

ROTATE

Resource-Oriented Trauma Therapy with Elements of EMDR

Version 1.1

**Treatment Manual for Psychotherapists and Counselors
in the Field of Psychological Trauma**

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Part 1:

Introduction, Diagnostics, and Basic Knowledge in Psychotraumatology

1 Introduction

ROTATE is a short-term resource-based trauma therapy approach that is especially suitable for clients with complex trauma conditions, i.e. posttraumatic stress disorder (PTSD) and comorbid conditions. It can be used as a tool for psychotraumatologists and counselors in the field of psychological trauma¹.

The name ROTATE means *Resource-Oriented Trauma Therapy with Elements of EMDR*. It exhibits three major features:

- First, it aims at strengthening resilience and coping capacities by activating positive personal resources and includes a variety of imaginative resource-activating methods within a framework informed by affective neuroscience and resilience research.
- Second, it largely draws on psychodynamic principles of therapeutic relationship and attachment theory.
- Third, it includes several elements of EMDR (Eye Movement desensitization and reprocessing, Shapiro 2001). EMDR is an evidence-based psychotherapy to treat PTSD which uses bilateral stimulation as its central agent. In addition to the EMDR standard protocol, several modifications have been developed, some of which involve resource-activation (e.g. Knipe 2011). Clearly, this approach does not include the full EMDR standard protocol; rather, a small number of EMDR techniques have been selected and adapted in order to reinforce the resources activated and to reduce the stress by traumatic memories.

The basic elements of ROTATE are:

- basic knowledge in psychotraumatology
- diagnostics and defining the aims of the therapy
- establishing a therapeutic relationship (safety, control) and dealing with difficult therapeutic relationships (transference, countertransference, therapists' self-care)
- managing flashbacks and dissociative states, emotion regulation, imaginative techniques to activate positive resources
- as an EMDR element the recommendation to use bilateral stimulation to strengthen and anchor the resources activated.
- as a further EMDR element the « Stress Absorption Technique » which is a modification of Resource Development and Installation (RDI), an EMDR technique to reduce current stressors by activating memories of earlier coping competences and anchoring them via bilateral stimulation (Korn & Leeds 2002; Leeds 1998; Popky 2005).

Research has shown that symptoms of PTSD and comorbid conditions can be effectively reduced by consequently activating resources using ROTATE (Steinert et al. 2016).

¹ Whenever this manual refers to "therapists", it also refers to trauma counsellors in the field of trauma.

ROTATE has several advantages:

- The approach takes into account the complex nature of trauma experienced by victims of man-made disasters and interpersonal violence.
- The approach is particularly suitable for clients in non-Western countries, as traditional healing resources and metaphors can be integrated into an overall resource activation framework. The techniques used in the approach ROTATE have been widely applied in trauma psychotherapy training in countries such as Indonesia, China, Haiti, Thailand, Kenya, Rwanda and Burundi (Mattheß & Sodemann 2014).
- The basic elements of the approach can be safely applied even in cases of complex traumas, no major side effects have been observed so far.
- Moreover, as it is not only based on language and also focuses on somatic aspects and body reactions, it can be considered more culturally independent than other psychotherapies.
- The basic elements can easily be taught. This aspect is of major importance to ensure wide dissemination of the basic elements of psychotherapy among the large number of traumatized clients in severely affected non-octagonal areas.

Two aspects should be noted:

First, ROTATE is a short-term approach and as such it is not a comprehensive psychotherapy for clients suffering from complex trauma conditions. Because of the broad range of trauma-related symptoms and interpersonal problems, generally a long-term psychotherapy is indicated. According to the “Consensus Model of Trauma Therapy” (Herman 1997; Chu 1998; Courtois 1999; Reddemann 2012) which involves stabilization, trauma processing and reintegration phases, ROTATE represents just the stabilization phase. Nevertheless, it is an important step to reduce severe posttraumatic symptoms, notably in clients living in low-income countries where long-term psychotherapy is not available.

Second, ROTATE is not a trauma confrontative technique. Rather, it aims at reducing trauma-related symptoms by offering a specific therapeutic relationship and by activating and strengthening positive resources. However, it can be combined with traditional trauma confrontative techniques, if necessary. In this context, it serves as a preparatory stabilization phase for confrontative techniques to be safely applied. For this purpose, there exists a supplementary « ROTATE-advanced » manual which is for use by psychotherapists only. It includes advanced techniques for working with traumatic memories. These techniques can be applied after having extensively worked through the contents of the ROTATE manual.

ROTATE is designed as a short-term intervention. Normally, 10 to 20 therapeutic sessions of 50 minutes each seem appropriate. However, additional sessions can be added if necessary.

2 The Main Principles of ROTATE

2.1 Psychodynamic Relationship Orientation

Given the high prevalence of interpersonal problems in complex trauma clients, an approach based on psychodynamic principles appears to be appropriate for several reasons:

- *Relationship issues* and *attachment disorders* are at the heart of interpersonal trauma conditions. Psychodynamic theory has provided the deepest understanding of relationship issues, and psychodynamic authors constantly underscored the importance of trust and relationship themes involved in interpersonal trauma (Ferenczi 1949; Reddemann 2012; Schottenbauer 2008; Wöller et al. 2012). Moreover, research has shown that these conditions can be effectively treated by psychodynamic approaches (Bateman & Fonagy 2009; Kruse et al. 2009; Lampe et al. 2008; Sachsse et al. 2006)
- The psychodynamic relationship orientation implies an *understanding of the client's symptoms against the background of current and earlier interpersonal relationships*. Hence, psychodynamic work aims not only to modify the client's symptoms, but, in addition, to influence the interpersonal relationships which maintain the current symptom pattern. E.g. depressive symptoms in the context of complex interpersonal trauma may be due to the clients' inability to avoid perpetrator contact. Therefore, strengthening their capacity to protect themselves can be the main focus of the therapy.
- Approaches informed by psychodynamic ego-psychology provide a broad spectrum of *interventions to develop deficient ego-functions* (i.e. basic competences) of complex PTSD clients. E.g., impaired emotion regulation and disturbed interpersonal regulation are very common among complex trauma clients (Bellak et al. 1973/13, 2004; Leichsenring et al. 2010; Wöller 2012). To this end, the ROTATE therapists teach their clients resource-activating techniques to enhance specific ego-functions.
- During the last two decades, the repertoire of psychodynamic interventions to strengthen the clients' ego-functions has been broadened by including *guided imagery*. These interventions have been found to be very useful to effectively treat complex trauma clients' disturbance of emotions regulation. E.g. "safe place" imagination can help clients improve their feeling of safety. Likewise, "container" technique is a useful distancing technique for flashbacks in PTSD.
- In some cases, re-building impaired ego-functions requires a *deeper psychodynamic understanding why these ego-functions have been rendered dysfunctional*. To achieve a deeper understanding of many traumatized clients' impaired capacity to care about themselves, the ROTATE therapist will conceptualize these impaired capacities in terms of internalized prohibitions to care for oneself which were originally imposed by early key figures (Jacobson 1964; Ferenczi 1949). S/he might explain it in a simple way to the clients that it is the inner voice of a traumatizing key figure that prevents them from caring about themselves.
- In line with consistent findings of psychotherapy research (Luborsky 1984), psychodynamic therapy places a strong emphasis on the quality of therapeutic alliance. Contributions on the basis of psychodynamic object relations theory are valuable tools

to understand the special relationship structures of traumatized persons which is necessary for constructing a strong therapeutic alliance (Balint 1956; Luborsky 1984; Winnicott 1960). Considering aspects of transference and countertransference can be extremely important for alliance building. Techniques to handle difficult transference and countertransference phenomena common in complex trauma clients are best elaborated in psychodynamic psychotherapy (Dalenberg 2000; Gabbard 1995; Wilson & Lindy 1994).

- Monitoring own countertransference reactions can be extremely important for the ROTATE therapist to protect himself or herself against secondary (vicarious) traumatization. E.g., if the therapist will be overwhelmed by negative emotions in the contact with a traumatized client, s/he should use ROTATE distancing techniques and/or seek help from a supervisor.

What does this psychodynamic framework mean for its practical application of ROTATE a short-term psychotherapy approach?

- Applying a psychodynamic approach in a short-term psychotherapy requires that the ROTATE therapist should not focus on symptom reduction alone. Rather, s/he should choose the focus of the therapy and the interventions needed according to the needs of the clients. Of course, symptom reduction can be the primary therapy focus of ROTATE, but often troubling interpersonal problems are found to maintain the presenting symptoms. Then, the focus will be on this problem area.
- The psychodynamic relation orientation underlying the ROTATE approach implies also that *diagnostic and therapeutic activities are inextricably intertwined*. The quality of a diagnostic strongly depends on the type of relationship established between the therapist and the client. If a client feels unsafe in the relationship, the therapist will not get the information s/he needs. Therefore, the therapist should refrain from asking the clients details of symptoms and traumatic events without having established a good relationship before.
- Applying ROTATE does not mean to teach psychodynamic theory in an extensive manner to ROTATE therapists nor does it aim at teaching psychodynamic theory to clients. However, it aims at giving the ROTATE therapists a basic understanding of how a psychodynamic relationship orientation works in practice. On this basis, they may choose the most suitable interventions for their clients.
- Likewise, applying ROTATE as a psychodynamically based intervention does not mean to use a “classical” neutral therapeutic style. There is growing consensus among psychodynamic trauma therapists that a “classical” psychoanalytic treatment approach which relies primarily on free association or interpretation of unconscious conflicts does not adequately take into account the impaired ego-functions of traumatized clients and the psychobiological nature of PTSD (Reddemann 2012). Instead, PTSD-specific and neurobiologically informed psychodynamic concepts are required. Therefore, a therapeutic style is recommended which actively addresses the clients’ needs and problems and encourages problem solving and resource activation. Moreover, the ROTATE therapists invite their clients to regularly practice and do the exercises they teach them. If needed, they provide calming, relieving, and other supportive interventions, address maladaptive and self-destructive behavior patterns and

encourage more adaptive ones. This type of therapeutic style is in line with modern relational and structural psychodynamic approaches (Greenberg & Mitchell 1983; Rudolf 2013; Wöller & Kruse 2014).

