by recording eligibility rates, recruitment rates and completion rates.

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Table 1. Sample characteristics

Variable		Mean (*SD*)/number (%)
Age (years)	—	35.17 (5.34)
Gender	Male	4 (57%)
	Female	3 (43%)
	Other	0 (0%)
Nationality	British	3 (42.86%)
	Non-British	4 (57.14%)
Language of treatment	English	6 (85.71%)
	Other languages	1 (14.29%)
Index trauma	Trauma experienced in adulthood	3 (42.86%)
	Trauma experienced in childhood	4 (57.14%)

Safety. Safety was assessed through monitoring and assessing adverse events for severity, expectancy, and relatedness to study procedures. Examples of adverse events include suicide attempts, serious violent incidents, and hospital admissions. As in Clarke *et al.* (2022), supervisors determined the event severity and expectancy based on participants' current and past context and the relatedness of an event to the study.

Acceptability. Acceptability was measured using the Treatment Acceptability and Adherence Scale (TAAS; Milosevic *et al.*, 2015). The TAAS is a 10-item self-report instrument that measures participants' perceived treatment acceptability and anticipated adherence to psychological interventions for anxiety and related disorders (e.g. 'I will be able to complete this treatment'). Items were rated on a 7-point Likert scale ranging from 1 ('disagree strongly') to 7 ('agree strongly'), with total scores ranging from 10 to 70. As recommended on the TAAS measure, questions in the TAAS were modified to reflect the point at which the participant was completing the scale (e.g. after completing a treatment session, or after completing a treatment component). Higher scores indicate higher acceptability and anticipated adherence to an intervention. The TAAS has demonstrated high internal consistency of 0.87 and 0.88 (Milosevic *et al.*, 2015). This questionnaire was delivered after the final intervention session.

Secondary outcome measures

Target trauma memory ratings. Ratings of the target trauma memories were measured using a visual analogue scale (VAS). The VAS is a 4-item self-report measure used to assess 'frequency', 'intensity', 'distress', and 'coping' with somatic flashbacks. Items were rated on a 10-point Likert scale ranging from 0 ('not frequent all') to 100 ('extremely frequent'), with total scores ranging from 0 to 400. The VAS was used at three time points to track changes in somatic flashbacks. Higher 'frequency', 'intensity', and 'distress' scores indicate more severe re-experiencing symptoms. Lower 'coping' score indicates a poorer sense of coping with re-experiencing symptoms. A similar measure was used in an existing pilot study exploring imagery rescripting for feelings of being contaminated (Steil *et al.*, 2011).

The Posttraumatic Stress Disorder Checklist for DSM-5 (*PCL-5; Weathers et al., 2013*). The PCL-5 is a 20-item self-report measure that assesses the 20 DSM-5 (American Psychiatric Association, 2013) symptoms of PTSD in the past month. Items were rated on a 5-point Likert scale ranging from 0 ('not at all') to 4 ('extremely'), with total scores ranging from 0 to 80. Higher scores indicate more severe PTSD symptoms. It has demonstrated high internal consistency (0.94) (Roberts *et al.*, 2021).

Procedure

Participants were recruited through two NHS clinical teams. Participants had typically been referred to these specialist PTSD treatment services by their GP or other secondary mental healthcare teams. Participants recruited into the study were all on a waiting list to receive trauma-focused therapy and

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remained on the waiting list whilst taking part in the ImRs intervention. The following screening question was used to identify potential participants: 'In the last 14 days, have you experienced any physical sensations in or on your body which resemble, in quality and location, the physical sensations experienced during the traumatic event (e.g. internal or external pain, tension, sensations of touch, pressure, warmth, coldness)?'. This question was either posed at assessment, by an assessing clinician in the service, or during initial symptom management sessions.

Eligible participants were provided with an information sheet about the study by their assessing clinician or by the lead clinician on the study. At least 48 hours were given to clients to allow time to read through the participant information sheet and ask questions about the study. Prospective participants were then contacted by telephone to confirm if they would like to take part in the research and provide informed consent. Where participants did not speak English, interpreters were used to translate the content of the consent form. Participants were made aware that opting in or out of the study would not impact their care within their respective NHS service. Participants who did not consent to take part in the study were not contacted beyond this stage.

