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"I Myself Am My Most Important Therapist": Dynamic Containing with a Female Refugee

By Freihart Regner, December 2024[1]

Introduction

Psychotherapy is generally quite effective and promotes health in a comprehensive manner,[2] even though, as with any form of treatment, there are potential risks and side effects.[3] The specific factors responsible for producing therapeutic effects remain, however, insufficiently understood.[4] Early psychotherapy research referred to this lack of definitive scaling as the "Dodo Bird Verdict". The name derived from a character in Lewis Carroll's *Alice in Wonderland,* referred to the tendency for all schools of therapy to appear to yield equally positive outcomes, and therefore are all declared winners and each must receive a prize.[5] Such methods for assessment are indeed striking, for the effective factors postulated by the various approaches stand, in part, in diametrical opposition to one another ("equivalence paradox").[6] Classical psychoanalysis, for instance, holds that disordered experience and behaviour originate primarily in problematic early relationships, which must be reenacted and worked through in the process of "transference". Changes brought about by behavioural therapy, therefore, ought not to occur at all, or could only be of a superficial nature ("symptom substitution").[7] Conversely, classical behaviour therapy maintains that disordered behaviour has been learned and can therefore be unlearned – making therapeutically induced "regressive processes" unnecessary and, under certain circumstances, even harmful.[8] It is certainly true that the dominant orientation of psychotherapy research has, in recent years, become considerably more differentiated. Examples of this shift include comparing the effect sizes of various therapeutic approaches for different clinical conditions according to the "gold standard"[9] of randomized controlled trials (RCTs), adopting the medical model[10] of psychopharmacological research[11] in its emphasis on evidence-based practice, and synthesizing the corresponding findings in meta-analyses[12]. However, none of these methods alter the fundamentally reductionist and fragmentary logic underlying the juxtaposition and comparison of a multitude of therapeutic models and variants.[13] Not least due to the unresolved nature of therapeutic change factors, the landscape of psychotherapy has by now become thoroughly opaque, having fragmented into a multitude of partly identity-based "schools of belief".[14] At least eight paradigms can be identified: psychodynamic, learning-theoretical/cognitive, humanistic, systemic, existential,

transpersonal, body-oriented, and integrative. What's more, within these paradigms more than four hundred distinct therapeutic approaches can be found.[15]

The German Psychotherapists Act, which came into force in 1999, was introduced with the (in principle understandable) aim of curbing this uncontrolled proliferation. Additionally, at least with regard to services covered by statutory health insurance, the act sought to limit reimbursement to a set of "guideline procedures" (Richtlinienverfahren) that have been subjected to rigorous scientific evaluation of their effectiveness. Covered therapies include behavioural therapy, psychoanalysis, psycho-dynamically based psychotherapy, and, more recently, systemic therapy.[16] However, this tactic has continually come at a very high cost, namely, the exclusion from standard psychotherapeutic care of proven beneficial therapies. Rejections were not only of individual schools of therapy, such as person-centred or Gestalt therapy,[17] which have proven themselves internationally over decades but have been excluded on the basis of highly questionable scientific reasoning, but also of entire paradigms – such as the humanistic approach, which has undeniably made essential and lasting contributions to the development of psychotherapy.[18] However, scientifically dogmatic regulatory rigorism does not mean that Gestalt therapy no longer plays any role in standard care in Germany. In fact, via the back door of the so-called "third wave of behavioural therapy"[19](which in contrast to previous "waves," places increased emphasis on relationship, emotion, and mindfulness) therapeutic principles are suddenly being recognised and made eligible for reimbursement that have, for decades, been practiced and cultivated above all in Gestalt therapy.[20] (One may already look forward with some anticipation to the "fourth wave," which will presumably emphasise the body and the transpersonal–spiritual dimension.)[21] This also includes schema therapy which is assignable to cognitive behavioural therapy and thus eligible for reimbursement through statutory health insurance. It should be noted that this therapy ultimately constitutes an amalgam of behavioural, psychodynamic, and Gestalt therapy concepts.[22]

The situation described above is highly unsatisfactory from the perspective and within the tradition of a *Clinical Philosophy* and in keeping with the practice of the founder of Integrative Therapy, Hilarion G. Petzold. Integrative Therapy is concerned with a comprehensive theoretical reflection on psychotherapeutic practice[23]. In this framework, the therapeutic profession presents itself as incoherent and inconsistent, often one-sided to the point of ideological bias – scientistic, profile-driven, and polemical[24] while the essential nature of psychotherapeutic communication remains unresolved.[25] Against this contested backdrop, the following position will present an ontotherapeutic process model and illustrate it by means of a case study. The term "onto-therapeutic" (from the Greek *ontos:* being, essence, and *therapeutein:* to care for, to serve, to heal) does not imply the mere addition of yet another variant to the already vast array of therapeutic models. Nor does the process model bring together a multitude of empirical individual studies from psychotherapy research into a generic framework[26]. Neither does it undertake a statistical meta-analysis aimed at identifying common factors across therapeutic schools.[27] Rather, *through systemic–phenomenological reflection, the aim is to grasp and describe the essential core and fundamental dynamics of the psychotherapeutic process* of which the various therapeutic approaches each represent a specific articulation and conceptual elaboration.[28] We refer to this ontotherapeutic model as *Dynamic Containing*. It is a delib-

erately simple, illustrative, and practical design of a *double container* enclosing a *double helix*. The model thus consists of two times two, correspondingly four, interrelated components, which will first be presented in graphic form and then explained in terms of their content.

