

# ROTATE

## Resource-Oriented Trauma Therapy Combined with EMDR Resource Installation

### Treatment Manual

Version 1.0, July 2016

Wolfgang Wöller, Helga Mattheß  
Trauma Aid Germany

## 1 Introduction

Resource-Oriented Trauma Therapy and Resource Installation with EMDR (Eye Movement desensitization and reprocessing; short: ROTATE) is a short-term psychodynamically based trauma therapy approach that is especially suitable for clients with complex trauma conditions, i.e. posttraumatic stress disorder (PTSD) and comorbid conditions.

The approach aims at strengthening resilience and coping capacities by activating positive personal resources. It largely draws on psychodynamic principles of therapeutic relationship and includes a variety of imaginative resource-activating methods within a framework informed by affective neuroscience, resilience research, and attachment theory.

One important element of ROTATE is « Absorption technique » which is a modification of Resource Development and Installation (RDI), a resource-activating EMDR technique. As opposed to EMDR standard protocol (Shapiro 2001), RDI does not use bilateral stimulation in order to process traumatic memories<sup>1</sup>. Working with traumatic memories is *not* the goal of ROTATE, nor is it a confrontative technique that activates traumatic memories. Rather, it is a strategy to strengthen coping resources and positive emotional states (Korn & Leeds 2002; Leeds 1998; Popky 2005). Nevertheless, research has shown that symptoms of PTSD and other comorbid trauma-related symptoms can be effectively reduced using ROTATE (Steinert et al. 2016).

ROTATE has several advantages:

- The approach takes into account the complex nature of trauma in victims of man-made disasters and interpersonal violence.
- Instead of solely focusing on PTSD symptoms, it considers the mental comorbidi-

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<sup>1</sup> The original EMDR standard protocol was designed to process traumatic memories using bilateral stimulation (Shapiro 2001). However, for complex trauma clients, several modified protocols have been elaborated (e.g. Hofmann 2011), some of which involve resource-activation in addition to trauma processing (e.g. Knipe 2011). The only EMDR protocol that exclusively aims at activating resources is RDI.

ties typically found in these clients, notably depression and anxiety.

- ROTATE can be safely applied even to complex trauma conditions, no major side-effects have been observed so far. Additionally, as it is not solely language based and also focuses on somatic aspects and bodily reactions, it can be viewed as more culturally independent than other psychotherapies.
- The approach is especially suitable for clients from non-western countries as traditional healing resources and metaphors can be integrated in an overall framework of resource activation. The techniques used in the ROTATE approach have been widely applied during trauma psychotherapy trainings in countries such as Indonesia, China, Haiti, Thailand, Kenya, Rwanda and Burundi (Mattheß & Sodemann 2014).
- The basic elements of the approach can easily be taught. This aspect is of major importance to ensure a broad dissemination of the approach's basic elements among the vast number of traumatized clients in severely affected non-western regions.
- ROTATE can be combined with trauma confrontative techniques, if necessary, e.g. EMDR standard protocol (Shapiro 2001) or inverted standard protocol (Hofmann 2011). In this context, it serves as a preparatory stabilization phase for confrontative techniques to be safely applied.

It should be noted that ROTATE 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) that involves stabilization, trauma processing and reintegration phases, ROTATE represents 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.

ROTATE is designed as a short-term intervention. Normally, 5 to 10 therapy sessions of 50 minutes each seem to be appropriate. However, more 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, a psychodynamic approach 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.
- Structural psychodynamic approaches informed by psychoanalytic ego-psychology provide a broad spectrum of interventions to develop *deficient ego-functions* (i.e. basic competences) of complex PTSD patients. E.g., impaired emotion regulation and disturbed interpersonal regulation are very common among complex trauma clients (Bellak et al. 1973, 2004; Leichsenring et al. 2010; Rudolf 2013; Wöller 2012). To this end, 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* (Reddemann 2012).
- 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, the «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 an understanding of many traumatized clients' impaired capacity to care for 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 for 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 traumatized clients' special relationship structures necessary for constructing a strong therapeutic alliance (Balint 1956; Luborsky 1984; Winnicott 1960). Considering aspects of transference and countertransference can be helpful for alliance building in complex trauma clients, even in short-term approaches such as ROTATE. Techniques to handle difficult transference and countertransference phenomena 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 distancing techniques and/or seek help from a supervisor.