Once recruited, all research procedures and therapy sessions were completed by one researcher (J.C.) under the clinical supervision of the other researchers (L.O. and F.B.). Weekly clinical supervision was available to discuss any questions. Each participant attended a pre-intervention session to complete the VAS, PCL-5, and to confirm the target somatic flashback. All participants then received two ImRs intervention sessions. At the end of the second ImRs session, participants completed the VAS, PCL-5, and the TAAS. The ImRs sessions occurred a week apart. Up to 90 minutes were allocated to complete each session.

At a 4-week follow-up session, participants completed the VAS, PCL-5 and were asked if any external events had impacted their symptoms of PTSD during the 4 weeks between intervention and follow-up. At the 4-week follow-up, participants also received a verbal and written debrief about the aims of the study.

Intervention

The protocol was developed drawing upon existing ImRs protocols (Holmes *et al*., 2019; Jung and Steil, 2012; Jung and Steil, 2013; Muller-Engelmann and Steil, 2017; Steil *et al*., 2011) and with the support of an NHS patient involvement group. An ImRs protocol which did not require imaginal exposure to the trauma was selected as it was felt this could be less intrusive and distressing for participants. Participants were supported to activate or develop a self-generated, strong, multi-sensory image that encapsulated the target somatic flashback (e.g. the moment they were physically assaulted). If participants reported multiple somatic flashbacks, a target flashback from a specific memory was agreed upon.

To develop the multi-sensory new image, the researcher gathered information about the participant's 'toxic' emotional experiences, somatosensory experiences, and beliefs (e.g. feeling scared, a hot sharp pain on their face, and believing they will die). Following this, a participant-generated, multi-sensory rescript was created, which encapsulated the participant's desired 'antidote' emotion, somatosensory experience, and beliefs at the time of the traumatic event (e.g. feeling safe, coolness and relaxation on their face, and believing they are no longer in danger). Participants were able to include whatever they felt would be useful within their rescript and were told this did not need to be realistic (for example, flying to a serene beach where the water cooled down the feeling of heat in their body). Table 2 details anonymised imagery rescripts. The order the cases are presented within the table have been randomised.

Data analysis

Feasibility, safety, and acceptability were evaluated through inspection of descriptive data and the TAAS. VAS scores were evaluated through inspection of descriptive data. PCL-5 scores were

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Table 2. Overview of imagery rescripts

Image	Emotions	Sensation(s)	Meanings. Rate how much you believe each meaning: 0% (do not believe at all) – 100% (completely believe)	Antidote emotions	Antidote sensation(s)	Antidote meanings. Rate how much you believe each antidote meaning: 0% (do not believe at all) – 100% (completely believe)	Antidote image
Drunken partner coming into their bedroom and assaulting them	Disgust and fear	Re-experiencing the sensation of pressure on their chest of someone lying on them	I can't get away (100%)	Calm and safe	Feeling lightness on their chest	I am free and they cannot hurt me anymore	They click their fingers and the ex-partner freezes and cannot getting closer. They get pushed far away and the person feels safe in the comfort of their bedroom with fairy lights gently lighting the room. They can feel the lightness of the duvet on their chest and the walm night breeze from the window dancing over their body
A bear coming into their bedroom at night and biting them	Terror	Re-experiencing the pain of being bitten on their neck and arms	It is going to kill me (100%)	Safe and calm	Neck and arm feeling relaxed and pain-free	I am an adult now and I am safe	Shrinking the bear until it disappeared and then teleporting to a tranquil beach on their own where the feeling of soft sand and sun on their body lets them know they are not being bitten and are relaxed and pain-free
In a busy café with their parent who dies in front of them	Fear and unsafe	Re-experiencing legs feeling wobbly and frozen to the spot	I could have saved them (95%)	Calm and protected	Legs feeling strong and able to move them	Nothing could have changed what happened	The cafe surroundings melt away and are replaced by the sand at the beach where they used to swim with their parents and siblings. Their legs feel strong and they can feel the texture of the sand below. They go into the water with their parents