Dynamic Containing

1. Self-Containing. In the sense of clinical philosophy, the human being can be understood as a bio-psycho-social entity composed of five layers: body, soul, mind, spirit, and community which exists in constant interaction with both its external and internal environment.[29] This extreme complexity necessitates demanding processes of adaptation, which are widely referred to in clinical psychology as *self-regulation*.[30] However, in order to render the model applicable to psychotherapeutic practice, the term *Self-Containing* is used here instead.[31] What is meant by this is that though at times burdensome, tension-laden, and conflictual these psychological elements, states, processes, and (centrifugal) forces must be held and integrated by the ego. That is to say, *contained,* in order to sustain a stable, coherent, and healthy experience of self.[32] For a wide range of reasons, however, the psyche may become overwhelmed, leading to distressing problems, up to and including psychological symptoms across the entire spectrum of psychopathology.[33] Figuratively speaking: the vessel of the Self-Container overflows with problems, complaints, and symptoms.[34]

2. Therapeutic Containing. An individual with insufficient self-containing may ultimately seek psychosocial or psychotherapeutic support and begin to speak about or express in nonverbal ways their psychological problems and complaints.[35] The overflowing vessel of the self is then held and supported by a therapeutic container, hence the term *double container.* The technical term *containing* originates from the psychoanalyst Wilfred Bion and refers to the vicarious "digesting" and processing of early, raw emotional states ("beta elements") by the analyst, who then returns them to the analysand in a more emotionally mature and symbolisable form ("alpha elements")[36]. Donald Winnicott describes the conceptually related *holding* as a therapeutic process of providing psychological and emotional support, analogous to early childhood experiences of being held.[37] *In Dynamic Containing, however, the term is understood in the broadest possible sense: as the receiving, encompassing, and holding together of all problems, com-*

plaints, and symptoms brought into psychotherapy by the client. The ontotherapeutic understanding of the therapeutic relationship as containment thus differs categorically from that found, for example, in classical psychoanalysis (working alliance / working through of transference), classical behaviour therapy (e.g. teacher / student), Gestalt therapy (contact cycle), transpersonal therapy (spiritual guide / seeker), or Integrative Therapy (co-respondence).[38] Rather, these and other concepts of the therapeutic relationship are here regarded as variations and specialisations of a *fundamentally underlying ontotherapeutic relationship here referred to as Dynamic Containing*.[39]

3. Psychotherapeutic Interventions. Within the Dynamic Container, or double vessel, the first strand of the double helix comes into play: targeted psychological interventions designed to produce specific therapeutic effects.[40] The therapy schools here assume specific factors to be effective in each case.[41] For example, psychoanalytic dream interpretation aims to make unconscious conflict laden material conscious, "Where id was, there ego shall be"; behavioural reinforcement schedules are intended to establish desired conditioning; and Gestalt experiments aim to stimulate personal growth. Contemporary psychotherapy research focuses primarily on these specific factors of effectiveness, as described above, by conducting randomized controlled trials and synthesising their results in meta-analyses.[42] In addition, a range of *nonspecific or common factors* are assumed to contribute to therapeutic effectiveness, such as social support, sustained attention, recognition, care, the instillation of hope, relief, clarification of problems, reality testing, and psychological empowerment, to name but a few.[43] These factors, however, are difficult to capture through experimental quantitative psychotherapy research due to their individuality, subtlety, and complexity,[44] and are therefore more commonly investigated by qualitative psychotherapy research, which is, however, less widespread and less widely recognised.[45]

4. Therapeutic Self-Organisation. Neither the various schools of therapy nor the dominant strands of either quantitative or qualitative psychotherapy research sufficiently account for the fourth component of Dynamic Containing: the self-organisational processes that, catalysed by therapeutic containing, take place within the self-container.[46] Such autonomous processes are touched upon in the framework of nonspecific factors,[47] yet they merit an independent consideration. Unlike the third component of Dynamic Containing, they do not follow an interventional logic, but rather a logic of *autopoietic self-organisation,* in which the therapeutic container merely functions as a stimulating environment.[48] The perspective, then, is not interventional, meaning from the therapist directed toward the client, but rather receptive and autonomous, from the client directed toward the therapist. These autotherapeutic processes do not follow a linear cause and effect principle; instead, they unfold in an autopoietic, circular, emergent, and discontinuous manner – often unexpectedly, surprisingly, spontaneously, and creatively guided by the client's intrinsic self-healing capacities.[49] At the same time, however, self-healing is inextricably intertwined with therapeutic interventions,[50] which is why it is represented in the Dynamic Containing model as an upward-spiralling double helix. If one finally includes the (psycho)energetic dimension in a systemic overall perspective, the regular therapy sessions may be conceived as a flame beneath the double container.[51] In turn, ensuring a continuous supply of energy, through which the thera-

peutic system gradually heats up, leading to catalytic processes of change and, in most cases, improvement.[52]

Case Study

Ms. N., a middle-aged woman from an African country, was referred to our institution by a church-based organization.[53] She had previous psychological training and had already undergone psychotherapy for several years in her home country. Heavily pregnant with her first child, she was forced to flee because her husband, a high-ranking government official, had been severely threatened by the ruling militia. While in transit on her way to Germany, she gave birth to her child under difficult circumstances in a third country and was eventually granted a visa after several months. The couple attended the initial interview at our centre together. Ms. N. presented with traumatic, depressive, anxiety-related, exhaustion-induced, and somatic complaints, all of which had intensified significantly since the birth of her child. In addition, there were serious marital difficulties. The following case study focuses primarily on Ms. N. Her psychosocial counselling and psychotherapy can be structured into five phases, which will be examined through the lens of the Dynamic Containing model described above.

