Chapter 7
Obsessive–Compulsive Disorders

7.1 Obsessive Thoughts, Compulsive Acts, and their Psychodynamic Function

According to the ICD (F42.-), *obsessive thoughts* are "ideas, conceptions or impulses that are recurrent and stereotypically occupy the patient persistently. They are almost always excruciating. The patient often tries unsuccessfully to resist them". *Compulsive behaviors* are repetitive stereotypical acts. "They are neither experienced as pleasant nor are they used to perform useful tasks. The patient often experiences them as a precaution against an objectively improbable event that could harm him or in which he could wreak havoc. […] Fear is mostly present all the time. If one suppresses compulsive actions, the fear increases significantly." According to Mentzos (2011, p. 104), obsessive–compulsive symptoms function as security measures. In individuals with obsessive–compulsive disorder and a more mature personality structure, the symptoms are "compromises between impulses that must not be allowed and the defense against these impulses. Sometimes it is the impulse […] and at other times (more often) the defense that predominates the manifest image" (Mentzos, 2011, p. 102).

Compulsive behaviors often have the "function of reconciling with the strict superego" (Mentzos, 2011, p.106). In the case of more severe psychological disorders "that border on psychosis", the constant repetition of magical acts serves "to stabilize the self or to ward off greater internal and external dangers" (Mentzos, 2011, p.103). According to Mentzos, the magical acts and rituals, which initially appear mysterious, are a "regressive updating of previous behavior patterns. They arise in times of need. They are very well known to us from the world of children, but also from the world of peoples and other cultures". Thus, the occurrence of a compulsion indicates 'not only a […]difficult underlying conflict but also the fact that it is about the self that needs to be protected and strengthened'.

Obsessive thoughts and compulsive behaviors are *symptoms* resulting from the acting out of a masochistic defense system in equivalence mode (see Sect. 2.6). They

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help them to energetically 'work off' the shame, guilt, and existential fears that arise in everyday conflicts, to maintain an adaptive attitude, and to stabilize themselves when confronted with a threat of disintegration of the self. The creative systemic development of the self (see Sects. 2.4.3 and 8.4.2) is fixed in the masochistic defense system *in everyday conflicts*. The masochistic defense system of patients often leads to disturbances in the therapeutic relationship. The therapist naturally identifies spontaneously with the patient's *defended* process of self-development *against* his sadistic superego in his everyday conflicts. Therefore, she tries to strengthen the patient's self-actualization in his everyday conflicts and intervenes accordingly.

Question

Why are early depth psychological interpretations therapeutically unhelpful in the treatment of obsessive–compulsive disorders and can even be harmful?

Central idea

Early depth psychological interpretations promote the self-actualization of the patients in their conflicts. In doing so, however, they also actualize the patient's sadistic superego and thus intensify their inner conflict tensions. This can intensify his obsessive-compulsive symptoms. It is possible that the patient *cognitively* knows more about the genesis of his symptoms at the end of the treatment. However, his obsessive-compulsive symptoms are still present because the cause of the symptom was not treated. *The therapist and the patient* are disappointed by the lack of success in therapy, giving rise to corresponding negative transferences and character-related countertransferences (see Sect. 2.10).

The therapist therefore initially treats the patient *metacognitively* in disorder-specific psychodrama therapy. She represents the patient's masochistic defense system involved in the formation of symptoms with chairs. A patient with obsessive–compulsive symptoms unconsciously switches back and forth between *three* different ego states and acts them out.

1. The *dominant defense mode* is the identification with self-destructive internal self-censorship developed in childhood. This is the ego state of 'self-injurious thinking' which gives rise to *obsessive–compulsive thoughts*.
2. The patient *reacts* to the danger evoked by his *obsessive thoughts* with *compulsive behaviors*. In the equivalence mode, the patient *externally* acts as if the threat posed by the *internal* obsessional thoughts is real. The patient acts out his *self-protective behavior through adaptation in his relationship* with his sadistic superego.
3. Unlike people with psychosis, the patient knows that his obsessive–compulsive thoughts and fears are exaggerated or absurd. So he *also* always thinks as a healthy adult.