(*Continued*)

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Table 2. (*Continued*)

Image	Emotions	Sensation(s)	Meanings. Rate how much you believe each meaning: 0% (do not believe at all) – 100% (completely believe)	Antidote emotions	Antidote sensation(s)	Antidote meanings. Rate how much you believe each antidote meaning: 0% (do not believe at all) – 100% (completely believe)	Antidote image
							and siblings. They make gentle movements with their legs stay afloat and feel safe here floating alongside their family
The darkness of being trafficked in the back of a van and the hot heat of the metal floor on their neck	Frightened	Re-experiencing a burning sensation on their neck and their body aching from having to sit for so long	I'm never getting out of here (85%)	Safe	A cool and soothing sensation on my neck	I am free and safe now	Standing beneath a waterfall with cooling water trickling down their neck. There is soft light pouring through the trees and the burning sensation subsides. Their neck unclenches and feels soothed
Stumbling out of an armed vehicle in an unknown location. Sound of gunfire and unable to see where it is coming from	Overwhelmed and confused	Re-experiencing throbbing pain on the back of head from the impact of the crash	I'm going to die (90%)	Calm	Head feeling relaxed and pain-free	I survived	The present version of them comes into the memory to explain where they have crashed and that they won't be killed. The loudness and chaos of the crash site fades away, and they are under a huge tree in a park they like in UK. They lay against the tree and rest their head on the smooth bark. They massage their head from side to side against the warmth of the tree. It

(*Continued*)

Table 2. (*Continued*)

Image	Emotions	Sensation(s)	Meanings. Rate how much you believe each meaning: 0% (do not believe at all) – 100% (completely believe)	Antidote emotions	Antidote sensation(s)	Antidote meanings. Rate how much you believe each antidote meaning: 0% (do not believe at all) – 100% (completely believe)	Antidote image
							feels relaxing and they are pain-free
In the kitchen of childhood home. A parent striking them on their arm	Fear and sadness	Re-experiencing pain in arm from being struck as a child	I'm not safe (90%)	Safe and happy	Arm feeling relaxed and pain-free	I am an adult now and they can't hurt me	They blink and are transported to a cliff top with views out to sea. There is no one else around and they feel safe. They pick some soft leaves from a tree and gently stroke it on their arm. It feels relaxing

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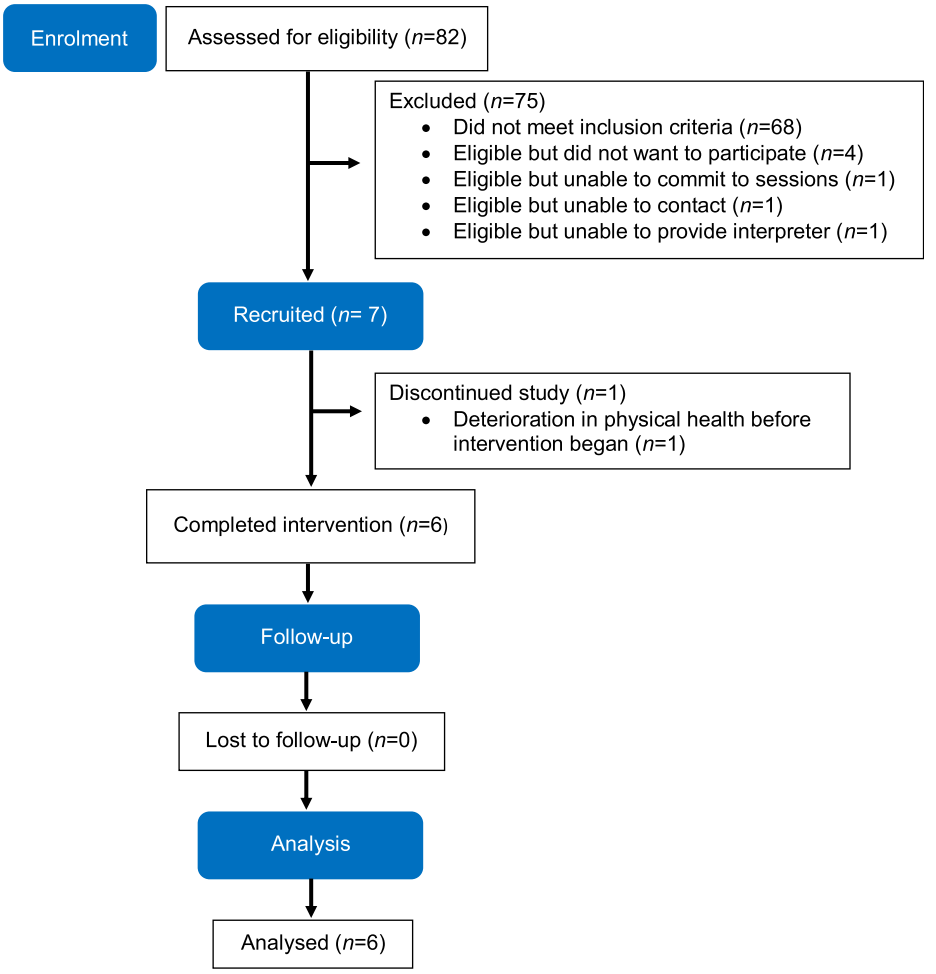