What does this psychodynamic framework mean practically when applying ROTATE as a short-term psychotherapy approach?

- Applying a psychodynamic approach in a short-term psychotherapy format requires that the ROTATE therapist focus not on symptom reduction alone. Rather, s/he should choose the focus of 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 if troubling interpersonal problems are found to maintain the presenting symptoms, the focus will be on interpersonal regulation problems.
- The psychodynamic relationship orientation underlying the ROTATE approach implies that *diagnostic and therapeutic activities are inextricably intertwined*. The quality of a diagnosis 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.
- Applying ROTATE as a psychodynamically based intervention does not mean to use a « classical » neutral or abstaining 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 information processing in PTSD (Reddemann 2012). Instead, PTSD-specific and neu-

robiologically informed psychodynamic concepts are required. Therefore, a therapeutic style is recommended which actively addresses the clients' needs 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

Enhancement of the clients' resilience is the major aim of ROTATE. In this context, activation of positive emotions and images is considered crucial for the development of resilience. A vast amount of research suggests a strong relationship between positive emotions, adaptive coping and resilience (Folkman & Moskowitz 2000; Fredrickson 1998). As trauma blocks the clients' access to positive emotions and coping capacities, resource activation is a key element of the ROTATE approach. Resources can be differentiated into internal and external resources.

Internal resources include

- capacities or competences
- pleasant activities
- positive memories of the past
- positive visions of the future
- positive inner images created by guided imagery.

External resource include support by

- family members
- partner
- friends
- organizations etc.

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

- *Activation of internal resources* is the central therapeutic tool for improving emotion regulation<sup>2</sup>. This can be accomplished by evoking memories of positive relationship experiences or by stimulating fantasies of positive experiences. For example, evoking a memory of a personal success can have positive effects on self-esteem.

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<sup>2</sup> In terms of psychodynamic ego-psychology, activation of internal resources means enhancing the clients' mastering and coping competences (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 relationships.

- However, many problems of traumatized clients result from their inability to *utilize external resources*. In this sense, the ROTATE therapist also assists the clients in contacting people or organizations that can give them the support they need.

### **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). Clinical studies have suggested PTSD to be a disorder involving both emotional undermodulation (lack of control over or disinhibition of emotional responding) and states of emotional over-modulation (overcontrol of emotional states). Emotional undermodulation occurs during re-experiencing and hyper-arousal reactivity, whereas overmodulation occurs during states of dissociation, numbing and analgesia. Emotional undermodulation was found 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 property of the resource-activating interventions to be modifiable according to the specific needs of the client and the context, ROTATE techniques are very appropriate to the therapeutic work in a transcultural context. In the specific cultural context of low-income countries, even traditional healing procedures can be utilized 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, s/he should make it as concrete as possible so that the client can understand it easily and work on it effectively.

In some cultures, imagination can be a challenge. Then, the ROTATE therapist will modify imagination exercises in order for the clients to better accept them (see paragraph 10.1).

### **2.5 Therapists' self-care**

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

### **3 Indication and contraindication for ROTATE**

ROTATE is primarily indicated for clients suffering from the symptoms of Complex Posttraumatic stress disorder (see paragraph 4.6).

It is not the first choice therapy for clients suffering from a « classical » PTSD without any signs of complex PTSD features. For these clients, confrontative trauma therapies as listed in international guidelines for PTSD (e.g. the CBT technique of Prolonged Exposure or the EMDR protocol for trauma confrontation) are likely to be superior to ROTATE. Nevertheless, in the absence of confrontative therapies, ROTATE may also be a good choice.

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.

It should be noted that ROTATE is not an adequate 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 patients so far.