7.2 The Disorder-Specific Treatment of Compulsive Behaviors

As in the disorder-specific therapy of people with personality disorders (see Chap. 4), the therapist works with individuals with obsessive–compulsive patients *explicitly metacognitively* in addressing their rigid defenses in the beginning (see Sect. 2.14). In addition to the two chairs of the symptom scene in everyday life (see Sect. 2.8), she represents the ego states involved in the patient's masochistic defense system with empty chairs and thus makes them the *direct* object of therapeutic communication.

Case example 16 (continued from* Sect. 2.9*)
A 20-year-old patient, Mr. B., has suffered from obsessive thoughts and compulsive behaviors for ten years. These had increased again in the last six months. He complained of 'increased aggression' even though he saw himself as a 'super social person'. In a previous therapy with another therapist, he spoke a lot about his aggression and the problematic relationship with his sister, who was three years older. In the initial interview, he reported that he feared contracting AIDS if he touched a doorknob. But he had informed himself thoroughly. He knew that an AIDS infection usually only comes about through physical contact. However, later he developed the fear that someone in the pedestrian zone of his city might stab him unnoticed with a syringe and infect him with AIDS. So he got some syringes and stabbed himself with them. He wanted 'to know how that would feel' so that he could notice an unwanted puncture more easily. Mr. B. also reported obsessive fear of driving over a pedestrian in his car. Whenever he drove through a pothole, he always looked in the rearview mirror to check the road and allay his fears. He often turned back in his car: "I know that running over a person should feel different. I would have seen the person too." Mr. B. had calculated that 'the probability of such a catastrophic event was only 0.000001%'.

To begin with, the therapist concretized the patient's three ego states involved in the patient's ego confusion with three empty chairs: he positioned a 'sadistic tormentor who instigates frightening thoughts' opposite the patient. For this, he placed the hand puppet of an aggressively-looking red devil on the chair in agreement with the patient. The symbolization of his obsessive thoughts as a devil in front of him was deeply moving for Mr. B. He immediately took a picture of the 'tormentor' with his mobile phone. Next, the therapist set up a second empty chair to the patient's left: "This is the chair for your self-protective behavior. First, your tormentor will alert you of the potential dangers. Then you think of some wise preventive measures and implement them. For example, you can turn around in your car. Or you can prick yourself with needles." The therapist then named the chair on which Mr. B. sat: "Regardless of your fears and compulsions, you also think as a healthy adult because you know perfectly well that your fears are unreal. For example, you have found that the probability of such events occurring is quite low. Therefore, the chair you sit in represents your healthy adult thinking." Mr. B. was amazed and relieved that the therapist appreciated his knowledge of the unreality of his fears so positively. After

establishing the three ego states, the therapist addressed the 'tormentor' directly. The therapist complained indignantly that he 'made life so difficult for the young man and tormented him so much' (see Sect. 4.10*).*

In the following session, Mr. B. shared that he had stopped taking his psychiatrist-prescribed neuroleptic Seroquel on his own initiative. He reported: "I felt much better after the last session! Now I say to myself: 'If something happens, that's how it is. I am just unlucky!' It helped me to see my fears as the devil. It also helped when you called the devil the 'tormentor' and didn't take him so seriously. Now I can already laugh a little at myself! In principle, I don't want to get rid of this fear completely. As a child, I was fearless. I wasn't afraid of anything. But to have no fear doesn't help either." Therapist: "I think it is important that you keep externalizing the sadistic tormentor and view it as a different person. Then you have better control over it. Buy a similar hand puppet for the tormentor and keep it at home! Or use the picture of the tormentor you clicked here."