Figure 1. Overview of recruitment and participation.

evaluated through inspection of descriptive data, reliable change index (RCI) and clinically significant change (CSC). RCI was calculated using thresholds reported by Marx *et al.* (2022). Given the small sample size of the present study, the more conservative threshold of ≥18 point reduction in within-person PCL-5 scores was applied. Clinically significant change was defined as post-intervention score of ≤28.

Results

Primary outcomes

Feasibility

Figure 1 presents an overview of recruitment and participation. In total, 82 people were screened for eligibility for this study. Of these, 14 (17.07%) were eligible for participation. Seven (50%) of these people were recruited into the study. Reasons for not participating were declining to take part in research ($n = 4$), feeling unable to commit to the sessions due to current employment

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demands ($n = 1$), and being uncontactable by the researcher ($n = 1$). In addition, one client who was eligible but did not speak English could not be recruited in the NHS service which was unable to fund interpreters.

Of the seven participants who were recruited, six completed the intervention. It was agreed with one participant that they would not continue in the study after session 1 (pre-intervention session) due to a deterioration in their physical health. This was discussed in supervision. The six remaining participants all completed the intervention (in person) and follow-up session (four participants attended this session virtually). All participants reported being able to use the rescript between sessions.

Safety

No serious adverse events were reported during the study.

Acceptability

Overall, on the TAAS (Milosevic *et al.*, 2015), participants rated the study as highly acceptable, with an average rating of 58.17 out of a maximum of 70 ($SD = 10.89$, range 40–70). No participants dropped out of the intervention after receiving their first ImRs session and all participants reported practising the intervention between sessions, which implies the intervention was tolerated well and that participants found the content relevant and useful.

Protocol adherence

One participant required two sessions to complete the pre-intervention measures due to arriving late to their initial session. This meant they attended five sessions in total instead of four. Whilst the protocol aimed for the intervention to be completed over 7 weeks, the average duration of the intervention was 9 weeks (ranging from 8 to 11 weeks). Reasons for delays included participant sickness, unplanned leave of treating clinician, public holidays, childcare difficulties and social stressors. On average, the first ImRs intervention session took 60 minutes to complete and the second ImRs intervention session took 45 minutes to complete. Supervision was provided to the clinician delivering the intervention to all participants. No other drifts from the protocol occurred during the study.

Secondary outcomes

Due to the design and sample size of the current study, the following analysis is exploratory. Any changes observed are intended to guide developments for sufficiently powered future studies. Data from the discontinued participant was excluded.

Frequency, intensity, and distress of somatic flashbacks and ability to cope

Based on previous research, changes in frequency, intensity, distress, and ability to cope VAS score (Steil *et al.*, 2011) are reported. Table 3 shows participants' VAS scores for each item and percentage change in scores at each time point.

Frequency of somatic flashback VAS scores

Between the pre-ImRs session and the follow-up session, participants' mean frequency VAS scores (range 0–100) reduced by 30 ($SD = 15.17$, range 10–55). This represents a mean reduction of 59.16% across the six participants. See Fig. 2 for frequency VAS scores at pre-intervention, post-intervention, and follow-up.