2.2 Resilience and the Principle of Resource Activation

Improving client resilience is the main objective of ROTATE. In this context, the activation of emotions and positive images is considered crucial for the development of resilience. Much research suggests that there is a strong link between positive emotions, coping and resilience (Folkman and Moskowitz 2000; Fredrickson 1998). Since trauma blocks clients' access to positive emotions and coping skills, resource activation is a key component of the ROTATE approach.

Resources can be differentiated into internal and external resources.

Internal resources include

- abilities or skills
- enjoyable activities
- positive memories of the past
- positive visions for the future
- positive interior images created by guided imagery.

External resources include support from

- family members
- companion
- comrades
- organizations, etc.

The purpose of resource activation is to help clients evoke positive emotional states by activating internal resources and using external resources.

- *Internal resource activation* is the central therapeutic tool to improve emotion regulation. This can be done by evoking memories of positive relational experiences or by stimulating fantasies of positive experiences. For example, evoking memories of personal success can have positive effects on self-esteem.
- In terms of psychodynamic ego-psychology, the activation of internal resources means the improvement of clients' coping and adaptation skills (Bellak et al. 1973). In terms of psychodynamic object relations theory (Kernberg 1976), it can be understood as a process of restoring the ability to activate positive internalized object relations.
- However, many problems of traumatized clients result from their inability to *use external resources*. In this sense, the ROTATE therapist also helps clients to contact the people or organizations that can provide the support they need.

To that aim, the ROTATE therapist systematically teaches the clients to actively seek positive emotional states. All kinds of positive activities, memories, capacities, and thoughts can be utilized as internal resources (as opposed to external resources like helping persons etc.). To this end, the therapist asks the client to practice activities that help him or her to

get out of negative emotional states, to remember positive experiences, and to create positive feeling states by way of imagination. Furthermore, the therapist encourages the clients to regularly practice imagination exercises. Given the broad variety of situations and activities which can contribute to resource activation, these techniques are very appropriate to the therapeutic work in a transcultural context as even traditional healing procedures can be utilized as resources.

2.3 Neurobiological Orientation

The *neurobiological orientation* of the ROTATE approach takes into account PTSD clients' impaired capacity of emotion regulation and altered information processing (van der Kolk et al. 1996) by adding trauma-specific techniques to improve emotion regulation and to process dysfunctional memories. (These trauma-specific techniques will be described later in this paper.)

Clinical studies have suggested PTSD to be a disorder involving both emotional under-modulation (lack of control over or disinhibition of emotional responding) which occurs during re-experiencing/hyperarousal reactivity, and states of emotional over-modulation (overcontrol of emotional states) in an attempt to restrict unwanted emotional experiences, which occurs during states of dissociation, numbing, and analgesia. Emotional undermodulation has been proposed to be mediated by failure of prefrontal inhibition of limbic regions, whereas emotional overmodulation may be mediated by prefrontal inhibition of the same limbic regions (Lanius et al. 2010).

2.4 Cultural Adaptation

Because of the particular quality of resource activation interventions to be modifiable according to the specific needs of the client and the context, ROTATE techniques are very appropriate for therapeutic work in a cross-cultural context. In the specific cultural context of low-income countries, even traditional healing procedures can be used as resources.

ROTATE therapists are strongly encouraged to modify the protocols according to the culture and personality of the clients. If a therapist finds it too difficult for a client to follow a protocol exactly, he or she should make it as concrete as possible so that the client can easily understand it and work through it effectively.

In some cultures, imagination can be a challenge. The ROTATE therapist then modifies the imagination exercises to make them more acceptable to clients (see section 10.1).

2.5 Therapists' Self-care

ROTATE places a special emphasis on the *therapists' well-being and mental health* because of the always impending danger of vicarious traumatization and professional burnout (Pearlman & Saakvitne, 1995). Therefore, the ROTATE therapist should monitor own countertransference reactions to detect emotional reactions which increase the risk of secondary traumatization (see section 16).

3 Indications and Contraindications for ROTATE

ROTATE is primarily indicated for clients with symptoms of complex post-traumatic stress disorder (see section 4.6).

As opposed to confrontative trauma therapies, there are no clear-cut contraindications for the use of ROTATE. Until now, substantial side-effects of trauma-specific stabilization methods have not been reported.

ROTATE is not the therapy of first choice for clients with "classic" PTSD without evidence of complex PTSD features. For these clients, treatment of conflictive trauma, as outlined in international guidelines on PTSD (e.g., the CBT technique of prolonged exposure or the EMDR protocol for trauma treatment), is likely superior to ROTATE. Nevertheless, in the absence of confrontational therapies, ROTATE may also be a good choice.

Clearly, ROTATE is not a first-choice treatment for severe psychiatric conditions like schizophrenic and bipolar psychoses. Likewise, clients with substance abuse need special treatment. However, no negative effects of stabilization interventions have been observed in these clients.

However, as a general rule, the ROTATE therapist should carefully observe all client reactions when introducing a new method. In some cases, e.g. when a positive memory or imagination is activated or a special imagination, trauma-related associations can be triggered. Then, the ROTATE therapist should choose another positive memory or imagination technique.

4 Basic Psychotraumatology Knowledge for the ROTATE Therapist

The ROTATE therapist should have a basic knowledge of the nature of traumatic events, traumatic memory disturbance, and related symptoms.

4.1 What is a Psychological Trauma?

A psychological trauma is defined as a highly distressing experience or repeating experiences which result in a psychological stress that exceeds a person's ability to integrate the emotions involved.

Psychological trauma can be caused by a broad variety of events. Traumatic experiences include:

- accidents, natural disasters such as earthquakes and tsunamis;
- violent events such as kidnapping or rape
- intrafamiliar violence like domestic violence or childhood physical, sexual or emotional abuse
- political traumas such as war, holocausts, terrorist attacks, hostage situations or torture
- witnessing violence

Traumatic experiences represent a threat to the integrity of a person and are accompanied by a feeling of helplessness, loss of control, terror, distress and abandonment. The same event can have different traumatic effects when experienced by different persons. Rape, torture and kidnapping constitute the events that result in the highest rate of posttraumatic symptoms.

4.2 Two Categories of Trauma (L. Terr 1991)

- Type-1 traumas relate to a unique and surprising event : accidents, natural disasters (earthquakes, plane crashes, assaults, rape, witnessing a murder etc.
- Type-2 traumas correspond to a situation which occurs repeatedly: the individual is again and again exposed to an identical or similar danger : family violence, war, torture, childhood abuse etc.

“Interpersonal” events, i.e. man-inflicted events, are usually experienced as being more damaging for the victims. They lead to even more severe consequences than single uncontrollable events, such as natural disasters.

4.3 Traumatic Memory

The symptoms of post-traumatic stress disorder (PTSD) can be understood as the result of incomplete treatment of a traumatic experience. High stress during the traumatic experience leads to sensory coding and memory fragmentation (van der Kolk, 1987). As a result of this stress, the memory of the trauma is poorly elaborated and poorly integrated into its context of time, place and other memories. Normal meaning-based encoding necessary for adaptive and intensive memory recall is disrupted. Instead, sensory encoding

will result in traces of perceptual memory that are invoked by perceptual stimuli. Thus, in PTSD, the intentional narrative recall of a traumatic event will be disorganized and automatic intrusions into memory will occur.

In PTSD, the survivor suffers from stressful repetitive memories or nightmares of the event. He/she feels anxious or afraid when confronted with internal or external cues that remind him/her of certain aspects of the traumatic event. The survivor relives the traumatic situation not as a reminder of the past, but as if it had happened again in the present. The extrication event has not been integrated into the person's life. Flashbacks" (intrusive memories) can occur in the form of images, noise, voices, smells or nightmares.

4.4 Triggers

Any vision, sound, taste, odor or physical contact similar to the sensations felt during the traumatic incident may "trigger" a physical, mental or emotional reaction similar to that experienced during the incident. E.g., watching scenes of war in television can remind someone of his own experience made during war.

4.5 Psychodynamic Understanding of Trauma-related Symptoms and Behaviors

Traumatic experiences can result in different types of symptoms: psychological symptoms, eg anxiety, depression, flashbacks, hyperexcitation, dissociation etc., or bodily symptoms, e.g. negative body feelings, functional disorders of the bowel. They can also result in maladaptive interpersonal behaviors.

There are several ways of how traumatic experiences lead to symptoms and maladaptive behaviors.

- First, there can be a *reactivation of traumatic memories* in daily life. If situations in daily life, even though they are lacking the dimension of a trauma, have some qualities common with the traumatic experience, they can trigger an intensive emotional response normally found in reaction to a trauma. As a consequence, the clients develop flashbacks and/or undifferentiated negative emotional states. These states contain traumatic emotional components of powerlessness, helplessness and desperate loneliness.

A woman experienced flashbacks of losses from genocide after her sister had moved to another place. At the time of genocide, she had been separated from her sister. Then, she felt completely alone and helpless. Currently, she has a good relationship with her sister and it is possible to visit her.

- Second, traumatic experiences can compromise the clients' capacity to cope with daily life conflicts. Thus, "normal" interpersonal conflicts can cause overwhelming feelings of distress. As a consequence, all kinds of symptoms may develop, e.g. somatoform symptoms or symptoms of depression or anxiety

A man became anxious and depressed when he had been criticized by his boss. His current feeling was very similar to his feeling as a child when he was heavily beaten by his father.

