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Kulak, the Trauma Fist

A body-related trauma model

by Freihart Regner, 2018/19[1]

Summary

The article discusses an interactive, body-related model for trauma education with refugees. Traumatic experiences get into a turmoil of memories in the self. These memories can be visualised as a red-hot fist *(kulak* in Russian) in the body-self. The *kulak* causes the familiar trauma symptoms on the physical, mental-psychological and social levels. With recourse to narrative exposure, the trauma fist (implicit "hot" memory) can be taken out of the inner self and opened. In a testimonio (a contemporary-witness report on political persecution) it can then be explicated, immobilised and neutralised (explicit "cool" memory). The procedure is discussed with reference to a case in which there had been complications. Finally, the author makes a number of recommendations for the health-policy sector.

Introductory Remarks

"What is this burning pain that I feel in my chest again and again? Sometimes there's also pain round my heart, for example, right now when we're talking about my bad memories. But the doctors haven't found any physical cause for it. And I have headaches every day. Sometimes they're so severe that I get even dizzy. Do I perhaps have a serious illness that could even kill me? Or am I possessed by an evil power that wants to punish me for something?". Traumatized refugees in psychotherapy often ask questions like this and other similar ones. When they do it is helpful to offer them a vivid, body-related trauma model that they can actively participate in, and that can be directly linked to some stabilizing physical exercises. The image of a glowing fist moving inside the self, called "Kulak" for short in our

1 The extended version of this paper including case presentations and a personal report was published in German in „Trauma & Gewalt“, 12. Jg, Heft 2/2018, S. 152–164. Individual copies of the article can be requested.

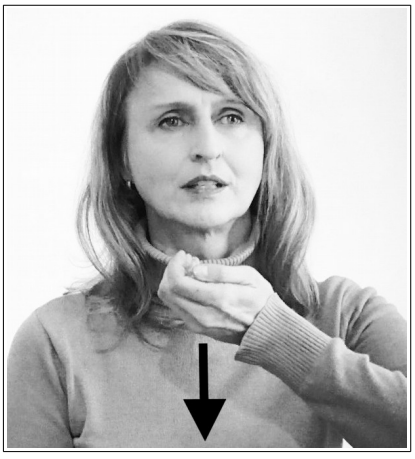
institution, has proved to be useful because the Russian word for fist is so aptly onomatopoeic, and we see many Russian-speaking clients from the Caucasus at our centre. In an earlier article (Regner, 2016), I described the method of narrative exposure (Neuner et al., 2009) that we use within the broader framework of an integrative-behavioural concept of *therapeutic scales* as a *psychological operation*. This is comparable to a surgical procedure by which "capsules of traumatic memory" (implicit "hot" memory) are lifted out of the interior of the self, opened and externalized (transformed into explicit "cool" memory, by means of a *testimony* (Cienfuegos & Monelli, 1983), i.e. a witness statement on experiences of political persecution).[2] In a later article I showed how the psychosurgical intervention can be post-treated with *the body ritual of trauma neutralization* (Regner, 2017). In what follows I shall describe how an explanation of the narrative exposure procedure can be provided as *trauma education,* firstly in order to convey a certain general personal control over the traumatic symptoms, secondly to create a therapeutic frame for the avoidance behaviour that is regularly associated with severely stressful experiences and to explain to clients why such a "psychological operation" is necessary.

The origin and dynamics of the Kulak

The explanation of the trauma model begins with the therapist making a backward and forward oscillating movement of the hand in front of the forehead (see Fig. 1), giving the everyday example of shopping in a supermarket. We stand in front of the bread shelf, take out a certain type of bread and place it in the shopping trolley. This provides information that is taken in by the brain and then compared with the shopping list. The bread to be bought is ticked off, i.e. information processing takes place. Then we might go to the cheese counter and obtain some new information, which is again compared with the shopping list, and so on. This leads to a "flow equilibrium" between information and information processing, experience and experience processing, as represented by the movement of the hand, until all purchases have been made. In Piaget's cognitive developmental psychology one can also speak of a "flow equilibrium" between *assimilation* (integration of information into existing schemata) and *accommodation* (formation of new schemata containing new information), a process commonly referred to as *learning*.

2 The image of a "psychosurgical operation" may seem somewhat drastic at first, but it corresponds to the severity and drastic nature of what the clients have experienced and survived, and is generally very well understood and accepted by them. It also makes it clear that therapy consists of more than simply "talking about problems empathically and supporting them psychosocially", but that these problems are actually treated effectively, which noticeably increases the clients' respect for the procedure.