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Table 3. Participant VAS scores and percentage change (VAS scores range from 0 to 100)

Participant	Pre-ImRs	Post-ImRs (% change from pre-ImRs)	Follow-up (% change from pre-ImRs)
		Frequency	
A	70	60 (−14.29%)	40 (−42.86%)
B	100	60 (−40%)	70 (−30%)
C	30	40 (+33.33%)	10 (−66.67%)
D	80	50 (−37.5%)	25 (−68.75%)
E	10	20 (+100%)	0 (−100%)
F	75	80 (−6.67%)	40 (−46.67%)
		Intensity	
A	80	50 (−37.5%)	70 (−12.5%)
B	100	70 (−30%)	80 (−20%)
C	100	100 (0%)	80 (−20%)
D	70	55 (−21.43%)	35 (−50%)
E	40	50 (+25%)	0 (−100%)
F	80	80 (0%)	36 (−55%)
		Distress	
A	75	75 (0%)	100 (+33.33%)
B	100	70 (−30%)	85 (−15%)
C	100	100 (0%)	65 (−35%)
D	70	40 (−42.86%)	50 (−28.57%)
E	60	30 (−50%)	0 (−100%)
F	85	85 (0%)	40 (−52.94%)
		Coping	
A	40	40 (0%)	85 (+112.5%)
B	25	70 (+180%)	80 (+220%)
C	50	70 (+40%)	90 (+80%)
D	50	60 (+20%)	70 (+40%)
E	20	50 (+150%)	50 (+150%)
F	60	75 (+25%)	90 (+50%)

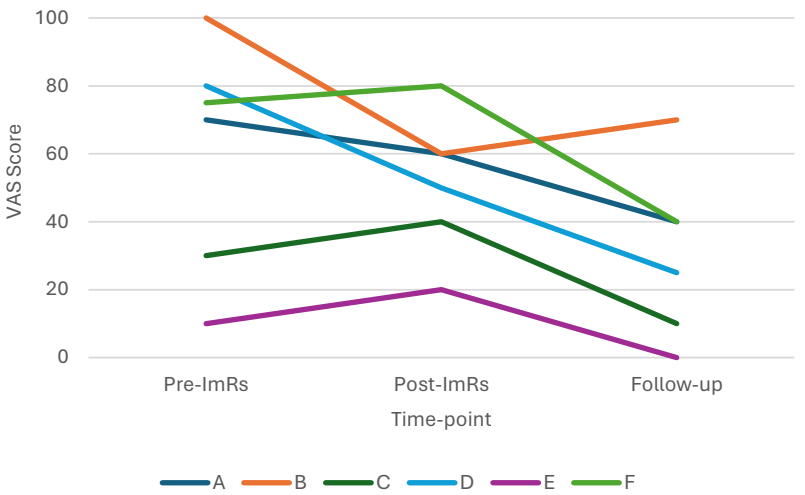


Figure 2. Participant frequency VAS scores (scores range from 0 to 100).

Intensity of somatic flashback VAS scores

Between the pre-ImRs session and the follow-up session, participants' mean intensity VAS scores (range 0–100) reduced by 28.17 ($SD = 13.42$, range = 10–44). This represents a mean reduction of 42.92% across the six participants. See Fig. 3 for intensity VAS scores at pre-intervention, post-intervention, and follow-up.