- Third, long-term traumatization can affect the capacity of emotion regulation. Thus, emotions that cannot be regulated adequately can produce all kind of symptoms. To compensate for the inadequate emotion regulation, some clients engage in maladaptive patterns like self-cutting, or substance abuse.
- Fourth, another maladaptive pattern connected with traumatic experiences is *dissociation*. Dissociation may be a valuable coping mechanism under traumatic circumstances as it protected the individual against overwhelming emotions. In current daily life, however, dissociative reactions cause substantial difficulties in interpersonal relationships. While dissociative amnesia disrupts the continuity of memory, in some dissociative states, the persons affected lose the contact with the outer reality and feel and react as if they were in a traumatic situation, thus producing major confusion and adverse reactions in their daily life relationships.
- Fifth, long-term traumatic experiences, e.g. childhood trauma, can compromise the clients' *capacity to care for themselves or to protect themselves*. Often there is an internalized prohibition of self-care or self-protection. If clients cannot care adequately for themselves or protect themselves against further traumatization, s/he will not get their needs fulfilled and run an increased risk of retraumatization.
- Sixth, traumatic experiences can damage the clients' *self-image* by modifying self-related cognitions. A client who has suffered a severe trauma can develop negative self-related cognitions as being unworthy, stupid, incompetent or a bad person. Or s/he can develop the conviction that s/he does not deserve a good treatment. If clients suffer from negative self-related cognitions resulting from traumatic experiences, they lack the ability to act in an appropriate way in different social situations. E.g. if a client is convinced that it is forbidden to say no, he or she will not be able to differentiate appropriately in different social situations. As a result, he will develop symptoms resulting from this inability. He will react in a similar way if he believes it is forbidden to protect himself. Also, self-care is not possible if there is a corresponding internal prohibition. Negative self-cognitions are e.g.:

A client was depressed after she had been raped. She stayed alone all the time and withdrew from social life. When she was in trouble she did not ask her neighbours for help. She was deeply convinced that she was a bad person who does not deserve receiving help. The therapist developed the hypothesis that her negative self-cognitions contributed to her social isolation which in turn further intensified her depression.

A client is unable to seek help (e.g. because she is convinced she does not deserve help). Instead of asking for help she raises serious allegations against those people who could help her. By consequence, she does not receive help by anybody.

- Finally, traumatic experiences can compromise a person's capacity to experience a normal *mourning process*.

A client became depressed after her father had died. He was unable to make peace with his father because his father had beaten him a lot when he was a boy.

In addition to the trauma-related psychodynamics outlined above, the ROTATE therapist

should also consider the possibility that the client's symptoms might also result from *conflict-related psychodynamics* which are not a direct consequence of his or her traumatic experiences. Especially, unresolved intrapsychic (inner) conflicts can also cause symptoms, e.g. a conflict between love and hate:

A client suffered from recurrent headaches. Psychotherapy revealed that the headaches worsened when she had contact with his brother. Then she found out that he loves her brother but she also hates him because he was a perpetrator during genocide. This situation created a conflict within her. While she was not aware of this conflict initially, with time, the client recognized the inner conflict and found a way to consciously deal with the emotions connected to it.

Another type of intrapsychic (inner) conflict is a conflict between aggressive impulses and moral values:

A man suffered from a paralysis of his right arm for which no organic cause could be found.

Psychotherapy revealed that he had a strong impulse to kill his mother's murderer but he could not do it because Christian religion forbids murdering.

In these cases, instead of trauma-oriented stabilization or memory work, clarification and further exploration of the intrapsychic conflicts are necessary.

4.6 The Symptoms of Post-traumatic Stress Disorder (PTSD) (Including Complex PTSD)

"Classical" PTSD diagnosis is defined by the following 3 symptom clusters:

- Re-experiencing (intrusions, flashbacks): A flashback is an involuntary recurrent memory, in which an individual has a sudden, usually powerful, re-experiencing of a past experience or elements of a past experience. Suddenly they act or feel as if a stressful experience were happening again. They feel as if they were reliving it. – Repeated, disturbing and stressful nightmares can also be intrusive symptoms of PTSD.
- Avoidance: Individuals with PTSD try to avoid thoughts, feelings or conversations about the traumatic event and places or people that bring the event to mind. They avoid thinking about or talking about a stressful experience from the past or avoid having feelings related to it. Moreover, they avoid activities or situations because they remind you of a stressful experience from the past. - Individuals experiencing avoidance may have emotional numbing symptoms such as feeling distant from others, losing interest in activities.
- Arousal: Individuals are "super alert" or watchful on guard. They feel jumpy or easily startled as if something dangerous could suddenly happen.

In addition to the "classic" symptoms of PTSD, according to a proposal for ICD-11 (Cloitre et al. 2011; Maercker et al. 2013), complex PTSD is defined by 3 additional symptom groups:

- *Affect*: The cluster of affects is marked by emotional dysregulation, as evidenced by increased emotional reactivity, violent outbursts, reckless or self-destructive behaviour, or a tendency to experience prolonged dissociative states under stress. In addition, there may be emotional numbness and a lack of ability to experience pleasure or positive emotions.
- *Negative self-concepts*: This group of symptoms is characterized by persistent beliefs about oneself as diminished, defeated or worthless. These beliefs may be accompanied by a pervasive sense of shame or guilt. Clients with complex PTSD may develop alterations in their sense of self-efficacy and a disruption in their perceptions of safety, trust, and independence.
- *Relationship Disruption*: Interpersonal disorders are defined by persistent difficulties in maintaining lasting relationships. Some people may consistently avoid relationships, while others may occasionally have close relationships but have difficulty maintaining emotional engagement.

4.6 Major Depressive Episode

Major depressive episodes can also be a consequence of complex trauma. Symptoms during depressive episodes may include:

- Feelings of sadness, emptiness or hopelessness
- Sleep disturbances, including insomnia or sleeping too much
- Loss of appetite
- Lack of energy – even small tasks take extra effort
- Loss of interest in most or all normal activities, such as sex, hobbies or sports
- Anxiety, agitation or restlessness
- Feelings of worthlessness
- Guilt feelings and tendency to blame oneself for things that are not the person's responsibility
- Difficulty to concentrate and to make decisions
- Loss of self-esteem
- Frequent or recurrent thoughts of death, suicidal thoughts, suicide attempts or suicide
- Unexplained physical problems, such as back pain or headaches

4.7 Dissociation

Dissociative symptoms are very common among complex trauma clients. People who had suffered long-term physical, sexual or emotional abuse during childhood are at greatest risk of developing dissociative disorders. However, other traumatic events, such as war, natural disasters, kidnapping, torture or invasive medical procedures, also may also cause dissociation.

Originally, dissociative disorders usually developed as a way to cope with traumatic experiences. In the present, dissociative symptoms are usually precipitated by stressful episodes which trigger traumatic memories. Specifically, a situation that is frightening or highly unpredictable enhances the probability (predisposes to) of developing dissociative

symptoms. Going into dissociation can be understood as a kind of “flight” from the stressful current reality. There are many types of dissociative symptoms the most common of them are:

- *Dissociative amnesia.* Individuals display a loss of memory for minutes to hours (in some cases also for days), mostly triggered by stimuli which are associatively connected to a traumatic memory. Amnesic symptoms may cause significant stress in the clients’ relationships, work or other important areas of their life as the individuals often miss important information.
- *Depersonalisation and derealization.* Individuals suffering from this type of dissociation may feel detached and foggy or dreamlike. Their perception of other people and things around them may be distorted and unreal. Some of them that their body doesn’t quite belong to them or is disconnected from them. Others observe their actions, feelings, thoughts and self from a distance as though watching a movie. They feel strange, as if they were floating away, or they feel cut off or distant from their immediate surrounding. They feel like looking at the world through a veil or glass. Some feel puppet-like or robot-like. In derealization, the world around the person may seem unreal. In depersonalization disorder, the surroundings seem unreal and/or far away. Both symptoms can be profoundly distressing. They may last only a few moments or for a long time.
- *Dissociative fugue.* This relatively rare dissociative disorder involves impulsive travel or wandering. People with this disorder may leave their homes or places of work and arrive at another place without knowing how they got there. There is typically amnesia for the fugue episode.
- *Conversion disorder:* This type of dissociation can involve a broad spectrum of bodily symptoms such as paralysis of arms or legs or inability to swallow, see or hear etc. All these symptoms appear with no underlying physical cause and do not react to medical treatment.
- *Dissociative seizures.* Dissociative attacks are also called ‘non-epileptic attacks’ or ‘psychogenic seizures’. Dissociative attacks can that look very similar to epilepsy. Typically, the client has thrashing movements that look just like a generalised epileptic seizure. People can experience shaking attacks or attacks when they simply ‘blackout’ for some time. Dissociative attacks are common. Nearly half of all people brought into hospital with suspected serious epilepsy have them. Many clients with dissociative attacks will have been wrongly diagnosed as epilepsy at some point and may have even taken drugs for epilepsy.
- *Uncontrolled behaviors.* indicate that a client has lost contact with the current reality. The states are triggered by stimuli which have an – even remote – similarity with the traumatic scene. Often, a client exhibits aggressive behavior, because s/he is immersed in a past trauma state where s/he feels threatened.
- *Dissociative identity disorder.* This type of dissociative disorder, formerly known as multiple personality disorder, is characterized by "switching" to alternate identities.

4.8 Somatoform Disorders

Somatoform disorders are mental illnesses that cause bodily symptoms even though medical evaluation reveals no explanatory physical pathology. There is a broad variety of somatoform symptoms. They range from symptoms such as stomachache and headache to tinnitus or gastrointestinal complaints and can include many other kinds of somatic complaints. Sometimes pathology is present but the client's complaints are grossly in excess of what would be expected from the physical findings. However, a medical cause has to be carefully ruled out before a somatoform disorder can be diagnosed.

Somatoform pain disorder is a specific somatoform disorder in which pain is the main symptom. Somatoform, i.e. medically unexplained pain is frequent in complex trauma clients. Lower abdominal pain is typically found after sexual abuse or rape.

Part 2: Interventions

5 Establishing a Feeling of Safety and Control in the Therapeutic Relationship

5.1 Feeling Safe in the Therapeutic Relationship

In the first place, a sense of safety in the therapeutic relationship has to be established.

- First of all, it is of major importance to know if there are threatening conditions around the client. If violence is going on, the therapist should help the client protect himself or herself.
- Safety can be threatened by a somatic disease. Then, medical examination and treatment are mandatory.
- Safety can be threatened by suicidal impulses which require closer examination and, if necessary, a hospitalization.
- In some cases, social safety is a problem if the client has no place to live. Adverse economic conditions can also be a threat to safety.

