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Review

Imaginative Techniques in Psychopathology: A Narrative Review

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Abstract

In recent years, imaginative techniques have effectively addressed the growing demand for brief, evidence-based treatments applicable in various contexts. Among these, Imagery with Rescripting (ImRs) was developed within the Schema Therapy model. ImRs can be applied individually or in combination with other protocols, demonstrating significant outcomes even after just one session. This narrative review aims to provide an overview of the applications of ImRs, with a specific focus on its effectiveness in trauma-related disorders. The search string used was "('imagery with Rescripting') AND (('Trauma' OR 'PTSD' OR 'dissociation'))". The following databases were utilized: PubMed, Scopus, Web of Science, Medline, Embase, and PsychInfo. The research included English-language and Italian-language studies, encompassing experimental and observational designs, case reports, and case series. Samples consisted of healthy participants or clinical populations aged 18 years and older, with no temporal limitations. A total of 56 articles were selected. The results highlight the efficacy of this intervention, whether administered individually or as part of combined protocols, across a wide range of diagnostic categories, including healthy samples, post-traumatic stress disorder (PTSD), borderline personality disorder (BDP), sleep disorders, psychotic spectrum disorders, chronic pain, anxiety disorders, depression, and eating disorders. The studies also support hypotheses about the mechanisms underlying the technique: ImRs facilitates the reprocessing of the meaning associated with mental representations and reduces the occurrence of negative intrusive images related to past events. This process alters and rewrites the individual's negative memories and images. The narrative review supports the effectiveness of ImRs in treating various psychopathological disorders, both trauma-related and non-trauma-related. In addition to highlighting the effectiveness of ImRs when appropriately integrated with other techniques, the review emphasizes the importance of conducting efficacy studies on larger samples to evaluate ImRs as a standalone intervention model.

Keywords: imagery rescripting; trauma-related disorders; psychopathology; brief psychological interventions

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1. Introduction

In recent years, imaginative techniques have gained increasing attention within clinical psychology due to their capacity to directly modify the emotional meaning of mental representation [1,2]. Among these, ImRs has received growing recognition in recent years as an evidence-based therapeutic method applied within both Schema Therapy (ST) [3,4] and Cognitive Behavioral Therapy (CBT) [5,6] frameworks. Originally developed for trauma-related conditions, ImRs is increasingly applied across a wide range of psychopathological presentations, highlighting its potential transdiagnostic relevance [7].

The primary aim of the present review is to provide an integrative narrative synthesis of the literature on imagery-based techniques, with a specific focus on ImRs, examining both its theoretical mechanisms of action and its empirical support across trauma-related and non-trauma-related psychopathology. In doing so, the review seeks to clarify whether ImRs can be conceptualized as a transdiagnostic intervention targeting shared emotional and imagery-based processes across disorders.

Adverse childhood events, including physical, emotional, and sexual abuse, neglect, domestic violence, and other forms of prolonged stress, can profoundly impact an individual's psychological and physiological development [8–11].

Childhood traumatic experiences vary in intensity, duration, and developmental context and are commonly classified into acute trauma and complex trauma. Acute trauma arises from isolated or repeated episodes of abuse or violence and is marked by high emotional intensity, often leading to short- and long-term psychological outcomes such as PTSD, anxiety, depression, and behavioral problems [11]. In contrast, complex trauma results from chronic exposure to adverse and emotionally inconsistent environments; although individual events may be less intense, their persistence undermines emotional security and contributes to enduring difficulties in attachment, emotional regulation, and self-organization [12]. Traumatic experiences affect development through neurobiological, psychological, and behavioral mechanisms [13,14]. Early stress exposure alters brain regions involved in emotion regulation and stress response, including the amygdala and hippocampus, increasing vulnerability to psychopathology [15]. Psychologically, complex trauma can impair identity development and self-esteem, with negative consequences for interpersonal functioning [16]. Emotional invalidation—defined as caregivers' systematic minimization or dismissal of a child's emotional experiences—plays a central role in these processes, disrupting the development of a coherent self-concept and contributing to shame, emotional dysregulation, and intrusive mental imagery [17–20].

Indeed, exposure to traumatic events can lead to significant symptomatic outcomes, including the development of depression and anxiety disorders, often accompanied by emotional dysregulation [21]. Depression may arise from feelings of helplessness and hopelessness associated with traumatic experiences, while anxiety disorders may stem from heightened perceptions of danger and persistent hypervigilance [22,23]. From the behavioral perspective, trauma is often associated with dysfunctional coping, such as substance abuse, self-injurious behaviors, or avoidance, that maintain and increase psychological distress [24,25].

Collectively, these findings underscore the central role of emotional and imagery-based processes in the maintenance of trauma-related difficulties. Traumatic experiences may create a rift between the narrative recollection of traumatic events and the unprocessed emotional and somatic responses, which may continue to influence self-perception in negative ways [26]. Because these memory traces are often stored as vivid sensory and emotional impressions rather than as coherent, structured narratives, therapeutic approaches that work directly with mental imagery have become increasingly important [6].

In recent decades, a large body of literature indicates that issues related to self-concept and emotional regulation are associated with emotional invalidation during childhood [17,18]. Emotional invalidation refers to behavior oriented to deny, trivialize, or minimize a child's emotions, thoughts, and emotional needs by caregivers [20]. These early adverse experiences are often associated with intrusive imagery and linked to distressing autobiographical memories [20]. Given this developmental pathway—from emotional invalidation to maladaptive imagery—imagery-based techniques appear particularly well suited to target processes that may be less accessible through purely verbal or cognitive interventions.

These techniques use imagination to modify mental experiences and influence emotions, behaviors, and perceptions. Through visualization, exposure to internal representations, or the creation of corrective emotional experiences, such techniques aim to alleviate distress, reshape negative beliefs, and promote adaptive self-regulation [2]. By working directly with emotionally salient mental representations, these techniques can "reset" affective responses and facilitate emotional learning in ways that extend beyond cognitive reinterpretation alone.

Beyond describing what ImRs does, evidence increasingly suggests that ImRs may operate through processes aligned with memory reconsolidation and inhibitory learning frameworks. During ImRs, distressing autobiographical memories are reactivated, bringing them into a labile state amenable to modification, allowing the integration of corrective emotional and cognitive information that may update the original memory representation in long-term storage—a process conceptually consistent with reconsolidation models of memory change [6,27]. Preliminary experimental work indicates that rescripting can reduce intrusive memories and alter the emotional valence of aversive representations following recall, implicating a revaluation of negative memory content rather than simple habituation to distressing stimuli [28].