As a general rule, the ROTATE therapist should carefully observe all client reactions when introducing a new technique. It is possible that a client does not get along well with the specific technique or exercise proposed by the therapist. The client might feel uneasy or might get in touch with traumatic memories. In this case, the ROTATE therapist chooses an alternative technique that fits better to the client's needs.

## **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 series of experiences resulting 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. Potentially traumatic events include:

- accidents
- natural disasters such as earthquakes and tsunamis
- violent events such as kidnapping or rape
- intrafamiliar violence like domestic violence
- 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. They are accompanied by feelings 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 with the highest rate of posttraumatic symptoms.

### **4.3 Two categories of trauma**

Terr (1991) distinguished two types of traumatic events:

- Type-1 traumas relate to single and surprising events: traffic or workplace accidents, natural disasters, e.g. earthquakes, plane crashes, assaults, rape, witnessing a murder etc.
- Type-2 traumas correspond to a situation which occurs repeatedly. Here, the individual is again and again exposed to an identical or similar danger such as family violence, war, torture, childhood abuse etc.

Interpersonal events, i.e. man-inflicted events, are usually more damaging for the victims than impersonal events like accidents or natural disasters.

### **4.4 Traumatic memory**

The symptoms of post-traumatic stress disorder (PTSD) can be understood as the result of an incomplete processing of a traumatic experience. High stress during the

traumatic experience leads to sensory-based encoding and fragmentation of the memory (van der Kolk 1987). Because of this stress, the memory of the trauma is poorly elaborated and inadequately integrated into its context in time, place, and other memories. Normal meaning-based encoding necessary for adaptive, intentional memory recall is disrupted. Instead, sensory-based encoding will result in perceptual memory traces that are involuntarily cued by perceptual stimuli. Thus, in PTSD, intentional narrative recall of a traumatic event will be disorganized and automatic memory intrusions will occur.

In PTSD, the survivor suffers from stressful repetitive memories or nightmares of the event. S/he feels distressed or scared when facing internal or external cues resembling aspects of the traumatic event. The survivor relives the traumatic situation not as a reminiscence of the past but as if happened once again in the present. The disturbing event has not been integrated in the person's life. « Flashbacks » (intrusive memories) can occur as images, noise, voices, odors or nightmares.

#### 4.5 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 traumatic experiences made during war and cause the same emotional stress experienced in the original traumatic situation.

#### 4.6 PTSD symptoms (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 of elements of a past experience. Suddenly the individual acts or feels as if the stressful experience were happening again. Repeated disturbing and stressful nightmares can also be intrusive symptoms of PTSD.
- *Avoidance*: Individuals with PTSD try to avoid all thoughts, feelings or conversations that remind them of the traumatic event. They likewise avoid places, people or activities that bring the traumatic event to their mind. They may also exhibit emotional numbing symptoms such as feeling numb and distant from others.
- *Hyperarousal*: Individuals may be extremely alert and watchful on guard. They may be constantly aware of threats and easily startled. They feel as if something dangerous could suddenly happen. Hyperarousal often leads to sleeping problem, irritability, difficulty of concentration or angry outbursts.

In addition to the « classical » PTSD symptoms, according to a proposal for ICD-11 (Cloitre et al. 2011; Maercker et al. 2013) complex PTSD is defined by 3 more symptom clusters:

- *Affect*: The affect cluster is marked by emotion dysregulation as evidenced by heightened emotional reactivity, violent outbursts, reckless or self-destructive behavior, or a tendency towards experiencing prolonged dissociative states when under stress. In addition, there may be emotional numbing and a lack of ability to experience pleasure or positive emotions.
- *Negative self-concept*: This symptom cluster is characterized by persistent beliefs about oneself as diminished, defeated or worthless. These beliefs can be accompanied by pervasive feelings of shame or guilt. Complex PTSD clients may develop alterations in their sense of self-efficacy and a disruption in their perceptions of safety, trust, and independence.
- *Relational disturbance*: Interpersonal disturbances are defined by persistent difficulties in sustaining relationships. Some individuals may consistently avoid relationships, whereas others may occasionally experience close relationships but will have difficulty maintaining emotional engagement.