This flowing learning process as described up to this point applies to how information and experience are processed in the ordinary course of things. The clients are asked to take part in the movement themselves, as in all subsequent steps of the representation. However, the process is clearly different when it comes to extreme, shocking, overwhelming or life-threatening experiences, i.e. *traumas,* for example, during an interrogation in which torture methods are used (see testimony below). (It is true that political traumatisation is usually *complex, cumulative, sequential traumatisation.* For the sake of simplicity and clarity of the model, the following nonetheless focuses on the development of a *monotrauma,* without losing sight of the overall individual and sociological complexity.) Such experiences cannot easily be classified into existing narrative schemata, since these structures – despite all the difficulties and strains that may have been experienced (several times) up to the present moment – are mostly positively charged ("healthy narcissism"), while the "information" that is being taken in is overwhelmingly negative and life-threatening. The flat hand, which has thus far symbolized the incoming information, thus becomes a fearsome *claw* (Fig. 2), which clings, as it were, to the experience and starts to circle destructively inside the psyche (cf. also the phase model of trauma-processing developed by Horowitz, 1986). Yet after the traumatic experience, life must somehow go on. The claw thus literally becomes a terrible "re-minder" ("Er-innerung"), which gradually sinks into the inner self (Fig. 3), increasingly closing into a fist and becoming an uncanny "alien body within the self" (Hirsch, 1996; other expressions used in the literature are "krypta", "phantom", "black hole" etc.). From a psychoenergetic point of view,[3] this compression is caused by the fact that the positively charged self exerts a permanent pressure on the negative memory, which thus becomes increasingly condensed and encapsulated.[4] As a result, the inner energy of the stressful memories increases, the trauma capsule becomes hot, as it were, and finally begins to glow, so that in pictorial terms we can speak of a glowing trauma fist, the *Kulak* (cf. implicit "hot" memory, "hot affects", "hot spots" etc.). With medium stress, a stable self



3 "Psychoenergetic" is used here in the broad sense of an analogy to physical processes, not in the narrow sense of "psychoenergetics" as described by P. Schellenbaum or in depth-psychological "psychodynamics", although there are some similarities.

4 Cf. Laub & Auerhahn (1993, p. 289; bolded text FR), "The different forms of remembering trauma range from not knowing; fugue states ...; fragments ...; transference phenomena ...; overpowering narratives ...; life themes ...; witnessed narrative ... . These ... vary in degree of **encapsulation versus integration** of the experience and in degree of ownership of the memory – i.e., the degree to which an experiencing 'I' is present as subject."

may be able to put the negative memory "under quarantine" – put a warm fist into its trouser pocket, so to speak – and thus keep it reasonably under control. However, following severe to extreme traumas such as torture and/or rape, the Kulak develops an unrestrained momentum of its own; it moves uncontrollably inside the self, where it causes damage to the person's health and leads to the well-known traumatic symptoms on the physical, mental and social level (Fig. 4).

At this point at the latest, many clients say: "Yes, that's exactly how it is: as if something red-hot were constantly moving inside me, damaging and burning me from the inside, especially at night, when I can't distract myself with daytime activities!" Here we first explain that the Kulak can go down as far as the legs – a psychosomatic process which in our experience tends to affect women more than men; quite a few complain that their legs and feet become painful, numb and/or swollen. The "trauma capsule" thus seems to block the circulation in the lower extremities like a thrombosis, resulting in the symptoms described above and also others. In other cases the glowing fist presses on the abdomen and causes stomach or intestinal pain, nausea, loss of appetite and/or constipation. In addition, the Kulak can develop a sting (see Fig. 5) which causes pain mostly in the region of the heart. Several clients report that they have already undergone ECGs. They tell us that the results were negative and that their doctor has told them that the symptoms are psychologically induced and that they should consult a psychologist. Another common symptom is produced when the condensed traumatic memory presses on the chest, resulting in anxiety, breathing difficulties and, when there is additional stress, hyperventilation, panic attacks, frequently also aggressive attacks ("Sometimes I ride my bike into the woods and shout out all the fear and anger that is trapped in my chest as I ride!"). The so-called "Alpdruck" (a German word meaning nightmare), which derives from the "Alp", a ghostly creature that sits on the chest of the sleeping person at night and frightens them, has become proverbial, very impressively depicted in the painting "Nachtmahr" by J. H. Füssli (1802; see fig. 6)[5]. This picture is in fact a precise depiction of the experience of a traumatised person and we therefore sometimes show it in therapy. Finally, the trauma fist moves further up and attacks the neck, again more frequently in women, causing an unpleasant difficulty in swallowing, obstructions in the throat, tension and pain. Both men and women frequently report, however, that they perceive the complaints as coming from outside, that the "Alp" or a similar dark creature not only sits

