

Katathym-Imaginative Psychotherapy for complex post-traumatic stress disorder: a trauma therapist's perspective

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Abstract

This article explores the application of Katathym-Imaginative Psychotherapy (KIP), also known as Symboldrama, as an effective therapeutic approach for patients with complex post-traumatic stress disorder (CPTSD), a condition often resulting from prolonged or cumulative trauma, such as childhood abuse or neglect. Drawing on the trauma therapist's perspective and clinical experience, the study provides a detailed analysis of KIP's symbolic motifs and their implementation across the three key stages of trauma therapy: stabilization, processing of traumatic experiences, and integration. Motifs are examined through patient case studies, highlighting their role in preventing retraumatization, fostering self-compassion, and restoring psychological continuity. The findings underscore KIP's diagnostic and therapeutic potential, particularly in addressing repressed affects, enhancing mentalization, and strengthening personality structure in patients with CPTSD. KIP offers a gentle, resource-oriented approach that mitigates the risk of retraumatization while promoting emotional regulation and identity reconstruction. The results advocate for the broader adoption of KIP in clinical practice and suggest directions for future research, including the development of new trauma-focused motifs and the exploration of KIP's long-term impact on CPTSD symptom management.

Keywords: PTSD, post-traumatic stress disorder, CPTSD, complex post-traumatic stress disorder, trauma psychotherapy, Symboldrama, Katathym-Imaginative Psychotherapy.

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Introduction

Complex post-traumatic stress disorder (CPTSD) is a diagnosis encompassing various symptom clusters that arise in individuals who have experienced prolonged traumatization. Typically, these are extended traumatic events associated with violence, disasters, participation in combat, or often childhood psychological traumas. Serial traumatization, a series of traumatic events, or so-called cumulative (prolonged) trauma, is one of the significant criteria for CPTSD. Complex post-traumatic stress disorder corresponds to the diagnosis of enduring personality change after catastrophic experience (F62.0 in ICD-10). In the International Classification of Diseases (ICD-11), it was included alongside post-traumatic stress disorder (PTSD) [1, 2].

The introduction of the CPTSD category in the ICD was primarily driven by the fact that PTSD criteria are associated with event-based trauma, which is clearly defined in time. Psychopathological disorders in cases of prolonged traumati-

zation — such as repeated physical and/or emotional abuse — were, to some extent, beyond the scope of the PTSD category. The traumatization of individuals who have experienced an accident or natural disaster differs significantly from that of those who have endured violence or rejection by significant others [1, p. 71; 2]. CPTSD may develop as a result of persistent or frequently recurring experiences of rejection, neglect, or disregard; exposure to domestic violence (physical, sexual, or verbal); betrayal trauma that undermines the foundation of trust; encounters with bullying or harassment; or experiencing traumatic events in a community without support from primary caregivers (parents or guardians). As significant stressors contributing to the formation of CPTSD, factors such as dependence on psychoactive substances and the presence of mental disorders in the family where the child is raised have been identified [1–4].

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Working with the symptoms of Complex PTSD requires a gentle approach. One of the most effective modern methods that meets the requirement of gentleness is Katathym-Imaginative Psychotherapy, developed by Hanscarl Leuner [5–7].

Katathym-Imaginative Psychotherapy for treating patients with CPTSD

The application of Katathym-Imaginative Psychotherapy techniques is indicated for acute and chronic stress reactions, as well as for post-traumatic stress disorder and complex post-traumatic stress disorder. In cases of psychosomatic and somatoform conditions associated with CPTSD, the following therapeutic strategies are employed in Katathym-Imaginative Psychotherapy:

- Healing narcissistic regression;
- Satisfaction of archaic needs;
- Progression (“action and development in imagination”);
- Working with aggressive impulses;
- Imagination in translating body language to verbal expression.

The symbol creatively connects the bodily symptom with the psychosocial conflict [5]. Working with imaginations allows the psychotherapist to gently address issues from the early, preverbal period of the patient’s life (early childhood traumas increase the risk of developing CPTSD). Patients with PTSD are particularly attuned to the language of images and symbols, which facilitates a connection with the unconscious, thereby aiding in restoring the continuity of time and events.