Inhibitory learning principles are also relevant: ImRs promotes new associations between formerly distress-linked cues and adaptive, emotionally salient imagery, potentially increasing tolerance and dampening maladaptive responses in a manner that complements classical extinction processes [29]. Compared to purely verbal cognitive techniques, the vivid, sensory-perceptual engagement inherent in ImRs may enhance both emotional processing and the formation of competing memory traces, contributing to its efficacy across trauma-related and anxiety disorders [30].

Within this context, ImRs has become one of the most widely studied and validated imagery-based techniques [6]. ImRs aims to modify the meaning and emotional impact of adverse experiences, including traumatic events, distressing fantasies, and recurrent nightmares [31,32].

The ImRs process typically targets the most distressing moment of a memory—known as the *hotspot*—and seeks to alter its mental representation to create a new scenario in which the individual's unmet needs are fulfilled, mastery and agency are promoted, and the perceived threat associated with past experience is reduced [6,31,33]. This may occur with or without prior cognitive preparation; in both cases, emotional and sensory components remain central to the therapeutic process, reducing negative affect through the rescripting of distressing imagery rather than through cognitive reinterpretation alone.

ImRs is believed to exert its therapeutic effects through several core mechanisms that facilitate emotional processing and lasting change. These include fulfilling unmet needs by allowing individuals to reimagine painful memories so that core emotional needs are met [34]; mastery, fostering control and empowerment in contrast to past helplessness [20,35,36]; unconditioned stimulus revaluation, which reduces the perceived threat of traumatic events [37]; and counterconditioning, replacing negative associations

with adaptive emotional responses [6,37]. The therapeutic impact appears strongest when rescripting directly targets the hotspot, facilitating emotional processing at the point of maximal affective activation [38].

From a clinical standpoint, although originally designed for post-traumatic presentations, ImRs has been successfully implemented across a wide spectrum of psychopathological conditions. Before detailing the range of diagnostic applications, it is important to note that the extension of ImRs across different disorders has not been driven merely by symptom overlap, but by the recognition of shared underlying mechanisms—such as maladaptive imagery, emotional memory traces, disturbances in self-concept, and difficulties in emotional regulation—that cut across traditional diagnostic categories. This conceptual shift provides the theoretical basis for considering ImRs as a potentially transdiagnostic intervention rather than a disorder-specific technique. Evidence supports its use in PTSD [39,40], PTSD related to childhood abuse [41], personality disorders [42], major depressive disorder [43], specific phobias [44], eating disorders [45], body dysmorphic disorder [46], obsessive–compulsive disorder [47,48], and psychotic symptoms [49], social anxiety [50], voice hearing phenomena [51], hoarding disorder [52], nightmares [53], voice hearers with comorbid PTSD [54], and generalized anxiety disorder [55]. More recently, the approach has also been extended to Pathological Affective Dependence and Intimate Partner Violence [56]. This breadth of application suggests that ImRs targets core emotional and imagery-based mechanisms that cut across traditional diagnostic boundaries.

Furthermore, several studies report that ImRs facilitates changes in core beliefs by altering the patient's learned evaluation of his or her own aversive emotions, defined as a meta-emotional problem [57,58]. Indeed, negative beliefs about aversive emotions can result in a secondary emotional response that may exacerbate and maintain the primary reaction and subsequent attempts at regulation [58–64]. By altering both the emotional meaning of memories and the interpretation of emotional responses, ImRs may therefore exert a dual effect on primary and secondary emotional processes. Given the rapid expansion of research on imagery-based interventions and the increasing application of ImRs across diverse clinical conditions, an updated integrative narrative review is warranted.

Previous narrative and systematic reviews have examined the efficacy and mechanisms of Imagery Rescripting, primarily within trauma-related psychopathology. Morina and colleagues (2017) provided a systematic review focusing on the effectiveness of ImRs in PTSD, highlighting promising outcomes alongside methodological limitations [65], while Visco-Comandini and colleagues (2025) offered a more recent narrative synthesis centered on trauma and dissociative conditions, with particular attention to developmental trauma and emotional memory [7]. Although these reviews have been instrumental in consolidating the evidence base of ImRs, they have largely focused on trauma-specific applications or circumscribed diagnostic domains. The present review addresses this gap by adopting a transdiagnostic, mechanism-oriented perspective, integrating evidence from both trauma-related and non-trauma-related conditions to conceptualize ImRs as an intervention targeting shared imagery-based and emotional processes across psychopathology.

The present work aims to synthesise the current evidence on imaginative techniques, with a particular focus on ImRs, examining its effectiveness in trauma-related disorders as well as its increasingly recognised role in non-traumatic conditions and transdiagnostic processes.

2. Methods

2.1. Search Strategy

A narrative theory-driven search of the literature was conducted using the following databases: PubMed, Scopus, Web of Science, Medline, Embase, and PsycInfo. The search

was carried out between February and April 2025. Consistent with a narrative review framework, the search strategy was designed to support a conceptual and clinical integration of the literature rather than to ensure exhaustive coverage or formal systematic synthesis. Given the exploratory nature of the review and the heterogeneity of existing evidence, a narrative search was deemed appropriate to capture studies employing imagery-based interventions. To identify relevant publications, the following search string was used: ("imagery with rescripting") AND (("trauma" OR "PTSD" OR "dissociation")). These keywords were selected following a preliminary scoping to identify the most commonly used terms to describe imagery-based therapeutic techniques. The use of an explicit search string and multiple databases was intended to enhance transparency and replicability of the narrative process, rather than to follow a systematic or scoping review protocol.

No restrictions were applied regarding the publication period; however, only articles written in English or Italian were included. Given the variability in how imagery methods are described in the literature, we used a broad operational definition. "Imagery techniques" referred to any intervention using guided mental imagery to influence emotional or cognitive states. "Rescripting" was considered present when the imagery procedure changed the original meaning or outcome of a distressing memory.

To enhance coverage and identify emerging evidence, we also applied the snowball technique not only retrospectively (by identifying studies cited in the included articles) but also prospectively (*forward snowballing*), by including new studies published in the following year that cited the previously selected papers. This approach allowed us to capture recently published relevant evidence [66–68]. This approach is commonly adopted in narrative reviews addressing heterogeneous and evolving fields, where terminology and intervention labels are not yet standardized.

2.2. Selection Criteria

The inclusion criteria encompassed experimental (RCT), observational (cross-sectional, case–control, cohort), case reports, and case series studies in which imagery treatment, with or without rescripting, was administered to healthy or clinical adult participants (>18 years). Although the original aim of the research was to evaluate the efficacy of the treatment in patients who had experienced trauma, the articles identified allowed for a broader overview, including its application to other conditions and the general population.

Exclusion criteria included studies involving minor participants, systematic reviews (with or without meta-analysis), dissertations, theses, editorials, and commentaries.