The patient's psychotherapy consisted of only 15 sessions in total. If the patient's obsessive–compulsive symptoms reappeared, the therapist would again work with empty chairs (see Sect. 4.8*) to address the patient's dysfunctional metacognitive processes. During therapy, the patient repeatedly performed his self-regulation in the three different ego states in the as-if mode of psychodramatic play. He also dealt with the conflicts between his ego states in psychodramatic dialogues with role reversals (see* Sect. 4.10*).*

The therapist did not interpret the patient's intrapsychic conflicts in depth. Instead, he waited until the patient recognized the relevant connections with the genesis of his conflicts on his own. In the fourth therapy session, Mr. B. spontaneously established a relationship between the 'tormentor' and the sadistic humiliation by his older, behaviorally disturbed sister in his childhood. The therapist validates this connection: "As a child, you were traumatized by your sister. The 'tormentor' reflects the conflict with your sister. If you felt angry as a child, your anger was a healthy reaction to your sister's behavior!" The therapist represented the 'older sister' with an empty chair behind the chair of the 'tormentor' (see Fig. 4.1 in Sect. 4.2*). He pointed with his hand at the chair for the patient's 'tormentor': "As a child, you learned to discipline yourself in a self-injurious way as a precaution. It protected you from the real external threat posed by your sister. As a result, you were less likely to get in the way of your older sister as a little rival." The therapist placed two empty chairs behind the patient's 'self-protective behavior' on the stage to represent the patient's 'traumatized child' and 'angry child'.*

The therapist did not deal with the patient's childhood conflicts in this therapy process. Instead, he used the information about the original conflict only to give the patient's defensive behavior a positive meaning. Six months after the end of the therapy, Mr. B's father reported gratefully to the therapist in a telephone conversation: "My son is symptom-free and has passed his final examination." The patient's obsessive–compulsive symptoms had not recurred even three years after treatment. Mr. B. was now working full-time and volunteering in his free time. He'd even confronted his sister about her childhood violent behavior.

The disorder-specific treatment aims to liberate the patient's creative process of self-development from a masochistic defense system. Therefore, it comprises the following steps (see case example 16 above)

1. The therapist initially centers the therapeutic work on *a typical compulsive act* on the part of the patient in his present day-to-day life. She uses the psychodramatic conversation (see Sect. 2.8) to determine *which self-injurious* thought provokes his compulsive action. The patient is not always aware of it: "You wash your hands repeatedly *because there is an inner voice in you that says: 'You must have been infected by the bacteria on the door handles!'"*
2. The therapist explicitly *names obsessive–compulsive thoughts* as 'self-injurious thinking'. She names it the 'inner sadistic tormentor'—a term *as close to the patient's experience* as possible.
3. The therapist *represents* the 'tormentor' with an empty chair three meters away from the patient as an object image and interaction partner. She places a suitable hand puppet on it, for example, a red devil or a witch: "The tormentor always brings up new, threatening thoughts with a lot of imagination."
4. The therapist gives the compulsive behaviors *a positive meaning* in the context of the patient's dysfunctional self-regulation. She interprets the *compulsive actions* as *appropriate reactions* to the catastrophic fantasies of the 'sadistic tormentor' and as 'self-protective behavior through adaptation to this tormentor': "You avert the tormentor's threats with your compulsive actions."
5. She *externally represents the 'self-protective behavior'* against his sadistic superego with an empty chair and a matching puppet (see Fig. 4.1 in Sect.4.2 and Sect. 4.8) and places it *next to the patient.*

Central idea

The therapist transforms the process of defense through obsessive thoughts and compulsive actions into a *psychodramatic symbolic play*. The patient is supposed to gain ego control over his rigid defense processes. The external representation of the interaction between the *object image* of the inner tormentor and the *self-image* of self-protection through adaptation with chairs is the prerequisite for the patient to be able to free his self-development from being fixed in his defense system.