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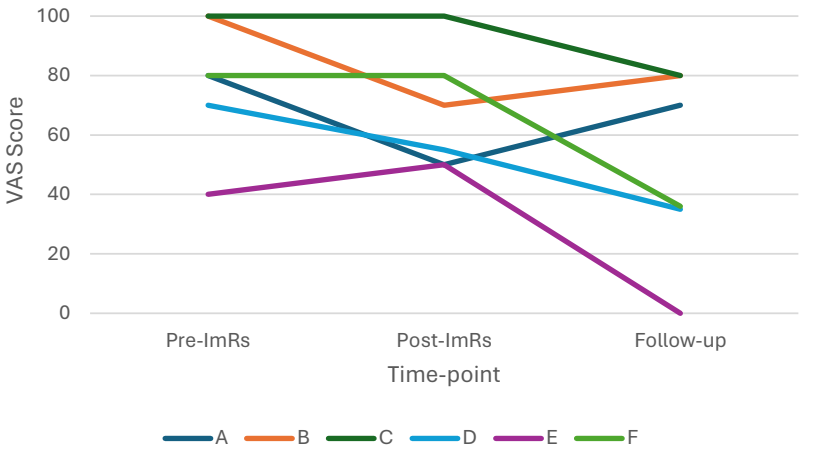


Figure 3. Participant intensity VAS scores (scores range from 0 to 100).

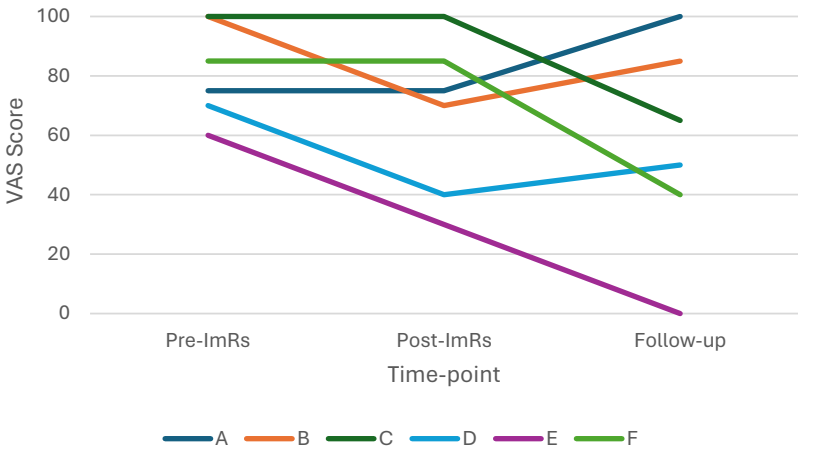


Figure 4. Participant distress VAS scores (scores range from 0 to 100).

Distress due to somatic flashback VAS scores

Between the pre-ImRs session and the follow-up session, participants' mean distress VAS scores (range 0–100) reduced by 25 ($SD = 29.50$, range −25–60). This represents a mean reduction of 33.03% across the six participants. See Fig. 4 for distress VAS scores at pre-intervention, post-intervention, and follow-up.

Coping with somatic flashback VAS scores

Between the pre-ImRs session and the follow-up session, participants' mean coping VAS scores (range 0–100) increased by 36.67 ($SD = 12.52$, range 20–55). This represents a mean increase of 108.75% across the six participants. See Fig. 5 for coping VAS scores at pre-intervention, post-intervention, and follow-up.

PCL-5 score

Table 4 shows participants' PCL-5 scores and percentage change in scores at each time point. Between the pre-ImRs session and the follow-up session, participants' mean PCL-5 scores

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Table 4. Participant PCL-5 scores (scores range from 0 to 80) and percentage change in scores

Participant	Pre-ImRs	Post-ImRs (% change from pre-ImRs)	Follow-up (% change from pre-ImRs)
A	43	48 (+10.42%)	54 (+25.58%)
B	67	56 (−19.64%)	63 (−5.97%)
C	68	72 (+5.56%)	66 (−2.94%)
D	38	38 (0%)	18 (−52.63%)
E	48	41 (−17.07%)	39 (−18.75%)
F	56	54 (−3.7%)	53 (−5.36%)