#### 4.7 Major depressive episode

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

- Feelings of sadness, emptiness or hopelessness
- Sleep disturbances, including insomnia or hypersomnia, i.e. 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

#### 4.8 Dissociation

Dissociation is a disruption of the usually integrated functions of consciousness, memory, identity, or perception. Dissociative symptoms are 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, traumatized clients had developed dissociative symptoms as a way to cope with traumatic experiences in that they allowed them « fleeing » from over-

whelming emotions. However, in the present dissociative reactions tend to be dysfunctional and disruptive for daily life. Usually, dissociative symptoms are precipitated by episodes triggering a traumatic memory. Specifically, a situation that is frightening or highly unpredictable enhances the probability of a dissociative reaction.

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 for days), mostly triggered by stimuli associatively connected to a traumatic memory. It is suggested that psychogenic amnesia is a defense mechanism that enables the individual to avoid remembering the traumatic experience. 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, foggy or dreamlike. Their perception of people and things around them may be distorted and unreal. Some of them feel 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 from their immediate surrounding. Some feel like looking at the world through a veil or glass, others feel puppet-like or robot-like. In derealization disorder, the world around the person may seem unreal or far away. Both symptoms can be profoundly distressing. They may last only a few moments or for hours to days.
- *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 look very similar to epilepsy. Typically the patient 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. Nearly half of all people brought in to hospital with suspected serious epilepsy have dissociative seizures. 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* may indicate that a client has lost contact with the current reality. The states are triggered by stimuli that have an – even remote – similarity with the traumatic experience. E.g., clients may exhibit aggressive behavior when they feel being immersed in a threatening state of past trauma.

- *Dissociative identity disorder*. This type of dissociative disorder, formerly known as multiple personality disorder, is characterized by « switching » to alternate identities.

#### **4.9 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 cardiac 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.

## 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 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 also 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. In psychodynamic terms, this occurs because the clients tend to transfer feelings they had experienced in the relationship to important key figures to the therapist. Specifically, clients who had suffered interpersonal trauma can unconsciously transfer the fear to be rejected, abused or humiliated to the therapist (see paragraph 15). Metaphorically speaking, it is the child parts of the personality that are afraid of being retraumatized by the therapist.

Therefore, in addition to providing external security, enhancing the feeling of safety in the therapeutic relationship is an explicit goal of ROTATE. To improve the clients' feeling of safety, the ROTATE therapist might ask them what they need to feel safer and more comfortable in the therapeutic situation. E.g. s/he might ask the client if the sitting position is agreeable. Some clients feel more comfortable when they sit next to the door because their inner child parts feel safer when they have the possibility to flee, i.e. to leave the room quickly. Other clients prefer to talk with the therapist outside the therapy room because child parts feel scary when enclosed in a small room.

*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?*

Inquiring after the clients' subjective feeling of safety is necessary as usually clients will not mention spontaneously when they feel uncomfortable or unsafe in the therapeutic situation.

### 5.2 Strengthening the feeling of control

In consideration of traumatized patients' frequent fears of losing control, their sense of being in control is extremely important and should be strengthened whenever possible. Therefore, the ROTATE therapist will explain to the clients that they will maintain full control over whatever happens during the therapy and that nothing will happen during therapy without their explicit consent.

To avoid counter-productive client feelings of being dominated, the ROTATE therapist strives at involving the client in all decisions concerning the therapy. The clients are requested to check whether they find the therapist's recommendations helpful or not. They should accept them only if they can accept them as useful. Whenever a client does not like a recommendation, it is useful 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 Therapeutic alliance**

A helping therapeutic alliance will develop if the therapist carefully listens to the clients' words in order to fully understand what they want to communicate. Rather than giving the client premature advice what to do, the therapist should take his or her time to find out what the client's needs and problems really are. If necessary, the therapist will ask detailed questions to ensure a better understanding.

