Chapter 8
Depressive Disorders, Masochism and Suicidale Crises

8.1 What is Depression?

Epidemiologically depression is the largest group of mental disorders by far (Mentzos, 2011, p. 125). The ICD-10 classifies these into depressive phases in the case of bipolar affective disorder (F31.-), *singular* depressive episode (F32.-), *recurrent* depressive episodes (F33.-), and *persistent* dysthymia in the case of chronic neurotic depression or a depressive personality disorder (F34.1). Depressive episodes can be *mild, moderate, or severe.* There are *severe episodes without* psychotic symptoms or *with* psychotic symptoms, such as hallucinations, delusional ideas, psychomotor inhibition, or stupor. Persistent dysthymia is characterized by a depressive mood lasting for at least a few years.

A variety of clinical psychopathological symptoms are included in these diagnoses. Therefore, according to Mentzos (2011, p. 125), "it would make more sense… not to speak of depression but of the group of depressions. […] In fact, the depressive mood is the common denominator of all variations in depression". Other symptoms can include psychomotor inhibition, listlessness, pronounced tiredness after the slightest exertion, sleep disturbances, decreased appetite, difficulty in concentrating, waking early, feeling low in the morning, helpless clinging tendencies, self-destructive behavior, suicidality, loss of interest in the outside world, and anhedonia, the inability to experience pleasure. There can also be a decrease in one's self-esteem and self-confidence. Feelings of guilt can arise and intensify into delusions of sin or impoverishment (Mentzos, 2011, p. 125 and ICD-10).

Central idea

The psychodramatic *idea of the spontaneously creative person* suggests that depressive states, according to Mentzos (2011, p. 126), should be understood as an indicator of "active but pathological processing of conflicts, trauma, and other stresses". The depressive affect signals the hopeless entanglement in seemingly unsolvable conflicts and an impending standstill in the ongoing half-conscious, half-unconscious conflict processing (Mentzos, 2011, p. 126).

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In the *constant conflict* between self-actualization and adaptation, those affected lack the ability for *adequate self-actualization*.

Important definition

Rogers (2009, p. 26 f.) describes *self-actualization* as "the organism's inherent tendency to develop all its possibilities; and in such a way that they serve to maintain or promote the organism. This tendency includes not only [...] the basic needs [...]but also [...] the ability to differentiate itself and its functions. It includes expansion in the sense of growth". The *self is a dual system*. It consists of the inner self-representation and individual object representation in the present, past, or future situation.

Central idea

The human *self is a dialogic process*. This process realizes constructing and representing the inner self-image and object image, appropriately to the *external* current situation, and interacting and rehearsing dialogically between the self-image and object image (see Sect. 2.9). Psychotherapy should therefore be bifocal and progressively develop both, the *inner* self-image as well as the *inner* object image, in the current *external* situation.

Appropriate self-actualization in a given external situation provides a *feeling of self-efficacy*. It is *not* to be equated with *external self-realization*. People become depressed when their self-actualization is severely restricted or blocked by external or internal pressure to adapt. With *conscious adaptation*, the affected person still has internal access to his internal self-actualization. Therefore, in an emergency, he can make an active choice to adapt. In the case of *unconscious adaptation*, however, the affected person does not even notice that he is adapting. Three different adaptation constraints can restrict self-actualization:

1. In a current conflict (see Sect. 8.3), self-actualization is restricted by *real external pressure to adapt*, for example, by the loss of a job or by the restrictions on physical contact during the Covid-19 pandemic.
2. Self-actualization is restricted by one's *neurotic inner compulsion to adapt*. In the current conflict, the affected person fights off appropriate self-actualization by identifying with the aggressor (see Sect. 8.4.2).
3. Self-actualization is also restricted by one's *internal structural pressure to adapt* (see Sect. 4.7). In such a case, the affected person defends himself by identifying with the system (Krüger, 1997, p. 211 ff.). According to Parin (1977), he identifies himself blindly in the present, as it were,

   (i) *With the role* assigned to him by his system of relationships, his institution, or society. He receives narcissistic gratification from the concerned system for taking on this role.
   (ii) *With the planning* of the relationship system.
   (iii) *With the explanation patterns* of the relationship system.
   (iv) With the goals, values, and norms of the relationship system.
   (v) The affected person and the members of his relationship system affirm each other narcissistically in their role behavior. The affected person unconsciously denies the *naturally existing* conflict between his self-determined role and the role determined by his partner's expectations. He feels identical

to the role assigned to him. But he becomes depressed when the narcissistic gratification for the role assigned to him is missing in his relationship system or when he loses that role, for example, when he is no longer the admired son of his family.

8.2 The Different Forms of Depression

The disorder-specific psychodramatic approach to treating people with depression comprises *three different methods.* These are determined by *how* the patient's *self-actualization is confined* in his current conflicts:

1. In the case of *current conflicts*, there is real external pressure to adapt, which forces an external and internal change, for example, the death of a relative, cancer, or a workplace conflict (see Sect. 8.3). In such a case, the therapist works with the psychodramatic dialogue with role reversal or the two-chair technique in a potentially traumatic situation (see Sect. 5.8).
2. In the case of a *neurotically induced conflict*, the therapist works on relationship conflicts using the seven steps of the psychodramatic dialogue (see Sects. 8.4.2–8.4.7). They systematically resolve the defense through identification with the aggressor, which restricts self-actualization.
3. In the case of *an internal structural pressure to adapt* (see Sects 4.4 and 8.5), the therapist also works on the patient's rigid defenses of splitting and denial in an explicit metacognitive manner (see Sect. 4.7). For example, when the patient *behaves masochistically*, she focuses on talking about the *general principle,* bringing forth the contents of the patient's self-injurious thoughts.
4. *Severe depression bordering on psychosis* (see Sect. 8.6) occurs in patients with severe deficit experiences in childhood or those with trauma-related disorders. The patient's capacity to mentalize has collapsed. As a result, the patient's ego can only be found in the patient's self-regulation *of his depressive mood* (see case example 71 in Sect. 8.6). The patient is unable to internally connect his depressive mood with the triggering interpersonal conflict that has caused it.

In the *initial interview*, the therapist uses the method of diagnostic psychodramatic conversation (see Sect. 2.8). In doing so, she concretizes the conflict stated by the patient with two empty chairs *externally* in the therapy room. But the patient does not shift to the chairs of this symptom scene. During the diagnosis, the therapist looks, shoulder to shoulder with the patient, at the two chairs of the symptom scene. She attunes her intuition with the holistic process of the patient's intuition (see Sect. 2.5) and lets him retrace the chronological course of *interaction sequences* in his inner conflict image from memory from the observer position. Thus, the patient resolves his defense through denial (see Fig. 2.5 in Sect. 2.3). As a cognitive doppelganger, she uses interviews and verbal doubling to help him create a psychosomatic resonance between his actions, physical sensations, affect, linguistic concepts, and thoughts and to fill gaps in the psychosomatic resonance (see Sect. 2.7). She then asks him about

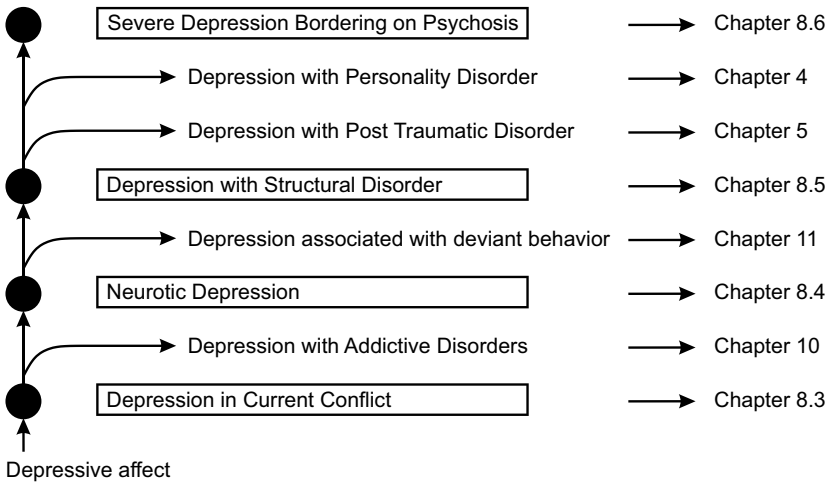

Fig. 8.1 Exclusion procedure in the diagnosis of depression

the onset of his depression: "For how long have you been feeling so exhausted and tired? When did this start?" She helps the patient describe the interactional framework in which his self-actualization was narrowed.

The therapist intuitively uses *the elimination procedure* for the diagnosis (see Fig. 8.1 below). She first looks for high-energy conflicts in the present (see Sect. 8.3). However, often one *cannot* explain depression in terms of a response to a current conflict *alone*. The current conflict would result in no depression or significantly mild depression *in other people*. This indicates that depression is also partly caused by neurotic conflict patterns (see Sect. 8.4). Even then, the therapist cannot understand the cause of the depression in some patients. Despite all efforts, she remains disoriented. This is a diagnostic indication that the patient's depression is partly due to a *structural* disturbance (see Sects. 4.4 and 8.5).