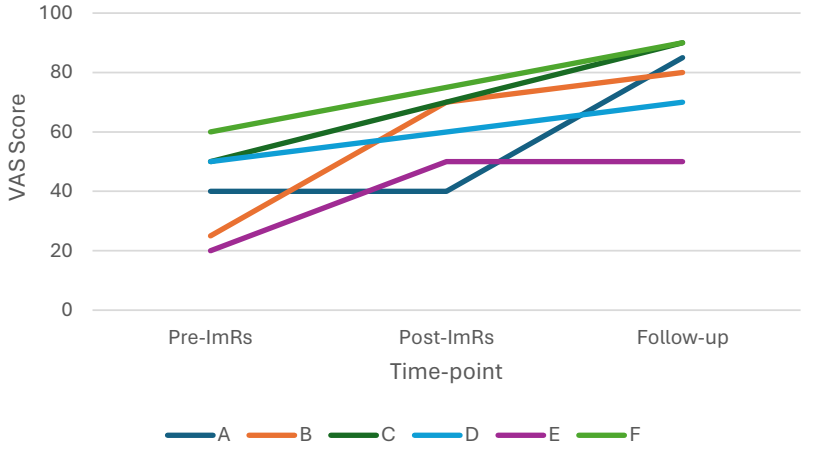


Figure 5. Participant coping VAS scores (scores range from 0 to 100).

(range 0–80) reduced by 4.5 ($SD = 10.09$, range −11 to +20). This represents a mean reduction of 10.01% across the six participants.

Applying the RCI and CSC thresholds used by Marx *et al.* (2022), one participant (D) demonstrated reliable improvement, evidenced by a 20-point reduction in their PCL-5 score. This participant also met criteria for clinically significant change, with post-treatment scores falling below the ≤28 threshold. No other participants demonstrated reliable improvement or met criteria for clinically significant change.

One participant (A) experienced an increase of 11 in their PCL-5 score, which they did not attribute to the intervention. When exploring potential reasons for this increase, this participant shared they had experienced a pain flare-up, and this often caused their PTSD symptoms to worsen.

Discussion

Somatic flashbacks are an acknowledged difficulty in people living with PTSD (Macdonald *et al.*, 2018), yet there is limited evidence regarding effective treatments for this symptom. This is the first study to investigate the feasibility, safety, and acceptability of a novel ImRs protocol for somatic flashbacks. It demonstrates the feasibility of delivering ImRs as an intervention specifically for somatic flashbacks and builds upon a growing body of research into the use of ImRs for symptoms of PTSD (Clarke *et al.*, 2022; Jung and Steil, 2013; Muller-Engelmann and Steil, 2017; Napel-Schutz *et al.*, 2022; Raabe *et al.*, 2022; Steel *et al.*, 2023; Steil *et al.*, 2011). This feasibility study shows that ImRs interventions can be successfully implemented to reduce overall disturbance associated with somatic flashbacks. On average, participants experienced a reduction

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in the frequency, intensity, and distress of their somatic flashbacks and an increase in their sense of coping with their somatic flashbacks. These benefits were maintained and continued at follow-up.

All participants that completed the intervention rated the intervention as acceptable and no adverse effects were reported or identified. The drop-out rate of this study (14.29%, one participant), which is inflated due to the small sample size, is in line with rates in existing ImRs research [7.1% (Murray *et al.*, 2021), 7.7% (Boterhoven de Haan *et al.*, 2020), 0% (Alliger-Horn et al., 2016), 0% (Jung and Steil, 2013), 0% (Steil *et al.*, 2011)]. In addition, the drop-out rate of this study is lower than the 22% average drop-out rate reported in a meta-analysis of trauma-focused treatments (Ehring *et al.*, 2014). This suggests that a brief ImRs intervention targeting somatic flashbacks is safe, acceptable, and tolerated well by survivors of trauma.

As recommended in previous ImRs research (Steel *et al.*, 2023), a flexible approach was taken to the delivery of the intervention. Clinical discretion was used to reschedule appointments where these were missed or cancelled. Appointments were offered in person or virtually and at a time of day the participant preferred. A female clinician was available to deliver the intervention should a participant request this. Interpreters were also available at one of the research sites. Within the context of the NHS, future research would need to demonstrate the clinical and cost-effectiveness of delivering the ImRs intervention in a flexible way with a diverse population so that commissioners and healthcare providers could justify implementing the intervention within their service. Failing to do this would risk perpetuating and compounding poorer health outcomes, particularly amongst culturally diverse populations (Napier *et al.*, 2014).

Methodological limitations and future considerations

This study has a number of methodological limitations which should be addressed in future research.