Phase 1 (8 months): Native Language Psychosocial Health Counselling

At our centre, we follow a stepped care model of service provision.[54] This means that, whenever possible, clients are initially supported through mid-threshold Native-Language Psychosocial Health Counselling (NLPHC) following the intake interview. Only if this intervention proves insufficient, or if the case is assessed as severe from the outset, are clients referred to the high-threshold level of psychotherapy or specialised psychosocial trauma counselling.[55] The core idea of NLPHC is to offer refugee clients focused and pragmatic support in order to foster psychosocial health orientation, emotional stabilisation, and social integration over a manageable period of time which is ideally several months, though often longer (a more detailed account is provided elsewhere).[56] Accordingly, Ms. N. was referred to a colleague with whom she engaged in a series of supportive counselling sessions aimed at emotional relief and practical assistance. She initially appreciated these conversations, attended them willingly, and even reported early signs of improvement. Throughout the process, we repeatedly clarified that this was not a form of psychotherapy. However, her health condition deteriorated following an emotionally taxing surgical procedure and the recurrence of domestic violence – a factor that had not been disclosed during the initial intake.[57] (The husband had also been offered NLPHC, but he made use of it only sporadically and without significant engagement.) After several months, the therapy-experienced client began to express dissatisfaction, stating that the mid-threshold intervention was not sufficient. She independently searched for options for native language online psychotherapy abroad and announced that she might discontinue all support offered at our centre, as it did not appear sufficiently effective to her.

Interpreting Ms. N.'s story through the ontotherapeutic model of Dynamic Containing, it becomes evident that her capacity for self-containing was no longer sufficient to cope with the psychological burdens resulting from persecution, flight, family and marital conflict, domestic

violence, and physical exhaustion.[58] Against this backdrop and informed by her psychological background, she turned to our institution in search of psychosocial-therapeutic containing: to be held, externally supported, and professionally held together in the face of overwhelming pressures.[59] According to the client's own account, the Native-Language Psychosocial Health Counselling was initially able to provide this holding function through its supportive conversations (Double Helix Strand 1, positive). However, over the medium term, it proved insufficiently effective, as additional existential stressors emerged in the course of the counselling process (Double Helix Strand 2, negative, "downward spiral").[60] At this point, it becomes clear that mid-threshold psychosocial counselling and high-threshold psychotherapy, while both grounded in the same principle of Dynamic Containing, differ significantly in terms of their clinical-psychological scope, intensity, and degree of intrusiveness. They must therefore be conceptually assigned to distinct levels of intervention.[61] If the dominant (German) psychotherapy discourse assumes it can establish itself as an independent profession by relying solely on "scientifically recognised guideline approaches" and drawing strict boundaries between itself and other forms of psychotherapy and counselling,[62] this appears to stem more from scientific and health policy reductionism than from the lived realities of psychosocial-therapeutic practice.[63] These realities which are particularly evident in centres for politically persecuted individuals, are shaped by especially complex and multilayered challenges.[64]

Phase 2 (2 months): "The House of Health"

After the mid-threshold intervention had proven insufficient, Ms. N. was offered a transition to high-threshold psychotherapy. Somewhat unexpectedly, given her previously expressed dissatisfaction, she accepted the offer.[65] Over the past years, a praxeological concept[66] has taken shape at our centre – one that applies equally to psychosocial health counselling and to psychotherapy. We refer to it as "The House of Health" (a detailed account including references can be found elsewhere).[67] The model uses the metaphor of a house to be built jointly, resting on four foundational pillars. These pillars must be in place to provide a stable base on which the higher floors of psychotherapeutic intervention can be constructed. The first pillar involves clarifying the client's *medication*. In Ms. N.'s case, her exhaustion appeared to have physical components as well, and she was therefore referred to our general practitioner, who conducted relevant examinations and prescribed appropriate medication or recommended nutritional supplements. The second foundational pillar consists of *body-based self-care exercises* – most notably Empowerment Dancing, a complex anti-stress practice we have developed. It draws on elements of bioenergetics, Somatic Experiencing, and Wing Tsun Kung Fu.[68] Although the exercise had already been introduced during the initial sessions, its fundamental importance for mental health was once again emphasised at the beginning of psychotherapy. The third pillar is a *structured daily routine*. Unlike many other clients, Ms. N. as a young and engaged mother showed no deficits in this area.[69] The fourth and final pillar is the *future perspective*. In the course of therapeutic exploration, it became clear that the client envisioned her future together with her husband. This was despite considerable marital difficulties and the fact that the recurring domestic violence had by then become a matter of police and child protection services.[70] Nonetheless, Ms. N. did not wish to endanger her young family. Despite her

husband's patriarchal conditioning, she recognised in him a considerable capacity for insight and change which in her view was a potential that simply needed to be supported and encouraged.[71] Both aspired to have their academic qualifications recognised in Germany and to complete their studies. Further interventions included psychoeducation and trauma education, as well as sociological reflection on patriarchal structures and intercultural understanding.[72] The client embraced all suggestions, practised the exercises diligently, and reported noticeable improvement; including in her husband, who, since the start of her therapy, had become more supportive and cooperative in their relationship.[73]