Beata Steiner, in her work on psychotraumatic stress disorders, notes that since the 1990s, the KIP method has been widely applied in the treatment of patients with psychological traumas. Since 2002, Katathym-Imaginative Psychotherapy of Trauma (KIP-T) has emerged as a distinct method from KIP. It is used in the treatment of acute and complex psychotraumatic disorders, with particular attention to working with childhood trauma. The development of this method aimed to integrate findings from scientific research on attachment, infant psychotrauma, self-psychology, and social neuroscience [5].

Therapeutic targets and tools for treating post-traumatic states

Katathym-Imaginative Psychotherapy offers a wide range of diagnostic and therapeutic opportunities, particularly beneficial for patients with post-traumatic states. Introjective externalization in KIP protects therapeutic relationships from disruption

caused by intense negative transference and serves as an intermediate step in treating patients with self-destructive tendencies [5].

When working with trauma, the psychotherapist’s attention should primarily focus on the patient’s resources and coping strategies. Motifs for imagination must be selected in a way that avoids reactivating intense trauma-related experiences and prevents potential retraumatization [5]. KIP motifs are also chosen with careful consideration of the patient’s personal history. For instance, an initially resource-oriented motif like *Picnic in the countryside* would be inappropriate for a female patient with a history of violence-related trauma that occurred during a countryside picnic with friends.

When determining therapeutic strategies, the following functions of imagination should be considered:

- expression and clarification;
- stabilization;
- structure formation [6].

Differential diagnosis using the diagnostic triad can help identify both therapeutic targets and strategies, as well as the tools of therapy, including specific imaginations. Harald Ullmann notes: “Mental disorders for which psychotherapy is indicated are typically classified using a tripartite model: we must distinguish between conflict-dynamic disorders, developmental deficits, and disorders resulting from psychotrauma. This diagnostic triad sets the direction for exploration during the initial sessions and in the first imagination exercise, known as the ‘initiating dream’” [5].

If the symptom is rooted in trauma, the therapist’s tasks at the initial stage will focus on preventing retraumatization and creating a safe and stable internal space. This involves working with resources and developing coping strategies. In cases where the patient exhibits a low structural level of psychic organization and early developmental deficits — common in cumulative trauma — the therapist must cultivate ego functions, strengthening the personality structure. After working with resources, at a later stage of therapy, the focus may shift to the affective domain, aiming to develop skills for perceiving and verbalizing affects, as well as enhancing the ability to regulate them. In the long term, the goal of therapy may include improving the level of mentalization.

At all stages of trauma therapy (stabilization, trauma processing, and integration), KIP-T incorporates various imaginative techniques that provide a resource-based “safety cushion” and ensure a gentle approach to the patient’s painful traumatic material.

To see more about the Katathym-Imaginative Psychotherapy approach, follow the link <https://figkip.org>

Stages of trauma therapy and recommended KIP Motifs

Let us examine the stages of working with psycho-trauma in greater detail.

1. Stabilization phase

At this stage, motifs that activate ego stabilization, narcissistic restoration, and help the patient feel safe are crucial. Narcissistic restoration is necessary because trauma disrupts the sense of self-worth, often leading to a fragmented ego. The following imaginations (motifs) may be offered to the patient: *A flower that has everything it needs to grow and thrive (Beautiful flower, Flower in a safe and protected place), Safe place (A place where I feel good, Place of strength), Meadow where I feel good or My meadow*, as well as the *Fortress* motif to restore and strengthen boundaries.

Additional stabilizing motifs may include *Temple of silence, Healing rays of the sun, Being a prince (princess)*. A special role is played by “water motifs” which involve contemplation and interaction with water. Their inclusion in psychotherapeutic practice is referred to as “katathym hydrotherapy”.

Motif “Spring of crystal-clear water” (patient case)

K., a 27-year-old female patient with cumulative trauma, experienced sexual abuse by her stepfather at the age of 14.