Even if the external environment is safe, many traumatized clients do not feel safe in the therapeutic relationship. Providing a feeling of safety is of outstanding importance in the first phase of therapy. In addition to providing external security, enhancing the feeling of safety in the therapeutic relationship is an explicit goal. It is essential for the clients to create an inner sense of safety. This includes a firm framework and a reliable structure of the therapy.

To enhance the clients' sense of safety, the ROTATE therapist asks the client what s/he needs to feel safer and more comfortable in the therapy room. This question is necessary as normally clients will not mention by themselves when they feel uncomfortable or unsafe in the therapeutic situation.

T: Please tell me what you need to feel safer and more comfortable in this room. Please make sure both of our seating positions are o.k. Maybe you would like me to sit closer or further away from you?

5.2 Strengthening the Feeling of Control

In consideration of traumatized clients' frequent fears of losing control, their sense of being in control has to be strengthened. The therapist should explain to them that they will maintain full control over whatever happens during the therapy and that nothing will happen during therapy without their explicit consent. Nothing should happen without her consent. Therefore all steps of the therapy should be discussed with the client. This may be unfamiliar to the client, since traumatized clients often have the idea that they have to "surrender" to therapy. If the client has the impression that something is happening to her that she did not agree to, she is asked to mention this immediately. When dealing with

situations in which the client loses control due to a disorder, as is the case with dissociative states, the client should work as quickly as possible to regain control over these states. Nevertheless, the therapist should assume that clients are not usually used to expressing their opinions and do not expect them to be heard. She should therefore pay particular attention to non-verbal signs and pick up all signals in this regard.

In order to prevent the client from feeling dominated, the ROTATE therapist strives to involve the client in all decisions regarding therapy. Clients are asked to check whether they find the therapist's recommendations helpful or not. They should only accept them if they can accept them as helpful. Whenever a client does not like a recommendation, it is helpful to look for an alternative.

T: Please tell me if it is o.k. for you to talk more about

T: What do you think we should do next: Should we work on X or on Y?

5.3 Dealing with Self-endangering behavior and Suicidal Impulses

Self-destructive behaviours or suicidal impulses are common in clients with complex trauma. They should be treated as a priority throughout therapy sessions.

Self-harming behaviour occurs in clients with PTSD as a reaction pattern used to cope with unbearable emotional states. It causes an emotional release, which can be biologically explained by the release of endogenous opiates. In addition, self-injury can put an end to dissociative states, especially states of agonizing depersonalization. In some cases, self-harming behaviour may also be an expression of a tendency to punish oneself. In contrast, other psychodynamic factors such as the search for attention or affection tend to be less important.

For the therapeutic approach it is important to distinguish whether it is a superficial incision or whether the client has made deep cuts. In the case of superficial incisions, an attitude has proven to be effective which neither morally condemns the self-injuring behaviour nor rewards it with additional attention and care. Instead, it should be pointed out to the client that the improvement of his emotional regulation should be at the forefront of therapeutic work in order to achieve that self-injurious behaviour is no longer necessary for emotional regulation. For example, the therapist may suggest that the client However, if clients tend to make deep cuts, a treatment agreement should be made which obliges them to completely abandon this self-harming behaviour pattern and to seek alternative forms of emotion regulation when difficult emotional situations arise.

Suicidal thoughts occur in clients with PTSD especially when there is a comorbid depressive disorder. *Acute suicidal impulses* can occur when traumatic situations of the past are revived by triggers of the present. The current life situation then feels so overwhelmingly threatening and hopeless for the client that the calm of death seems like a longed-for release. In these cases, the therapist should support the client in reorienting into the here and now.

For the therapeutic work it is necessary to clarify whether concrete suicide impulses have occurred recently or are still present. If this is the case, the client must be able to give the therapist a guarantee that he will not harm herself, at least until the next therapy session.

The must commit himself to addressing any suicide impulses that occur during the therapy session or, if he feels that he can no longer keep his guarantee until the next session, to consult a clinic. In the case of clients at risk of suicide, the therapist may have to call for the guarantee statement repeatedly. He must also be able to judge whether he considers the client capable of making arrangements.

Treatment contracts are advisable for suicidal impulses and self-destructive behaviors. For emergency situations, the therapist develops a detailed emergency action plan. The clients should know what to do and whom to contact when in distress.

5.4 Therapeutic Alliance

A helping therapeutic alliance develops if the therapist listens carefully to the client's words in order to understand what they want to communicate. Rather than giving premature advice to the client, the therapist should take his or her time to determine the client's real needs and problems. If necessary, the therapist asks detailed questions to ensure better understanding.

First of all, a good therapeutic relationship implies that the client feels safe and confident in the relationship (see above). It also implies an agreement on goals and tasks between the therapist and the client.

Throughout the therapy, the ROTATE therapist must check whether the client is still "on the same boat", i.e. whether he/she is still pursuing the same goals as the therapist. The therapist continuously asks the clients to give him/her their comments :

- Do you feel comfortable with the therapeutic situation?
- Do you understand what I have explained to you?
- What interventions do you find useful?
- Is there anything scary or embarrassing about the therapy?

The ROTATE therapist should carefully check for negative or idealized manifestations of transference (see paragraph 15). With regard to negative transference, he should try to understand whether there is anything in the therapeutic situation that frightens or embarrasses the client.

6 Diagnostics, Main focus of the Therapy, and Treatment Plan

After a basic relationship has been established, the ROTATE therapist establishes a diagnosis by asking the client about his or her main symptoms.

In addition to a careful examination of the client's symptoms, the ROTATE therapist defines the psychodynamic focus of the therapy. The focus can be given by the symptoms the client is presenting, but in many cases the symptoms do not constitute the main reason for the clients' suffering. Therefore, a psychodynamic focus will be formulated.

Instead of proclaiming abstract therapy goals, the clients are asked to describe in detail which positive effects will occur if therapy will be successful. Generally, the therapist is more focused on solutions than on how the problem has developed.

Based on the therapy focus, the ROTATE therapist will design a treatment plan. Given the limited number of sessions available, the therapist has to carefully select the most appropriate therapeutic procedure. The following examples may illustrate this:

- If intrusions are the main problem, the ROTATE therapist should teach the client the "container technique" as a distancing technique.
- If a client suffers from a major depressive episode, the ROTATE therapist will empathically understand the client's suffering and combine encouraging interventions with resource activation.
- If a client repetitively gets (enmeshed) in interpersonal conflict situations, the ROTATE therapist will strengthen his or her capacity to deal with interpersonal conflicts and him
- If low self-esteem is the main problem area, the therapist develops an understanding about the situations and relationships in which the problem shows up. Then s/he and chooses a resource activating technique to enhance self-esteem.
- If self-care is the main problem area, the therapist aims to understand the reasons for the clients' difficulty to practice self-care and helps him or her to better practice self-care in daily life.
- If the client is afraid of a stressful situation in the near future, the therapist can use the "Stress Absorption Technique" (see section 13) to activate memories of positive adaptation and positive skills.

7 Psychoeducation

At the beginning, information about the disorder, its origin, and treatment modalities are communicated to the clients. Clients are informed about the nature of posttraumatic disorders.

The client should develop a basic understanding of the symptoms of Posttraumatic stress disorder (PTSD) and the broad variety of affective, anxiety, dissociative, and somatoform symptoms in addition to the PTSD symptoms as defined in ICD-10 or DSM-IV. However, the extent to which explanations are given should be adapted to the cultural and educational background of the client. It is better to give little bits information the client can digest instead of overwhelming the client with a huge quantity of information s/he cannot integrate.

Some of the contents of psychoeducation can be:

- Many trauma sequelae can be understood as adaptive behavioral patterns in the face of extremely stressful conditions and can thus be depathologized: The circumstances are the pathological, not the client or her reactions. A basic understanding of the biological basis of the traumatic reactions can help the client to feel less abnormal and relieve her from self-reproach. For many clients who are accused of "making a mountain out of a molehill", the reference to the increased sensitivity or instability of their nervous system can bring relief. With dissociative clients it can also be the other way round, in that they make "a mosquito out of an elephant".
- Avoidance and anaesthetic symptoms become understandable as a protective measure against emotional flooding by traumatic memories.
- The persistent overexcitement of clients with PTSD can be explained as increased alertness to the possibility of renewed trauma.
- In the case of intrusions (flashbacks), it can be important to note that the clarity of the details contained in an image does not allow any reliable conclusions to be drawn about the actual course of the traumatic event.
- Also important is information about the design of the therapeutic working relationship and the course of therapy. E.g., the client should understand that psychotherapy can only be successful in an effort to be mastered together and includes tasks to which both sides, therapists and clients, have to contribute equally. By demanding a contribution from the client, the therapist also brings her confidence in her competence and ability to act to the aud-ruck. By simultaneously offering her help, she signals to her that she does not have to remain alone with this task.

8 Flashback Management

To manage flashbacks (intrusive or disturbing memories), the « container » technique is a valuable tool (→ Annex 1). This exercise of guided imagery is appropriate for distancing from negative affect states and intense traumatic memories. This exercise gives the client control over traumatic material. It is helpful to consciously dissociate, at least for a period of time. The client locks traumatic material in and decides if and when he/she wants to take pieces out to look at them. To be able to do so is often a prerequisite to be able to go on with the work.

The container exercise can also be used if traumatized clients are "flooded" by undifferentiated trauma-related emotional states which contain elements originating in the traumatic past and elements originating in the current situation. These undifferentiated emotional states are characterized by feelings of powerlessness and/or abandonment. Therefore, the treatment aims at helping them to categorize these affect states into components with respect to their origin in the past or in the present, and to regulate the negative affect arising from the traumatic component. To this end, the clients are educated to use imaginative techniques to separate those parts of the feeling belonging to the traumatic past from those belonging to the present. For establishing distance to the traumatic affect portion, they are invited to use the "container technique" to "pack away" those parts which belong to the past (Allen, 2001).