The therapeutic container can be understood metaphorically as the walls and roof of the House of Health, within whose floors and rooms psychosocial interventions and therapeutic self-organization take place.[74] Containing, in this sense, is by no means merely a formless act of holding or support; rather, the necessary structure must be derived praxeologically from the specific problems faced by clients – in this case, individuals burdened by psychological distress or trauma, such as refugees.[75] In other words, psychosocial and therapeutic concepts must adapt to the problems and symptoms presented by the clients and not the other way around. It would be inappropriate to expect clients to conform with the conceptual preferences, or even the ideologically charged assumptions of particular schools of therapy.[76] Nor should clients be subordinated to the so-called "guideline procedures,"[77] or to the research agendas, influence strategies, reputational interests, or funding priorities of certain academically remote university institutes and clinical departments – particularly in the field of psychotraumatology.[78] The House of Health, and more broadly, the concept of Dynamic Containing, does not stand in isolation, but is situated within a community that symbolically represents society as a whole.[79] According to the German Basic Law (Grundgesetz), this society is committed to the protection of human rights.[80] Consequently, psychosocial and psychotherapeutic practice must likewise be shaped and permeated by these fundamental rights.[81] We refer to the corresponding conceptual framework as Normative Empowerment (NE), which may be described as a human rights–based form of enabling self-help.[82] Within the NE framework, five sociopolitical dimensions are distinguished: power, law, truth, freedom, and publicness; from which five corresponding psychosocial-therapeutic strategies can be derived: em-powerment (Er-mächtigung), en-justicement (Er-rechtigung), pursuit of truth (Er-schließung von Wahrheit), liberation (Er-freiung), and publication (Er-öffentlichung). A functioning democratic constitutional state also includes the state monopoly on the legitimate use of force, which is a principle that prohibits the exercise of violence within the private sphere and, where necessary and appropriate, places those affected under police or child protection.[83] At the same time, this monopoly on violence is democratically legitimized – that is, state authority ultimately derives from the people, from the totality of citizens, which also includes refugees. Accordingly and as exemplified for instance in the case of Ms. N, the individual process of empowerment must be brought into a well-balanced relationship with the collective sovereignty of the democratic state.[84]

Phase 3 (2.5 months): Stabilisation following domestic violence

When Ms. N. returned to her session after the initial stabilisation phase described above, she appeared demoralised and visibly affected. Following a recurring pattern, her husband had once again become physically aggressive, declaring, "I am the man here; I make the decisions." Although the violence had not been severe, it had left minor visible injuries, which Ms. N. showed voluntarily.[85] The session was highly charged and serious, particularly because her husband was already known to the police, and it was now imperative from our side to ensure the protection of both the child's welfare and the client's physical and emotional safety.[86] Nevertheless, Ms. N. explicitly insisted that the authorities not be notified. She regarded her husband as a victim of patriarchal socialisation who (unlike many other men shaped by similar patterns) was showing genuine insight, remorse, and willingness to change.[87] In the following step, we arranged a joint session involving both partners. This session was also attended by the husband's psychosocial health counsellor, who also serves as our centre's psychosocial legal advisor.[88] During this session, the husband indeed presented himself as open, understanding, and willing to change. According to Ms. N., he was motivated by the shared responsibility for their child, for whom he was actively caring.[89] The cultural and psychological roots of his violent behaviour were discussed, and behavioural techniques for violence prevention were demonstrated.[90] Furthermore, an agreement was reached to refer him to psychotherapy, which some time later was successfully initiated within the framework of a psychiatric outpatient clinic.[91]

The third phase of therapy vividly illustrates a point already touched upon in the context of Normative Empowerment. This point is that sociopolitical dimensions must be incorporated into the practice of Dynamic Containing, with consideration of how flexibly the concept should be applied.[92] The psychosocial-therapeutic setting can, in this sense, serve as a mediator and agent of social integration.[93] Had the family dynamic in this case been left to the automatic functioning of social subsystems, it is likely that the husband's pattern of patriarchal violence would have persisted. The state's legal apparatus would then have had to intervene and impose sanctions, possibly alongside child protective services, and the young family might well have been crushed in the machinery of institutional response.[94] Instead, a kind of mediation was able to take place within the "soft" and empathetically moderated psychosocial-therapeutic container. This allowed for a degree of stabilization both of external circumstances and internal states. It facilitated a transference of the man's repeatedly bursting vessel of self, overwhelmed by uncontrollable aggression, into a psychotherapeutic container outside our institution. This move carried the "risky opportunity" for him to undergo a profound and lasting transformation in behaviour.[95]