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

At all moments of the therapy, the ROTATE therapist should check if the client is still « on the same boat », i.e. if s/he still follows the same goals as the therapist. Therefore the therapist continuously asks the clients to give feedback:

- Do you feel at ease with the therapeutic situation?
- Did you understand what I explained?
- Which interventions did you find helpful?
- Is there something frightening or embarrassing with the therapy?

Establishing a therapeutic alliance.

The ROTATE therapist should carefully check for negative or idealized transference manifestations (see paragraph 15). As for negative transferences, s/he should strive for an understanding if there is something in the therapeutic situation that is frightening or embarrassing for the client.

### **5.4 Dealing with self-endangering behavior and suicidal impulses**

Self-endangering behavior or suicidal impulses are common among complex trauma clients. They have to be addressed with top priority throughout all therapy sessions. For emergency situations, the therapist develops a detailed emergency action plan. The clients should know what to do and whom to contact when suicidal thoughts get

out of control. For some clients, treatment contracts are advisable for suicidal impulses and self-destructive behaviors should be considered.

### **5.5 Should clients talk about traumatic experiences or not?**

Normally, the ROTATE therapist does not encourage traumatized clients to talk in detail about their traumatic experiences. It is the philosophy of ROTATE that talking about details of traumatic experiences is not therapeutic per se. On the contrary, it can also deteriorate the condition because without prior stabilization and resource activation the clients run the risk of being overwhelmed by traumatic memories. Notably, if the client reports highly stressful fragmented memories (flashbacks; see paragraph 4.6), talking about traumatic events may not be helpful for a reduction of posttraumatic stress. Moreover, it may activate intrusive reliving of the trauma and deteriorate the condition.

However, there may be exceptions. Sometimes traumatized clients express a deep wish to talk about their traumatic experiences. They urgently need someone to listen and witness what happened to them. The possibility to talk about traumatic experiences in a good and safe relationship can give them great relief and a feeling of being understood. If these clients do not suffer from intrusive symptoms such as flashbacks, the therapist can consider allowing them to talk about their traumatic experience in a safe framework, i.e. with prior resource activation and for a limited period of time during the session. For example, the client might start with a resource-activating exercise, talk about his or her trauma for say 10 or 20 minutes, and close the session again with a resource-activating exercise. If the client definitively reports relief after this procedure, it can be repeated during the next session. It is of utmost importance that the client leaves the session in a stable and resourceful emotional state.

In each case, the therapist should carefully examine whether verbalization of the traumatic experience brings the client relief or not.

## 6 Diagnostics and main focus of the therapy

After a basic therapeutic relationship has been established, 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. Then, an interpersonal focus will be formulated.

Instead of defining abstract therapy goals, the ROTATE therapist asks the clients to describe in detail what positive effects will occur if the therapy turns out to be successful. The clients should develop a concrete positive vision of the change in their life they expect if therapy works well. Generally, the therapist is more focused on solutions than on how the problem has developed.

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

- If intrusions are the main problem, the ROTATE therapist may 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 is repetitively being involved in interpersonal conflict situations, the ROTATE therapist will strengthen his or her capacity to deal with interpersonal conflicts and assist in solving the specific conflict situation.
- If low self-esteem is the main problem area, the therapist will strive for an understanding of the situations and relationships in which the problem arises. Then s/he will choose resource-activating techniques to enhance self-esteem. For example, s/he may activate a positive memory of a (small) success or have the client practice the « point of power » technique.
- If self-care is the most prominent 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 may activate memories of positive coping and competencies using the « absorption technique ».

## **7 Psychoeducation**

### **7.1 Adjust the style of information provision to the cultural background of the client**

Information about the disorder, its origin, and treatment modalities is an important element of ROTATE. The clients should develop a basic understanding of the disorder to which their symptoms belong – be it Posttraumatic stress disorder (PTSD), depression, dissociative disorder, somatoform disorder or another trauma-related disorder. 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 of information the client can digest instead of overwhelming the client with a huge quantity of information s/he is unable to integrate.