6. Patients with obsessive–compulsive symptoms already know that their fears are inappropriate and unreal. This knowledge is what distinguishes them from people with psychosis. Therefore, the therapist positively appreciates the patient's insight into the unreality of his fears: "Despite all your problems, you also think as a healthy adult! This is what the chair you sit on stands for." This therapeutic intervention relieves the patient of his fear of going 'crazy' and has an ego-strengthening effect.
7. In conversation, the patient internally switches back and forth between his ego states. With every change, the therapist points with her hand to the corresponding *other* chair and, as a metacognitive doppelganger (see Sects. 2.4.1 and 4.8), verbalizes the special thoughts, feelings, and intentions of the 'sadistic tormentor', 'self-protective behavior', or 'healthy adult thinking' in the as-if *mode of the play.*

8. The patient internally experiences his sadistic superego as a diffuse threat. As in child psychotherapy, the therapist lets the patient develop the form of the 'tormentor' in the symbolic play into a holistic form with typical action sequences, physical sensations, affect, linguistic concepts, and thoughts. The therapist and the patient transform the obsessive thoughts into statements by the "tormentor" and give it a voice: "The inner tormentor is saying it again: 'You must have contracted AIDS!'" They make a list of all the warnings and threats expressed by the 'tormentor' and number them. The patient reads this list aloud to the therapist item by item. In doing this, the patient and the therapist feel the absurdity of the warnings intensely and sometimes have to laugh without wanting to.

Central idea

The therapist, as a metacognitive doppelganger, helps the patient to feel the sadistic pleasure of the tormentor in the inner role change. In this way, the patient expands his inner object image of the 'tormentor'. He resolves his projection of the tormentor's good intentions when warning against a threat (see Sects. 2.4.3, 2.9, 8.4.2, and 8.5). This also relaxes the patient's *defenses through introjection* and adaptation. The defense through projection and introjection stabilizes each other.

9. The therapist lets the patient switch to the chair of his 'self-protective behavior through adaptation' and psychosomatically work out the *positive meaning* of his compulsive actions in interaction with the 'sadistic tormentor'. In this way, the patient creates a holistic inner *self-image* in the interaction with the tormentor with action sequences, physical sensations, affect, words, and thoughts. The therapist helps him as a metacognitive doppelganger. Thus, the patient gains psychosomatic access to his own self and resolves his defenses through introjection. He gains ego control of his defenses through adaptation.
10. In the case of *rigid defense through introjection*, the therapist, as a doppelganger, *interacts on behalf of the patient* with his 'tormentor'. She feels the tormentor's threat *externally* on the chair next to her. This spontaneously triggers her resentment against the 'tormentor'. As a doppelganger, she looks directly at the patient's 'sadistic tormentor' (see Sect. 4.8), stands up, rebukes him of her own will, and insults him: "I think you are tormenting Ms. Müller! She has suffered enough already. I don't want it to go on like this!" The therapist asks the patient whether the 'tormentor' reacts. If necessary, she turns the hand puppet representing the tormentor around so that it is facing the wall: "Stop it! You have tormented Ms. Müller enough." The therapist then sits down in her chair again and observes whether *her feeling* of constriction has disappeared. If necessary, she confirms this with the words: "Yes, I feel better now!"

Central idea

The therapist must not ask the patient to protest against his 'tormentor' *on his own* because that would trigger his restricting superego and possibly intensify his compulsive actions. The patient should experience *the therapist* as "guilty" from the perspective of the tormentor, and not himself.

11. The patient moves back to the chair of his healthy adult thinking (see Fig. 4.1 in Sect. 4.2). He sees the interaction system between his self-image and his object image of the 'tormentor' from the metaperspective. Thus, he also psychosomatically develops inner distance from his masochistic defense system. This also helps him to represent his defense processes internally and to *think in the as-if mode.*
12. In the next few months, the patient repeatedly acts out *similar or different* obsessive–compulsive symptoms. Together, the therapist and the patient then *repeatedly* represent the masochistic defense system consisting of 'inner tormentor' and 'self-protection through adaption' with chairs and enact them psychodramatically in the as-if mode.
13. The symbolic play enables the patient *to act* against his 'blind sadistic tormentor'. He knows his name and what he looks like. He can buy an appropriate hand puppet and imprison his inner 'tormentor' in a cupboard (see Sect. 8.5) and lock it. He can get the 'tormentor' out and interact with him of his own free will. He can put the 'tormentor' in his place in the as-if mode of play, and make him answer. He notices himself: "I can obey the 'tormentor". But perhaps I *don't have to*, or not always, or not so strongly." The patient develops ego control over his adaptation and sadistic superego.