Phase 4 (3 months): Self-Empowerment

Following the couples counseling and the therapeutic perspective that had also been extended to the husband, he succeeded in better managing his aggressive impulses, distracting himself when necessary, and taking care of the child. At the same time, Ms. N. was able to establish a

certain emotional distance from him and to focus on herself guided by the maxim "right now, I'm no longer dependent on him".[96] Since she tended to strongly identify with different states of consciousness and roles and to shift between them, she was introduced as part of the psychoeducation process to the concept of Ego State Therapy.[97] This therapy focuses on working with various parts of the personality in different contexts. She went on to explore the topic further on her own initiative and developed plans for her respective self-states. A key role in this process was played by her efforts to learn German. She had met a fellow migrant woman who, despite having lived in Germany for several years, still spoke little German. The two began meeting regularly to practise the language and Ms. N. made such significant progress that, for a time, therapy could be conducted in German rather than in English, as had previously been the case.[98] In this context, she was asked one of our standard questions: "Who is your best and most important German teacher here in Germany?" The generally correct answer is: "I am!". In the following therapy session, the client reported that she had reflected on this question and applied it to her therapeutic process, arriving at the insight: "I am also my most important and best therapist!". This observation was immediately affirmed by the psychologist.[99] In line with this realization, she made every effort to support her own healing: a prescribed medication helped her regain weight and overcome her exhaustion; she regularly practised the recommended physical exercises and felt more energetic and active overall. She had developed a more nuanced view of her own personality, pursued her goals with determination, and was ultimately one of the few participants in the course to pass the B1 German language exam. She joyfully sent us a photo of her certificate and reported a subjectively perceived improvement of 65 percent compared to her condition at the initial consultation.[100]

The fourth phase of therapy points most clearly to the fourth component of Dynamic Containing: client-based therapeutic self-organisation.[101] Prompted by the question regarding the best German teacher, Ms. N. chose to become her own best and most important psychotherapist. This remarkable act of psychological self-empowerment enabled her to pursue her life goals with even greater determination.[102] Whereas the term self-organisation is used here in a more general, systemic, and decentered sense,[103] the notion of self-empowerment designates the client as an agent of self-efficacy and purposeful action.[104] It is worth noting that the attending psychologist had long worked within an empowerment-oriented framework (as found in this text's earlier discussion of Normative Empowerment). However, despite his breadth of experience the therapist was exceptionally positively surprised by this explicit adoption of perspective on the part of the client. Since then, her response has been shared with other clients as a model for observational learning.[105] In terms drawn from Ego State Therapy,[106] Gestalt Therapy,[107] or Psychodynamic Imaginative Trauma Therapy,[108] one might say that individuals possess, within their repertoire of internal roles, the potential figure of the *Inner Psychotherapist*.[109] So that they activate a helpful internal agent whose task is to maintain self-containing and to respond to inner and outer pressures, burdens, and injuries with support, healing, and containment in an increasingly complex, demanding, and at times overwhelming "psychological society."[110] A central task of the therapist, then, would be to serve

initially as an external model for the Inner Psychotherapist, in order to gradually activate and ideally establish this internal figure as a lasting resource.[111] This approach is also supported by our own follow-up interviews,[112] which indicate that clients generally reported feeling noticeably better one to two years after the end of therapy, as if the therapeutic dialogue had continued to resonate within them. It became particularly evident during the final phase of therapy that therapeutic self-organisation and self-healing have their limits and that, in moate to severe cases, self-containing still relies on external therapeutic containment in the sense of the dual-container model.[113]

Phase 5 (2 months): Narrative Exposure

As described above, Ms. N. had made considerable therapeutic progress within a few months. Nevertheless, she continued to struggle with one central burden that she could not overcome on her own: she was unable to forget or forgive her husband for what she experienced as abandonment and "betrayal" during the profoundly difficult and vulnerable period surrounding the birth of their first child.[114] Although he had expressed remorse and repeatedly apologised, she remained tormented by the question of how he could have behaved in such an irresponsible way. Especially in moments of loneliness, these ruminations would trigger uncontrollable anger and, subsequently, severe and irreconcilable reproaches directed at her husband, which placed considerable strain on their relationship.[115] On a bodily level, these obsessive thoughts manifested as a recurring, painful pressure in the forehead.[116] Ms. N. herself drew a connection to her childhood, in which she had been forced to assume responsibility for her family at a very early age.[117] In therapy, the initial task was to clarify a difficult question: were these ruminations existential in nature,[118] in the sense that the marital relationship had, from the client's perspective, suffered a fundamentally unforgivable breach of trust – or was she, in fact, willing to forgive, but hindered by a traumatic interpersonal memory that was now manifesting as compulsive rumination?[119] The client, who had considerable psychological insight, believed the latter to be the case. She was therefore offered, as part of psychoeducational guidance, the possibility of engaging in a narrative exposure of the distressing memory employing a trauma-therapeutic procedure to which she immediately agreed.[120]

In the first round of this "psychological trauma operation," in which the memory, which was shaped by deep helplessness and despair, was recounted in detail and documented sentence by sentence. This process proved to be highly emotional and was accompanied by intense grief, severe psychic pain, and powerful bodily sensations.[121] Normally, we conclude the narrative exposure with a body ritual of trauma neutralisation: the therapist repeats the narrated episode and, following the principle of protective grounding, figuratively transfers its affective charge into the earth, in line with the Albanian proverb: "What the body cannot carry, the earth can."[122] In Ms. N.'s case, however, this was not possible because she was too emotionally unsettled, and a full recapitulation of the trauma narrative would have clearly been overwhelming to her.[123] Instead, a brief and symbolic version of Empowerment Dancing was practised,[124] in which the hands are placed on the ground at the end of the ritual. The client ap-

peared visibly relieved and stabilised afterwards, remarking that although she had previously engaged in Empowerment Dancing on a regular basis, it was only this time that she truly experienced its tension-reducing effect. In the second round of the narrative exposure two weeks later during which the *testimonio* was revisited, her level of tension had already decreased significantly. She was able to revise and supplement her account in a composed state and reported feeling markedly better and relieved overall.[125]