Indications of depression due to structural disturbances: (1) The patient keeps changing the subject and the reason for his problem (see Sect. 2.8). He *cannot* describe his conflict in a comprehensible manner. (2) The therapist herself repeatedly feels confused. (3) When working with the table stage (see below), the patient lays stones symbolizing elements of his inner conflict area in a row next to one another. This rationally *controlled* order depicts the patient's *inability* to think *in pictures*. (4) The therapist quickly senses a latent disturbance in the therapeutic relationship. She cannot resolve this disturbance in psychodramatic self-supervision (see Sect. 2.9). She must include the constellation work with the ego states in the self-supervision. These are steps 13–17.

In the case of *depression bordering on psychosis* (see Sect. 8.6), the patient's mentalizing has collapsed. Therefore, as a doppelganger, the therapist first helps the patient improve his sense of self and authority in the process of self-regulation in

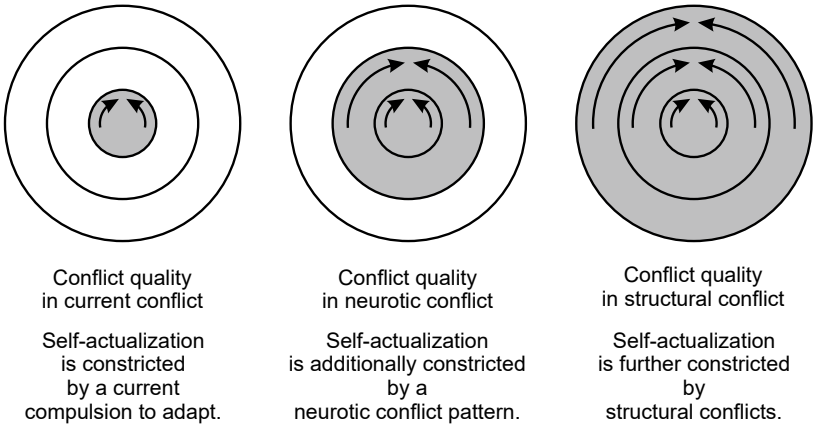

Fig. 8.2 The three different conflict areas in depressive disorders

his *everyday life*. It is a prerequisite for him to relate his depression to triggering interpersonal conflicts (See Fig. 8.2).

The therapist can *also use the table stage* for diagnostic work (Sect. 5.10.10). In doing so, she uses the language *of symbols* in addition to *verbal* language. When working with the table stage, the patient and the therapist get an overview of the *connection between the patient's various conflicts*. For this purpose, they build the symbolic image of their 'soul landscape' together during the conversation (Krüger, 2005, p. 266 ff.) and represent it with stones and wooden blocks on the table: (1) The patient's ego, (2) His feelings, (3) Other people involved in his conflicts, (4) The institutions involved, (5) Important objects such as the bed in which the patient lies at home until noon, (6) His ideals and values. (7) The development of his depression is symbolized as a *timeline* with three stones, one for the beginning of the conflict, another for the current situation, and a third for future development. The therapist moves the stone that represents the patient forward or backward along this timeline on the table during the therapeutic conversation. She empathically names the patient's affect, differentiates them verbally doubling together with him, and represents them on the table with matching stones. The therapist and the patient, together, look at the symbolic soul landscape of the patient represented on the table, from a *meta-perspective*. In the last third of the therapy session, the therapist can point with her hand at the symbolic picture on the table and ask the patient: "Do you always do it this way?—And if you do, why is it the best solution for you? Are you afraid of something?" The collaborative work with the table stage activates the patient's *inner* perception and processing of conflicts.

In the case of *structural conflicts* in the patient, the therapist also names and symbolizes the patient's rigid defense, for example, his self-injurious thinking, with the help of chair work (see Sects. 4.7 and 4.8), thus making it the subject of therapeutic communication.

Case example 60

In the first interview, the 42-year-old Ms. A. reports: "I've had problems for a long time now, more than ten years. My problem is that I always have to apologize for my existence!" Therapist: "So you deny your right to life. I am putting a chair across from you for your inner judge." Ms. A: "Yes, I have to do everything one hundred percent. Nothing is good enough!" Therapist: "How old is your inner judge?" Ms. A: "It's always been there since school." After extended maternity leave, the patient is now working part-time in a nursing home. Therapist: "But you are not able to show yourself at work? You pretend as if there is no problem?—I'll put another chair next to you for your self-protection behavior that pretends as-if." Ms. A: "That's right. Once, when I had to ask my supervisor something, she said: 'You don't need to sneak up like that! Just be open and say what you want!' That was when I realized that I had had depression for ten years. But I only realized that afterward."

The therapist evaluates this realization of the patient as inner progress: "That's when you saw yourself through a different set of eyes and took yourself seriously." Ms. A: "Ten years ago, we moved into our own house on the outskirts. But that was just a shell structure. Even at Christmas, we sat amidst unpacked boxes. Before that, we lived in a nice little apartment in the city. I couldn't sleep after moving. I would wake up at four in the morning, electrified. Then I had destructive thoughts in my head. I was depressed for a year. Most of the time, I sat at home and just cried!" The therapist points to the chair for her self-protection through adjustment: "Secretly!" Ms. A: "Yes, secretly, I can do that very well!" Therapist: "What were these destructive thoughts?" Ms. A.: "Oh, I thought: 'If only you hadn't moved in here! If only I could get sick.' Or: 'If my husband gets sick and dies, then I will move out from here!'" Therapist: "Oh, you were angry with your husband too. You got in touch with your inner angry child! I will put an extra chair over here for this angry child. But of course, such thoughts do not go well with your strict conscience! Were people very strict with you in childhood? As strict as you are with yourself now?" Ms. A: "Yes, my parents, they were teachers. My father was often in a bad mood and choleric. He always insisted that one be the best at everything in school. I didn't do everything well enough for him. For example, I wasn't allowed to mow the lawn because I didn't cut the edges well enough. My mother was also impatient, and she always took everything from me. If you wanted to help, you couldn't. We always had 16-year-old interns to look after us children. They changed every year."

8.3 Therapy for Depression in Current Conflicts

In the case of current conflicts, self-actualization is restricted by *an actual* stressor or a need to adapt to everyday life (ICD-10 F32.-, F43.0, and F43.2). This stress often leads to burnout or severe exhaustion. Triggers can include serious physical illness, a pain syndrome, serious relationship conflict, separation conflict, grief reaction after the death or loss of a close one, or the loss of a job. In such a case, the therapist and the patient collaboratively grasp the *real conditions* in his current conflict and the *real*

magnitude of the current pressure to adapt. They look for the patient's self-developed coping strategies and appreciate them. This activates the patient's conflict processing and recognizes his ability to resolve conflicts.

Case example 61

A 54-year-old man, Mr. B., is in a sanatorium because of chronic lung disease. He is suffering from chronic reactive depression (ICD F32.2). During the diagnosis, with the help of the table stage, the therapist learns that his wife died nine years ago. Six years ago, he lost his job as a truck driver due to lung disease. His children live in a different city. Mr. B. ekes out his existence in poor circumstances as an early retiree. Despite his good ego strength, the need to adapt to his severe lung disease blocks the transition to better self-actualization. Mr. B. suffers from threatening attacks of shortness of breath. He puts a four-centimeter large stone for his 'lung disease' next to the two-centimeter small stone representing his ego on the table stage. The therapist allows herself to be empathically drawn into the patient's hopelessness. But then she notices that she is defending herself internally against the patient's paralysis. As a doppelganger, she reaches for a wastebasket in desperation, takes the stone for the 'lung disease' from the table, and puts the wastebasket in its place: "This is your lung disease. You have no choice; you must submit to your lung disease—Crap! Crap! Crap!—Is the wastepaper basket big enough for you? How did you manage to cope with this serious illness at home? What possible solutions did you find?" The patient shares many small creative solutions that he has newly developed to cope with his life. The therapist appreciates the patient's ingenuity. Symbolizing the lung disease with the wastebasket made the existential quality of his disease clear. At the end of the therapy session, everything essential in the patient's current life situation is symbolized by stones outside on the table. His various areas of conflict and his resources are visible side by side. The depressed patient perceives the abundance and diversity of his externally restricted life. That helps him reconcile a little with himself.

Patients whose depression is caused *solely by current conflicts* have, *by definition*, an excellent ability to mentalize. They can *play and change roles*. They can internally grasp and report on the conflict causing their depression. The therapist first identifies *the temporal development of the current conflict* with these patients. To do this, she uses protagonist-centered plays in group therapy, and the psychodramatic conversation (see Sect. 2.8) and the table stage in individual therapy.

If necessary, the therapist verbally *doubles* or interviews the patient during a psychodramatic dialogue with her conflict opponent in *the two* complementary roles (see Sect. 8.4.2). Soliloquy in his role, verbal doubling, the interview, and the role feedback improve his *inner* mentalization and fill gaps in his inner psychosomatic resonance between sensorimotor interaction patterns, physical sensations, affect, linguistic concepts, and thoughts. The *sharing by others* or *amplifying interpretations* during the debrief stabilizes the patient's self-actualization in his conflict. *Amplifications* are fairy tales or stories from social contexts that reflect a similar life experience. The patient recognizes himself as the hero or the heroine of the story. With his *individual* conflict, he is no longer different from everyone else. He no

longer feels excluded from the human community. This helps him to give legitimacy to his feelings and desires.