In line with the narrative nature of the review, inclusion and exclusion criteria were defined to guide the thematic scope of the analysis rather than to support quantitative comparison or risk-of-bias evaluation. No formal quality assessment or risk-of-bias evaluation was performed, as the aim of the review was descriptive and integrative rather than evaluative. Section 2 has been revised to more clearly articulate the rationale for choosing a narrative approach and to explicitly distinguish it from systematic and scoping reviews, thereby improving methodological transparency and helping readers appropriately interpret the scope and strength of the conclusions.

2.2.1. Study Selection and Data Extraction

Studies were selected through a three-step process. All citations identified through the initial search were imported into Zotero Web Library (Corporation for Digital Scholarship, Vienna, VA, USA; version 8.0.3.), where duplicates were removed. Next, two reviewers (AP & FM) independently screened the titles of the remaining articles. Then, two additional authors (FG-S) independently reviewed the abstracts for further elimination (SF). In case of disagreement, a fifth independent author (FV-C) was consulted.

If the abstract did not provide sufficient clarity on the article's content, the study proceeded to the full-text analysis stage. The full texts of potentially eligible studies were obtained and assessed by two more reviewers (AU & CC). Disagreements regarding full-text inclusion were resolved by consulting another independent reviewer (SF & AC).

2.2.2. Screening Procedure

The search yielded 601 articles. After removing duplicates, 202 articles remained. Following the title and abstract screening, 155 articles were retained. Ultimately, 68 articles were deemed relevant and included in the general overview of results.

3. Results

A total of 68 studies were included. Of these, 10 focused on healthy subjects [28,38,69–76], 15 on trauma-related disorders (PTSD and C-PTSD) [34,37,40,41,77–87], 10 on borderline personality disorder [3,42,88–95], 2 on Non-Trauma-Related Psychopathology [96,97], 5 on eating disorders [33,45,98–100], 1 on sleep disorders [53,79], 10 on anxiety disorders [32,50,55,101–107], 5 on psychotic disorders [49,51,54,108,109], 4 on chronic diseases [110–113], 5 on depressive disorders [114–118]. It should be noted that Wagner and colleagues (2023) is reported in two separate sections because it addresses two distinct disorders; however, for the purpose of the overall count, it was considered as a single paper [79]. To enhance transparency and allow readers to evaluate the strength of the available evidence, a summary of the main diagnostic categories, study designs, sample size ranges, and overall level of evidence is provided in Supplementary Materials.

3.1. The Efficacy of Imaginative Techniques in Healthy Subjects

Across analogue and experimental studies, imaginative techniques, including ImRs, imaginal exposure, and safe-place imagery, have been shown to modulate emotional responses to aversive internal experiences in healthy adults [28,38,69–76].

Several studies indicate that ImRs can significantly reduce distress connected to intrusive and distress-inducing images, even when such imagery is not trauma-related. In a randomized laboratory experiment, ImRs was experienced as significantly less distressing than imaginal re-experiencing during the intervention phase and elicited lower levels of fear-related emotions (e.g., anxiety, horror) as well as anger and disgust immediately afterward [28].

Findings regarding intrusive memories are more heterogeneous. In analogue trauma paradigms using aversive or traumatic film clips, late application of ImRs was associated with fewer intrusions and reduced intrusion vividness compared with early ImRs, imaginal exposure, and control conditions, whereas early ImRs paradoxically increased intrusion frequency [69]. In a recent analogue study, imagery rescripting did not significantly reduce intrusion frequency, vividness, or emotionality compared to a no-intervention control, whereas a visuospatial dual-task intervention (Tetris) was associated with fewer intrusions at follow-up [70].

Results from another study indicate that ImRs was more effective than positive imagery and no-intervention control in reducing subjective distress and feelings of helplessness associated with aversive memories. However, ImRs did not demonstrate superior effects on other emotional responses, perceived mastery, or state stress symptoms. Across all conditions, physiological indices of emotional reactivity, including heart rate and facial electromyography, decreased from pre-intervention to follow-up. These findings suggest that while ImRs reliably reduces subjective distress, its effects on mastery and physiological reactivity may be comparable to other imagery-based or non-specific interventions [38].

However, another study reported no overall group differences in the total number or trajectory of intrusive memories following ImRs relative to imaginal exposure or control conditions [71]. Nonetheless, other studies indicated that ImRs accelerated the decline of intrusions over time compared with no intervention, despite comparable absolute intrusion counts during follow-up, and led to memories being rated as less negative, less distressing, and less central to identity, alongside increases in state self-esteem and positive affect and reductions in anxiety [28,72].

Imagery-based interventions also appear to influence emotional and physiological reactivity to stress. Safe-place imagery, used either as a standalone exercise or integrated within ImRs, produced stronger reductions in negative affect than violent or non-violent revenge rescripting, and did not increase aggressive emotions [73]. Moreover, positive imagery prior to threat exposure reduced freezing and bradycardia responses during subsequent aversive viewing, indicating that imagery can modify automatic defensive physiology [74]. More recent work showed that ImRs led to greater reductions in distress, fear, and anger than imaginal exposure when targeting autobiographical events, although effects on shame and guilt were limited and imaginal exposure unexpectedly increased negative affect [75].

Beyond emotional outcomes, the cognitive effects of ImRs have also been examined. Declarative memory accuracy does not appear to deteriorate following rescripting; on the contrary, one randomized study found improved free recall of correct details and no increase in false memories in the ImRs condition relative to controls [76]. Furthermore, while ImRs reliably increased perceived mastery over the memory compared with imaginal re-experiencing, effects on general self-efficacy were small or inconsistent [71].

Overall, research in healthy individuals highlights the capacity of imagery-based interventions, including ImRs and Safe-Place imagery, to elicit meaningful emotional shifts even with minimal exposure, supporting their potential as flexible and efficient tools for emotion regulation.

3.2. ImR in the Treatment of Post-Traumatic Disorder

Across randomized control trials and clinical studies, ImRs has demonstrated robust efficacy in reducing PTSD symptom severity, with consistent improvements across multiple clinical domains. Across studies, consistent and clinically relevant improvements have been observed in clinician-rated and self-reported PTSD symptoms, alongside reductions in depression, anxiety, dissociation, trauma-related cognitions, guilt, shame, anger, hostility, sleep disturbances, and nightmare severity, as well as gains in emotion regulation, psychosocial functioning, quality of life, and general psychopathology [34,37,40,41,77–87]. Notably, these results highlight the transdiagnostic utility of ImRs in addressing the multifaceted manifestations of trauma-related distress.