The narrative exposition in the case of Ms. N. points first and foremost to the third component of Dynamic Containing: the psycho(trauma)therapeutic intervention.[126] This technique is employed to deliberately push the self-container to its breaking point at a neuralgic spot, so that the disturbing memory can be held within the trauma-therapeutic container, while at the same time keeping the destabilised self intact.[127] The focused narrative exposition or, when the entire life story is processed via Narrative Exposure Therapy (NET),[128] is in our *Four-Frame Model* (see final diagram, fourth frame), and is embedded within the concept of the *therapeutic scales* (third frame).[129] That is to say, there is a literal weighing of whether, when, and at what phase a more trauma-focused or a more resource-oriented approach is indicated. The therapeutic scales are in turn held within the psychosocial *"House of Health"* (second frame) described above, which provides a broad, integrative, and stable foundation for psychotherapeutic interventions.[130] Finally, the House of Health itself is framed by the sociopolitical concept of *Normative Empowerment* (first frame), grounding psychosocial (trauma)therapy in a human rights–oriented perspective and normative orientation.[131]

The four conceptual frames support and interpenetrate one another. The five strategies of Normative Empowerment described above as em-powerment, en-justicement, pursuit of truth, liberation, and publication, find their clearest and most concrete expression in the *testimonio,* which is a therapeutically generated report developed through narrative exposure.[132] Ms. N.'s testimonio, for instance, is a striking document that sheds light on the humiliating conditions endured by women within modern patriarchal societies and structures.[133] Implicitly, it calls for: (1) the empowerment of women through civil society, (2) their legal protection when other "protective systems" fail, or worse, become instruments of repression, (3) the truthful documentation and processing of such oppression, (4) their liberation from coercive social structures (as captured, for instance, in the Iranian slogan "Woman, Life, Freedom"), and (5) the appropriate public dissemination of histories of persecution, all of which are something that this very text seeks, at least in outline, to achieve.[134] All of this is intended to stimulate the fourth component of Dynamic Containing, therapeutic self-organisation and self-empowerment. Such that, in a final expansion of the model, both the self-container and the psychosocial-therapeutic container must ultimately be seen as contained within a larger (global) sociopolitical and human rights–based container.[135]

Conclusions and Outlook

In the final therapy session, during which an evaluation interview is always conducted, Ms. N. reported a subjective improvement of at least 90% compared to the beginning of therapy.[136] She stated that she now felt calm and balanced, occasionally sang, and had even spontan-

eously danced in the street not long ago.[137] In comparison to previous interventions, she had experienced this psychotherapy as particularly profound (especially the narrative exposure work toward the end) and was now considering learning the method herself, perhaps with the aim of applying it in the future.[138] In response to the first *general evaluation question* asking what had helped her most in achieving such significant improvement, she expressed her gratitude that sufficient time had always been taken to speak with her. This had enabled her to develop a life plan for Germany, something she had previously lacked.[139] Additionally, she had found the second round of narrative exposure particularly helpful, during which she was able to view her distressing memory from a more distanced perspective, as if watching a film.[140]

Questions then followed concerning changes on various psychological levels. With regard to *cognition,* Ms. N. stated that she had at times previously felt worthless and lonely, but now understood that one should talk to others about one's problems, and that one lives not only for one's child but also for oneself.[141] Prior to therapy, she had predominantly experienced negative *emotions* toward her husband; now, she reported feeling positive emotions for him once again.[142] Overall, she felt stronger and more courageous. *Physiologically,* she had previously suffered from sleep disturbances and nightmares; today, she was able to sleep through the night without difficulty.[143] The pressure and pain in her forehead, present since the birth of her child, which had been accompanied by difficult circumstances, now occurred only in response to specific associations and had significantly diminished.[144] In the *social domain,* her family situation had markedly improved, and her husband was now also engaged in therapy with renewed motivation.[145] Regarding her *memory,* she reported that the traumatic complex related to the birth of her first child had largely resolved; another distressing topic was now tolerable, and she intended to continue working through it independently.[146] She practiced *self-care body exercises* regularly, especially Empowerment Dancing, and had even begun teaching it to others.[147] As a *future perspective,* she expressed a wish to work for a children's aid organization in Germany and to provide psychosocial support herself.[148] A follow-up interview conducted six months after the end of therapy revealed that the treatment effects had been sustained and had even further improved.[149] Domestic violence, which had been present until the fourth phase of therapy described above, had not recurred, and according to the client, her marital relationship was now characterized by love and partnership.[150] She was offered additional follow-up counseling in case of future crises.[151]