In the psychodramatic processing of an actual conflict, the therapist can orient herself on the 12 steps of psychodramatic self-supervision (see Sect. 2.9). The therapeutic effect primarily arises from role reversal. Once a patient perceived herself as a 'lump of grief' through the eyes of her conflict partner while reversing roles. The therapist confirmed that she had actually behaved in this way. This perception led to a change in her behavior *in all of her intimate relationships*. Ziehm-Kossatz (2013, p. 264 f.) once helped a patient, as a general practitioner, psychodramatically in only two sessions of 20 min each to cope with a serious current conflict.

Case example 62

"A 36-year-old, slightly overweight orthopedic shoemaker comes to my general medical consultation for the first time. He immediately gushes off: 'I've had a new job in my company for three months. A predecessor was fired because he got bogged down and left some important jobs behind. I am now doing one and a half person's job. […] I feel overwhelmed. I have trouble sleeping. I can't go on.' I ask him how he thinks I can help him. He says: 'I would like to take sick leave.' From what I've heard, that doesn't seem like a good solution. I ask him what it will be like when he returns to work after his sick leave is over. The patient: 'Then my workload would have doubled because no one else can do my work. So this would not be a good solution!' I affirm what he says and place a chair next to him […]: 'This chair represents a part of your personality that is a kind of advocate for your interests and protects you from being overburdened and ultimately falling ill'". (The therapist used the technique of a fictional doppelganger that supports the patient's healthy adult thinking. Supplement by the author). "This part also made sure you got an appointment with me. But, you are now sitting in the chair of the well-functioning employee […]. Unfortunately, I cannot help this part because I always get sick when I overload myself." (The therapist herself offers a sharing. Supplement by the author.) "But I could support your advocate! Would you please sit in the advocate's chair and tell me what your client really needs?' The patient sits on the advocate's chair and reports: 'This year (it is now the beginning of November), I have only had five days of vacation. I really need a vacation!'.

Therapist […]: 'Could you help your client enforce the legally guaranteed right to vacation?' Patient as an advocate: 'I can try.' As a therapist, I set up an additional chair for the boss. The patient describes this boss as a young, self-confident, and dynamic person. The patient presents his concerns from the role of an advocate: 'I would like to apply for two weeks' leave.' At my instruction, the patient changes into his boss's role and […] replies […]: 'But you still have to train the new colleague.' There is another role reversal. Patient: 'Others will have to take care of that, I feel drained, and I'm afraid of falling ill. I urgently need some rest so that I can do my job well.' In the rest of the play, 'the boss' approves of the vacation.

Two weeks later, the patient returns with a […] flight booking to Gran Canaria. He reports that it gave him a lot of strength to have 'an advocate by his side'. He made it clear to the boss that he urgently needed a vacation. We work psychodramatically again for twenty minutes and use the table stage to determine which tasks he urgently needs to be relieved of and how to deal with the overtime hours. I saw the patient again just before Christmas. During his vacation, the work areas were redistributed. He is now working on field and is completely satisfied with it. […] He can do his job well." In this therapy, the therapist understood the patient's symptoms of exhaustion as an expression of a current workplace conflict. She defined the conflict as a relationship conflict between the patient and his employer. She let the patient fictitiously carry out this conflict as a psychodramatic dialogue and placed an inner, fictional doppelganger at his side in the form of a 'personal advocate'. The 'advocate' helped him improve his self-actualization in the conflict with the boss.

8.4 Therapy for Depression Caused by Neurotic Conflict Processing

The constriction of self-actualization in patients with depression can result from neurotic development (ICD F34.-, F32.-, or F33.-). In these cases, they had to learn to *adapt* and *not* notice their wishes and needs *in their childhood*. They defend through introjection, denial, projection, and identification with the aggressor in conflicts. These forms of defense were the best solution for them *in their childhood*. But the patients continue to practice these *old* solutions *in their current relationships* without any awareness.

Important definition

Anna Freud (1984, p. 88) understood the defense through 'identification with the aggressor' as *a combination of the defense through introjection and the defense through projection.*

When interacting with others, each person develops an *inner image* of the conflict partner as well as an *inner image* of himself. He then acts in the *external* relationship as determined by his *inner image* of the relationship.

1. In the case of *defense through introjection* (Ferenczi, 1970, p. 100) (see Sect. 2.4.1), the patient *automatically* takes over parts of the reality construction *of his opponent* and makes them his own during a conflict. He, therefore, also perceives the opponent's misperceptions as his own *without realizing it*. For example, he also integrates the attributions and expectations of *his opponent* into his inner self-image. The patient in case example 63 (see below) constantly felt a latent tension in her relationship with her husband. Whenever she brought up the conflict, her husband always grumbled: "You're crazy. This emotional talk is never-ending!" The patient then defended by introjection and thought: "I'm crazy. I'm too emotional." "I do not feel well. So *I* am a problematic person." The patient was trapped: The further development of her inner self-image was fixated

in a 'false' self-image through introjection. This hindered her from validating *her own emotions* and resolving the conflict.

2. In the case of *defense by projection* (see Sect. 2.4.2), the person concerned is fixated on a particular object image of his conflict partner *without reviewing it any further*. Over time, by holding on to this 'false' object image, he pushes his opponent into a role complementary to his own behavior. As a result, he fights in his conflict partner what he defends in himself. The patient in case example 63 (see below) projected her *own* sense of suffering onto her husband and excused the husband's unreasonable behavior: "My husband suffers from my emotions and my *abnormal* need to talk. *That's why* he reacts so contemptuously." The further development of her object image of her husband was fixed on the image of suffering. Therefore, it did not occur to the patient to name his indifference toward her and check whether, for example, he was unable to love or perhaps had a lover.
3. In *defense through identification with the aggressor* (see Sect. 2.4.3), the person affected is firmly fixated on a specific self-image and object image through *the combination* of defense through introjection and projection. Anna Freud (1984, p. 92) defined defense through identification with the aggressor as *an unconscious "exchange between the aggressor and the attacked person"*. The hare shoots the hunter, as it were. The patient in case example 63 believed that *she was aggressive* when talking to her husband, and *her husband suffered because of her*. But in fact, she *suffered* because of her husband and *her husband was the aggressive one*.

   A patient who adapts neurotically and defends himself by identifying with the aggressor decompensates into depression,

   1. If the pressure to adapt increases even further in a situation of failure.
   2. If the external gratification for an exhausting adjustment is missing, for example, gratification for being a habitual helper.
   3. Or when the patient becomes aware of the joylessness of his life in a situation of temptation but thinks that he cannot or should not change anything.

Case example 63 (*Krüger, 2003*, p. 95 ff., abridged)

As a child, 49-year-old Ms. C. had "never done anything forbidden". She met her husband when she was sixteen. She was emotionally drawn to him because he was reliable. So he stabilized her adaptive attitude in the first instance. However, the couple had grown increasingly distant in the almost thirty-year marriage. The husband bought a motorcycle, drove it through the United States, and wanted to camp with her. But the patient did not want to go along, ultimately because of her chronic back pain. Ms. C. increasingly became aware that something was amiss in their relationship. But the husband "didn't want to talk". One day her husband suddenly separated from her and said: "I don't want to lead a life like this!" The patient was utterly shocked. She collapsed mentally and physically and reacted with massive, prolonged depression and suicidal fantasies (ICD F32.2). She was treated medically by a psychiatrist. Before the separation, Ms. C. had "always given her husband his

freedom" in order to avoid arguments: "He was allowed to do everything, and I was not allowed to do anything!" She had increasingly submitted to him and took his devaluations of her in her self-image. However, that didn't prevent the breakup of their relationship. An inpatient convalescence treatment stabilized the patient a little. In the subsequent outpatient psychotherapy, the somewhat large, clever woman would cry immediately every time she spoke about her "husband" (*continuation in* Sects. 8.4.2 and 8.4.3).

Exercise 19
Try to experience being depressed *by conscious introjecting*: Think of a relationship conflict that you have already resolved. Re-enact the conflict with your 'conflict partner' in a psychodramatic dialogue with role reversal (see Sect. 2.4.3). Please adapt yourself entirely to the expectations of your ´conflict partner´: Imagine that your opponent "naturally" *cannot* feel, think, and act *differently* and that he would suffer from your protest. Adopt the explanations he uses to justify his actions toward you as your own. Fade out from your perception all behaviors of your "conflict partner" that trigger aggression in you. Think about eliminating the disturbance in the relationship "*without* hurting your conflict partner". You will notice that you are starting to feel depressed.

8.4.1 The Basic Principle of Psychodramatic Therapy for Depressed People with Neurotic Conflict Processing

Central idea

In persons with neurotic depression, self-actualization is blocked in conflicts. The inner representing of the self-image is fixed in a 'false' self-image as a result of defense through introjection. A 'false' self-image always provokes a fixation in the inner object image, too. This further results in defense through projection (see Sect. 2.4.2). Therefore, the therapist works with two focal points: She tries to free the patient's inner self-image as well as the inner object image from their fixations using the psychodramatic dialogue with role reversal.