5 https://de.m.wikipedia.org/wiki/Datei:Johann_Heinrich_F%C3%Bcssli_053.jpg.

passively on their chest or threatens them from behind, but also attacks and tries to choke them. In one young man from the Middle East who had been referred to us from a psychiatric hospital such phenomena had taken on a life of their own and had even become psychotic. In the first session he told us that a few days earlier he had seen the figure of a big, fat, eerie child sitting on his bed at night, saying: "Well, you've just been to the clinic – but there's no hope left for you, so go and kill yourself!" Then the figure had taken hold of him and wanted to kill him, which had frightened him immensely. As his treatment progressed it became possible to reassure him by explaining about the Kulak, which helped him to understand that such threatening figures do not come from outside, but are condensed memories of bad experiences, which are projected outwards by the psyche in order not to have to endure them constantly on the inside. When the hallucinatory figure next appeared to him he immediately remembered the Kulak and was thus better able to distance himself from the frightening apparition. This example shows that trauma education is an intervention in itself which helps clients to develop cognitive and personal control and thus a certain degree of inner security. In this case the young man finally became largely symptom-free and it was possible to discharge him from psychosocial trauma therapy – without him having to undergo narrative exposure in the strict sense of the term.

The general direction of the Kulak's thrust, however, is from bottom to top, into the head (Fig. 7). This is particularly evident in dissociative convulsions or fainting spells, which are not uncommon in severely afflicted refugee women and are difficult symptoms to treat, since the traumatic dynamics have become largely independent and can have serious consequences. Clients (in some cases pregnant women!) may, for instance, fall and injure themselves. What makes up the core of traumatic experiences are *feelings of powerlessness,* which, as described above, condense into a memory complex that is negatively charged and dynamically encapsulated. *The Kulak is therefore a highly charged condensation of powerlessness that rages within the self-agency ("Selbstmächtigkeit", Schmid, 1998) of the subject* and literally knocks it out from inside and below, in other words it can cause a fainting spell! In men, on the other hand, we often find that the feelings of powerlessness are compensated by uncontrollable attacks of aggression that rise to the head, so that the inner trauma fist, imagined or real, turns into an *outer* fist – a trauma-induced potential for aggression and violence that is further intensified by the crowded, stressful conditions in the refugees' shared accommodation and also by certain characteristics of patriarchal cultures, which then in turn have negative effects, primarily on women. Less acute than such attacks of aggression or autoaggression, but very common or in fact a feature of almost all cases are tension headaches. The Kulak may also produce the experience of stabbing in the head, causing piercing and migraine-like pain

(Fig. 8). Clients are told that the heat emanating from the glowing fist rises from bottom to top, as is known from everyday experience. For further illustration we have also found it helpful to use the image of a house in summer in which it gets warmer and warmer on every floor as you walk upstairs, all the heat finally accumulating under the roof, i.e. in the head. From a psycho-energetic point of view, this is the cause of the feelings of pressure and dizziness in the head that clients frequently report and which lead to intrusive thoughts and sensations, nightmares, rumination and even psychosis-like phonemes (see above).

The Kulak and narrative exposure

The explanations described above give clients an easily understandable overview of their traumatic psychosomatics using a dynamic body image that they can actively reproduce, allowing them to gain some control over their symptoms. At this point the question arises as to what the Kulak actually intends and what its ultimate goal is. The point here is not simply to depict the trauma fist in a way that is not merely negative, but in fact to attribute a positive intention to it, i.e. that it wants to heal the self. Here we can use the simple image of a wasp crawling into an empty bottle of lemonade, after which a small boy has pressed a cork into the bottle. What does the wasp then want when it flies wildly around in the bottle, becoming more and more angry and trying in vain to stab the glass wall with its poisonous sting? Here at the latest it becomes apparent that the wasp doesn't really want to sting and harm, but is desperate to get out of the bottle into the open! And how can this be achieved if the main thrust of the hot Kulak – to return to the main image here – is bottom up, into the head? The only opening through which the encapsulated memories of powerlessness can firstly be *brought out again* (see Fig. 9) and secondly be *opened* (see Fig. 10) is of course the mouth! The entire trauma dynamic shown here thus amounts to *expressing* the *implicit* "hot" memory in a controlled and respectful therapeutic process, carefully documenting it, thereby transforming it into an *explicit* "cool" memory that is manifested in the form of a testimony, and empathically reflecting it back to the client. It is thus *narrative exposure in the sense of a psychosurgical intervention,* by which the