T: Try to imagine this feeling of rage as an object which you can see and grasp.

P: I'll try. ... o.k., I got it.

T: Now identify that part of the feeling which fits to the real situation and that part of the feeling which fits to the past. What percentage of the feeling fits to the real situation?

P: About 20 percent.

T: Keep these 20 percent and put the remaining 80 percent into the "container".

9 Improving Emotion Regulation

The main aim of ROTATE is to increase the client's ability to master and modulate negative emotional states and extreme arousal. Traumatized clients are often overwhelmed by severe negative emotions. Mostly, they suffer from undifferentiated emotional states consisting of intensive negative emotions like scare, rage, despair, shame, feelings of abandonment, and guilt feelings. Normally, these emotions are triggered by daily life stimuli which are associated with an earlier trauma. Activating positive resource states and the teaching of imaginative techniques to engender positive emotional states is central to the stabilization work.

To improve emotion regulation, the ROTATE therapist may choose several techniques:

- activities that help to get out of negative emotional states
- positive memories of (small) successes or positive encounters
- imagination exercises

As a first step, the therapist may ask the clients which activities helped them in the past to cope with negative emotional states. If necessary, the therapist can give them a list of typical activities. Some of them are:

- listening to music
- jogging
- meeting friends
- playing soccer
- reading comics in the newspaper
- taking a walk with friends
- playing
- swimming
- watching television
- walking in the garden
- taking a rest – take a nap
- staying alone
- praying
- talking with the husband
- playing with the baby
- changing the place
- sleeping
- singing

It is important to note that all these activities can help or not. Each client will have to find out his or her favourite activity.

Alternatively, the therapist may encourage the client to identify, remember, and vividly imagine memories of positive experiences. The therapist can follow these steps:

- He asks the client to identify a memory of a (small) success or other positive experience (e.g., a positive encounter, etc.) in the past few months or years.
- He invites the client to imagine a scene that represents this (small) success or other positive experience.
- The client should feel the pleasant feeling associated with the positive memory.
- The client should feel the pleasant body sensation associated with positive memory.

- The procedure can be repeated several times.

Sometimes the positive emotion linked to the memory of the resource can be transformed into a negative emotion. This may be the case if the positive memory is associatively linked to a memory of trauma or loss, for example, if the client activates the memory of a positive encounter with a deceased person or the positive memory of a success in a job he or she recently lost. Rather than evoking a sense of ongoing well-being, the client experiences the negative emotion of failure or loss. Therefore, it is important to find a memory that is not related to an experience of trauma or loss.

If a client suffers from depressive symptoms, additional soothing, guilt-relieving, and encouraging interventions are necessary. To treat severe depression, antidepressant medication should be considered. Resource activating techniques can be helpful but the ROTATE therapist has to make sure that applying techniques which promote positive emotions is not a way to minimize the clients' suffering.

10 Imagination Exercises to Improve Emotion Regulation

10.1 General Aspects

ROTATE offers a variety of imaginative techniques to enhance emotional regulation by increasing positive emotional states of security, calm and well-being. There are several aspects to consider when working with imagination techniques:

- *All imagination techniques need practice.* First, the ROTATE therapist explains the technique to the client. Then he/she practices it with the client. And after that, the client practices the exercise himself/herself.
- Clients should understand that at the beginning, when practicing imaginative exercises it is normal to have *difficulties*. Therefore, the ROTATE therapist encourages clients to report any difficulties that arise. Most of the time, there are solutions. For example, if a client finds that the inner "safe place" is not really safe, the therapist will help the client change the place until it is safe.
- *Client preference.* The therapist may consider the client's preference for specific imagination exercises. It is not necessary for each client to master and practice every exercise the therapist presents. Rather, the client should identify one or two imagination exercises that he or she likes to practice.
- *Compatibility with the culture:* The clients' cultural backgrounds require modifications to the exercises. Often, clients need explanations. They need to be given examples to show them how to work with the exercises in a concrete way. For example, in Cambodia, some clients needed to draw their own safe place or inner garden to develop a feeling of safety. They would carry these drawings with them and look at them when they felt stressed. For the container technique, therapists sometimes had to bring a real container (a small box) to show to their clients before working on the exercise. Some clients chose other objects such as a large wooden box. However, they could find a way to make it stronger and more protective after hospitalization.
- As for the "tree exercise", some therapy sessions were held close to or under a real tree. Therapists accompany their clients to the tree before starting the therapy session. Or, clients draw a tree (Commentary by Thearom Ret).
- In Rwanda, therapists reported that clients living in rural areas preferred to put negative material in a river rather than in a container. For them, it was safer to have the material taken away than to be put in a container without a key to lock it (Comment by Wolfgang Wöller).
- *Stability of the state of the resource.* As with positive memories, the positive emotion associated with a resource-activating imagination can sometimes be transformed into a negative emotion if the content of the imaginative exercise is associatively linked to a memory of trauma or loss. This may be the case if the client visualizes a "safe place" near a place where a traumatic event occurred. If this occurs, the ROTATE therapist should assist the client in finding another location or using another imagination technique.

10.2 The Safe Place (The Place of Well-being)

As emotion regulation has a lot to do with feeling of unsafety, the “Inner safe place” imagination can be helpful to improve the feeling of safety. The imagination of a “safe place” aims at enhancing the feeling of safety. As trauma blocks the clients’ access to positive emotional states, the approach aims at evoking in traumatized clients a psychological state of well-being. Furthermore, it aims at improving coping strategies by directly activating the respective ego-functions and internalized object relationships (see Annex 2).

10.3 The Inner Garden

Another imagination exercise is the imagination of the “inner garden” (→ Annex 3). It is also suitable for regulating the mood. With its help, clients can create a garden in their imagination according to their own taste. The therapist helps the client to make changes to the inner garden again and again until the garden has become an imaginary place of well-being.

Another imagination exercise allows you to create a garden according to your own taste in your imagination.

10.4 The Tree

Another option for creating a resourceful condition is to exercise the “tree”. The fantasy of a close and nurturing relationship in a positive sense can be created, for example, through the “tree” exercise” (→ Annex 4).

10.5 The Inner Helpers

A further valuable imaginative technique is the imagination of the “inner helpers” (→ Annex 5). It allows clients to create ideal beings in their imagination who are imagined as exclusively good and helpful and who can be called for help or asked for advice at any time. The inner helper figures can be imaginatively equipped with all the abilities that the clients need: strength, calmness, wisdom, reliability or speed. Whenever they are needed, they are there. Frequently chosen are figures from fairy tales, guardian angels or a “good fairy”, an old wise woman, “good” animals or idols from movies and television. Not suitable are real people who are close to the client, because close relationships are never free of ambivalence. Imaginable, however, are idealized persons standing far away, with whom no real contact exists, or those who have already died, like an understanding grandmother. The client can create as many inner helper figures as she wishes.

10.6 The Point of Power

This is a technique to be used when there is need to install a positive feeling or a resource to cope with a specific problem at present time or in the future (→ Annex 6).

10.7 The Light Stream (“The Healing Light”)

The Light Stream (“Healing Light”) exercise is helpful to sweep away bad body sensations and as a closure exercise at the end of a session. It is especially useful for trauma-related pain somatic disorder (→ Annex 7).

11 Furthering Self-care and Self-protection

Furthering self-care and self-protection is an important topic of ROTATE. Most clients with complex trauma in their history display major problems with self-care and self-protection. Often they feel that caring for themselves or protecting themselves is not allowed. Some of them have a feeling that they do not deserve caring for themselves or protecting themselves because they are unworthy persons. A psychodynamic understanding of these problems often reveals internalized prohibition of self-care and self-protection resulting from childhood abusive relationships with key figures.

The ROTATE therapist educates the client about the importance of self-care and self-protections. S/he declares that self-care and self-protection are important and necessary to improve the condition. The therapist can also give examples how self-care and self-protection could work. Often, it is necessary to activate the resources necessary to practice self-care and self-protection.

T: I understand that it's hard enough for you to say "no" if you don't agree. What do you need to clearly say "no" in situations where you disagree? Maybe you need a moment to think first? As a first step, you could ask the person to give some time for reflection instead of giving a quick answer. Then you can think about whether you agree or disagree.

For some clients, it is advisable to work on the negative cognitions that underlie the lack of self-care and self-protection. Whenever possible, the ROTATE therapist links negative cognitions and negative relational experiences of the client with abusive key figures:

T: Again and again, your mother called you "selfish". She wanted you to care for her. As a child you had no choice other than seeing yourself as "selfish". From that perspective, it is understandable that self-care is difficult for you. But now that you have grown up, do still think that you are selfish when you take care for yourself?

12 Reorientation Techniques to Get Out of Dissociative States

If a client is engulfed in a dissociative state, the ROTATE therapist will use a reorientation technique. Reorientation techniques are simple strategies which help them “to stay present in the here and now” by focusing outward on the external world, rather than inward toward overwhelming traumatic emotions. Normally, clients fall into dissociative states at the moment when a traumatic memory is triggered. Unconsciously they use the mechanism of dissociation to “flee” the situation they perceive as threatening.

There are two ways to use a reorientation technique:

- When a client *has lost the contact with the external reality* because of an acute dissociative state, the ROTATE therapist actively helps him or her out of this dissociative state by directing his or her attention towards external visual, acoustic, or bodily stimuli or towards rational thinking.
- When a client *repeatedly loses contact* with external reality and plunges into dissociative states again and again, the ROTATE therapist teaches him or her how to stay in the present.