The psychodramatic dialogue with role reversal realizes the four metacognitive tools of natural mentalization in producing inner relationship images in the as-if mode of play, thereby freeing mentalization from its fixations (see Sect. 2.2 and Fig. 2.5 in Sect. 2.3). The internal *representing* of the relationship is fulfilled through the external scene construction, the internal *interacting* through external role play in the relationship picture, the internal *rehearsal* through the external role reversal and the internal *integrating* of a neurotic affect or behavior into other conflict images through the external change of scene.

In patients with neurotic depression, the inner processing of conflicts is blocked by defense through introjection, projection, and identification with the aggressor. The psychodramatic dialogue frees their conflict processing from their blockades. As a result, his conflict-solving abilities are again freely available to him in the next

real encounter with his conflict partner. He can reorient himself and *look for a new appropriate response to the situation.*

From 1936, Moreno initially worked 'only' with role-plays (see Sect. 6.8.1) in his development of psychodrama therapy in his sanatorium. He was not yet familiar with the direct exchange of roles between the patient and an auxiliary ego which takes on the role of the conflict partner in the play (Moreno, 1945, p. 11 ff.; 1985, p. 185 ff.; 1959, p. 221 ff.). It was in 1959 that he first described the *role reversal* in protagonist-centered plays in the writings accessible to me (Moreno, 1959, p. 248 ff.). At that time, he reported on a treatment described by Robert Drews (Group Psychotherapy VI, 1952, quoted in Moreno, 1959, p. 248), which had taken place in 1946.

Case example 64

The therapist healed a patient, Mr. Rath, in only three therapy sessions. He had suffered from writer's cramp for fifteen months and thus could not work. Three of his fingers on the writing hand, "the middle, ring, and little fingers were bent in various positions". As a result, the patient was incapacitated in his job as a court reporter, and his income became meager.

During the first therapy session, Mr. Rath told the therapist about a relationship conflict with his superior, a judge. He had initially supported the judge when he was conspicuous in court due to his alcohol addiction. However, the judge increasingly despised the patient and ended the friendship. Until the initial therapeutic conversation, the patient had "not expressed his feelings to the judge or anyone else for that matter".

The therapist let the patient take on the role of the judge in the first therapy session. The therapist himself played the role of Mr. Rath, imitated him by doing his paperwork, and was submissive and humble. He thereby mirrored the patient in an unexpressed manner. In the role of the judge, Mr. Rath was at first humorous and witty but then increasingly tense, angry, and hostile. Finally, he turned red with anger, raged, and insulted Mr. Rath, played by the therapist. He knows too much. That would be enough to bring him, the judge, to the gallows.

The therapist and the patient changed roles. The therapist himself took on the role of the judge. In his role, Mr. Rath began "to attack the judge […] in coherent, profane, and hurtful language. He walked around the room with quick steps, sweating, cursing. […] He spontaneously clenched his right fist with his cramped fingers and hit the table with such force that the glass plate cracked. About five minutes after the discharge […], he started crying and yelling that he had been a damn coward for enduring this miserable comedy for so long […]. Then he sat down […] and wept silently to himself. […] Then, the patient got up again and noticed that his 'paralyzed' fingers were free, flexible, and relaxed. Delighted, he exclaimed: 'My God, I am healed!'" He called his wife and told her.

A catamnestic survey in 1952, seven years after treatment, discovered that 'his hand was in perfect shape'. His relationship with the judge had changed. The patient had been accepted into a legal firm on the judge's recommendation and was 'now the successful head of a staff of court reporters'. What is remarkable about this

case example is that for the treatment to be successful, it was not necessary to link the patient's compliance with an authority figure with similar experiences in his childhood: There was 'no psychogenetic penetration of his life experience outside of the patient-judge relationship'.

The patient was fixated on defense through identification with the aggressor, i.e., in the combination of defense through introjection and projection (Freud, 1984, p. 88). He had *defended through introjection* and, in doing so, adopted the judge's accusation and felt guilty without realizing it. He also *projected* his perfectionism and sense of justice onto the judge and submitted to it.

The therapy was successful because the patient reenacted, reviewed, and changed his inner self-image, object image, and causal construction in the relationship conflict with the judge. He did so with the help of the psychodramatic dialogue with role reversal in the as-if mode of play (see Sect. 2.4.3).

(1) The therapist first invited the patient to change to the opposite role and explore the inner reality of the judge in the relationship through *psychosomatic acting*. It helped him dissolve his projection of perfectionism and sense of justice and his denial of the judge's inhuman behavior. (2) First, the therapist himself enacted the behavior of the docile patient as an auxiliary ego. The patient perceived his own behavior through the eyes of the judge as cowardly. That didn't fit with his self-image. He felt angry with himself for conforming, and angry at the judge for his unjust behavior. (3) In his role, he allowed his previously suppressed anger toward the judge beyond the previous reality. In this way, he self-actualized in relation to the judge and dissolved his defense by introjecting the blame. The cathartic psychosomatic integration of his anger into the relationship image made his writer's cramps disappear. The patient became spontaneous through the dissolution of his defense through identification with the aggressor in the relationship with the judge (Moreno, 1974, p. 13). He *internally* perceived the judge anew in the following encounters in real everyday life. He, therefore, also *externally* behaved in a new way toward him and appeared more courageous. This made the judge respect him again, or at least fear him more. As a result, the judge even advanced the patient's career.

Central idea

In patients with *neurotic depression*, *internal role reversal* is blocked in a conflict. In relationship conflicts, they have relatively rigid images of themselves and of their conflict partner through a combination of their defense through introjection and projection. However, with the help of psychodramatic dialogue and *free external role reversal*, they can liberate their object image and self-image from their neurotic fixations. This, in turn, liberates the patient to *reorient* himself *in real life* in the encounter with his conflict partner and to look for a more appropriate solution. *Without planning it,* he spontaneously acts more appropriately in his relationship conflict and becomes more self-confident and expansive.

8.4.2 The Seven Steps of Psychodramatic Dialogue in Neurotic Depression

Recommendation

In the therapy of people with a neurotic arrangement of relations, the psychodrama therapist uses the technique of *diagnostic psychodramatic conversation to lay the foundation of the therapeutic work* (see Sect. 2.8 and Fig. 2.9). She represents the patient's symptom scene with two additional chairs in the therapy room for self-image and object image in his everyday conflict. As a result, the patient and the therapist view the patient's relational conflict from the meta-position. The patient perceives himself from the outside as interacting *separately from* his conflict partner and becomes a doppelganger for himself.

In the psychodramatic dialogue with role reversal, the patient further develops his self-image and also his inner object image through psychosomatic acting in the as-if mode of play. In doing this, he complements his psychosomatic resonance patterns between his memory centers of sensorimotor interaction patterns, physical sensations, affects, linguistic concepts, and thoughts (see Sect. 2.7). *Psychosomatic participation* is the difference between psychodramatic dialogue and psychodramatic conversation. Therefore, Moreno (1959, p. 98) says: "Speech is important. However, action precedes and includes speech." The *psychodramatic dialogue with role reversal* is always a joint effort between the patient and the therapist. The therapist uses her intuition to follow the patient's psychodramatic conflict processing and, if necessary, intervenes with psychodramatic methods. When working with the psychodramatic dialogue and role reversal, the therapist uses *seven different steps* to improve the patient's self-actualization in the conflict, if necessary. These liberate the inner self-image *as well as the inner object image* from their fixations in conflict:

1. *The therapist* herself takes on the role of the patient in the psychodramatic dialogue and *acts on his behalf* as his doppelganger. The patient changes into the opposite role of his conflict partner.
2. In his role and in changing the role, the patient *reenacts* a confrontation from memory with the associated interaction sequences in chronological order.
3. In a hypothetical psychodramatic dialogue with role reversal, *the patient* behaves *more expansively of his own volition* in the relational conflict and tries something new by going beyond reality.
4. The therapist and the patient discuss the previous psychodramatic play. In the *focal role feedback*, they look for what has been new or has become more apparent in the last play. In doing so, they validate the expansion of the patient's self-image and object image in his conflict, if available.
5. Mirroring from the meta-perspective: The therapist and the patient jointly name the behavior of the patient's conflict partner from the meta-perspective and look for amplifications for the conflict.
6. The therapist takes on the role of the patient in the psychodramatic dialogue, if necessary, and *mentalizes as a doppelganger on his behalf*. In his role, she expresses, going beyond reality, what she thinks, feels, and perceives in the

interaction with his conflict partner. The protagonist takes on the role of his conflict partner in the play.

7. As a doppelganger, the therapist *conducts contract negotiations* with the patient's "conflict partner". *As a doppelganger*, she tries to negotiate a more appropriate balance between giving and taking in the patient's relationship conflict and thus to make the relationship *systemically fair*.

In each therapy situation, the therapist only applies the steps of the psychodramatic dialogue indicated currently. The more patients with depression are fixed in the defense through introjection and projection, the more they need the therapist's or group members' help (see Sect. 8.4.5).

1. *The therapist, as a doppelganger, takes on the patient's role in the psychodramatic play.* Depressed patients often protest about what happened to them. They express their *suffering* from the event but do not name their *own feelings* in the conflict situation because they defend themselves self-injuriously through introjection. In doing this, they often project their strict or sadistic superego onto their conflict partner. Patients who think masochistically often refuse to work through their conflict psychodramatically because the inner representation of their self-image in the conflict is blocked by an authoritarian conflict partner (see case example 15 in Sect. 2.14 and case exmample 70 in Sect. 8.5).