## **8 Flashback management**

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

## 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.

The container exercise can also be used if traumatized clients are « flooded » by undifferentiated negative trauma-related emotional states. Typically, these undifferentiated trauma-related emotional states contain elements originating in the traumatic past and elements originating in the current situation. They are characterized by feelings of powerlessness, abandonment and other strong negative emotions.

Therefore, the therapist helps the client differentiate 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 patients 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; Wöller et al. 2012, 2013).

*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 ».*

Help the client talk about his experiences but do not let him fall into a trauma state. In the case of traumatic information processing as found in Posttraumatic Stress Disorder, expression of traumatic memories is not beneficial. In addition, it entails the risk of falling into a state of abandonment and helplessness. Because of this, teach to the client distancing techniques.

## 9 Improving emotion regulation

Traumatized clients tend to be flooded 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 associated with an earlier traumatic experience.

Therefore, the main aim of ROTATE is to increase the client's ability to master and modulate negative emotional states and extreme arousal. Therefore, teaching imaginative techniques to engender positive emotional states is central for the stabilization work of ROTATE.

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 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 favorite activity.

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

- S/he asks the client to identify a memory of a (small) success or another positive experience (e.g. a positive encounter etc.) during the last months or years.

- S/he invites the client to imagine a scene that represents this (small) success or the other positive experience.
- The client should feel the pleasant feeling connected with the positive memory.
- The client should feel the pleasant bodily sensation connected with the positive memory.
- The procedure can be repeated several times.

Sometimes, it may happen that the positive emotion connected to the resource memory may turn into a negative one. This may be the case if the positive memory is associatively connected with a memory of trauma or loss, e.g. if the client activates a memory of a positive encounter with a person who has died or a positive memory of a success in a job s/he recently lost. Instead of evoking a constant good feeling, the client feels the negative emotion linked to the trauma, failure or loss. Therefore, it is important to find a memory that is not connected with an experience of trauma or loss.

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

## 10 Imagination exercises to improve emotion regulation

### 10.1 General aspects

ROTATE provides a variety of imagination techniques to improve emotion regulation by increasing positive emotional states of safety, calm and well-being. Several aspects have to be kept in mind when working with imaginations:

- *All imagination techniques need practice.* At first, the ROTATE therapist will explain the technique to the client. Then, s/he will practice it together with the client. Finally, the client will practice the exercise himself or herself.
- The clients should understand that in the beginning it is normal to face *difficulties* when practicing imagination exercises. Therefore, the ROTATE therapist encourages the clients to report all difficulties that occur. Mostly, solutions will be found. For example, if a client finds that the «inner safe place » is not really safe, the therapist helps the client modify the place until it will be safe.
- *Client preference.* The therapist may take into account the *client's preference* for specific imagination exercises. It is not necessary that each client master and practice all exercises the therapist is introducing. Rather, the client should identify one or two imagination exercises s/he likes and practice them.
- *Cultural compatibility.* Usually, the clients' cultural background requires modifications of the exercises. Often, clients need explanations and examples how to work with the exercises in a more concrete way. For example, in *Cambodia*, some clients needed to draw their own safe place or inner garden to make them completely safe. They used to keep these drawings with them and looked at them when they felt stressful. For « container » technique, the therapists sometimes had to bring a real container (small box) to show them to their clients before working on the exercise. Some clients chose other objects like a big wooden box. However, they could find the way to make it stronger and more protective afterwards. As for the « tree exercise », some therapy sessions had been done near or under a real tree. Therapists walk with their clients to see the tree first before starting the therapy session. Or, the patients draw a tree (Comment by Thearom Ret). In Rwanda, therapists reported that clients living in rural areas preferred putting negative material into a river rather than into a container. For them, it was safer to see the material being swept away than being put into a container without having a key to lock it up (Comment by Wolfgang Wöller).
- *Stability of the resource state.* As with positive memories, the positive emotion connected to a resource-activating imagination may sometimes turn into a negative one if the content of the imagination exercise is associatively linked to a memory of trauma or loss. This can be the case if the client visualizes a » safe place « that is situated near a place where a traumatic event occurred. If this happens, the ROTATE therapist should help the client find another place or use another imagination technique.