Central idea

The symbolic play between the conforming ego and the tormentor liberates the patient's creative process of self-development from his masochistic defense system. The patient *creates, completes, and condenses* his psychosomatic resonance pattern between the memory centers of his action sequences, physical sensations, affect, word concepts, and thoughts (see Sect. 2.7). At some point, this links itself with a psychosomatic analogous resonance pattern of an original conflict (see case example 16 above). This usually is a traumatizing relationship from childhood. The appropriate integration of his masochistic defense system into the childhood conflict liberates his *present conflicts* from undue self-censorship. But his insight should appear like a ripe apple falling from the tree into his hand *on its own.* As long as the patient does not create this connection *autonomously*, his defense through projection and introjection is not sufficiently resolved.

14. The therapist includes elements of trauma therapy in the treatment of relational trauma in childhood (see Sect. 5.6).
15. At the end of the treatment, the patient's inner change must also be integrated into the internal *relationship images* of the present and the past (see Sect. 4.12).

7.3 The Treatment of Obsessive Thoughts Without Compulsive Actions

Obsessive thoughts that occur *without compulsive actions* (F42.0) can be attributed to the patient's *own* repressed sexual or aggressive wishes or his 'self-injurious thinking'. The patient dissociates in the service of the ego (see Sect. 7.1), shifts the taboo impulses to a non-integrated, autonomous part of the self, and thereby

experiences them as distressing and ego-dystonic. In this way, the patient stabilizes his old adaptive attitude and restrictions from his superego.

The *technique of* projective *personalization* is therapeutically helpful for isolated obsessive thoughts. The therapist takes the following steps with the patient in doing so

1. The therapist symbolizes the patient's *obsessive thoughts* with a larger stone, places it on a second empty chair further away, and explains: "Please imagine a person or a figure sitting there on the chair with the same feelings and impulses that torment you. But these impulses and thoughts are *appropriate and absolutely necessary in the other living environment* of this person to maintain their dignity or their own life. Please look for a figure or person you find suitable for this. You shouldn't know this person. You can choose a person from the Middle Ages, from a fairy tale, or from the world of your fantasy. Who could that be?" As a doppelganger, the therapist must help the patient to find a suitable fictional person. This person is not an amplification of the motto: Other people *have also* experienced conflict. Instead, the *negatively* evaluated obsessions should give *a positive meaning* in the other world of the fictional person according to the motto: The taboo thoughts are totally appropriate *if they occur in this other unique context*.
2. The patient finds a suitable figure or a person. Then, he and the therapist give this fictional figure an appropriate name.
3. The therapist asks the patient to tell a short episode from this other person's life. Like a film script, this episode should have a beginning and an end and describe the plot and interactions in concrete terms. Then, the therapist helps the patient to create the story as a doppelganger.
4. Over the next ten weeks, the patient writes ten short stories from *this other person's* life. In these episodes, the fictional person *must* act out the impulses and thoughts contained in the patient's obsessive thoughts. The patient brings these stories with him to the following therapy sessions.
5. The therapist reads the story each time and asks the patient what he experienced while writing the story. However, she does *not* interpret the story's contents using depth psychology.
6. Sometimes a patient spontaneously makes friends with the inner impulses displaced onto the fictional person at the end (see case example 58). In such a case, the therapist asks him to look for a hand or finger puppet *for the fictional person*. The patient can carry this with him in his everyday life and, if necessary, *consult* with the fictitious person.