Central idea

Projection and introjection stabilize each other and add up to defense through identification with the aggressor. The patient projects his own positive characteristics onto the conflict partner, otherwise, he would not be able to maintain his defense through introjection.

When there is a blockage in the inner representation of the self, the therapist first tries to free the patient's *inner object image* from its fixation through projection. Thus, the defense by introjection is no longer stabilized by defense through projection. The therapist herself plays the role of the patient and, as a doppelganger, verbalizes what she thinks and feels *on behalf* of the patient. The patient himself assumes the role of his conflict partner and reacts as he thinks he would act. It usually turns out that the conflict partner is *different* from the patient's own sadistic superego. Or the therapist and the patient realize that the conflict partner is truly as bad as the patient described him. For instance, the patient in case example 63 immediately panicked due to the projection of her severe superego onto her husband when asked to assume her own role in the psychodramatic dialogue with her 'husband'.

Case example 63 (1st continuation, see* Sect. 8.4*)

During therapy, Mrs. C. decides to deal with her marital conflict psychodramatically. The therapist represents her inner relationship picture with two empty chairs. At the beginning of the play, Mrs. C. wants to take on her own role in relation to her 'husband' on the empty chair. But she immediately begins to cry helplessly. Therefore, the therapist himself takes on the role of the patient as her doppelganger. He asks her to switch to the role of her husband. The therapist assumes her posture. He verbalizes her thoughts and feelings toward her husband on her behalf. In terms of content,

he adheres to the information that Mrs. C. had previously given in the therapeutic conversation: "I cannot live like this. I know nothing of you. I trust your promise. But when I am in need, you are not reachable. I'm desperate and disappointed!" In doing this, the therapist expresses the patient's inner despair through his gestures, facial expressions, and inner attitude. Mrs. C. has changed to the role of her husband. But she remains herself: "Now my husband would be leaving the room. He always says I shouldn't be so emotional!" The therapist doesn't want to force anything. So he interrupts the play and moves on to the debriefing: "When in your role, I noticed some anger rise in my stomach from deep down below. I was petrified of this anger but was also fascinated by it." Mrs. C.: "I'm feeling sick!" The therapist interprets her body sensation as a psychosomatic reaction to the relationship conflict: "It's as if you get a poisoned apple from your husband and swallow a bite of it, just like Snow White did from her stepmother".

After the play, the therapist and the patient used psychodramatic conversation (see Sect. 2.8*) to discuss how the marital conflict had come about: What had the patient experienced in the conflict with her husband so far? In retrospect, what did she see as the cause of the conflict? During the debriefing, the therapist repeatedly pointed to the patient's chair on stage or, if necessary, to her husband's chair. He supported her in verbalizing her feelings. (2nd continuation below).*

In the play, the therapist *acted as* the patient's *doppelganger. He* freely expressed *his* experience in *her* role. In the role of her husband, the patient perceived herself, played by the therapist, as a tormented person from the outside. In doing so, she developed empathy for her own feelings. Patients with neurotic depression are often deeply touched when the therapist, as a doppelganger, authentically plays out their feelings of suffering in their relationship conflict. They are amazed that another person understands them so well and can put their feelings into words (see case example 15 in Sect. 2.14 and 19 in Sect. 4.4).

Question
Why does the patient integrate the therapist's statements as a doppelganger into his self-organization?

Answer
Because the statements made by the therapist as a doppelganger perfectly complement the patient's psychosomatic resonance pattern in his conflict. In doing this, the therapist must fully identify with the patient and bring the patient's thinking and feeling, on his behalf, into the as-if mode of thinking. She should not want the patient to be different than who he is.

2. *Re-enacting a memory*. The patient and the therapist work together to reproduce the patient's inner construction of reality in her past conflict in the as-if mode of play. A group member or, in an individual setting, the therapist himself takes on the counter-role as an auxiliary ego (see Sect. 8.4.4). In a psychodramatic dialogue with role reversal, the patient shows the *temporal* sequences of interactions in a *recalled* confrontation with her conflict partner in both roles. That dissolves the

defense through denial (see Sect. 2.4.2). Taking on the counter-role also dissolves the defense through projection (see case example 63, 4th continuation below). In the counter-role, the patient reproduces the inner sensorimotor interaction patterns, physical sensations, affect, linguistic concepts, and thoughts of her conflict partner *psychosomatically*. She thereby expands her image of the object and liberates it from its fixation. Thus, she recognizes anew how her conflict partner ticks. She thus perceives the reality of her conflict partner in a new way in everyday life.

3. *The patient tries something new out of her own will in a psychodramatic dialogue with role reversal with her conflict partner*. The therapist asks the patient to rehearse her conflict in the as-if mode of play: "Do you want to express your thoughts and feelings to your husband here in the role play?—It's not about whether you *do* the same to him *in real* everyday *life*! We are only working on your inner picture of the relationship. We will pretend that your husband is sitting across from you. In reality, of course, your husband is sitting at his computer at his place of work." *In the as-if mode of play*, the patient verbalizes *what he feels and thinks, beyond the previous reality,* and demands what he needs. In this third step of the psychodramatic dialogue *in the as-if mode of play*, the patient *tries a new action* of his own volition in the conflict. In doing so, he expands his self-actualization in his inner conflict image and dissolves his *defense through introjection.* The patient should "only" communicate *his truth* to his 'conflict partner'. There is the *subjective truth of the conflict partner* and the subjective truth of *the patient*. It is not about blaming the conflict partner.

The therapist *often* has the patient *reverse roles* during the *rehearsal*. In the opposite role, the patient shall develop the appropriate response to *each* of her own statements. In the role of her conflict partner *in role reversal*, she assumes *his* posture to get well settled into his holistic self-organization.

Recommendation

If necessary, the therapist *verbally* asks the patient how she feels in the conflict partner's role. In the play, however, as an auxiliary ego, he only repeats what the patient truly said in the conflict partner's role. Thus, in the role of her conflict partner, the patient may discover a possible *discrepancy between* the thinking and acting of her conflict partner.

The mental rehearsal expands the patient's knowledge of cause and effect in her relationship conflict. In the subsequent encounter with her conflict partner *in real everyday life*, she will then know how her conflict partner would react to her *old* behavior. But she *can* also leave out her old behavior and look for new, more appropriate behavior in the relationship. The dissolution of the defense through identification with the aggressor results in the patient spontaneously changing her behavior toward her conflict partner.

Central idea

Role-theory-oriented psychodrama therapists focus mainly on the patient's role development *in his own role, i.e., on the development of the role of self-representation* (see Sect. 2.14). In this way, they fail to resolve the projection that stabilizes the patient's fixation in a self-injurious self-image. But, the patient must liberate her *object image* from fixation, too. In

this way, she recognizes appropriately whether and how *she* can influence the behavior of her conflict partner.

Empathy cannot replace the external role reversal with the conflict partner. In a role reversal, the protagonist *psychosomatically* experiences how her conflict partner ticks *internally*. She assumes her conflict partner's role and retraces the neuronal connections between his memory centers of sensorimotor interaction patterns, physical sensations, affect, linguistic concepts, and thoughts. The *psychosomatic* experience in his role gives her experience a greater degree of certainty than a mere *internal* role reversal.

Case example 63 (2nd continuation, see above and Sect. 8.4)
For the first time, Mrs. C. takes on her own role in a psychodramatic dialogue with her husband. The therapist takes on her husband's role as an auxiliary ego and insults Mrs. C. according to her instructions: "You're crazy! This emotional talk is never-ending!" Ms. C. answers and directs the conversation to their son Walter: "When you talk to him on the phone, you don't even ask him how he's doing!" Mrs. C. and the therapist switch roles. Mrs. C. responds from her husband's role: "Walter doesn't even want to talk to me anymore. You are raising him. That is your bad influence!" Back in her own role, Mrs. C. defends herself desperately from her husband: "I tried to persuade Walter to call you. But he didn't want to. Now I stay out of it!" The therapist changes into the role of Mrs. C. and repeats her statements. The protagonist remains rigid in her husband's role: "That is your influence, that is the result of your upbringing!" The therapist and the patient recognize that Mrs. C.'s husband does not seem to be or is no longer willing to question his behavior for her sake. Her husband's negative attitude is evidently a reality and not a projection. (3rd continuation below).

The therapist can use a *short form* for the 3rd step of the psychodramatic dialogue. She instructs the patient to adequately practice the 12 steps of psychodramatic self-supervision (see Sect. 2.9) in the therapy room. This method includes the 3rd and 4th steps of the psychodramatic dialogue. It only takes 15–20 min.

4. *Intermediate discussion with focal role feedback and psychodramatic conversation*: In *focal role feedback,* the therapist specifically asks the patient: "Did you experience something *new in the play* in your conflict partner's role or your role? Or has something just *become clearer* to you in the play?" With these questions, the therapist prompts the patient to compare her experience in the play with her experience in everyday life *and* to recognize differences autonomously. Thus, the patient learns to perceive differences in her psychosomatic experience in everyday life. The therapist actively gives her responsibility *for her own* mentalizing in conflict. The patient writes down her answers to the two questions on a piece of paper (see Sect. 2.9). She then verbally communicates them to the therapist. Sometimes the patient does *not* recognize a new experience *herself*. In such a case, the therapist draws the patient's attention to what she herself said in the play: "Did you know, *before the play,* that your conflict partner is afraid of your spontaneity?".