If a client is in a dissociative state (i.e. if s/he feels or behaves as if s/he were in a situation of the traumatic past), the ROTATE therapist may follow these steps:

- 1 – S/he should stay calm and use a very clear language.
- 2 – S/he addresses the person and says his/her name: “I am Mr. ..., I am here to help you.”
- 3 – S/he should say very clearly: "You are safe here. We are in the year 20... There is no danger now. "
- 4 – Ask the client to divert his or her attention away from the inner experiences and direct it toward the outer reality. Convince the client that s/he is now in safety.
Say very clearly: Open your eyes, look at me, I am ..., look e.g. at that building, do you know what it is? Look at that tree. Look at this person. Do you know who it is?
- 5 – Try to touch the person gently (observe if this helps – sometimes touching causes fear)
- 6 - Give the client an object, e.g. a pencil etc., and have him/her touch and grasp it. Say e.g. : Look, this pencil etc.
- 7 – You can ask the client
 - to smell something (e.g. a perfume)
 - to walk in the room
 - to observe something
 - to feel his own body
 - to pursue an activity
 - to carry out a mental arithmetic

T: While you feel the ground below your feet, you can look around in the room. Look at this room. How many red objects are there in this room? Look at that house. You know that house? Look at everything around. Be aware that you are completely safe.

When the client repeatedly plunges into dissociate states, the ROTATE therapist can teach him or her a procedure how to stay in the present rather than to go into a dissociative state. Normally, clients plunge into dissociative states not suddenly, but it takes a few seconds or minutes.

1 – The therapist educates the client to notice the minor alteration of conscience which often precedes the loss of conscience – a kind of weakness of perception (a feeling of being “detached”, a kind of “fog”, a feeling of being “behind a glass wall”) – the moments when the client begins to “go away”.

2 – S/he educates the client to decide consciously not to plunge into a dissociative state (not to “go away”) and to stay in the present.

3 – S/he asks the client to use the techniques of the “reorientation to the here and now,” e.g.

- grasping something
- smelling something
- walking in the room
- observing something etc.

4 – The therapist asks the client to carry out bilateral stimulation or the “butterfly hug” while concentrating on the feeling to be safe in the present.

13 Stress Absorption Technique

The EMDR absorption technique is a resource activation technique to improve the ability to cope with stressful trauma-related situations. It is based on EMDR which aims to strengthen specific coping capacities (Hofmann 2009). It is a modification of the EMDR protocol for resource development and installation (RDI) originally developed by Korn & Leeds (2002).

To strengthen and generalize resources to cope with difficult and stressful situations in the present or future, the therapist uses short sets of 4 to 8 bilateral eye movements (tapping or tones) to increase the intensity of activated positive emotions and coping resources. Normally, the stress related to the original difficult life situation decreases.

The following protocol of the Stress Absorption Technique was modified from Andrew Leeds, HAP-EMDR-Manual, and Arne Hofmann:

The therapist proceeds as follows:

1. The therapist asks the client to identify a stressful situation in the present or near future and to name the stress load associated with it. The subjective stress scale already mentioned (SUD, Wolpe 1969, where "0" means no stress and "10" means the highest stress imaginable).
2. It asks the client to name the resources needed to cope with the current or impending stress in terms of abilities or characteristics. In general, three different resources are sufficient. The client must ensure that these qualities are different, e.g. calm - energy - self-confidence (resources such as "rest", "relaxation" and "calm" have almost the same quality and should be counted as one resource).
3. In a next step, the client is asked to look for situations in his or her life history where the first ability or quality was available to him or her.
4. The client is then asked to imagine the scene in which she had the corresponding capacity or characteristic available to her and to feel the positive emotion that occurred as well as the positive bodily feeling that belongs to her.
5. The therapist repeats the procedure one after the other with the other two capacities or qualities and asks the client to find the scenes in her life in which she was available and make them come alive and physically positive.
6. Finally, the therapist now asks the client to connect the positive emotional states and positive body sensations with each other and to feel them intensely by thinking of the three past experiences of competence.

Part 3: Difficult Relationship Issues

14 Resistance

What is resistance? If a client responds negatively to therapeutic actions, we call this type of behavior resistance. Often, clients are called “difficult clients” or unmotivated clients. Therapists are often left feeling frustrated, stressed, or helpless when facing client resistance behavior. Clients may ...

- engage in small talk about irrelevant topics
- engage in intellectual talk by repeatedly using abstract concepts
- ask a series of meaningless questions
- produce a lot of physical problems
- show a preoccupation with past events instead of discussing current problems

When they communicate these feelings to the clients, typically even more resistance occurs. Therefore, there is a challenge to better understand the reasons for resistance and to find ways to react to it in a way that allows the client to remain in the therapeutic relationship.

A traditional definition defines resistance as “any behavior that indicates covert or overt opposition to the therapist and the therapeutic process.” The problem with this traditional definition is that it places the problem within the client: It is the client who does not cooperate adequately, whereas the therapist remains without control over the therapeutic process. However, such a negative perspective is not compatible with a resource-oriented stance .

In contrast to the traditional definition, a newer understanding conceptualizes resistance as a way to avoid unpleasant or dangerous feelings that impair functioning. As such, it is viewed as a self-protective as it functions to preserve daily life functioning. Given this background, a social interaction theory approach of resistance encourages a new understanding of clients’ resistance behavior as it might protect the therapeutic relationship from negative emotions. Thus, instead of placing the problem within the client, the therapists might consider new ways how to manage resistance by carefully exploring his or her fear and shame reactions when facing the therapeutic task. This perspective not only contributes to a more empathic understanding of the client, it also empowers therapists in managing the clients’ resistance.

The first step is to recognize signs of resistance in the client. Some signs may be:

- You feel stressed when working with the client.
- You feel that you try to convince a client unsuccessfully of something you find important.
- You feel you are working harder in the session than your client does.
- You feel you are struggling with the client.

The second step is to identify the sources of *resistance*.

Fear. Fear is the most frequent reason for resistance. In many cases clients experience fear when they try to focus their problem clearly as they are afraid of the consequences it has. Or they feel shame for whatever reason. Often, the main problem is not finding a

solution, but think of the solution causes fear or shame. Thus it is necessary, to extensively explore fear and shame aspects of the problems and their possible solutions.

A client repeatedly talked about her hate toward her husband and how badly she wanted a divorce. Although she had the clear wish to get divorced, she did not move into this direction and stayed in the relationship. With the help of the therapist, she discovered how dependent she was on her husband, and step by step she realized the big amount of fears when thinking of the divorce.

Transference. Transference might also be a reason for resistance. If a client is consciously or unconsciously convinced that the therapist has a critical stance toward him or her (because s/he projects aspects of his or her father onto him), s/he will not freely discuss all aspects of the problem as s/he fears being criticized by him.

Too big steps and poor timing of intervention. Often, the steps therapist expect from their clients are too big. Too big steps might cause fears of failure or trigger other fears. Then, it is advisable to suggest taking “the smallest possible” step to move into the wished-for direction. Sometimes a therapist tend to confront a client with a problem he had identified while the client is not ready to work on. Then, slowing down the process and taking smaller steps might be a way out of the resistance.

Lack of agreement about therapy goals. It often happens that therapists follow a therapy goal that was not mutually agreed-upon. Therefore, it is necessary to regular check for an agreement about therapy goals.

15 Transference

Difficulties to create a helping therapeutic alliance can result from clients' transferences to the therapist. Transference is a phenomenon in which a person in treatment directs feelings for important figures in his or her life onto the therapist (Freud 1917)

Transferences are common among in the treatment of traumatized clients. From a psychodynamic point of view, this has to do with the insecure attachment status found in most complex trauma clients. Transferences can disrupt the therapeutic relationship and hinder progress in therapy (Dalenberg 2000).

Psychodynamic theory distinguishes several types of transferences. In the treatment of traumatized clients, two types deserve special attention: negative (perpetrator) transferences and overly positive (rescuer) transferences.

A negative (perpetrator) transference directed towards the therapist means that the client consciously or unconsciously projects negative feelings from earlier traumatizing key figures to the therapists. If a client has a history of emotional childhood abuse with one parent abusing or humiliating the client, the client may project this feeling to the therapist. E.g. s/he is afraid of being re-traumatized, e.g. hurt, humiliated or rejected by the therapist. Negative transference phenomena typically occur whe a client gets triggered by a certain characteristics of the therapist or certain circumstances of the therapeutic situation that remind him or her to own inresolved traumatic issues.

A negative (perpetrator) transference may result in a negativistic attitude towards the therapy and make cooperation in therapy impossible. One typical consequence of a negative transference to the therapist is that the client does not talk about shame issues or own failures because s/he is afraid of being criticized or humiliated by the therapist.

An overly positive (rescuer) transference means that the client adopts an idealizing relationship towards the therapist and projects all wishes to be healed and rescued to him or her. The client perceives the therapist as if s/he were an omnipotent rescuer. On the basis of such an idealizing attitude the client will expect to be completely healed or rescued by the therapist without own contributing to the progress of the therapy. Likewise, s/he expects that the therapist will have a solution for all his or her problems. This passive stance will not only disrupt cooperation, it will finally result in severe disappointment over the therapist's failure to satisfy the expectations.

Therefore, the ROTATE therapist should carefully and gently check for transference reactions which prevent a feeling of safety and cooperation in therapy. Likewise, the therapist should carefully monitor subtle disruptions of the therapeutic alliance as a result of transference phenomena or unconscious perpetrator identifications. Not infrequently, repairing alliance deficits can provide an opportunity for strengthening the alliance. Clarifying transference reactions includes educating the client about the reality of the therapeutic situation. Specifically, the client should be reminded that s/he has full control over the therapy and no therapeutic actions will be taken without his or her consent.

T: Obviously, the topic was very frightening for you. Maybe you couldn't tell me this because you assumed that I would criticize you?

16 Countertransference and Therapist's Self-care

Countertransference refers to the totality of reactions of the therapist toward the client (Heimann 1950). It includes the therapist's reactions to the client's transference in therapy, but there are several other sources of countertransference as well. One important source of severe countertransference reactions is the therapist's own trauma history. Countertransference responses can vary from strong positive to strong negative reactions to the client.

Client disclosure of his or her traumatic experiences can evoke emotions such as compassion and sadness in the therapist. The therapist may be ashamed of the disgust they s/he feels when listening to the trauma stories of the client (Wilson & Lindy 1994). Another countertransference reaction difficult to deal with may be rage toward the client's perpetrator. When the therapist recognizes familiar aspects of the trauma story of the client that can be related to her or him, overidentification with the client may be a problem. Intensive rage can also distract the therapist from the treatment process and lead to overidentification with the client. The therapist may have difficulties to keep a professional stance that hinders him or her to think rationally. Overidentification with the client may create suffering for the therapist. At worst, it may inflict professional burnout or secondary traumatization to the therapist.