Strong evidence for the efficacy of ImRs derives from randomized controlled trials (RCTs) using waitlist or active comparators. In a large RCT, ImRs produced substantial symptom reductions compared with a waitlist control, with the majority of patients no longer meeting diagnostic criteria at post-treatment and gains maintained at follow-up, and no convincing added benefit of preparatory skills training [41]. Converging support comes from uncontrolled and pilot studies, which consistently report marked pre–post decreases in PTSD severity following ImRs-based interventions [34,84,86]. Together, these findings indicate that ImRs is not only associated with improvement over time but exerts specific therapeutic effects on core PTSD symptoms.

Head-to-head comparisons indicate that ImRs performs at least as well as established trauma-focused therapies. In a large trial comparing ImRs with eye movement desensitization and reprocessing (EMDR), both treatments yielded strong and durable reductions

in PTSD severity at post-treatment and 1-year follow-up, with no significant between-group differences and low dropout rates [40]. In a randomized trial comparing EMDR and ImRs in adults with childhood trauma-related PTSD, comorbid major depressive disorder emerged as a significant moderator of treatment outcome, although not a direct predictor [78]. Patients with comorbid depression showed greater improvement following ImRs, whereas those without depression benefited more from EMDR, while anxiety disorders had no significant impact [78]. These findings highlight the clinical relevance of considering depressive comorbidity when selecting PTSD treatments.

Recently, Rameckers and colleagues (2024) examined the underlying mechanisms of EMDR and ImRs in patients with childhood-related PTSD [37]. Across 12 treatment sessions, changes in memory vividness, distress, and encapsulated beliefs were assessed in relation to PTSD symptom severity. While EMDR produced stronger early effects on all predictors, only reductions in distress were maintained over time, and memory vividness did not predict symptom change. In contrast, improvements in distress and encapsulated beliefs during ImRs significantly predicted reductions in PTSD severity, partially supporting its proposed mechanisms of action [37].

Consistent with these findings, evidence from comparative trials focusing on chronic interpersonal trauma indicates that ImRs performs at least as well as established trauma-focused interventions. ImRs has been shown to be non-inferior to prolonged exposure (PE), with both treatments producing large and sustained reductions in PTSD symptoms [85]. Earlier clinical case series similarly reported that patients who failed to respond to PE, often characterized by prominent non-fear emotions such as anger, guilt, and shame, experienced marked symptom improvement following imagery-based rescripting procedures [80].

Treatment effects appear durable over time and have been replicated in trials evaluating enhanced or combined variants. In a two-arm randomized trial with a 12-month follow-up, very large reductions in clinician-rated PTSD severity were observed in both standard ImRs and ImRs combined with an additional intervention (ImRs + GST), with no significant between-group differences; improvements also extended to personality disorder symptoms, functioning, quality of life, and general psychopathology [81]. Similarly, sustained improvements have also been reported in smaller randomized trials and pilot studies with follow-up periods ranging from several weeks to one year [84,119], and in samples with notable treatment non-completion, suggesting robust benefits among treatment completers [82].

Beyond global PTSD severity, ImRs has demonstrated specific benefits for sleep-related symptoms. A retrospective pilot chart study documented significant reductions in nightmare frequency, intensity, and distress, alongside improvements in sleep quality and coping with nightmares, as well as concurrent decreases in PTSD symptoms even when sleep items were excluded from symptom scales [79]. These findings suggest that ImRs may be particularly useful for trauma-related sleep disturbances, which are often resistant to standard interventions.

Evidence also indicates that ImRs can be effectively delivered across different treatment formats, including individual, group, and online sessions, demonstrating the flexibility and scalability of ImRs [34,83]. Randomized trials of group-based and internet-delivered ImRs reported significant reductions in PTSD and complex PTSD symptoms, as well as in depression and anxiety, with effects maintained at 3- and 6-month follow-up [83]. Pilot work further suggests that standard face-to-face ImRs may be more effective than virtual-reality-based implementations in reducing PTSD symptoms, although trauma-related cognitions improved in both conditions [34]. These findings collectively underscore not only the efficacy but also the durability of treatment gains.

The mechanisms through which ImRs exerts its therapeutic effects appear multifaceted. Across studies, ImRs enhances emotional processing by fulfilling unmet emotional needs, fostering a sense of mastery and agency, reducing the perceived threat of traumatic stimuli through unconditioned stimuli revaluation, and counterconditioning distressing memories [34].

ImRs helps survivors of childhood abuse or war trauma cultivate self-compassion and re-parent their younger selves, creating a safe internal space for neglected aspects of the self [40,85,87]. It allows individuals to revisit traumatic memories with agency and protective guidance, reducing emotional overwhelm and fostering coherent self-narratives. Engaging with the internal child promotes adaptive emotional regulation, mitigates self-blame, and supports corrective internal relational experiences. The re-parenting element repairs disrupted attachment schemas and strengthens compassionate autobiographical narratives. This process integrates past and present self-experiences, lowering trauma-related distress. Ultimately, it enhances resilience and adaptive coping in daily life [40,85,87].

3.3. The Efficacy of Imaginative Techniques in Borderline Personality Disorder

Borderline Personality Disorder (BPD) is closely linked to early adverse experiences, including emotional neglect, emotional and sexual abuse, and attachment disruptions, which contribute to the development of maladaptive schemas, unstable self-concepts, and dysfunctional coping modes [88–90]. Given the centrality of trauma in the etiology and maintenance of BPD, ST incorporates ImRs as one of its most important experiential components for modifying painful childhood memories and restructuring deeply ingrained beliefs [42,91].

Across RCTs, ST has demonstrated significant efficacy in reducing BPD symptomatology and improving functioning and quality of life when delivered in individual formats and when combining individual and group modalities [88–90]. In a landmark trial, ST outperformed transference-focused psychotherapy in recovery and symptom reduction and was associated with lower dropout [88]. Subsequent studies replicated beneficial outcomes and reported meaningful recovery rates following prolonged ST, with generally acceptable retention [88], while group-based implementations also showed large clinical improvements compared with treatment as usual [90]. More recently, a large multicenter randomized trial conducted across five countries, involving 495 patients, showed that the integrated individual-plus-group ST format produced the most substantial reductions in BPD severity, outperforming both group-only ST and optimized Treatment as Usual [92].

While these trials do not isolate the unique contribution of ImRs, its central role within ST has motivated efforts to examine its timing more directly. The ongoing LUCY trial is testing whether introducing ImRs during the initial phase of treatment improves clinical trajectories of BPD symptoms compared to later implementation, with potential implications for treatment duration and cost-effectiveness [42].