Case example 58

A 28-year-old female patient, Ms. A., suffered from obsessive–compulsive disorder. As a result, she had already been in treatment as an inpatient psychiatric patient. By the end of two years of outpatient group therapy, she had generally made good progress. But she was still tormented by her obsessive *thoughts of 'fuck, bang, suck'. These repeated themselves stereotypically in her head. The therapist challenged the*

young woman, who appeared to be bourgeois on the outside, to look for a figure or a person who would use these street words. After some thought, Ms. A. named the 'red Zora' from the book with the same title written by Kurt Held. But she modified the story. 'Red Zora' was a 14-year-old girl who lived alone in a hut she herself built in the woods in front of the walls of a medieval town in the seventeenth century. During the day, she would go into town and steal things to eat from the market stalls. If children, especially boys, teased her, she would beat them up. In doing so, she would curse, insult them, and use the above ugly words. She would always win the battles! In the evening, she would go back to her 'home'. The therapist and the patient agreed that she should write ten episodes from 'Red Zora's' life over the subsequent ten sessions. Ms. A. brought the one or two pages long, lively but straightforward stories with her to the therapy sessions. The 'red Zora' was initially alone, but then she gathered a gang around her. While reading the last of the ten stories, the therapist was amazed and delighted: The patient had written in it that she visited the world of the 'red Zora' and 'apprenticed' with the 'red Zora'. Ten years later, Ms. A. reported that the obsessive–compulsive thoughts had disappeared two years after the therapy ended. There were no other obsessive–compulsive symptoms either. She commented on the work at the time with these words: "I didn't even know that I could be so creative! I wasn't sassy enough!".

The technique of projective personalization specifically resolves the defenses of introjection and adaption to a rigid superego. The patient actively and playfully shifts her own taboo impulses and wishes contained in her obsessive thoughts *to another person, at another time, in another place,* and to the life context of this *other* person. The content and impulses of their obsessive thoughts find a *suitable* framework in that *other* person's difficult life context. The fictional person's thinking and acting are *absolutely appropriate in their difficult situations*. Therefore, he *does not defend* himself through introjection and projection.

Central idea

In writing the ten stories, the patient ascribes a *positive meaning* to her own taboo wishes and impulses in another life context. *By definition*, she can identify with her own taboo desires in the *metaphorical stories*. Over time, she thus resolves her own defenses through introjection. However, this does not trigger her strict superego because these taboo wishes and impulses belong to *another* person. As a result, over time, the process of her self-development is liberated from the fixation on the defense of identification with the attacker.

Carmen Kollenbaum (2014, verbal communication) reported on the therapy of a 30-year-old patient whose obsessive thoughts disappeared *after just a few weeks* of working with the technique of projective personalization. The patient had already been treated for severe destructive obsessive–compulsive thoughts three years before that. The current obsessive thoughts arose after having a spontaneous orgasm *during an argument* with her husband: 'All she could think about was that she had to masturbate'. The tormenting thoughts prevented her from relaxing. Meanwhile, the obsessive thoughts also interfered with her sexual intimacy with her husband. The patient was generally very unsettled by this. The previous procedure with the behavioral in vivo confrontation did not bring any lasting relief this time. The therapist, therefore, used this new technique of *projective personalization*. The patient invented

three fictional people to whom she attributed her disturbing thoughts and feelings: (1) a 'woman in dreary everyday life who leads a completely fulfilled, never again dreary life through masturbation', (2) a dying woman 'who defeated her tumor for a short time through masturbation', and (3) a prostitute 'who finds it thrilling and exciting to stand on the street and entertain clients'. A few weeks after this work, the patient decided to stop taking the pill and wanted a second child. The obsessive thoughts had disappeared. The patient looked alive again and was full of energy.

Central idea

The patient *justifies* her impulse to act on her destructive fantasies *in the life of this other fictional person* and lets this other person carry out the impulse *to the end*. In this way, she indirectly dissolves the existing blockages in her thinking, feeling, and behavior and liberates her creative ego from its constraints.