The eight-month psychosocial health counselling followed by ten months of psychotherapy with Ms. N. unfolded in accordance with the ontotherapeutic process model of Dynamic Containing. Due to the manifold strains and challenges she faced, the client's *self-containing (Component I of the model)* was no longer sufficient to sustain a coherent experience of self or a future-oriented approach to life. Against this background, and drawing also on earlier therapeutic experiences, she sought *psychosocial-therapeutic containing (Component II),* in order to be held, supported, and contained from the outside. Within this therapeutic container, both *psychosocial and psychotherapeutic interventions* were carried out *(Component III),* ranging from the highly specific to the more general. Taken together, these elements catalysed and stimulated

Ms. N.'s psychosocial and *therapeutic self-organisation and self-empowerment (Component IV),* culminating in her statement: "I myself am my most important psychotherapist."[152]

The psychotherapeutic interventions drew upon a wide range of paradigms: *psychodynamic* ("There appears to be an (unconscious) connection between the early responsibility you took on as a child and how you are currently experiencing your family situation"),[153] *cognitive-behavioural* ("Try to see your situation in Germany as an opportunity for a new life – and ideally, write that down as well"),[154] *humanistic* ("It's truly remarkable that, despite everything, you're willing to give your husband a second chance"),[155] *systemic* ("Let's arrange a couples session – and feel free to bring your little daughter along"),[156] *existential* ("Perhaps you shouldn't delegate the meaning of your life entirely to your child"),[157] *transpersonal* ("Do God and religion play a role in your life?"),[158] *body-oriented* ("Anti-stress exercises such as Empowerment Dancing are as essential for mental health as brushing your teeth is for dental hygiene"),[159] *trauma-therapeutic* ("Narrative exposition is a bit like a somatic operation – as if removing an inflamed abscess"),[160] *integrative* ("You're telling me about your problems, and I'll draw on all the evidence-based theories, methods, and techniques I know as a clinical psychologist to support you in the best possible way").[161] In addition, a number of *non-specific interventions* – by no means to be underestimated in their effect – also played an important role (e.g., "We can talk regularly here about your life challenges; I will always listen to you patiently, and if anything urgent comes up, you can call me or our general practitioner at any time").[162]

It is impossible to "evidence-base" (in the narrow sense)[163] this entire interplay of paradigms, approaches, schools, methods, and techniques and above all, their highly complex interweaving in the sense of a creative psychological craft.[164] Nor can they be codified into fixed "guideline procedures".[165] On the contrary, in the long term, such a move can be even detrimental, if not harmful. It risks fragmenting the profession of psychotherapy, reducing it to a scientistic patchwork and simultaneously cementing it into rigid procedural blocks.[166] While in actual lived practice, therapeutic work follows its own (intuitive–eclectic) logic. A genuinely adequate *general psychotherapy for the future* must instead begin by using clinical philosophy, praxeology, and phenomenology to grasp the *ontotherapeutic essence*[167] of the curative process. From this grounding, one can move, with *transversal reason,*[168] into the various therapeutic paradigms. Both to acknowledge and honour the rich and diverse tradition of more than 120 years of psychotherapeutic theory and practice, and at the same time to relate this plurality to a shared therapeutic ground.[169] Within such a clinical-philosophical framework, it would be essential to advance empirical research in integrative psychotherapy.[170] For instance, building on the seminal *Contextual Meta-Model* of Bruce E. Wampold and Zac E. Imel, with which Dynamic Containing shows substantial agreement, albeit with certain differences.[171] Quantitative-experimental research following the "medical model" should, of course, continue to be pursued, but under the metascientific criterion of appropriateness to the subject matter, it should no longer be regarded as the sole dominant "gold standard".[172] Rather, it should be integrated into and subordinated under a broader, pluralistic programme of social-scientific research.[173] The essential core of psychotherapy proposed here has been described in terms of *Dynamic Containing*, which is understood as a general ontotherapeutic theme from which the various schools of therapy may be regarded as specific variations and

elaborations, or in some cases even as psycho-ideological overlays. The concluding diagram illustrates how Dynamic Containing is integrated within our institution into a Four-Frame Model specifically developed for psychosocial-therapeutic work with refugees.

1 Uploaded on 23 December 2024. A shortened version was publ. in: **Psychotherapie-Wissenschaft 15 (2) 2025 27–34, https://psychotherapie-wissenschaft.info/article/view/1664-9583-2025-2-27/pdf.**

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31 Cf. Bion, W. R. (1962): Learning from Experience. London: Heinemann.

32 Cf. Kohut, H. (2016): Die Heilung des Selbst. Gesammelte Werke, Bd. 6. Hrsg. v. Rass, E. & Köhler, L. Gießen: Psychosozial.

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34 J. D. Frank: "[... The hypothesis is] that demoralization characterizes all individuals who seek psychotherapy, and that it is the primary reason they enter treatment. It is claimed that the effectiveness of all forms of psychotherapy is based on features they share in common – features that counteract demoralization." (Ibid., 1992, S. 468 f: Die Heiler: Wirkungsweisen psychotherapeutischer Beeinflussung: Vom Schamanismus bis zu den modernen Therapien. Stuttgart: Klett-Cotta. Transl. by FR).

35 For example, in times of crisis: Deutsche PsychotherapeutenVereinigung (2023): Report Psychotherapie. Sonderausgabe: Psychische Gesundheit in der COVID-19-Pandemie. Berlin: DPTV.

36 Bion, W. R. (1962): loc. cit.

37 Winnicott, D. W. (1965): The Maturational Processes and the Facilitating Environment: Studies in the Theory of Emotional Development. London: Hogarth Press.