In addition to quantitative outcomes, qualitative research offers insight into how ImRs modifies internal experience in BPD. Baelemans and colleagues [110] documented how patients engaged in ST frequently described punitive internal voices or self-critical modes, sometimes resembling auditory hallucination-like phenomena [93]. ImRs helped reduce the intensity and credibility of these internalized punitive messages, fostering the emergence of healthier internal representations and greater self-compassion [93]. Moreover, Schaich and colleagues (2020) reported that ImRs is often experienced as highly emotional and exhausting in the short term, yet many patients describe long-term benefits such as improved emotion regulation, increased self-compassion, better understanding of schemas and needs, improved relationships, and reductions in self-injury [3]. Patients also identified process factors that may shape outcomes, including the importance of structure and

preparation, a sense of safety and control (e.g., stop signals), therapist involvement within imagery, gradual pacing, and adequate debriefing [3]. These qualitative accounts align with mechanisms proposed in ST, in which the activation and transformation of distressing memories play a pivotal role in reducing emotional instability, impulsivity, and chronic self-criticism.

Finally, clinical complexity may moderate treatment response in subsets of patients: comorbid psychotic disorders are relatively frequent in BPD presentations and have been associated with poorer outcomes and greater severity [94]. Relatedly, when BPD co-occurs with PTSD, trauma-focused protocols within DBT frameworks (e.g., DBT-PTSD; DBT-PE) have shown feasibility and substantial PTSD symptom reductions, supporting the broader role of imagery-based exposure/rescripting-related work in BPD populations with trauma comorbidity [91,93,95]. Collectively, the literature portrays ImRs as a central therapeutic mechanism within ST, supporting the reprocessing of trauma-related schemas, promoting emotional integration, and attenuating the self-critical internal dynamics often characteristic of BPD.

3.4. Effectiveness of Imaginative Techniques in Non-Trauma-Related Psychopathology

Beyond trauma-related disorders, imagery-based interventions, including ImRs, have been applied across a diverse range of psychological conditions, offering insight into their transdiagnostic potential. Evidence suggests that imagery techniques influence core emotional, cognitive, and physiological processes implicated in eating disorders, sleep disturbances, anxiety disorders, psychotic symptoms, chronic pain, and depression. Early clinical evidence supporting the transdiagnostic applicability of imagery rescripting was provided by Rusch and colleagues (2000), who examined the use of this technique in patients presenting with recurrent, distressing intrusive images that were not related to autobiographical traumatic memories [96]. In a case series of eleven patients with heterogeneous clinical presentations, including depressive symptoms, somatization, and post-accident distress, imaginal exposure alone failed to reduce symptom severity, whereas a single session of imagery rescripting was associated with a marked and sustained reduction in subjective distress linked to the intrusive images. These findings highlighted the potential of imagery rescripting to target maladaptive imagery processes across non-trauma-related forms of psychopathology. More recent evidence further supports the applicability of imagery rescripting beyond trauma-related psychopathology. Tenore and colleagues (2022) investigated the effectiveness of a group-based imagery rescripting intervention delivered via telehealth, focusing on childhood memories linked to currently distressing dysfunctional beliefs. In a mixed, predominantly non-clinical sample, participants underwent three group imagery rescripting sessions targeting unmet emotional needs [97]. The intervention was associated with a significant reduction in dysfunctional belief endorsement, decreased shame and arousal levels, and high rates of reported needs satisfaction. Importantly, greater emotional immersion in the imagery was positively associated with perceived needs satisfaction [97].

3.4.1. Eating Disorders

The application of ImRs in eating disorders (EDs) has expanded considerably in recent years, reflecting growing interest in how aversive imagery, shame-based memories, and internalized critical voices contribute to the onset and maintenance of ED symptoms.

Clinical evidence suggested that ImRs can be safely integrated into treatment for underweight eating disorders without interfering with weight restoration trajectories. In a multiple-baseline case series study of underweight patients with EDs and comorbid PTSD, Napel-Schutz and colleagues (2022) found significant reductions in trauma-related

symptoms, negative core beliefs, and dysregulated emotions following ImRs, with benefits maintained during follow-up [33]. Importantly, these improvements emerged without disrupting nutritional rehabilitation, indicating that ImRs is feasible and safe when integrated into standard care.

Complementary findings come from smaller experimental and case-based studies. Dugué and colleagues (2019) showed that a single-session ImRs intervention, targeting imagery of social rejection, significantly reduced negative emotions and dysfunctional core beliefs in individuals with binge-eating disorder and bulimia nervosa, with effects maintained at one-week follow-up, although no clear superiority of ImRs over cognitive restructuring emerged [98]. Similarly, a clinical case study documented a marked and durable reduction in bulimic behaviors following a single ImRs session after partial improvement with CBT, underscoring the potential of imagery-focused interventions to shift entrenched emotion-laden schemas [99]. Notably, ImRs yielded particularly strong reductions in emotionally encoded core beliefs, an important mechanism in ED pathology.

In preventive contexts, Zhou and colleagues (2020) found that both general and body-focused ImRs, as well as psychoeducation, led to significant reductions in global eating psychopathology and increases in body image acceptance compared with a control condition [100]. Body-focused ImRs additionally enhanced self-compassion and reduced fear of self-compassion, whereas general ImRs reduced dysfunctional attitudes such as perfectionism and low self-esteem. However, no significant short-term effects were observed on the frequency of disordered eating behaviors [100]. By contrast, Kadriu and colleagues (2023) found no significant effects on emotional responses to autobiographical memories, negative core beliefs, or ED symptoms at follow-up compared with a control condition in a subclinical sample [45]. Although modest reductions in anger and shame over time were observed in the ImRs groups, these effects were not robust after adjustment for covariates. The authors concluded that brief, self-guided ImRs may be insufficient to produce meaningful changes in ED-related beliefs or symptoms in at-risk individuals [45]. Overall, the emerging literature suggests that ImRs may address central maintaining processes in EDs, including shame, self-criticism, and relationally anchored negative memories, offering a promising adjunct to standard treatments.

3.4.2. Sleep Disorders

Nightmare disorder and trauma-related sleep disturbances represent key areas in which imagery-based techniques have been used extensively. Although Imagery Rehearsal Therapy (IRT) remains widely implemented, studies have increasingly compared ImRs with imaginal exposure (IE) to clarify mechanisms of change.

Kunze and colleagues (2017) demonstrated that both approaches reduce nightmare frequency and distress, but through distinct psychological pathways: ImRs acts primarily by enhancing mastery and perceived controllability over nightmare content, whereas IE improves tolerance of negative affect elicited by the nightmare [53]. These differential mechanisms support the idea that ImRs may be especially suited for nightmares involving helplessness, shame, or early attachment-related themes, where mastery and need fulfillment are central [53].