At the beginning of the motif presentation, K. struggles to concentrate, noting that various images flash before her eyes. Eventually, she manages to visualize a spring struggling to break through a pile of branches, last year’s leaves, and debris. The weather resembles autumn — overcast with a light drizzle. Near the spring, there are large boot prints and trampled grass. The patient sees herself near the spring at the age of 14 (the age of the trauma). After some time, she feels a desire to clear the spring. She begins removing debris left by tourists and fishermen (her stepfather was an avid fisherman). Over time, she notes that it has become warmer (she also feels warmth in her hands, feet, and chest area). The sun comes out, reflecting in the spring and creating playful sunbeams. K. washes her hands and face with water from the spring. The patient starts cleaning the polluted spring (i.e., she takes active steps, which facilitates a shift away from the victim position).

In this case, the motif *Spring of crystal-clear water* became a turning point for the patient, transforming her relationship with herself and the world. This motif is recommended for work with psychosomatic patients, as well as those with post-traumatic consequences of violence, particularly sexual abuse (victims of sexual abuse often feel “dirty”).

Before proceeding to the next stage, which focuses on working with psychotraumatic experiences, the

therapist must introduce motifs that help the patient encounter inner protectors and helpers (companions, allies, support groups, etc.). These characters may possess various qualities, the activation of which provides the patient with a sense of strength and the ability to protect themselves (counteracting the helplessness often experienced by patients with PTSD and CPTSD), as well as wisdom, resourcefulness, and the ability to navigate new circumstances. Beata Steiner mentions that in trauma cases, a modified form of the imagination “Inner safe” is used for controlled engagement with traumatic material [5]. All these motifs help the patient cope with fear and feel more stable. A detailed list of recommended motifs of KIP for the treatment of CPTSD is presented in the [Appendix](#).

Another critical aspect of therapeutic interventions at the stabilization stage is working with the “inner child”. Beata Steiner describes the following concept of interacting with the “inner child” image:

- Motif *Healthy, non-traumatized child* is a stabilizing and stimulating motif that allows the patient to experience an ideal representation of themselves, feeling a sense of completeness, wholeness, and vitality;
- Motif *The child you once were* is focused on a representation of the self that encapsulates the entire experience of childhood at a specific age;
- Motif *Traumatized child* shifts the focus to the representation of the traumatized self, gently turning toward the traumatic experience — a cautious first glance into a painful past.

Thus, to prepare the patient for working with traumatic experiences without rushing the process and to prevent retraumatization, they may be invited to imagine meeting their helpers (protectors) and the “non-traumatized child” as well as “the child they once were” in a safe place as an adult. The primary therapeutic task at this transitional stage is to gently establish an indirect connection with the traumatized child. The latter is not explicitly named; instead, attention, protection, care, and comfort are directed toward “some child” [5].

2. Phase of processing traumatic experiences

At this stage, the patient encounters the “traumatized child,” confronting difficult memories. There is a gentle and gradual approach to trauma-related introjects. Sometimes, a significant amount of time passes between the first session and the initial encounter with the wounded child, during which the patient may experience resistance that hinders establishing contact with the traumatized child. Feelings of tenderness, joy, or the desire to care for and protect this child may not arise immediately.

Motif Traumatized child (patient case)

N., a 32-year-old female patient with a request to build partner relationships.

N. imagines a baby toward whom she feels hostility, irritation, fear, and alienation. She looks at the baby and almost immediately says she does not want to see this girl, then opens her eyes.

It takes four more sessions before the patient finds the strength to look into the baby's eyes and hold her. The patient's life story begins with her parents' rejection of her birth. Her parents, both 18-year-old first-year university students, were unprepared for a child. The patient's hostility, rejection, and disregard for her child self likely stem from her parents' feelings toward her.

Throughout therapy, the patient repeatedly returned to the theme of relationships, complaining about her partner's inattentiveness and his accusations of her being "clingy" and intrusive. During one session, she realized she was seeking a parental figure in her partner — not only a father figure but also a mother figure.

After the initial confrontation with the trauma, the patient requires a prolonged stabilization phase. Subsequently, a controlled re-approach to painful and traumatic scenes can be undertaken using imagination techniques. Experiencing traumatic scenes in the "as if" mode allows for controlling the imagined scenes, adding new details, and modifying them as desired [5].