In the case of masochistic obsessive thoughts, the projective personalization sometimes only succeeds with the other fictional person living in a grotesque world. For example, one patient suffered from obsessive thoughts about wanting to kill her infant. She invented the fictional character of Frankenstein for her murderous fantasies. Frankenstein wanted to kill the monster he created because it wanted to destroy the world. The patient began to cry while telling the story of Frankenstein. She knew, of course, that her child didn't want to destroy the world. She spontaneously linked the interaction pattern "Frankenstein and his monster that must be killed" with the interaction pattern "herself and her infant" internally. In identifying with Frankenstein, she also allowed *the destructive impulses* within herself. This resolved her projection of destructive impulses onto her child. It also relaxed her defense by introjecting the child's *supposed* accusations, "You're a bad mother." She realized that she loved her child and, of course, *didn't* want to kill it. Her child's *demands* bothered her, but not *the child* itself. She discussed with her therapist her difficulties in drawing healthy boundaries.

7.4 Self-stabilization and Ego-Strengthening Through Role-Playing

Straub (1972, p. 181), like Mentzos (2011, p. 105), recommends that the therapist focuses on ego-strengthening in patients with obsessive–compulsive disorder. The awareness of repressed conflicts and their causes can lead to an intensification of symptoms or a displacement of symptoms in individuals with obsessive–compulsive disorder.

Straub (1972) used psychodramatic role-plays to strengthen the ego. She integrated her experiences from psychodramatic therapy for children into therapy for adults (Straub, 1972, p. 182). (1) She asked her patients to imagine that they were employed with a television company and had the task of creating *children's programs*: (2) She asked the patients to 'think, if possible, of scenes to be played in the 'television programs'". (3) Next, the patient makes up a fantasy story. This story should

have a beginning and an end. (4) The story should *turn out well* in the end. It should include what the child or the inner child of the patient *needs* and *wants*. (5) If the fantasy story does not end well at first, the therapist encourages the patient to think of a *happy* ending. She justifies this with the argument: "Otherwise the children would not like to watch the television programs. They won't sleep well afterward!" (6) The patient enacts the fantasy story psychodramatically and is supposed to play the roles appearing in the 'programs' *himself*. (7) The therapist plays each opposite role. In this way, she helps the patient to differentiate and expand their own roles. She also steers the play in a way that the story ends well as planned. When patients create stories *for children's television*, they often, without realizing it, invent stories that are a metaphor for their *own* inner conflict.

Central idea

Straub let her *adult* patients further develop their *healthy inner child* in this way. Like working with the coping fairy tales and the positive counter-images, the role-play *for children's television* strengthens the patient's internal natural self-healing system (see Sects. 5.13 and 5.14).

Straub generally treated her patients with obsessive–compulsive disorder in individual therapy "because then the patient can be activated more intensively in each session than in a group" (Straub, 1972, p. 182).

Case example 59 **(Straub, 1972, p.182 ff.)**

A patient with a severe obsessive–compulsive disorder "invented […] the role of the 'little braggart', a roughly seven-year-old boy who confidently dares to take on all sorts of undertakings". First, the therapist suggested scenes 'which she considered important for the patient to create'. 'For example, in one such scene, little braggart persuaded his teacher not to give homework because of the good weather.' In another scene, he 'argued aggressively with his friend's mother for his friend's benefit. The mother was over-anxious and did not want to let him play on the playground. Soon the patient invented 'similar scenes herself and […] took on some of the associated roles'. She played the child roles in an increasingly carefree manner, was more spontaneous in the adult roles, and restricted her 'children' less because of her concerns. In parallel, the patient felt 'more self-confident and carefree' in her everyday life; she 'hardly interrogated her children when they came home' and 'no longer asked them to constantly […]change their clothes'.

After about a year of individual therapy, one day, the patient wanted to play 'a completely different scene' than usual: "She wanted to enact a scene where a man kidnapped a child. […] She would play the man's role and 'simply' imagine the child." The therapist should not play along. So it happened. The patient "spoke to a child in the role of the kidnapper, […] and lured the child to her with the words: "Come, come, I'll show you something beautiful". Then she pulled it away by the hand: 'Just come with me, come with me. […] Now we are in the forest. […] I'll show it to you soon. Look, there's a cave; that's where we're going. 'The patient pushed the 'child' in front and continued in a threatening tone: 'So now I have you!' She knelt on the floor, leaned over the 'child', pressed her hands on him, leaned lower, and groaned: 'Ah, now I have you, so, ah, so!'".