Wagner and colleagues (2023) report a pilot study evaluating a brief intervention for chronic nightmares in veterans with PTSD, integrating IRT with principles from Narrative Therapy (N-IRT) [79]. A retrospective chart review of eight veterans assessed outcomes following a single 60 min narrative-enhanced rescripting session with a one-month follow-up. Results showed significant and clinically meaningful reductions in nightmare frequency and intensity, along with improvements in nightmare-related distress, coping abilities, sleep quality, and overall PTSD symptoms. Despite methodological limitations, the findings

provide preliminary support for N-IRT as a promising and efficient treatment approach for trauma-related nightmares in veteran populations [79].

Such findings further illustrate how ImRs can modify the affective meaning of internal representations even when the precipitating event is not overtly traumatic.

3.4.3. Anxiety Disorders

A substantial body of research supports the use of ImRs across anxiety disorders, where maladaptive imagery, negative self-representations, and distressing memories play a significant role in the maintenance of symptoms. Although the literature is still characterized by relatively small samples and a predominance of pilot and open studies, findings are convergent in indicating that ImRs can reliably reduce imagery-related distress, weaken negative core beliefs, and contribute to symptom improvement across different anxiety presentations.

The strongest evidence comes from studies on social anxiety disorder (SAD). In an early clinical study, Wild, Hackmann, and Clark (2007) found that a single ImRs session targeting early socially traumatic memories produced marked within-session reductions in image and memory distress and vividness, as well as in conviction of negative self-beliefs, with additional improvements in social anxiety and related cognitions at one-week follow-up [101]. A subsequent pilot-controlled study showed no effects after a control session but large immediate and short-term reductions in fear of negative evaluation, social anxiety, and imagery-related distress and vividness after ImRs, although image frequency remained unchanged [50]. These findings were extended in a randomized controlled trial by Lee and Kwon (2013), who reported greater reductions in social avoidance and distress in the ImRs condition, maintained at three months [102]. Norton and colleagues (2021) further showed that adding ImRs to group CBT reduced fear of negative evaluation, negative core beliefs, maladaptive appraisals, negative affect, and depressive symptoms, though not social anxiety severity beyond standard CBT [103]. Process-focused research supports a specific mechanism of change: ImRs was associated with stronger emotional activation and increased heart rate during memory reactivation, followed by larger reductions in negative affect, increases in positive affect, and higher heart rate variability during the rescripting phase, consistent with models emphasizing emotional activation followed by corrective regulation [55].

Evidence in other anxiety disorders is more limited but broadly consistent. In health anxiety, ImRs has been associated with significant reductions in health-related anxiety and worry, as well as in the distress, vividness, and frequency of intrusive illness-related imagery, together with high treatment acceptability and the absence of adverse events [32]. In panic disorder, reductions have been reported in the distress linked to panic-related images, memories, and encapsulated negative beliefs, although these changes are not consistently reflected in overall symptom severity [104].

Smaller studies further suggest benefits in performance-related anxiety and heterogeneous clinical samples. Decreases in test anxiety and intrusive imagery, alongside increases in general and academic self-efficacy, have been observed in student populations [105], and clinically reliable improvement at six-month follow-up has been reported when ImRs is embedded within a CBT framework [106]. Converging psychophysiological evidence indicates that stronger autonomic activation during memory evocation predicts lower subsequent anxiety and greater well-being, further highlighting emotional engagement as a key mechanism of change [107].

Taken together, these findings suggest that imagery-based interventions effectively modify emotionally encoded beliefs and internal representations that verbal cognitive techniques may struggle to access.

3.4.4. Psychotic Disorders

Initial case studies demonstrated that imagery rescripting (ImRs) can reduce stress associated with hallucination-related imagery, decrease negative beliefs about voices, and diminish the frequency of intrusive images. These early findings were subsequently replicated in small-sample trials, including studies involving patients presenting with dissociative symptoms, although a greater number of sessions was required to achieve comparable therapeutic effects [49,51,54]. More broadly, image rescripting has consistently been shown to reduce distress associated with intrusive images and memories across a range of mental health conditions. However, research on imagery-based interventions in psychosis has historically underrepresented individuals who experience auditory hallucinations. Addressing this gap, a recent exploratory study examined the feasibility and potential clinical utility of image rescripting in people with psychosis who experience both intrusive imagery and voice hearing [109]. Using a single-session intervention and an A–B single-case design with four participants, the study reported clinically meaningful reductions in distress, negative affect, and conviction in maladaptive beliefs at follow-up. Although preliminary, these findings suggest that image rescripting may represent a promising extension of cognitive–behavioral therapy for psychosis, particularly for patients whose symptomatology is characterized by intrusive imagery and distressing voices [109]. More recently, the iMAPS protocol (Imagery-focused therapy for persecutory delusions), which integrates ImRs with CBT techniques, has shown large effect-size reductions in persecutory delusions, distressing imagery, and negative self-schemas, with high tolerability and adherence [108]. These results highlight the unique potential of imagery-based work to access emotionally laden material that is often resistant to purely verbal interventions in psychosis.

3.4.5. Imagery with Rescripting in Patients with Chronic Pain

ImRs has also been applied to chronic pain conditions, where intrusive imagery, catastrophizing, and affective distress are common contributors to symptom persistence.

Observational evidence indicates that pain-related mental images are highly prevalent and that exposure to such imagery increases negative affect, maladaptive appraisals, and perceived pain intensity, particularly in individuals with elevated trauma symptoms [110]. Experimental studies suggest that these representations are amenable to change. Rescripting pain-related images has been shown to produce marked reductions in pain intensity, negative emotions, and dysfunctional appraisals, with a substantial proportion of patients reporting a complete absence of pain during rescripted imagery, and effects not attributable to repetition or habituation [111].

Controlled trials further support these findings. Kip and colleagues (2014) found that a combined EMDR + ImRs intervention outperformed attention control conditions in reducing pain and associated distress [112]. Follow-up research indicates that such improvements are durable and may be enhanced within multidisciplinary frameworks that integrate psychological, medical, and physiotherapeutic components [113].

These findings suggest that ImRs may influence both cognitive-emotional processing and somatic perception, potentially disrupting the feedback loops that maintain chronic pain.

3.4.6. Depressive Disorder

Large randomized and controlled studies indicate that ImRs can produce clinically meaningful reductions in depressive symptoms and improvements in functional outcomes. In a controlled pilot RCT, ImRs was associated with significantly greater clinician-rated improvement and increased daily physical activity compared with control conditions,

although self-reported symptom differences were less robust [114]. Comparative evidence further suggests that ImRs is at least as effective as cognitive restructuring in reducing depressive symptoms and may be superior in decreasing rumination, worry, and experiential avoidance—processes strongly implicated in the maintenance of depression [115].