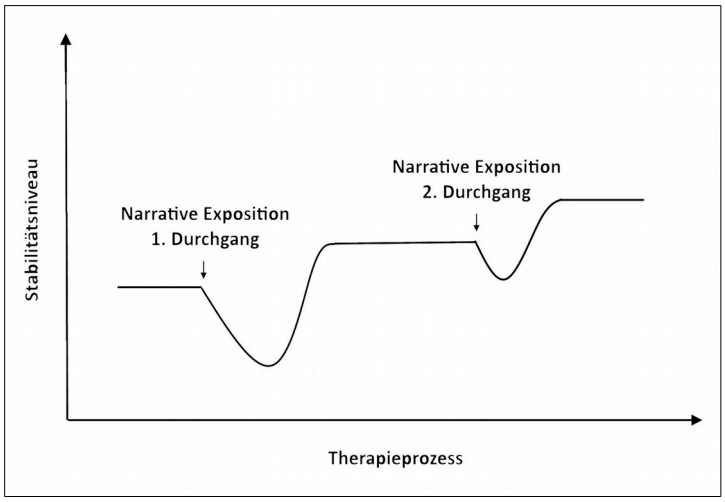
traumatic memory or its affective charge is virtually operated out of the self, explicated in a testimony and finally neutralized by means of certain physical exercises. The clients are told that the terrible memory moves, so to speak, from their head into the report, thus becoming an external memory, and as a result there is less pressure and more space in their head for free and orderly thinking – an effect that is often spontaneously reported at the end of the therapy.

Trauma education using the model of the Kulak is usually easy for the clients to understand, the necessity of the psychological operation is thus recognized and the traumatic avoidance behaviour is placed within a therapeutic frame ("If your dentist tells you that a tooth with a root infection must be extracted to prevent the inflammation from spreading to the other teeth – would you then refuse this intervention because you are afraid of the pain and afterwards have a fat cheek for a week?"). Then there is the willingness and the mental preparation to actually undergo the operation as early in the therapeutic process as possible ("The earlier, the better, because then we will have the worst behind us and everything else will be easier"). But what happens to the encapsulated, affectively condensed memory after the trauma fist has been opened? This content can best be imagined as a *hot acid* that comes out of the capsule through narrative exposure and then takes three paths. Some of the acid evaporates into the therapeutic space, as it were, due to the interpersonal sharing of the personal story. Part of it is still released inside the self during that process and then has to be "sweated out" for self-cleansing – similar to an influenza infection –, a psychosomatic process that often causes fever, tension and physical pain during the post-exposure phase. The third observation is that the previously encapsulated high voltage of traumatic affects (cf. "ball lightning") is now distributed over the entire surface of the skin like a surface tension. This third path taken by the "trauma acid", especially, then offers the therapeutic opportunity to discharge this negative surface tension following the principle of protective grounding, that is from top to bottom into the ground, to wipe it off, tap it off, drain it off, dance it off, wash off the hot corrosive acid with cool water, as has already been described in detail elsewhere (Regner, 2017). It is therefore an exact *reversal of the traumatic dynamic: inside / negative / hot / from bottom to top > outside / positive / cool / from top to bottom,* with a therapeutic effect.

Case presentation: narrative exposure with psychosomatic complications

The case of a middle-aged man from Africa is presented to illustrate the body-related trauma model. After the first testimonio there were some complications, which, however, in fact help to understanding the concept better than the perfect process as shown in Figure 11. In the ideal case, in the pre-exposure phase, there is a mental health baseline characterised by

mainly traumatic, depressive and anxious cognitions and emotions. Then the narrative exposure is carried out, after which the client's well-being shows a clear decline for a few days in the post-exposure phase, which is often associated with an increase in symptoms. Finally, the client recovers – not least through appropriate physical exercises – and the self stabilises at a higher level of relief. This is followed by the second round of exposure, again with a decline in well-being in the post-exposure phase, albeit to a lesser extent and over a shorter period. Finally, the self is strengthened at a higher level of well-being and stability, which is experienced as more inner peace, resistance and self-agency. In the following case presentation (data partly altered), however, the trauma processing took a somewhat different and more complicated course.