Central idea

It is important to quickly write down the seemingly small *new* experiences in the two roles in the play because protagonists forget their new *psychosomatic* experiences in the roles within a few hours. They often "only" remember the *interpretations* they have derived from them. But, a new *psychosomatic experience* in one of the roles changes the inner relationship image and has a more lasting effect than an interpretation.

The therapist validates the patient's *new* experiences and thereby gives them importance. Then, if necessary, he explains to her *how* her new experience could possibly change the relationship with her conflict partner *in real everyday life*: "In the play when in the role of your boss, you noticed that his distant behavior is only for *self-protection* and that he *does not reject* you. Believe it! You will notice: this perception changes your relationship with your boss when you meet him again."

The therapist repeatedly uses the method of *psychodramatic conversation* in the interim discussions (see Sect. 2.8). To do this, he places chairs for the patient's self-representation and object representation in their conflict outside in the therapy room (see Fig. 2.9 in Sect. 2.8). By looking at the symptom scene, the protagonist experiences her own truth in the relationship as well as that of her conflict partner as *existing side by side*. She perceives the conflict between herself and her conflict partner *systemically* as a *relationship conflict* and no longer just her individual problem.

5. *Mirroring from the meta-perspective and searching for amplifications*. If necessary, the therapist and the patient look at the two chairs representing the relationship conflict from the outside. They describe what happens between the two conflict partners and how they perceive the conflict partner's external behavior from the meta-perspective. "How would you describe your conflict partner's behavior?" This is the technique of mirroring. Sensitive patients often use a term in their response that describes the *absence of a positive quality*. For example, they say 'he is unempathetic' or 'he is disrespectful' instead of 'he is selfish' or 'he is arrogant'. They avoid calling the negative or evil by its name. This helps them deny their own negative affect toward the egoistic conflict partner. In such a case, the therapist asks the patient: "No, please do not use the term 'unempathetic' and 'disrespectful'. Say *what is* and *not what is not*!" By using an adequate term, the patient gives herself permission to perceive her conflict partner's negative behaviors and characteristics and react emotionally appropriately (see case example 63, 4th continuation).

If necessary, the therapist and the patient also look for *amplifications* for the patient's conflict in the psychodramatic conversation. For example, it can be a relationship image from a fairy tale. Or the therapist talks about other patients who have had similar experiences and how they dealt with such a conflict. Or she describes symbolic images from social references. The sharing of participants in a *group* setting (see Sect. 8.4.5) also have a similar function as the amplifications of the therapist in the individual setting. The *amplifications* positively confirm the patient's

self-actualization in her conflict. The patient learns to validate her feelings and perceptions.

Case example 63 (3rd continuation, see above and Sect. 8.4)
At the beginning of the session, Mrs. C. says: "I don't know what to say. Actually, I'm fine now, much better than a year ago. But when the conversation turns to my husband, I keep crying." Spontaneously she adds: "I have always avoided any points of friction that could have led to arguments in my relationship with my husband. I've always felt like I'm not normal. Whenever we fought, I was always told: 'You're crazy! This emotional talk is never-ending!' But if my husband was in a bad mood, for example, because of something at work, he could let it all out. I couldn't!" The therapist: "It seems to me that your husband is behaving like a tyrant. But Gandhi already said: "Tyranny is not the fault of the tyrants but of the oppressed! For if you would not allow yourself to be oppressed, there would be no tyrants'" (4th continuation below).

6. *Vicarious mentalization as a doppelganger*. In the case of *a strong neurotic fixation*, the patient often remains stuck in the defense through introjection and projection. The patient *also* does not dare to openly share her truth with the conflict partner, *even in the play*.

Central idea

In such a case, the therapist identifies *spontaneously* with the oppressed self of the patient in her conflict and *feels constricted on her behalf*. He then often reacts with countertransference and would like the patient to be different from what she is. For example, he *verbally* asks the patient to be more expansive in her role. However, the patient then often feels criticized and develops a negative transference to the therapist.

Recommendation

It is therapeutically more productive if the therapist experimentally takes on the patient's role and makes *his protest* useful for the therapy. For example, as a doppelganger, he integrates his affect into the patient's conflict image *on behalf of the patient* on trial in the as-if mode of play. In doing this, the patient plays the role of her conflict partner. The patient and the therapist thus *jointly* answer the question of cause and effect in the relational conflict: Does the patient's conflict partner behave in such an authoritarian manner only because she demonstrates no resistance? Or does she adapt to him because her conflict partner is so authoritarian? (see case example 15 in Sect. 2.14)

In *vicarious mentalization as a doppelganger*, the therapist mindfully verbalizes *his* true physical sensations, affect, motivation, and thoughts toward the "conflict partner". He actively justifies, on behalf of the patient, why it *is the best solution* for the patient to think, act, and feel so inhibited. As a doppelganger, he states his motivation, and, in the process, integrates ethical values and personal necessities into his argument. The patient is mostly fascinated by being understood so well (see case example 19). In this way, the therapist and the patient together assess whether the "conflict partner" *would* react empathetically with the patient verbalizing their

feelings and thoughts. That would be the case in a loving or respectful and not merely functional relationship (see case example 5).

Case example 63 (4th continuation, see above and Sect. 8.4)
The therapist requests the patient: "I would like to try something different with your husband in your role in the play. Please play your husband's role and try to react the way your husband would!" The therapist takes on the patient's role and turns to her 'husband': "You have changed: In the past, one could rely on you. We got married, built a house, and started a family. You thought it was good back then, just like me! Now I don't even know you anymore! You want to be the father of our son, but you ignore him. What do you feel about it?" Mrs. C. as her husband: "I think Walter could care a little more for me!" Therapist as doppelganger: "No, I do not want to know what you think. I want to know what you are feeling!" Mrs. C. slips out of the role of her husband: "My husband would have left the room long ago!" The therapist: "You are your husband. If he would have walked out, then you go too!" Mrs. C. gets up from her chair. In the role of Mrs. C, the therapist feels disappointed and angry. He yells: "You are a coward! You are a coward! A motorcyclist but such a coward! When things get tough, you always just run away!".

In the debriefing, Mrs. C says: "I didn't feel anything in my husband's role!" The therapist confirms: "When I played your husband's role, I felt the same way. What you said did not affect me very much. I held a shield in front of me and was careful not to let my wife's allegations hit me. In truth, my thoughts were elsewhere. I hoped the conversation would soon be over because my girlfriend was waiting." Mrs. C.: "Actually, after my treatment in the psychosomatic clinic, I decided: 'I don't want to understand my husband anymore.' Do I need to understand him?" The therapist: "No, you shouldn't learn to understand him by playing his role here. The point is that you should recognize its inner reality! That you know how he functions on the inside! Because if you know how he thinks and feels, it is easier for you to assert yourself against him!" Mrs. C.: "I once went after him and asked him why he wanted to separate." The therapist: "I think you know why he's leaving, and you don't need to ask him anymore, do you? He's afraid of losing his freedom! He thinks that he is a great guy. He is uncomfortable with being questioned by you. He is a coward! You should dare to call a spade a spade, at least in front of yourself." Mrs. C.: "Maybe I should tell him he is a coward!" (5th continuation in Sect. 8.4.3).

7. *Vicarious contract negotiations.* If the "conflict partner", *enacted by the patient*, continues to react uncompromisingly and authoritatively *in* the first six steps of the psychodramatic dialogue, the therapist moves on to the 7th step, the vicarious contract negotiations. Doing this, the therapist, as a doppelganger, demands *a different external behavior* from the "conflict partner" in the relationship. The therapist does not need to or have to know *before* the play what he wants to ask of the "conflict partner". He may initially engage in the *soliloquy* in the role of the patient. In doing so, he integrates all the information he has from her in his actions, physical sensations, affect, and thinking *in her role*. In this way, he feels the patient's *actual needs and desires* (Krisztina Czáky-Pallavicini 2014,

only orally communication). While in the patient's role, he intuitively searches for what she would need from the conflict partner to improve the *quality of the relationship.* The *demand* can seem small: "If you want to end our friendship, I wish that we agree, nevertheless. Please allow me to email you at least every two months and ask how you are. And I would like you to reply to me with one sentence. Is that possible for you?" Or: "I'm allergic to your contemptuous tone. I got enough of that from my mother when I was a kid. I didn't need that again. I want you to be caring with me." In the role of her conflict partner, the patient responds the way she believes the conflict partner *would*.

The therapist *ethically* justifies his demands toward the patient's "conflict partner" with general human values and norms. He demands, for example, "respect for the other" or "fairness in giving and taking". In this way, he investigates whether the patient's "conflict partner" would take the patient's wish *seriously* because of rational factors and whether he would be willing to come to a concrete compromise. The goal is a *systemically fairer relationship*: "I want and need from you … and I am also ready to give you this and that."