## 10.2 Inner safe place imagination

The « Inner safe place » imagination can be helpful to improve the feeling of safety.

### INNER SAFE PLACE

- 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 as 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 caring 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.

### 10.3 The Inner Garden

The Inner garden exercise is also useful to improve emotion regulation.

#### 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.

## 10.4 The tree

The tree exercise is another option to create a resourceful state.

### 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 sunlight 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 goodbye. 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.

## 10.5 Inner Helper

The « inner helper » exercise is especially useful for clients who feel alone and helpless. Creating an inner helping figure can represent wisdom, support, love, and safety.

### INNER HELPER

- 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.

## 10.6 Point of power technique

This is a technique 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.

### POINT OF POWER TECHNIQUE

#### Instructions:

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 month*
  - 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

## 11 Light stream technique in reduce somatoform pain and bad body sensations

This 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.

### LIGHT STREAM

- 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

## 12 Furthering self-care and self-protection

Furthering self-care and self-protection is an important topic of ROTATE. Most clients with a history of complex trauma 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 negative cognitions typically reveals an 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-protection. S/he declares that self-care and self-protection are not only allowed but also necessary to improve the self-regulation. If necessary, the therapist gives practical examples how to start with self-care and self-protection in daily life.

*T: I understood that it is rather difficult for you to say « no » if you don't agree. What do you need to clearly say « no » in situations where you don't agree? Maybe you need a moment to reflect first? As a first step you could ask the person to give a little bit of time to reflect instead of giving a quick answer. Then you may reflect on whether you will agree or not.*

With some clients it is advisable to work on the negative cognitions underlying the lack of self-care and self-protection. If possible, the ROTATE therapist connects the negative cognitions to the client's negative relationship experiences 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?*

### 13 Reorientation techniques to get out of dissociative states

If a patient is engulfed in a dissociative state, the ROTATE therapist will use reorientation technique to help him or her out. Reorientation techniques are simple strategies which help clients to come back to the present in the « here and now ». To this end, the ROTATE therapist asks the client to focus outward on the external world rather than inward toward the inner world full of overwhelming traumatic emotions.

There are two ways of using 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 falls 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 – The therapist should stay calm and use a very clear language.

2 – S/he addresses the person and introduces himself or herself: «I am Mr./Ms. ..., I am here to help you.»

3 – S/he should say very clearly: «You are safe here. This location here is .... 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 moves into dissociate states, the ROTATE therapist can teach him or her a procedure how to stay in the present rather than fall into a dissociative state.

Normally, clients go into dissociative states at the moment when a traumatic memory is triggered. Unconsciously they use the mechanism of dissociation to « flee » from the situation they perceive as threatening. Usually clients say that they loose contact with the daily life world all at once. However, closer observation shows that they do not move into a dissociative state quite suddenly. Rather, they report a brief time slot of a few seconds or minutes during which they might react and try to stay in the present.

1 – The therapist educates the client to notice the minor alteration of conscience which mostly 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.

## 14 Absorption technique

Absorption technique is an EMDR-based resource activating technique that aims to strengthen specific coping skills (Hofmann 2009). It is a modification of the EMDR protocol for Ressource 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 in the future, the therapist uses short sets of 4 to 8 bilateral eye movements (taps or tones) to enhance the intensity of activated positive emotions and coping resources. Normally, the stress connected with the original difficult life situation will decrease.