After the play, the patient was pale and agitated and said hesitantly: "You have to show something like that in children's programs." The therapist replied: "That's probably why you did it". A week later, the patient spontaneously said, "All these ideas were so strange. […] I am very concerned why they came to my mind." The therapist replied to the 'woman plagued by feelings of guilt', that "sometimes all of us have ideas that worry us […] as we cannot see their origin". The therapist had to 'expressly assure the patient that even she would have 'outrageous ideas' occasionally. That 'seemed to put the patient at ease'. The patient changed the subject and invented another television program: This time, she was a nine-year-old boy who went on a flight to see relatives abroad on his own because his parents did not want to come with him. He experiences many exciting things on his trip, and everyone admires him for his independence.

*In her everyday life, the patient's behavior towards her children was 'becoming more and more normal'. She now […] let them play outside their own house and garden without […] feeling restless. 'In the following conversation, the patient criticized her mother for the first time, who she had described as a loving and understanding mother until then.' Her mother sometimes let her down 'if, for example, a teacher had mistreated her at school'. She always said, "Teachers are always right". The patient did not want to pass on her submissiveness and insecurities to her children. She was, therefore, glad that she no longer restricted her children. Even five years after the end of the treatment, the patient was still 'in a good psychological state, free of anankastic symptoms' (*Straub, 1972*, p.185).*

Straub (1972, p. 184 f.) assumed that the "ego-strengthening role play had reduced the patient's tendency to repress, thereby opening the path to an eruptive discharge of previously repressed emotions (in the role of kidnapper)". Straub interpreted that "the patient invented the child abduction scene also because of the unconscious rejection of her children. Therefore, she felt compelled to play the massively aggressive kidnapper role". She interpreted the role of the child abductor as a *symbolic* image *of the patient's* aggressive impulses. She did not realize that by playing the role of the perpetrator, the patient was *autonomously* resolving her defense by projecting good intentions onto him and thereby indirectly relaxing her defenses through introjection (see Sects. 2.4.3, 7.1, and 8.4.2).

Straub's case example dates from 1972, i.e., when the findings of today's trauma therapy were not yet available. In my opinion (see Sect. 5.5), in this case, the therapist should have asked the patient *directly* whether she experienced sexual assault as a child or whether her mother was traumatized by rape. If necessary, the therapist could then have continued to work within the trauma therapy framework. The following speaks in favor of sexual trauma or secondary traumatization of the patient in case example 59: (1) She had the intense urge to play a scene involving the sexual abuse of a girl. (2) The therapist should not take on any role, unlike the usual format. (3) The role of the abused little girl did *not* come alive in the play. The patient would then have probably seen herself in the 'girl'. That would have ushered her into her old traumatic experience and triggered a flashback. (4) The patient complained to the therapist that her mother sometimes let her down. (5) Like many patients with a trauma-related disorder, the patient acted anxiously and controlling toward her

children. (6) At 14, she was 'shocked to learn that men had raped women and girls in many places at the end of the war'. In this context, she would also have heard that some of the raped individuals had become sexually ill." That would have prompted her at the time to 'fear the risk of getting infected herself' (Straub, 1972, p. 181).

In this case, Straub did not work in the narrower sense of trauma therapy. Nevertheless, Straub's approach led to the patient becoming *symptom-free*. It was helpful to concretize the traumatic fears symbolically and give them a coherent framework in a story. The therapist thus became an *implicit* witness of the truth for the patient (see Sect. 5.8). Straub did not leave the patient alone. She empathized with the patient's feelings of horror without trivializing them (see Sect. 5.15). She gave the patient permission to think and feel such complex fantasies. In her approach, Straub specifically dissolved the patient's defense through introjection, but not her defense through projection (see Sect. 7.1).

References

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