Smaller clinical studies converge with these findings. Open and uncontrolled trials report large reductions in depression and anxiety, accompanied by decreases in intrusive memories and rumination and increases in self-compassion, with effects maintained at follow-up [118]. Similarly, imagery-focused interventions have been shown to reduce the vividness, distress, and uncontrollability of intrusive memories, often replacing them with compassionate or mastery-based imagery [116], and to produce clinically significant improvement in patients with shame- and guilt-laden memories [117].

Hiramatsu and colleagues (2021) have integrated imagery rescripting into routine cognitive behavioural therapy (CBT) for patients with major depressive disorder (MDD) to evaluate its clinical utility [116]. Sixteen patients identified intrusive memories and rated their vividness, distress, interference with daily functioning, and perceived uncontrollability before and after two rescripting sessions. The intervention led to a significant reduction in the overall intrusive memory index. The rescripted images predominantly incorporated elements of compassion, mastery, or a combination of both, highlighting the adaptive nature of the technique [116].

Overall, ImRs appears particularly effective in addressing emotionally encoded components of depression that are less responsive to verbal cognitive approaches, such as shame, self-criticism, and early attachment-based representations.

4. Discussion

The present narrative review aimed to synthesize the expanding literature on imagery-based interventions, with a particular focus on ImRs, across trauma-related and non-traumatic psychopathology. Consistent with the theoretical assumptions outlined in the introduction, namely, that early adverse experiences and emotionally encoded memories contribute to persistent maladaptive schemas, negative self-representations, and affect dysregulation [11,15–20,22–26,58,96,120–123], the findings confirm that interventions targeting imagery and the emotional meaning of memories hold substantial transdiagnostic potential. As summarized in Supplementary Materials, the strength of evidence supporting ImRs varies across diagnostic categories and study designs, ranging from preliminary evidence based on pilot and case-series studies to more robust support derived from randomized controlled trials, particularly in PTSD and within Schema Therapy for Borderline Personality Disorder.

Across experimental and analogue studies in healthy participants, imagery-based techniques consistently demonstrated the capacity to modulate emotional reactivity, reduce intrusion frequency, and alter the cognitive-emotional appraisal of aversive memories. ImRs showed particular promise in diminishing distress associated with negative imagery and promoting mastery and self-efficacy, even after minimal intervention exposure [28,38,69–76,96]. These preliminary findings illustrate the sensitivity of mental imagery, and its modification through rescripting, to cognitive and affective processes that are not exclusively linked to traumatic experiences, reinforcing the conceptualization of imagery as a central mechanism in emotional regulation.

Consistent with previous conceptual and clinical models, the evidence reviewed suggests that ImRs is supported by robust evidence of effectiveness, particularly for PTSD and Complex PTSD, producing substantial reductions in core symptoms and associated emotional disturbances (e.g., guilt, shame, anxiety, depression) across diverse trauma types [7,40,78,81]. The reviewed trials demonstrate that ImRs performs comparably to, or

better than, other established trauma-focused interventions such as EMDR and Prolonged Exposure [79]. Importantly, the durability of therapeutic gains across long-term follow-up periods underscores the potential of ImRs to modify both primary trauma symptoms and deeper disruptions in self-organization typically associated with complex developmental trauma [119,124]. Mechanistically, the results support theoretical accounts proposing that fulfilling unmet emotional needs, enhancing mastery, and reevaluating unconditioned stimuli are pivotal components of therapeutic change [34,37].

In BPD, the findings highlight the centrality of ImRs within ST for modifying maladaptive schemas rooted in early adversity [42,89,90]. The reviewed evidence shows that ST is effective across individual and combined modalities [88,89,92,95], with large-scale trials confirming the superiority of integrated individual-plus-group formats over treatment-as-usual [92]. Emerging data suggesting that trauma work may be safely and effectively initiated earlier in treatment challenge the traditional staged model of ST, potentially paving the way for more efficient therapeutic protocols [91,125,126]. Qualitative findings further elucidate how ImRs transforms punitive internal modes and fosters self-compassion, addressing core dysfunctions that verbal therapies alone often fail to target [3,93].

Across non-traumatic psychopathology, the review indicates that ImRs can successfully address imagery-based mechanisms that contribute to distress and symptom maintenance [96,97]. In eating disorders, ImRs effectively reduces shame, negative self-beliefs, and emotionally encoded relational memories, with effects observed both in clinical and preventive contexts [33,45,98–100]. In sleep disorders, evidence suggests that ImRs enhances perceived mastery of nightmare content, operating through mechanisms distinct from imaginal exposure [53,79]. In anxiety disorders, ImRs reliably reduces intrusive imagery and dysfunctional appraisals in social anxiety [101–103], shows beneficial—though mixed—effects in panic disorder [104], and demonstrates utility in specific phobias [50,106] and health anxiety [32]. Psychophysiological data identifying emotional activation as a predictor of therapeutic outcome provide empirical support for theoretical models that emphasise the necessity of engaging with affectively charged imagery during treatment [107].

ImRs also shows promise in conditions once considered less responsive to imagery-focused work, such as psychotic disorders. Results from small trials and case series indicate reductions in hallucination-related distress, negative beliefs about voices, and intrusive imagery [49,51,54,109]. More structured interventions, such as the iMAPS protocol, demonstrate that integrating imagery and rescripting within CBT frameworks can lead to significant reductions in persecutory thinking and negative self-schemas, with high patient acceptability [108].

In chronic pain, ImRs consistently reduces pain intensity and negative emotional responses to pain-related imagery, even after very brief interventions [110,111]. Improvements appear particularly robust when ImRs is combined with other evidence-based psychological techniques such as EMDR, supporting multimodal treatment models [112,113]. Finally, in depressive disorders, ImRs effectively targets intrusive autobiographical memories, rumination, shame, and negative self-concept, elements central to the maintenance of depression. Benefits emerge across outpatient, self-help, and inpatient contexts [114–118], with some studies suggesting that ImRs may outperform cognitive restructuring in reducing experiential avoidance and negative imagery [114].

Taken together, the evidence reviewed strongly supports the relevance of imagery-based change processes across a wide spectrum of psychological disorders.

At a broader level, ImRs may exert its therapeutic effects by modulating neurobiological mechanisms central to trauma processing. By directly engaging cortico–limbic networks involved in emotional regulation, threat processing, and memory reconsolidation, ImRs has the potential to attenuate maladaptive patterns of both hyperactivation and

hypoactivation commonly observed in trauma-related and dissociative states [86,127]. The combination of vivid emotional engagement with cognitive reappraisal may facilitate the updating of maladaptive memory traces, promote more adaptive integration of affective and autobiographical information and lead to enduring changes in symptom expression and self-referential meaning.