The ROTATE therapist proceeds as follows:

- S/he asks the client to identify a stressor in the present or in the near future (e.g. an exam or a job interview).
- S/he asks him or her to evaluate the stress level of this stressor on a scale ranging from 0 (no stress at all) to 10 (maximum stress).
- To cope with this stressor, the therapist asks the client to identify the resources (capacities, competencies) needed to cope with it. The client should identify 3 different resources (e.g. courage, calm, energy, self-esteem etc.)
- For this purpose, the therapist encourages the client to search for situations in their life history where the client had access to these resources. The client should remember 3 resourceful scenes.
- Then, s/he asks the client to create a vivid imagination of each of the 3 resourceful scenes. The client should feel the positive emotional state and the positive body feeling connected with the scenes.
- To generalize the resource feeling, the therapist anchors each of the 3 resourceful states with 4-8 sets of slow bilateral stimulation.
- Finally, s/he asks the client to evaluate again the stress level of the original stressor (0 = no stress at all, 10 = maximum stress).

### ABSORPTION TECHNIQUE

#### Instructions:

1. *Which is the incident / stressful situation that you want to work with?*

Describe:

2. Ask the SUD: \_\_\_\_\_
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 memories related to adaptive networking!

If there is **any affect bridge to negative material, go to another situation** with the same capability (or change focus). 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 !!)*

Skill, strength	Order	Situation / Picture	Word / Symbol

(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 eye movements or other bilateral stimulation) 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: \_\_\_\_\_

17. You can go on with more resources, if the client needs more.

## 15 Difficult relationship issues: Transferences

Difficulties to create a helping therapeutic alliance can result from clients' transferences to the therapist. Transference is a common phenomenon in which a person in treatment directs feelings for important figures in his or her former life onto the therapist (Freud 1917). Transferences can become a problem in the treatment of traumatized clients. In the worst case, they can disrupt the therapeutic relationship and hinder progress in therapy (Dalenberg 2000). From a psychodynamic point of view, this has to do with the insecure attachment status found in most complex trauma clients.

Psychodynamic theory distinguishes several types of transferences. In the treatment of traumatized clients, two of them deserve special attention: negative (perpetrator) transferences and overly positive or idealized (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 these feelings to the therapist. E.g. s/he may be afraid of being re-traumatized, e.g. hurt, humiliated or rejected by the therapist. Negative transference phenomena typically occur when a client gets triggered by a certain therapist behavior or by certain circumstances of the therapeutic situation that remind him or her of own unresolved traumatic experiences.
- An *overly positive (idealized, 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.

Both negative and overly positive transferences may have adverse consequences for the therapy:

- 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 towards the therapist is that the client does not talk about shame issues or own failures because s/he consciously or unconsciously expects criticism or humiliation by the therapist.
- On the basis of an *overly positive and idealizing (rescuer) transference* the client will expect to be completely healed or rescued by the therapist without own contributing to the process of 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 inevitable failure to satisfy the expectations.

Therefore, the ROTATE therapist should carefully and gently check for transference reactions that prevent the client's feeling of safety and tendency to cooperate in therapy. Likewise, the therapist should carefully monitor subtle disruptions of the therapeutic alliance as a result of transference phenomena. Not infrequently, repairing alliance deficits can provide an opportunity for strengthening the alliance. Clarify-

ing transference reactions includes educating the patient about the reality of the therapeutic situation. Specifically, the patient 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 countertransference reactions is the therapist's own trauma history. Countertransference responses can vary from strong positive to strong negative reactions to the client (Wilson & Lindy 1994).

- Client disclosure of his or her traumatic experiences can evoke emotions such as compassion and sadness in the therapist. When the therapist recognises 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. Overidentification with the client may create suffering for the therapist. At worst, it may inflict professional burnout or secondary traumatization to the therapist.
- The therapist may be ashamed of the disgust they s/he feels when listening to the trauma stories of the client.
- Another countertransference reaction difficult to deal with may be rage toward the client's perpetrator. 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.

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 paragraph 4.3).

The ROTATE therapist should be aware of own countertransference reactions toward his or her client in order to provide secure emotional presence and reliable therapeutic boundaries. Awareness of 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 countertransferential reactions can protect against both overidentifying with and overly distancing oneself from the patient (Wilson & Lindy

1994). The ability to identify negative countertransference reactions as a result of projected patient states can help the therapist regain a detached, but nevertheless empathic stance in therapy.

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