"The worst memory of my life dates back to a time many years ago when I was an 18-year-old soldier on the front line in a war between two African countries. During a break in the war there were so many corpses on the battlefield that they could not all be buried. In Africa this has to happen quickly because of the heat, otherwise epidemics will develop and therefore the corpses had to be burned. The military unit in which I was fighting was divided into two: one half, to which I myself was assigned, had to fight directly, belonging to the rear troops that used the heavy weapons; the other, front half had to burn the corpses. So I wasn't involved in the burning of the dead myself, but I saw the piles of corpses, and that was such a terrible sight that it has remained imprinted on my mind since. There were about 2000 bodies, mainly of the enemy army, spread over five or six piles, as far as I could see from about 200 metres, and it took several hours to burn them all. Seeing this in my teenage years was such a terrible experience for me because in my country people are usually buried according to religious custom. I thought that if I were to fall in the war myself, I would not be buried either, but burned in such a heap, and that was an absolutely horrible idea for me. In addition, there was the sight of a human body gradually decaying after death, with all its signs of decay in great heat, and the nasty smells that come from it – and not being buried afterwards, but being burned on a huge heap, I found it completely unbearable and still do."

The post-exposure phase of this testimonio was such that the client, who had suffered from a serious skin disease since childhood, developed a severe abscess in one armpit a few days after the second round of the trauma exposure, during which the testimony had been read out, corrected and added to sentence by sentence. The abscess had to be surgically removed in

hospital. In addition, many pustules had developed on one side of the upper body. This disturbed the client greatly and made him angry; yet after a few weeks he returned to therapy seeking advice and help. Due to the immediate formation of the abscess following the trauma exposure and due to what we have frequently observed in other – less distinctive – cases, it is very likely that there was a psychosomatic link at this point, for which the client had been prepared in advance. The ulceration can be understood as a "sweating out" of the released "trauma acid", and the pustules as a corrosive effect on the skin surface. Accordingly, the client was asked whether he had carried out the recommended physical exercises after the two rounds of exposure – sun-heart posture, rain exercise, empowerment dancing[6] – which had already led to a noticeable reduction in his symptoms in the previous weeks. He said no, however, because he had been so frustrated by his new symptoms that he had not wanted to do anything and had simply withdrawn angrily. He was then told, in a strict empowerment manner, that he should not be surprised because anyone who does not follow his therapist's advice and fails to do anything to neutralize his trauma after exposure, and even facilitates the traumatic reaction through his avoidance behaviour, can become seriously ill! He had been supposed to perform these exercises before the next session. He was advised to adopt the sun-heart posture every day and then lay his hands on the affected parts of the skin for a few minutes. When he came back to treatment three weeks later he had done all the exercises regularly and all the pustules had completely disappeared – whether caused by the exercises and/or other healing factors – and after that complication had been overcome, the further treatment took the ideal course as described above. At the end of the therapy it was possible for the client to give a second testimonio on his time in prison, which is reproduced here in full (data partly altered), since it is important for such eyewitness reports to reach the democratic (professional) public in order to help promote the development of a society consistently based on human rights (cf. Bamber in Regner & Witkin, 2017). [For security reasons, this part is omitted in the English version.]

Therapeutic outcome

What happens to the Kulak after such narrative exposures and testimonies? It retracts back into the self, but only closes halfway. After the affective discharge it contains much less encapsulated acid. The trauma fist becomes, as it were, a limp shell that symbolizes the cognitive memory, but which has largely lost its affective charge, has cooled down psychoenergetically, so that it no longer moves excessively in the self. Thus it can no longer cause any real damage there, and moves in the memory timeline to where it belongs – into the past.