Some countertransference reactions toward a client can be understood as a result of defence mechanisms to counterbalance the negative emotions when listening to the clients' trauma stories. Some therapists unconsciously use distancing strategies by developing a disconnection to the emotional aspects of the clients' traumatic event description. Others minimize the dimension of the client's traumatic experience and convince themselves that the client is exaggerating in what he says. Although understandable, these defense mechanisms can disrupt or damage the therapeutic relationship with the client and compromise the outcome of the treatment.

Secondary traumatization is the most severe countertransference reaction that results when an individual hears the story of a traumatized client. Its symptoms mimic those of post-traumatic stress disorder (PTSD). Accordingly, therapists affected by secondary stress may experience flashbacks, avoidance reactions, and an increase in arousal. Likewise they may develop dissociative symptoms including loss of memory or depersonalization and derealization (see x.x).

The ROTATE therapist should be aware of own countertransference reactions toward his or her client in order to provide a secure emotional presence and reliable therapeutic boundaries. Awareness of their own countertransference reactions may also enable the ROTATE therapist to detect first signs of own vicarious traumatization.

If necessary, the therapist should utilize self-regulatory skills in order to manage own negative emotions and prevent vicarious trauma reactions. Recognizing, understanding and managing one's own countertransference reactions can protect against both overidentifying with and overly distancing oneself from the client (Wilson & Lindy 1994). The ability to identify negative countertransference reactions as a result of projected client states can help the therapist regain a detached, but nevertheless empathic, stance in therapy.

References

- Balint M (1956). *Primary Love and Psycho-Analytic Technique*. London: The Hogarth Press.
- Bateman A, Fonagy P (2009). Randomized controlled trial of outpatient mentalization-based treatment versus structured clinical management for borderline personality disorder. *Am J Psychiatry*, 166, 1355-1364.
- Chu JA (1998). *Rebuilding Shattered Lives: Treating Complex Post-traumatic and Dissociative Disorders*. New York: John Wiley & Sons.
- Courtois CA (1999). *Recollections of Sexual Abuse: Treatment Principles and Guidelines*. New York: W. W. Norton.
- Dalenberg CJ (2000). *Countertransference and the Treatment of Trauma*. Washington, DC: American Psychological Association.
- Ferenczi S (1949). Confusion of the Tongues Between the Adults and the Child (The Language of Tenderness and of Passion). *Int J Psycho-Anal*, 30, 225-230.
- Folkman S, Moskowitz JT (2000). Positive affect and the other side of coping. *Am Psychol* 55, 647–54.
- Fredrickson BL (1998). What good are positive emotions? *Rev Gen Psychol* 2, 300-319.
- Freud S (1917). *Introductory Lectures on Psychoanalysis*. (Part III). S.E. 16, 243-463.
- Gabbard GO (1995). Countertransference: The emerging common ground. *Int J Psychoanalysis*, 76, 475–485.
- Greenberg J, Mitchell SA (1983). *Object Relations in Psychoanalytic Theory*. Cambridge, Mass./London: Harvard Univ Press.
- Heimann P (1950). On countertransference. *Int J Psychoanal*, 31, 81–84.
- Herman J (1997). *Trauma and Recovery*. New York: Basic Books.
- Hofmann A (2011). The inverted standard protocol for unstable complex post-traumatic stress disorder. In: Luber M (ed). *Eye Movement Desensitization and Reprocessing (EMDR) Scripted Protocols. Special Populations*. New York; 313-316.
- Jacobson E (1964). *The Self and the Object World*. New York: New York: International Universities Press.
- Kernberg OF (1976). *Object-relations Theory and Clinical Psychoanalysis*. New York: Jason Aronson.
- Korn DL, Leeds AM (2002). Preliminary evidence of efficacy for EMDR resource development and installation in the stabilization phase of treatment of complex posttraumatic stress disorder. *J Clin Psychology*, 58, 1465-1487.
- Knipe J (2011). The method of Constant Installation of Present Orientation and Safety (CIPOS). In: Luber M (ed). *Eye Movement Desensitization and Reprocessing (EMDR) Scripted Protocols. Special Populations*. New York; 235-244.
- Kruse J, Joksimovic L, Cavka M, Wöller W, Schmitz N (2009). Effects of trauma-focused psychotherapy upon war refugees. *J Trauma Stress*, 22, 585-592.
- Lampe A, Mitmansgruber H, Gast U, Schüssler G, Reddemann L (2008). Therapieevaluation der Psychodynamisch-Imaginativen Traumatherapie (PITI) im stationären Setting. *Neuropsychiatrie*, 22,189-197.
- Lanius R, Vermetten E, Loewenstein RJ, Brand B, Schmahl C, Bremner JD., et al. (2010). A dissociative subtype of PTSD: Clinical and neurobiological evidence. *Am J Psychiatry*, 167, 640–647.
- Leeds AM (1998). Lifting the burden of shame: Using EMDR Resource Installation to resolve a therapeutic impasse. In: Manfield P (ed.). *Extending EMDR. A case book of Innovative Applications*. New York: W.W. Norton.

- Leichsenring F, Masuhr O, Jaeger U, Dally A, Streeck U (2010). The effectiveness of psychoanalytic-interactional psychotherapy (PIP) in borderline personality disorder. *Bull Menninger Clin*, 74, 206-218.
- Luborsky L (1984). *Principles of Psychoanalytic Psychotherapy. A Manual for Supportive-Expressive Treatments*. New York, Basic Books.
- Pearlman LA, Saakvitne KW (1995). *Trauma and the therapist: Countertransference and Vicarious Traumatization in Psychotherapy with Incest Survivors*. New York: Norton.
- Reddemann L (2012). *Psychodynamisch imaginative Traumatherapie. PITT – Das Manual*. 7. Auflage. Stuttgart: Klett-Cotta
- Popky AJ (2005). DeTUR, an Urge Reduction Protocol for Addictions and Dysfunctional Behaviors. In: Shapiro R (ed), *EMDR Solutions: Pathways to Healing*. New York: W. W. Norton; 167-188.
- Rudolf R (2013). *Strukturbezogene Psychotherapie*. 3. Auflage. Stuttgart, New York: Schattauer
- Sachsse U, Vogel C, Leichsenring F (2006). Results of psychodynamically oriented trauma-focused inpatient treatment for women with complex posttraumatic stress disorder (PTSD) and borderline personality disorder (BPD). *Bull Menninger Clin*, 70, 125-144.
- Schottenbauer MA, Glass CR, Arnkoff DB, Gray SH (2008). Contributions of psychodynamic approaches to treatment of PTSD and trauma: A review of the empirical literature and psychopathology literature. *Psychiatry*, 71, 13-34.
- Shapiro F (2001). *Eye Movement Desensitization and Reprocessing (EMDR): Basic Principles, Protocols and Procedures*. 2nd ed. New York, NY: The Guilford Press.
- Steinert C, Bumke PJ, Hollekamp RL, Larisch A, Leichsenring F, Mattheß H, Sek S, Sodemann U, Stingl M, Ret T, Vojtová H, Wöller W, Kruse J (2016). Treating post-traumatic stress disorder by resource activation in Cambodia. *World Psychiatry*, 15: 183-185.
- van der Kolk BA, McFarlane A, Weisaeth L (1996). *Traumatic Stress: The Effects of Overwhelming Experience on Mind, Body, and Society*. New York: Guilford.
- Winnicott, D. W. (1960). *The Maturational Processes and the Facilitating Environment*. London: Karnac Books.
- Wöller W, Kruse J (2018). *Tiefenpsychologisch fundierte Psychotherapie*. 5th. ed. Stuttgart: Schattauer.
- Wöller W, Leichsenring F, Leweke F, Kruse J (2012). Psychodynamic psychotherapy for posttraumatic stress disorder related to childhood abuse. Principles for a treatment manual. *Bull Menninger Clin*; 76: 79-93.
- Wöller W, Lampe A, Schellong J, Leichsenring F, Kruse J (2020). Psychodynamische Therapie bei Komplexer Posttraumatischer Belastungsstörung (in press).

Annex: Working Sheets and Exercises

1 The Container

- Please imagine a container that can be locked or think of such.
- Look at it closely: What size?, ... material?, ...colour?, ...how to close the door?,.. noises?,.. How to lock it?, Which kind of lock(s)?
- If you look at your container: is it absolutely safe? If not change it until it is. (Check material, solid walls, strong locks,..)
- Put whatever you want to lock up into a box, take it to your container, open the door and put it inside.
- Then close the door and decide where to leave the key.
- Then bring your container to a place where you can reach it when you wish to, but not too close by.

If it's difficult to put the experiences into the container it helps to materialize them. E.g.:

- *Affects* (e.g. extreme fear or body sensations as pain): give it a form/ Gestalt and shrink it to a very small size until it fits into a box.
- *Thoughts*: write it down on a paper with unreadable special ink, put it into an envelope and then into the container.
- *Pictures*: handle as a photo, maybe shrink it, let the colour fade out, put another paper in front of it and then put it into an envelope.
- *Inner films*: handle as a video, if necessary use the remote control to take of colour, sound, etc., turn of the TV and take the videocassette to the container.
- *Sounds*: handle as if on a CD or sound cassette, turn off the volume, fast rewind and take it to the container.
- *Smells*: e.g. take them into a bottle, close it.
- *Taste*: give it form and colour, shrink it and store it in a glass.

Check if everything is gone. If there is something left, put it away into the container like you did before.