The ImRs intervention protocol only focused on one somatic flashback, even if a participant reported experiencing several. Future studies should explore whether offering more sessions of ImRs leads to a greater reduction in symptoms for people experiencing multiple somatic flashbacks or people who had had high numbers of traumatic experiences.

The TASS outcome measure (Milosevic *et al.*, 2015) has three items which asked participants to rate how distressing, exhausting, and intrusive they found the intervention. Participants reflected that whilst they felt the intervention was distressing, exhausting, and intrusive, this felt unavoidable when working with their PTSD memories and did not make the intervention feel less acceptable to them. This context is not captured within the TAAS scores and can result in a score that suggests the intervention was less acceptable than what participants experienced. Using a mixed method approach in future research, considered a more valuable strategy in feasibility research (Donald, 2018), would gather rich qualitative data about how the intervention is experienced and give context to ratings on the TAAS.

In addition to the limitations mentioned above of the VAS measure, as mentioned in Clarke *et al.* (2022), the VAS used in this study did not specify specific emotions. Any changes in scores, therefore, do not capture shifts in emotions. This is important to capture as certain emotions (such as guilt and shame) can play a role in maintaining PTSD symptoms (Cunningham, 2020), and a shift away from these emotions may indicate the positive processing and updating of the trauma memory. Future research would benefit from specifying the emotion(s) being rated within the VAS. The VAS used in this study also did not specify the main sensations experienced during the somatic flashback, such as pressure and heat. Future research could benefit from recording the main sensations experienced during the somatic flashback to understand if certain sensations respond to the ImRs intervention more than others.

Due to the small sample size in the study and lack of control, secondary outcome results should be interpreted with caution. Future research should use an increased sample and a more rigorous study design (randomised control trial).

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Conclusion

In conclusion, this study suggests that a brief ImRs intervention for somatic flashbacks is feasible, safe, and acceptable. All six participants who completed the intervention rated it as acceptable, and overall improvements were observed in their somatic flashback symptoms. The findings build upon the existing literature, indicating that ImRs is an effective intervention for symptoms of PTSD. The ImRs intervention for somatic flashbacks could complement existing therapies and lead to more effective treatment protocols for a specific symptom that has been overlooked in the existing literature. It could be used as a brief but effective intervention and integrated into existing treatments (Tf-CBT or EMDR) or developed into a stand-alone intervention. Future research is needed to explore the prevalence of somatic flashbacks, how to measure these more effectively, the underlying mechanisms of ImRs, the optimal intervention protocol, and if this can be integrated into existing trauma therapies.

Key practice points

(1) The brief ImRs intervention for somatic flashbacks was feasible, safe, and acceptable.
(2) Overall improvements were observed in somatic flashback symptoms.
(3) The ImRs intervention for somatic flashbacks could complement existing therapies and lead to more effective treatment protocols.
(4) Further research into ImRs interventions for somatic flashbacks is needed to explore its efficacy.

Further reading

Arntz, A. (2012). Imagery rescripting as a therapeutic technique: review of clinical trials, basic studies, and research agenda. *Journal of Experimental Psychopathology*, *3*, 189–208. https://doi.org/10.5127/jep.024211

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Supplementary material. To view supplementary material for this article, please visit https://doi.org/10.1017/S1754470X26100610

Data availability statement. The data that support the findings of this study are openly available in figshare at: http://doi.org/10.6084/m9.figshare.29963297

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Competing interests. The authors declare none.

Ethical standards. All authors abided by the Ethical Principles of Psychologists and Code of Conduct as set out by the BABCP and BPS. Ethical approval was obtained from the East of England-Essex Research Ethics Committee (REF: 23/EE/0125) and the Health Research Authority (HRA). The protocol was registered on clinicaltrials.gov (REF: NCT05996913). All participants recruited into the study provided informed consent. There was a potential ethical issue that taking part in the

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ImRs intervention could destabilise a participant whilst they were on the waiting list for trauma-focused therapy (i.e. they might experience an increase in PTSD symptoms and distress associated with this). This was closely monitored by the researcher delivering the intervention (J.C.), a trainee clinical psychologist and registered Cognitive Behavioural Therapy therapist and EMDR therapist.

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