6 Each described in Regner (2017).

For this client, who had initially been diagnosed with a post-traumatic stress disorder, a moderate depressive episode and a somatoform pain disorder,[7] the trauma-oriented psychotherapy following the concept of the *therapeutic scales* and was very successfully completed after three trial and fifteen therapy sessions over a period of eight months. In the last therapy session, which is always used for detailed evaluation,[8] he stated that subjectively he felt his problems and symptoms had been 100 % reduced, that he was extremely satisfied with this result ("like a newborn") and very grateful. (The client explicitly confirmed that his improvement was complete, in response to the therapist's delighted but somewhat disbelieving response. Such a positive outcome is certainly rare after a short-term therapy with the limited goal of *basic stabilization,* which is assessed as an experienced improvement of 70 % or more, especially considering that the client's immigration status was still uncertain and he was living in shared accommodation. It is important to state that This exceptional result is due not least to the client's optimal cooperation. At the end of the therapy he no longer seemed overly concerned on the *cognitive* level and said in the qualitative evaluation that he could now look optimistically into the future. He no longer seemed *emotionally* bitter and said that he now felt much more relaxed and not constantly depressed any more. *Physiologically* he appeared strengthened and was able to treat his headache and skin problems himself; *socially* he seemed much more communicative and motivated other clients as well. What remained were current strains due to the fact that he still had no long-term residence permit and was subject to the stressful situation in the shared accommodation where he lived.

According to the client himself, the decisive factor for the therapeutic success was that he had left every therapy session with a concrete result. The narrative exposure and documentation of severely traumatic memories (see above: burning piles of corpses during the war, several years of imprisonment including torture) enhanced the healing process, as did the various relaxation and physical exercises and the supporting psychosocial programme – the clients' café, table-tennis and psychosocial health counselling – in which he regularly participated. A few weeks after completing therapy, the client received a three-year residence permit, which delighted him and further motivated him to learn German and to seek work. His above testimony had been made available to his lawyer and, according to him,

7 Regarding the symptoms see from the treatment plan: "[In mid-2015 the client stated that] he felt mentally disturbed and therefore frequently complained to the social worker in the shared accommodation where he was living. He reported that it was very noisy there, he would only sleep for an average of four hours and often had nightmares about killings, burned bodies and being maltreated in prison. During the day, he would ponder on his life, of which he had already lost half. The opposite of what he had wanted had happened, all his dreams were destroyed, he felt disappointed and frustrated and wanted to be alone all the time. He could not rest, was very irritable and sensitive to noise, the mere sound of a door opening would make him angry and displeased. Every unexpected noise would make him aggressive, he would immediately feel belligerent and start to tremble. Pictures or conversations that reminded him of what he had experienced reinforced his bad mood, so he avoided them. He sometimes had strong headaches that 'split my head' for days, during which he feared he would lose control and become aggressive. At the time he was only taking medicine for his skin disease, which caused him severe pain. Because of large open wounds, the exact cause of which could not be determined, several treatments of the skin were carried out.

8 The following has been taken from the therapy final report and modified.

contributed to the granting of the residence permit. The client was invited to continue participating in our medium and low-threshold services (e.g. clients' café) for psychosocial follow-up and consolidation, of which he sometimes made use. He submitted his testimonio for human rights work. Unfortunately, the psychotherapy costs were not paid by the responsible social welfare office, but were kindly covered by Amnesty International.

Follow-up one year after end of therapy

The question remains whether such short-term psychotherapies conducted with the *limited therapeutic goal of basic stabilisation* and provided within the framework of an institution specialized in political traumatisation which sees itself as *a bridge to standard care* are appropriate for (severely) traumatised refugees? Is it not necessary to treat traumas which have been caused by "man-made disaster" and thus in the broadest sense by interpersonal relationships from the outset in long-term therapies that are clearly relationship-oriented and "holistic"? Is it not the case that narrative exposures understood as "psychosurgical interventions" possibly merely bring about a short-term, superficial relief effect, the sustainability of which must be critically questioned - and do they not even cause harm in the medium and long term? In order to examine such questions and other similar ones, we have for some time been conducting follow-up sessions on a regular basis about one year (in some cases longer) after the end of therapy. These sessions are based on the final report of the therapy (see above) and ask about further developments in a semi-standardized interview.[9] The results obtained in 20 follow-up sessions to date are that the outcome of the therapy has remained stable or even improved in 85 % of all cases and the reduction in traumatic symptoms in the stricter sense (restlessness, intrusions, brooding, etc.) in 90 % of all cases. An average representative answer would be: "The terrible memories still come into my mind sometimes, you can't forget something like that. But the past no longer controls me anywhere near as much as it used to. It doesn't make me as restless and tense as before therapy and I can now distract myself much more easily and turn to other, positive topics. This improvement has even increased in the year since the end of therapy (also, but not only, because my living conditions have improved in the last year). (It should be emphasized that these results are neither "independent" nor "objective", but can only claim a certain methodological and clinical plausibility. Although attempts have been made to control such variables as "social desirability" or "dependence on the therapist" by communicative means (e.g. "Please don't answer in the way you think I would like to hear it as a therapist, but say how you really feel. That helps us most in the evaluation"), we cannot, of course, completely eliminate bias. For further details see www.inter-homines.org/IH-Brandenburg.pdf.)