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43 Wampold, B. E. & Imel, Z. E. (loc. cit.).

J. D. Frank identifies, with remarkable precision, five such common therapeutic factors: opportunities for learning, hope for improvement, experiences of success, social interaction, and emotional stimulation. (Ibid., p. 449 ff., loc. cit. Transl. FR.).

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However, for the predominantly quantitative investigation of the therapeutic relationship, see J. C. Norcross & M. J. Lambert: "To repeat one of the Task Force's conclusions: The psychotherapy relationship makes substantial and consistent contributions to outcome independent of the type of treatment. Decades of research evidence and clinical experience converge: The relationship works! These effect sizes concretely translate into healthier and happier people." (Norcross & Lambert, 2018, p. 313. In: Psychotherapy, 55(4), 303–315. Psychotherapy Relationships That Work III)

45 J. Krüger & J. Frommer: "With the growing number of qualitative psychotherapy studies, there is increasing appreciation for intersubjective experience and interaction, for the perspective of patients and clients, and for the contextual dimensions of experience and behaviour. Power dynamics within the therapeutic relationship are examined, and new approaches to understanding often unexpressed personal experiences are opened up […]. This allows for a deeper understanding of the role of clients in the emergence of therapeutic effects – a role that may help explain why nearly all forms of therapy show demonstrable and roughly equivalent outcomes." (Ibid., 2020, p. 438: Qualitative Psychotherapieforschung. In: Mey, G. & Mruck, K. (Hrsg.): Handbuch Qualitative Forschung in der Psychologie, pp. 431–441. Wiesbaden: Springer. Transl. FR.).

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47 Wampold, B. E. et al. (loc. cit.).

48 Cf. Kriz, J. (2014): Personzentrierte Systemtheorie. In: Eberwein, W. & Thielen, M. (Hrsg.): Humanistische Psychotherapie: Theorien, Methoden, Wirksamkeit. 283–296. Gießen: Psychosozial.

49 A. C. Bohart & K. Tallman: „[… O]ur view is that the client is a creative, active being, capable of generating his or her own solutions to personal problems if given the proper learning climate. For us, therapy is the process of trying to create a better problem-solving *climate* rather than one of trying to fix the *person.*" (Ibid., p. XI, loc. cit.).

50 Cf. Kriz, J. (2017): loc. cit.

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99 A. C. Bohart & K. Tallman: „It is the client's self-healing capacities and resources that are responsible for resolu-tion of problems and for change in everyday life and in any form of psychotherapy." (P. VII, loc. cit.).

100 A. Bandura: „Effective Self-regulation is not achieved through an act of will. It requires the development of self-regulatory skills. […] They must learn how to monitor the behavior they seek to change, set short-range attain- able subgoals to motivate and direct their efforts, and enlist positive incentives and social supports to sustain the effort needed to suceed." (Ibid., 1997, p. 286: Self-Efficacy: The

Exercise of Control. New York: Freeman.).

101 Cf. Tschacher, W. & Brunner, E. J. (loc. cit.).

102 A. C. Bohart & K. Tallman: „Clients have a lot of built-in intrinsic generativity and creativity. […] This means clients in varying degrees can solve their own problems, come up with their own ideas, and actively contribute to the therapy process by investing their own creative understanding in whatever the therapist is doing. Clients often generate good solutions. […] Clients know the intimate details and the intimate ecological connections that are created by their problems, and they have a sense of the factors that create the problems. They also have a much more intimate sense of what is possible in their life space than does the therapist. Therefore, they are experts equal to the therapist." (Loc. cit., p. XV).

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163 J. Kriz: "Overall, the extent of methodological misunderstanding and the factual misuse of the good idea of 'evidence-basing' – particularly by influential bodies such as the G-BA [Federal Joint Committee] – is so severe that EBM [evidence-based medicine] must be viewed very critically when it comes to the evaluation of psychotherapy. By now, it seems to serve more the interest-driven selection of certain psychotherapeutic approaches than the communication of the current state of scientific research – let alone the well-being of patients." (Ibid., 2023, p. 53: Wie evident ist Evidenzbasierung? In: Psychotherapie, 28(2), 33–54.).

164 V. Tschuschke: "Like every academically acquired, science-based discipline, psychotherapy must also be implemented in everyday practice in a more or less 'artful' manner. [...] Theoretically acquired, scientifically grounded knowledge inevitably requires the 'art of application' in practice – in psychotherapy, this would be, as you say, the 'art of listening'. But psychotherapy requires many more such 'arts': the 'art of empathy', the 'art of timely intervention', the 'art of authenticity', and many others. However, an overemphasis on the notion of art in psychotherapy can easily produce the opposite of what is intended: it would play into the hands of prejudices that see psychotherapy not as a scientific endeavour but as something belonging more to the realm of creativity – and therefore, perhaps, to esotericism and non-scientific domains." (Ibid., 2015, p. 95. Transl. FR.).

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point that patients are increasingly cut off from parts of treatments suited to their needs and are, for ideological reasons, prescribed certain forms of treatment. This one-sidedness cannot be justified by the current state of psychotherapy research, nor by the international development and diversification of treatment options, but solely by professional-political power interests. This situation has been significantly worsened by the Psychotherapists Act (PsychThG) of 1999." (Ibid., p. 54. Transl. FR.).

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