Important definition

There are two types of justice, legal and intersubjective. Legal justice is determined by external rules or laws. But *intersubjective justice* has to be renegotiated in every new situation. Ultimately, relationships only succeed if both partners *try to do justice to one another and themselves.* Only then will the resources of *both* relationship partners be fully used in the situation. A hiking group can, for example, set up the rule that each group member should carry the *same amount of weight* in their backpack. However, if *one* hiker has a fever, it is intersubjectively fair for *another* hiker to take some of the sick person's luggage, unlike the day before. In this way, everyone moves forward better together.

Intersubjective, systemic justice is already described in the Christian Bible as a central development principle for relationships. The focus of systemic justice is inherently emancipatory. It helps to hear the voices of the oppressed and the excluded and to make their experiences fruitful as a resource for social contexts. The doppelganger technique and role reversal can help to process this systemic development principle in a relationship conflict (Krüger, 1997, p. 174). *Sustainable* conflict resolution is about *cooperation* and not victory or defeat. The seven steps of psychodramatic dialogue in the as-if mode of play systematically help widen the possibilities for *cooperation in the conflict* (see Sects. 2.1 and 2.9).

Central idea

Self-actualization *succeeds* when the individual lives their *abilities* and limits in the relationship (Ciompi, 2019, p. 186) and integrates themselves into the *community's well-being* (see Sect. 2.1). It is a *dialogical process of self-organization.* This process includes the development of the inner self-image and object image in the given situation. The inner self-image and object image constantly change as the external situation is continually evolving. A *sustainable solution* to the conflict comes about when *both* conflict partners free their inner self-image and object image in the conflict from their fixation through the defense and develop them further to suit the external reality. Thus, they can *cooperate* in shaping external reality.

The vicarious contract negotiations are therapeutically fruitful even if *the therapist* fails with his request to the "conflict partner". If the patient, in the role of her "conflict partner", rejects *every* suggestion from her doppelganger, it indicates that she is indifferent to her conflict partner. The "conflict partner" doesn't see any advantage if he were to respond to her wishes. The patient then *realistically* assessed her conflict partner before the play and *does not* defend through projection. The therapist and the group members recognize *the true extent* and the drama of the patient's relationship conflict for the first time. They positively affirm that the patient thinks, feels, and acts appropriately toward his conflict partner.

But if the "conflict partner" is ready for a systemically more equitable solution to the conflict, the patient realizes psychosomatically, in the counter-role, that there is *more room* in the relationship *for her self-actualization* than she previously thought. She expands her inner image of her conflict partner and dissolves her defense through projection. In the subsequent encounter in real everyday life, she will see him with a different set of eyes and behave more demandingly on her own. Because she knows that he would respond to her wishes, even if perhaps reluctantly (see case example 15 in Sect. 2.14).

After steps 6 and 7 of the psychodramatic dialogue, the patient does *not change back to her role*. She should *not practice* the behavior demonstrated by the therapist. That would be premature pushing. It could trigger the patient's superego prohibitions and, thus, worsen her depression. *The therapist* should take responsibility for *his* expansive behavior *in the patient's role* because *he* wanted to rehearse and investigate the cause and effect in the conflict and whether the patient 'only' defends through projection. The patient experiences that, *in the role of her conflict partner,* she does not break down, become violent, or end the relationship if her doppelganger, the therapist, behaves more expansively. Her physical and emotional experience in the role of her conflict partner differentiates and expands her inner image of him and liberates her object image from its fixation. She becomes internally free to perceive her conflict partner without projections in everyday life. As a result, she then *autonomously* finds a new and appropriate behavior for the current situation. She must *not rehearse* a new behavior. A new behavior, recommended by the therapist or group, would hinder her from behaving appropriately in the current situation in everyday life.

Central idea

Some therapists who observe the psychodramatic vicarious mentalization and contract negotiations in a seminar, rate these procedures as a *directive style*. In doing this, they get caught in internal-external error (see Sect. 2.14). The therapist and the patient work together on the patient's *inner images* and do not modify his *behavior in real everyday life*. I have never had an experience where a patient simply adopts the therapist's arguments and negotiation goal from the representative contract negotiations. In steps 4–7 of the psychodramatic dialogue, the therapist adheres to the *rule of abstinence* more clearly than if he would *verbally* suggest a different role behavior toward the patient's conflict partner.

Exercise 20

You cannot understand these processes just by reading them. The therapist develops his therapeutic impulses from his *psychosomatic perceiving* in the encounter with

the patient. Therefore, try to apply steps 6 and 7 of the psychodramatic dialogue in counseling or therapy. You will notice: There is a difference between *watching* steps 6 and 7 from outside as an observer or *psychosomatically acting them* as a doppelganger. Your acting as a doppelganger liberates the patient from defense through projection. By changing her inner object image, the patient *autonomously* finds a new appropriate solution for the current relationship conflict in her everyday life *without* any therapeutic help.

Central idea

Defense is a dysfunctional *metacognitive* process, which produces the same old dysfunctional thinking, feeling, and acting in new conflict situations. If the patient dissolves the defenses in his conflict with the help of *metacognitive psychodrama techniques*, he will automatically arrive at new thoughts in the process of dealing with the conflict. We call this new thought process the 'surplus reality'. The patient then *perceives* the reality of his conflict in everyday life with a fresh set of eyes and, *therefore, also acts differently and more spontaneously* in his conflict in everyday life. That is the secret of the therapeutic effect of the psychodramatic dialogue with role reversal.

8.4.3 The Integration of Improved Self-actualization in Relationship Images from Childhood

Recommendation

In treating people with depressive disorders, the therapist initially addresses the patient's *current* conflicts in a *solution-oriented* manner by applying the psychodramatic dialogue with role reversal. In steps 6 and 7 of the psychodramatic dialogue, the patient resolves his defense through introjection and projection and experiences that he *can influence* the external behavior of his conflict partner and change it. However, many patients wonder why it is so difficult for them. This experience then lets them *spontaneously* search for *why* they have always adapted so strongly to the expectations of others *until now*.

Case example 63 (5th continuation, see Sect. 8.4 and 8.4.2)

In the following one-on-one session, Mrs. C. starts by saying: "I asked my father whether he actually wanted a boy. He was furious! He said: 'That was your grandmother! When you were born, she said: 'Another girl!'" The therapist: "So you have a permanent place in your father's heart!" Mrs. C. spontaneously: "Yes!" She radiates heartfelt joy at this thought: "Yes, my father never really liked my husband. He found him brash and naughty." She continues: "My mother told me: Until I was five years old, I was always a delightful child, and I laughed a lot. My cousin's husband also said: 'You were always so friendly!' Somehow others seem to see me differently than I see myself!" Mrs. C. is on the way to rediscovering herself. The therapist: "Are you amazed?" Mrs. C: "Yes. If I relate that to what my husband said, that I keep bickering and nagging, I feel a bit stuck, and it still impacts me. Sometimes I still feel worthless. But sometimes, I can snap out of it again!".

In the following therapy sessions, the therapist and the patient use psychodramatic dialogue to explore further the causes of the failure of the marital relationship. Mrs.

C.: "In my relationship with my husband, I was always made to be the ass! Now my mother has also said: 'He was very dominant.' Over time, it seems like that to me as well. Years ago, a friend said that my husband was a maverick with a wife and a child!" In the following therapy session, Mrs. C reports: "I visited my parents on the weekend. Even there, we talked about my husband. I said, 'He was a prick!' My mother laughed. But my father made telescope eyes like that!" She playfully holds her hands to her own eyes and shows how she imagines telescope eyes. As a child, the patient had never done anything forbidden. But now, she feels fun shocking her bourgeois father with her choice of words.

After a four-week vacation, Mrs. C. ponders during the therapy session: "I'm thinking about whether my son and I should move out of our house. I don't particularly appreciate that my husband can walk into our house and behave in any way he wants. I'm fine. I am blissful. I simply have to be careful not to lose the ground under my feet. Only in the last few weeks have I realized that the people I am with support me. So many say: 'Do it! Move out of your house! We'll come and help.' I think they've been supporting me all along. But I am only noticing it now! When I recently called my husband about a tax payment, I told him I was looking for a new apartment. And that we have to think about whether we should get a divorce. He went very quiet and only said yes or no. When I hung up, I didn't feel as cramped and uncomfortable as I usually did after using the phone." The therapist: "Now the buck lies with your husband. Now he has to decide and respond!".

Many psychodramatists let their depressed patients switch to childhood scenes relatively quickly when dealing with *current* relationship conflicts psychodramatically. Together, they explore *the childhood scenes* for reasons that may explain their patients' strong willingness to adapt in the present. This process tempts the patient and therapist to believe that the current conflicts would *not exist if the patient had had a "better childhood."* In extreme cases, the patient finally knows a lot about the genetic causes of his current conflict but he has changed little (see Sect. 7.1). Or he tries, with a positive confirmation from his therapist, to assert his needs without any consideration for the needs of their conflict partner.

Central idea

When reenacting scenes from childhood, the patient psychosomatically experiences that his mother, for example, didn't take an interest in his thinking and feeling as a child. He then knows *why* he is so allergic to his wife's distancing. However, he doesn't know if his wife would accept him asserting himself. Reenacting scenes from childhood doesn't resolve the defense through projection in *current* conflicts. The patient remains fixated in the old object image of his conflict partner. With the help of the psychodramatic dialogue with role reversal, the patient must *check if* his conflict partner behaves dominantly because *he* always adapted, or if *he* adapted because his authoritarian conflict partner allows no compromises.