9 Many thanks to our interpreter and psychosocial health consultant Denis Shatov, who suggested this helpful evaluative measure.

The follow-up session carried out with the above-mentioned client less than one year after the end of therapy showed the following. According to his own statements, his overall well-being had further improved. *At the cognitive level,* he was still optimistic and trying to realize his plans even more concretely – for example, to visit his family in a country that borders on his native country. He hardly thinks about the bad memories any more, and when he is reminded of them, for example, in a conversation with friends, he becomes a little sad but does not feel permanently affected by them. *Emotionally,* he was generally still relaxed and without bitterness. He did report experiencing irritability and nervousness at times ("In my country they say one is bewitched in such moments"), but that they subsided again after a while and he could easily control them. *At the physiological level* – without sleep medication, which he had taken temporarily during the therapy –, he reported that he rarely had nightmares any more and no longer had any migraine-like headaches, and since shortly after the end of the therapy the extensive skin inflammation for which he had needed four operations, three of them in Germany alone, had no longer occurred. He is still practising the physical and relaxation exercises shown him in the therapy, and is now also doing fitness exercises. His *social contacts* had further increased in the past year. He had, for example, become friends with a Turkish man with whom he can hardly communicate verbally, but whom he still understands perfectly and whose back he sometimes massages. He is still living in a dormitory, which is a strain, but he is intensively looking for his own apartment. He now works half-time in a restaurant and has registered for a German course.

While in the long run these results[10] certainly need to be verified in independent, controlled studies, they show that the ignorance and rigidity with which some health insurance companies (and also some social welfare offices, see the above case) refuse to pay for psychotherapeutic treatment, including interpreting costs, at specialised centres, are not only counterproductive from a human rights and humanitarian point of view. *They are also inconsistent from a business and economic perspective,* since the insurances and authorities are

10 The results of the one to one and a half-year follow-up after the two testimonies described in previous articles were as follows. The female client who had to flee her native country in Africa due to persecution by an Islamic terrorist militia and was raped while on her escape route through Spain was granted a three-year residence permit in Germany at the end of the therapy (the costs of her therapy were assumed by the social welfare office responsible for her). Her testimony probably contributed to her receiving this permit. In the year following the end of therapy, however, she experienced some health crises, not least due to chronic sequelae of female genital mutilation as well as personal stressors (accidents in the family). We thus referred her to psychosocial health counselling in her native language to consolidate the results of the therapy. The client now says that she is as well as she was at the end of her therapy. The basic stabilization, i.e. an experienced improvement of at least 70%, had been achieved and while she still occasionally experienced traumatic memories of the brutal rape, they were significantly weakened and no longer significantly affected her. – The other client from East Africa whose sister was burned to death and who had been on a death row as part of persecution by an Islamist terrorist militia, reported that she had had a strong year after the end of therapy (the costs were largely covered by the social welfare office) and that she was now doing much better than before. She was now working full-time in southern Germany. In this case also, the traumatic memories had not completely disappeared, but they no longer burdened the client excessively.

accepting that they are likely in the future to be faced with additional costs of medium- and long-term additional health problems, in addition to the obstacles to integration that traumatic stress creates – and they are fully aware of this! Instead, health policy should insist that generous exceptions be made when it comes to covering the costs of efficient psychotherapeutic treatment and psychosocial counselling for severely burdened to extremely traumatised refugees. Such human rights-oriented treatments should be based on the principle of self-responsibility and of sustainably and effectively helping people to help themselves.

Health policy recommendations

Psychotherapy with refugees having experienced severe stress and/or traumatisation can be regarded as an intensive interpersonal "laboratory" from which recommendations for broad social and health policy practice can be derived. The following five areas of intervention have proved to be particularly effective and can be instituted on a low-threshold basis.