Consistent with this neurobiological perspective, findings from the present systematic review underscore ImRs as a brief yet potent intervention capable of producing durable improvements in trauma-related psychopathology. The reviewed evidence suggests that ImRs is particularly effective in accessing emotionally encoded memories and self-representations that are often resistant to purely verbal or cognitive interventions. Its capacity to simultaneously target emotional, sensory, relational, and meaning-level processes may account for its broad clinical efficacy across both trauma-related and non-trauma-related conditions. Future research should further delineate the neurobiological boundary conditions of ImRs and optimize treatment sequencing, especially for individuals with complex interpersonal trauma, dissociative symptoms, or moral injury, in whom imagery-based interventions may uniquely support neural integration, self-coherence, and psychological reintegration [7,128]. Taken together, these findings highlight imagery-based change processes—and ImRs in particular—as central therapeutic mechanisms within a transdiagnostic framework, with neurobiological modulation representing a key pathway of clinical change.

An additional aspect that warrants critical consideration concerns the delivery format of Imagery Rescripting, particularly in telehealth settings. While the growing literature on telehealth-delivered ImRs suggests promising feasibility and acceptability, particularly in trauma-related populations, several important limitations warrant consideration. Remote delivery may pose challenges in the management of intense emotional activation or abreaction, as the therapist has reduced control over the physical environment and fewer opportunities for immediate in-person containment. In addition, the attenuation of non-verbal cues, such as subtle bodily signals, posture changes, or dissociative responses, may limit the clinician's ability to promptly detect emotional overload or disengagement during the rescripting process. These factors may be particularly relevant when working with patients presenting with complex trauma, dissociation, or severe affect dysregulation. Consequently, telehealth-delivered ImRs should be implemented with caution, careful patient selection, and clear safety protocols, and further controlled studies are needed to directly compare in-person and remote formats with respect to both efficacy and safety.

Nevertheless, several limitations warrant consideration. First, while experimental analogue studies provide valuable insight into mechanisms, their ecological validity remains limited. Second, many clinical trials involve small sample sizes, heterogeneous protocols, or lack active control conditions, affecting generalizability. Third, despite promising evidence for online and brief formats, further work is needed to establish optimal dose–response relationships and identify which patient characteristics predict better outcomes. Finally, a more rigorous examination of neurobiological and psychophysiological mechanisms would deepen the understanding of how ImRs facilitates memory updating and emotional change.

Overall, the findings underscore that imagery-based interventions, particularly ImRs, represent a clinically potent, flexible, and transdiagnostic approach. As research continues to refine mechanisms, delivery formats, and applications across diverse populations, ImRs is well-positioned to play an increasingly central role in the treatment of both trauma-related and non-traumatic psychopathology.

5. Limitations

Although this narrative review provides a broad and updated overview of the literature on imaginative techniques, and in particular on ImR, several limitations should be acknowledged.

First, being a narrative review rather than a systematic review, a structured protocol such as PRISMA was not followed. Consequently, study selection may have been influenced, at least in part, by the authors' subjective judgment. Despite the use of multiple databases and the application of snowball technique, both retrospectively and prospectively, it is possible that some relevant studies were not identified.

Another limitation concerns the heterogeneity of the included studies, which differ in terms of clinical populations, research designs, and outcome measures. This variability makes it difficult to directly compare findings and limits the ability to draw definitive conclusions about the overall efficacy of the technique. Accordingly, the summary provided in Supplementary Materials should be interpreted as a qualitative synthesis of the available evidence rather than a quantitative comparison of effect sizes, which would require a systematic review or meta-analytic approach.

Moreover, several of the included studies involved small sample sizes or employed preliminary research designs (e.g., pilot studies, case reports, or case series), which limits the robustness and generalizability of the available evidence. Moreover, the variability in demographic and clinical characteristics across studies, and the incomplete reporting of such variables in some investigations, may limit the generalizability of the findings to broader or more diverse populations.

Finally, this review included only studies conducted with adult populations and published in English or Italian, which may have led to the exclusion of relevant research produced in other languages or with different age groups.

Future research should adopt systematic and meta-analytic approaches to confirm these findings, clarify the underlying mechanisms of ImR, and evaluate its comparative efficacy relative to other therapeutic interventions.

6. Conclusions

This paper provides an overview of the current applications of imaginative techniques, with a particular focus on ImRs, especially in trauma-related disorders, where the method has been most extensively investigated. Over recent years, research has generated growing enthusiasm for imaginal and rescripting-based approaches, whose use has expanded well beyond PTSD to encompass a wide range of clinical conditions. Empirical studies provide supportive evidence for the effectiveness of ImRs in treating anxiety disorders, obsessive–compulsive disorder, borderline personality disorder, and sleep disturbances, showing both rapid and, in many cases, sustained reductions in symptom severity as well as meaningful improvements in quality of life. Notably, ImRs has shown promising results both as a standalone intervention within specifically developed therapeutic protocols and as a component integrated into broader treatment frameworks, underscoring its transdiagnostic flexibility and clinical relevance [118,129]. However, given the heterogeneity of study designs included in this narrative review, these findings should be interpreted as indicating supportive and promising evidence rather than definitive efficacy, particularly outside randomized controlled trial settings.

Beyond clinical populations, ImRs has also shown promise in subclinical cases, where individuals may not meet diagnostic criteria but nonetheless present with nonspecific or varied symptomatology. This finding highlights its versatility and potential utility as a preventive intervention [118]. Overall, studies in nonclinical populations suggest that imaginative techniques can function as supportive tools to counteract unpleasant emotions

or mild symptoms. In particular, ImRs has been shown to reduce emotional distress and aggressive affect, decrease the vividness and emotional intensity of intrusive images, and foster a greater sense of psychological and somatic distance from traumatic or aversive memories. Through this process, individuals can reappraise and transform the emotional meaning of past experiences, thereby enhancing self-regulation and emotional well-being even in the absence of clinically significant symptoms.

Despite these encouraging results, further rigorous investigation is needed to consolidate the evidence base for ImRs. In particular, randomized controlled trials (RCTs) are essential to confirm its efficacy and to clarify its mechanisms of action. Exploring the neurophysiological and cognitive processes involved in imagery rescripting may open new research avenues; for example, preliminary evidence suggests that the act of rewriting mental images may influence memory consolidation and support a more adaptive integration of traumatic memories [6,130]. Recent meta-analyses, such as that by Kroener and colleague (2023), have synthesized findings across multiple clinical trials and highlighted ImRs as a promising—though still evolving—therapeutic technique, particularly when compared with more established interventions [130].

To enhance its accessibility and consistency in clinical practice, the development of standardized guidelines and treatment protocols is crucial. Such resources would facilitate broader implementation and ensure that ImRs is applied reliably across diverse clinical contexts.

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