An effective technique for working with the aftermath of trauma is to invite the patient to become the screenwriter and director of their own film, "re-writing" the plot.

Following another stabilization episode, work aimed at engaging with trauma-related introjects can continue. Trauma-related introjects are expressed through metaphors such as "inner devaluer," "sadist," "offender," "critic," or "accuser," which are then processed imaginatively [5]. In cases of prolonged traumatic experiences or cumulative trauma, this approach is meaningful only within the context of long-term, extended therapy.

3. Phase of integration of traumatic experiences

Trauma, particularly early childhood trauma, becomes part of the psychic structure, requiring lengthy processing in psychotherapy. The most challenging aspect to overcome is the so-called loyalty conflict, where patients, on the one hand, suffer from aggressors, tormentors, or sadists, but on the other hand, are strongly attached to them — especially if these are parents or other family members. At this stage, working with affects and "unfreezing feelings," as well as rehabilitating the emotional sphere,

is essential. Beata Steiner recommends the "House of feelings" motif, which allows the patient to connect with a wide range of emotions, such as guilt, resentment, rage, and shame. In this journey through the landscapes of the soul, the patient can also visit rooms of joy, dreams, and happiness.

Conclusions

Katathym-Imaginative Psychotherapy simultaneously serves in diagnosis and direct trauma therapy from initial stabilization to integration. Differential diagnosis, including the use of imaginations, helps not only to identify therapeutic targets and strategies but also to incorporate KIP motifs that can address various symptoms of psychotrauma, including manifestations of depression, self-harming behavior, and psychosomatic conditions.

When supporting patients with CPTSD symptoms, KIP focuses on preventing retraumatization, creating a safe and reliable internal environment, utilizing personal and external resources, and fostering healthy coping mechanisms. Additionally, it addresses early developmental deficits and strengthens the personality structure. Katathym-Imaginative Psychotherapy promotes a gentle attitude toward oneself, self-compassion, and the ability to be a good parent to oneself.

Psychotherapy for patients with CPTSD using Katathym-Imaginative Psychotherapy helps reduce psychoemotional tension; gradually recognize the origins of problems, establishing a causal link between life events, personality traits, and symptoms; and more clearly understand the meaning of symptoms and their secondary benefits. The method enables work with repressed affects, facilitating the restoration of identity and the psychological timeline of life.

All this together support the use of Katathym-Imaginative Psychotherapy as a highly effective modern therapy for patients with complex post-traumatic stress disorder. Further research into the impact of imaginations on various symptoms of CPTSD, as well as the development of new trauma therapy strategies leveraging the vast potential of KIP, holds promising prospects.

Declaration of interests

The author declares that there is no conflict of interest.

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Appendix

Recommended Katathym-Imaginative Psychotherapy motifs for treating CPTSD symptoms

Resource-oriented motifs:

- *Water where it felt pleasant*
- *Spring of crystal-clear water*
- *Oasis*
- *Source of strength*
- *Paradise fruit*
- *Lying in a hammock*
- *On a warm beach*
- *In a warm room*
- *Land of abundance*
- *Picnic in the countryside*
- *Resort vacation*
- *Planting a garden*
- *In the garden*
- *Tending to plants in the garden*

Working with the “Inner child”:

- *Healthy, non-traumatized child*
- *The child you once were*
- *Traumatized child*
- *Box of toys*
- *My favorite plush toy*

Boundaries:

- *Building a house*
- *Managing your own plot of land*
- *Ruling your kingdom*

Aggression:

- *Storm*
- *Watching a thunderstorm*
- *Thundercloud*
- *Letting off steam*
- *Throwing mud and rolling in mud*
- *Volcano*
- *Secret weapon*

Depressive states:

- *New clothes*
- *Golden ball*

Body Self, psychosomatics:

- *Journey inside your own body*
- *Cloud*
- *Massage*
- *Two gardens*

Life scenarios:

- *In a fairytale land*
- *My fairytale*

Timeline:

- *Imagining yourself 10–20 years older*
- *I am 80 years old*
- *Time machine*
- *Journey through time*