(1) Empowerment. The guiding principle for dealing with refugees suffering from stress and/or traumatisation should not be a compassionate humanitarian, therapeutic-pathologising or over-empathic caring attitude ("At least every second refugee is traumatised and needs years of culture-sensitive therapy within the framework of a trusting therapeutic relationship"...), but the consistent appeal to the principle of self-responsibility and help for self-help, according to the maxim: *as much empowerment as possible, as much (trauma) therapy as necessary.*

(2) Meta-German courses. According to the empowerment approach, it should not only be top priority to support refugees to learn German as the number one vehicle for integration, it should be insisted upon, for instance, as follows.[11] "You want to live and work here in Germany, don't you? Then I have five pieces of good news for you: 1. Every refugee in Germany has an interesting and challenging job right from the start, up to eight hours a day, and this work consists of learning German as quickly and well as possible, as a prerequisite for everything else. 2. This work is even paid for, if you look at the at least 1,000 Euros on average that the German state spends every month on each refugee as a kind of grant for learning German. 3. In addition, the state provides you with a well-maintained workplace, i.e. the public libraries, many of which are now equipped with learning aids especially for refugees. So if the dormitory is too noisy, too dirty and too socially stressful for you, go to the quiet, tidy city library every day for a few hours and do your work there. If you learn German consistently every day you will also note that it has a therapeutic effect on you. It will structure your day, it trains concentration and memory and provides you with daily experiences of success that will reduce your depression. 5. A good knowledge of German and

11 We frequently present the situation like this in therapy.

progress in integration will increase your chances of staying in Germany longer or even permanently. In all of this, you yourself are your best German teacher, because it is your willingness to learn that matters most! So don't just rely on the conventional German courses, but also learn the language on your own with many different methods ("Meta-German course"), this may even help you more than the usual courses (at least that's what all our interpreters say).

(3) Meditation, mindfulness and creativity. Countless studies and clinical experience show that regular meditation and (creative) mindfulness practice reduce stress and promote resilience – see especially the *Mindfulness Based Stress Reduction* by J. Kabat-Zinn (2011) and the impressive TEDx lecture "Empowerment through Transcendental Meditation" by N. Roochnik & St. Guerrero (2016). Mindfulness thus effectively counteracts the fivefold *stress continuum* described by D. Silove (1999) for refugees suffering from stress-related problems. Meditation is – apart from a few justified exceptions – also indicated in cases of political traumatisation: Quite a few of our clients say at the final evaluation that regular exercises in stillness and concentration were one of the most important components of their therapy. For this reason, mindfulness and creativity-based activities such as meditation, Qi Gong, yoga, as well as music, painting, poetry, etc., should be promoted somewhere in the vicinity of the refugees' accommodation, not least in order to reduce aggression.*(3) Meditation, mindfulness and creativity.* Countless studies and clinical experience show that regular meditation and (creative) mindfulness practice reduce stress and promote resilience – see especially the *Mindfulness Based Stress Reduction* by J. Kabat-Zinn (2011) and the impressive TEDx lecture "Empowerment through Transcendental Meditation" by N. Roochnik & St. Guerrero (2016). Mindfulness thus effectively counteracts the fivefold *stress continuum* described by D. Silove (1999) for refugees suffering from stress-related problems. Meditation is – apart from a few justified exceptions – also indicated in cases of political traumatisation: Quite a few of our clients say at the final evaluation that regular exercises in stillness and concentration were one of the most important components of their therapy. For this reason, mindfulness and creativity-based activities such as meditation, Qi Gong, yoga, as well as music, painting, poetry, etc., should be promoted somewhere in the vicinity of the refugees' accommodation, not least in order to reduce aggression.

(4) Exercise, sport, dance, fitness. As described above, (political) traumatisation manifests itself to a large extent in psychosomatic complaints. Conversely, suitable physical exercises are beneficial to the health of soul and mind. This begins with ordinary sports such as football or table-tennis, becomes more specific with the "physiotherapeutic" types of movement such as running, swimming, cycling, and can also consist of tailored anti-stress exercises that clients can do on their own, such as empowerment dancing. Accordingly, a whole range of physical exercises should be offered in services for refugees and their integration.

(5) Testimonio. Narrative exposure in combination with the trauma education as described above is certainly most effective in the context of a comprehensive therapy programme lasting several months. However, it can – with appropriate changes and precautionary measures – also be applied at a medium-threshold level within the general healthcare service. The aim here is to develop a whole spectrum of suitable formats, including digital formats, which can be used by people who have been traumatised or have experienced severe stress to help them communicate their histories of persecution and injustice and bring them to the notice of the democratic public. However, risks and side effects must be taken into account, because every such publication is also a psychosocial opportunity that is wasted or whose effect is only limited if it is not made use of at the right time or in the right context.

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