2 The Inner Safe Place (The Place of Well-being)

- Please look in your inner world for a place, where you can feel absolutely safe and comfortable. This place can be a mixture of places, where you felt safe and comfortable before, ... can be a mixture of real places, but it can also be a place in your imagination. Maybe it is a place close to you, far away, on our earth or anywhere in the universe.
- Take time now to find such a place. Perhaps you have pictures or an imagination or thoughts. Whatever comes up is fine, as long it is soothing, healing and safe.
- Please let me know when you've found such a place. And you decide whether you want to tell me about it.
- And now you should check again, if the place is absolutely safe and comfortable. Check with all senses.
- Do your eyes like everything that you see? If there is anything you don't like, change it. And remember, in your imagination you can arrange everything as you like it, it is like magic.
- Do your ears like everything that you hear? If yes, stay with it, if not, change it.
- Is the temperature okay?
- Does your nose like everything that it can smell?
- Have you got enough space to feel comfortable? Can you move, is any posture possible?
- Now check if you need a border to feel absolutely safe, to have the control that nobody can enter this place. Decide what kind of border you want, a hedge or a wall or a magic border... And imagine it and change it until it feels safe enough.
- Now ask yourself if you want to invite one or more beings to stay with you there. There shouldn't be any human beings at your place, but helpers who are always friendly, benevolent and taking care of you. If there are pictures coming up of beings who don't have these qualities, you should send them away. They don't belong to this place!
- When you have finished creating this place, what could make it even more safe and comfortable? How does it feel in your body to be at this place? What do you see, hear, smell....? What do you feel on your skin? What about your muscles, your breathing, your belly?
- If everything is okay for now, you can decide to choose a gesture that will help you in the future to come back to this place whenever you like it. You can also find a name for your place. Try your gesture, think of the name and feel with all your senses how it is to be at your safe place.

- It might happen that you have to change something or that it becomes necessary to add something in order to make your place even safer. So, check it from time to time and keep careful.
- Now take a moment to feel again the safety and comfort at your place and then come back to this room with your full awareness and feel the contact of your feet with the ground.

3 The Inner Garden

The size of your garden

- I would like to invite you to create a garden completely as you want it to be. Imagine a stretch of land, untouched by human hands, with fresh earth, full of strength.
- Maybe a handful of earth is enough for you, or the size of a small balcony-terrace, but maybe you would like a huge estate, to turn into a park-landscape.
Allow yourself a moment of time to find the size and landscape that fits you....
- First of all, create the borders of your garden, just as you would like them: with fences, hedges, walls, or trees.
If you prefer, you can also leave your garden open and refrain from any boundaries..... Find out what makes you feel best.....

Planting your garden

- Now plant your stretch of land. Let grow whatever you would like to grow in your garden...flowers, trees, bushes, grass....
- Just in case you want to change and reshape your garden now or later, make a compost heap in one corner of your garden. You can take anything that won't grow anymore or that you don't like any longer within your garden to this heap, where it will turn into useful earth.

Further shaping

- If you like, you can shape your garden even more: maybe it would be nice to have a water in your garden, a pond, a source or a small river.....
- If you like, you create a place to sit.....
- Maybe you want animals in your garden, and if so, which ones?.....
- You can change your garden at any time.....

Enjoying your garden

- Once you have shaped your garden to your wishes, you can sit down in a beautiful place and enjoy your garden.
- Look around you, what colours and forms do you see?....What do you hear?.....
What do you smell?..... How does it feel to your body to be in this place?....
- You can also consider to invite someone you like to your garden. But make sure it is a person who can value your garden and all the care you invested in it.
- You can return to your garden anytime, and also change it, whenever you want.
- Please come back now at your own speed to the room, with full awareness.

4 The Tree

- First of all imagine a landscape where you feel comfortable and where you like to be. It may be a landscape you know and that exists, but as well it can just be imagined, existing only in your mind...
- And in this landscape there is a tree, that attracts you and you approach it and get in touch with the tree. You can look at it, but you can also touch it. May be you like to imagine that you lean against it or embrace it. And then perceive that tree, its trunk, the structure/nature of its bark, its smell, notice how the trunk branches out, the leaves, etc...Take time to perceive this tree exactly...
- Now try to find out what it means to the tree that it has roots, that branch out in the earth and to be nurtured this way. And try to find out what it means to the tree to have leaves that can take in the sun light and transform/convert it...
- And then think about the question how you yourself want to be nurtured now. What kind of nourishment would you like now – nourishment for your body, for your emotions, for your mind or for your spiritual being? Specify that as exactly as possible...
- And now you may imagine that you get this nourishment from the earth and from the sun. And imagine that what you got from the sun and from the earth unites with each other within you. And that you grow by that... physically, emotionally, mentally or spiritually...
- And now remove from the tree and say good bye. If you like you can make plans to come back to your tree often. Perhaps you can promise to come back. You can also, if you like, thank your tree for supporting/helping you...
- Now please take the time you need to come back to this room with full awareness and notice the contact of your body to the ground.

5 The Inner Helpers

- Take a few moments to become aware that your body is a wonder, and that in your body works an inner wisdom – greater than your conscious ego – that causes the cooperation of all the cells of your body, the organs, the locomotor system, etc.
- Become aware that the body heals itself if necessary and how complex that is. And that it is impossible for your conscious mind to regulate all that – but nevertheless - it works. You can name/call that the ‘inner wisdom’.
- And now I invite you to make contact with your inner wisdom. Either by giving it a gestalt or by perceiving it especially in one part of your body...
- And then you may ask your inner wisdom to establish contact to one or more helpful beings...
- When it has been possible to make contact then you might ask for help or a piece of advice...
- If you got anything you might thank for it. You might also thank for the appearance of the helpful beings. Or you might thank your inner wisdom...
- And if you didn't get into contact, but wish to do so, you should repeat this exercise again and again. And sometime the contact will be established.
- Now please take the time you need to come back to this room with full awareness.

6 The Point of Power

1. *Look for a positive feeling in the last 2 hours*
(instead of a general positive feeling you can also look for a more specific feeling your client needs at the moment)
 - Do sets of 4 – 6 slow bilateral stimulation (if necessary you can do longer ones)
 - Repeat, if the effect is generalizing
 - *Stop immediately* if you have the impression that the positive feeling could switch into a *more negative* one
2. *Look for a positive feeling in the last 2 days*
 - Follow the same procedure as before:
short set of slow bilateral stimulation (as before), repeat as long as positive process generalizes
3. *Look for a positive feeling in the last 2 months*
 - Same procedure
4. *Look for a positive feeling in the last 2 years*
 - Same procedure
5. *Look for a positive feeling in the past in general*
 - Same procedure

7 The Light Stream (“The Healing Light”)

- If there is any negative body sensation check where it is, what size it has, give it a form/ Gestalt, a colour, a material.
- Imagine healing light in the colour you associate with it, coming from above... Maybe it's warming or cooling light...
- Allow this light to shine/flow through your skin into your body
- Realize how it feels.
- If you like, let the light flow around and through your bad feeling body part.
- Realize how it feels having this healing light in this area and what it does to it.
- If you want you can fill your whole body with healing soothing light.
- – Maybe you want your light flowing down into your feet and then down into the ground or you want it to shine in all directions.
- Let the light go for now. You can have it back whenever you like.
- Please come back to this room in your own time.

8 Stress Absorption Technique

1. Which is the incident / stressful situation that you want to work with?
Describe:
2. How much stress do you feel *now* when you think about this situation? (SUD = Subjective Unit of Distress)
..... ("0" = no stress, "10" = the highest stress you can imagine)
3. I want to propose to work with this situation indirectly by looking for positive experiences that could support you to cope better with this situation. It will be important to find strictly positive and non-ambivalent experiences
4. Which positive resource, skill or strength will help you to deal better with this stressful situation? (Try to find 3 different ones, look for different action systems like inner or bodily strength, inner peace, ability to set boundaries, being together with friends etc., fill in the order, situation etc. only if you are proceeding with Steps 4 – 12,

Instruction throughout the whole processing: only work with activated resources and positive memories. If there is any affect bridge to negative material, go to another resource situation. If the client is not able to maintain and strengthen a positive picture together with a positive body sensation proceed with the container exercise and safe place instead!! Do not continue with bilateral stimulation when the client is processing stressful and / or maladaptive material !!)

Order	Skill, strength	Situation / Picture
1		
2		
3		

(If several skills mentioned you can install also more or try to find clusters. It is important to find strength coming from different action systems, specifically positive attachment experiences are important)

5. With which positive resource, skill or strength do you want to work first?
(Start with the skill the client mentions – or with that one where the client shows the strongest affect)
6. Has there been a moment or situation in your life during the last two years or earlier when you experienced that _____ (resource, skill or strength)?

(Let the client describe a clear situation that s/he remembers and where s/he had at least some positive reaction)

7. What image represents this situation the best?
(The image that brings up the affect most strongly)
8. Where do you feel it in your body? (that you already had achieved some abilities related to this skill)
9. Now bring up the image, experience the feeling in your body. Do you feel it? Yes? (if client says yes, say.) ... Think about it and then follow my fingers./ I start with tapping (Do 4-8 slow eye movements or other bilateral stimulation, e.g. slow tappings) and then ask:
10. What do you experience (in your body) now?
(Ask specially for changes in body sensations. As long as the experience is strengthened in a positive way, do another set of 4-8 eye movements.)
11. Look for a cue word or a symbol that represents this resource
Add another set of bilateral stimulation. If you find affect bridges to negative material, look for new, less ambivalent situations with this skill ("has there been another situation where you experienced this strength?) If you do not find one go to the next one.
12. Enhance the following resources with the same procedure using bilateral stimulation
13. When the resources have been fully developed:
Please get in contact with all the resources that we found during our session. Do you feel it? Yes?
Add one set of bilateral stimulation.
14. Go in contact with all (three) abilities (name them and mention cue word / symbol) Are you in contact? ... Yes? (Do one set of bilateral stimulation)
15. Finalize the enhancement only if there is a secure stability and installation of the resources: (if not stop with step 14)
Connect now this positive feeling with the situation / problem you mentioned at the beginning. Do you manage? ... Yes?
Do one set of bilateral stimulation.
16. Take another look at the stressful situation you identified.
How disturbing does it feel to you right now, from 0 to 10?

SUD: _____ ("0" = no stress, "10" = the highest stress you can imagine)
17. You can go on with more resources, if the client needs more.