The black-and-white pattern of *either* self-fulfillment *or* adaption doesn't apply in relationships. They always exist side by side. A relationship conflict must be resolved *systemically* if the solution is to succeed in the long term. *Both* partners in a *couple relationship*, for example, benefit from the relationship in the beginning through mutual love and appreciation. After a while, however, they enter the second phase of the relationship, the *battle for resources.* Who is allowed to realize their

own interests to what extent in the relationship? The battle for resources triggers old neurotic solution patterns in both partners. As spouses feel connected, they learn to resolve most of these conflicts with one another over time. However, despite all love, a *mutual neurotic allergy* sets in (Krüger, 2010). Two things come together: (1) What is progress for the *inner child of the husband* triggers an old neurotic wound *in his wife* and gives rise to negative transference in her. (2) *In addition, however,* what is progress for the *inner child of the wife also* triggers an old neurotic wound *in the husband* and *also* leads to a negative transference *in him.* In this situation, there is only one solution: If the relationship is to survive, the partners must inform each other about their neurotic or traumatic wounds and try to be mindful of the other's wounds. In this way, the partners free the blocks in their inner role reversal. They can come to an agreement: If the *husband* doesn't keep an appointment, *he* should tell how important his other duty is *for him* on a scale from 1 to 10. If he says 10, the wife must let him go. However, the wife should also say how important it is *for her* on a scale of 1–10 that he stays, because otherwise, her childhood trauma film of being an unwanted child will come alive. If *she* says 10, the husband *must* stay with her no matter how urgent his other duty is. This agreement empowers both partners to act mindfully *in a potentially retraumatizing situation.* They don't have to separate from one another to protect themselves.

Case example 65

A patient had realized during therapy that she would decompensate into a trauma film whenever her husband distanced himself from her in an argument and frowned. She worked through the marital conflict with the help of psychodramatic dialogue. However, the first six steps did not lead to a solution. The therapist, therefore, continued to the 7th step of the psychodramatic dialogue (see Sect. 8.4.2*). As a doppelganger, he informed the "husband", played by the patient: "When you frown, I always slip into a trauma film. I need three days to feel stable again. You know how it was for me in my childhood with my hot-tempered father. So if you frown, may I ask you what you are feeling and thinking in the moment? Would you be ok with that? You also benefit if I don't feel depressed and withdraw for three days." In her husband's role, the patient noticed that he was happy to agree to this new compromise. She was amazed in the debriefing: "It would never have occurred to me to ask my husband that. It's in fact very easy!".*

Central idea

The happiness in a marital relationship is love. The *drama*, however, is that you are not one but two.

In the treatment of depressed people with neurotic conflict processing, there is a risk that the neurotic solution patterns in the relationship images from childhood will spread to the current relationship images over and over again. The patient should, therefore, also integrate her improved self-actualization, *free from defenses* in the present, into her inner relationship images from childhood.

As with the patient in case example 63 (see Sects. 8.4, 8.4.2 and 8.4.3, this often happens spontaneously. Otherwise, the therapist will occasionally ask *specifically*

about the age of the adaptive attitude (see case example 53 in Sect. 6.3): "Since when have you been blindly meeting the expectations of others?" This question prompts the patient to link her new experiences in the current relationship conflict with her childhood experiences: "As a child, I always had to function no matter what. My brother was sick. I didn't want to burden my parents anymore!".

If necessary, the therapist supports the patient in further developing her inner images from childhood: For example, he asks her to write a *fictional letter* to a person from childhood (see Sect. 4.12). The patient informs this caregiver that she is depressed as an adult because of the adaptation she learned in childhood. She also shares what she would have needed as a child instead. Or the therapist lets the patient, as the adult she is now, engage in a hypothetical psychodramatic dialogue with role reversal with the caregiver from childhood (see Sect. 4.12). In this way, the patient can integrate her *new* insights into her *old* inner relationship image from childhood.

At the end of her therapy, the patient should develop a coherent answer to the question: "What do I have to do to feel depressed again?" In answering this question, the patient grasps the *old path of her neurotic self-regulation* that led her to depression. She should write this insight in her dream and self-experience book. Later, when she feels depressed *again*, she can read the book and discover what *she did or did not* do before her decompensation.

Recommendation

In short-term therapy or counseling, the therapist works with the patient or the client on the systemically equitable structuring of relationships in their *current* relationship conflicts due to the shortness of time (see Sect. 3.3). Thus she works in a *solution-oriented* manner.

Central idea

In long-term therapies, the following rule applies: *the more tumultuous* the conflict between adaptation and self-actualization in a current relational conflict, the more the therapist should limit his work to the present conflict *alone*. However, *the less* patients with depression suffer from the imbalance between adaptation and self-realization in their current conflicts, the more the therapist has to go with them psychodramatically into their inner relationship images from childhood, address their old defense patterns (see Sect. 4.8) and change them.

8.4.4 The Therapist's Participation as a Doppelganger and an Auxiliary Ego in the Psychodramatic Dialogue

In psychotherapy, the therapist combines *her intuitive process* with the *patient's* intuition (see Sect. 2.5). She identifies concordantly with *the patient's* self-actualization at one point and complementarily with the self-actualization of *his "conflict partner"* at another time. The group members (see Sect. 8.4.5) perform this changing identification as auxiliaries in the as-if mode of play also by reversing roles. In individual therapy, the therapist potentially takes on *three different roles* in the individual setting: (1) The role of the leader in the therapeutic *meta-position outside the scene* (see Fig. 2.9 in Sect. 2.8), which is the *standard position* of the therapist during the psychodramatic dialogue, (2) The role of the protagonist's doppelganger when

he changes into the opposite role, and (3) As an auxiliary ego also the role of the protagonist's conflict partner.

Inexperienced psychodramatists easily get stuck in identification with one of the two complementary roles of the patient when they play along in the psychodramatic dialogue, and lose the overview. It is then helpful to return to the therapist's standard position, the *therapeutic meta-position outside the scene.*

Exercise 21

If you are a beginner in psychodrama, please accompany your patient in their play *"only"* from the meta-position initially. If the patient is currently in his *own* role, position yourself slightly *on the patient's side* and look at his "conflict partner". However, if the patient takes on the role of *his conflict* partner in a role reversal, position yourself slightly *on his "conflict partner's" side* and look at the "patient". In this way, you *energetically activate* your patient's thinking, feeling, and acting *in his two complementary roles*. The meta-position helps you to *internally* keep an overview of the dialogue between the two conflicting partners, thanks to the *external* distance to the scene. You remain in the professional role of yes-but and focus on the *process between the conflicting partners.* Thus, you do not forget to ask the patient to reverse roles.

Beginners in psychodrama can *gradually practice* their leadership skills:

1. The therapist initially directs the patient's psychodramatic dialogue *only* from the meta-position outside the play scene. She *herself* does not take on *any roles* in the protagonist's play. She "only" helps him realize the 12 steps of psychodramatic self-supervision in his play (see Sect. 2.9).
2. In the next step, the therapist also takes on *the protagonist's role* when the protagonist is playing the role of his conflict partner in role reversal. The therapist's action in his role helps the patient to arrive at the counter-role and to *psychosomatically* experience how her conflict partner feels (see Sect. 8.4.2).
3. If the therapist feels reasonably safe in this work, she gradually takes on also *the role* of the patient's *conflict partner*, if necessary, and enacts it. In doing so, she can vary her *enactment in the counter-role*: (1) She stands *outside the scene* and only *verbally repeats* what the patient said in the role of his conflict partner. (2) She stands *behind the chair of his conflict partner* and repeats what the protagonist said in this role. (3) She sits *on a second chair next* to the chair of his conflict partner (see Sect. 8.4.7) and plays her role according to the patient's instructions. (4) Or she sits on the chair of his conflict partner and plays his counter-role. As an auxiliary ego, like the protagonist himself in role reversal, she always adopts the posture of the patient's conflict partner and imitates their gestures and facial expressions.

Recommendation

The therapist follows her own *intuition* when deciding *whether and how* she wants to take on the counter-role, as an auxiliary ego, in the patient's play in the individual setting.

The more heated the argument in the conflict and the more actively the patient deals with his "conflict partner", the more likely she is to take on *the respective counter-role.* Because even

people who can imagine well have a hard time arguing with an empty chair. The therapist's enactment in the opposite role activates the protagonist's physical sensation, affect, and thinking in his own role. This increases the authenticity and depth of his self-experience in the play.

Central idea

In both roles, as auxiliary ego and doppelganger, the therapist internally complements the relationships between actions, physical sensations, affect, thinking, and language intuitively to a holistic psychosomatic resonance pattern (see Sect. 2.7). As a result, she understands more quickly and comprehensively how each of the protagonist's conflict partners ticks. This further helps her to emphasize important statements in the roles by modulating her language and leaving out unimportant sentences.

The therapist should not play a counter-role in protagonist-centered plays of *patients with severe structural disturbances* because these patients think in the equivalence mode (see Sect. 2.6). The patient may then make no distinction between the *role played* by the therapist and the *real therapist* (see case example 19 in Sect. 4.6). In such a case, when the therapist *in the role of the conflict partner* says, "I am angry with you", the patient believes *the therapist herself* is angry with him.

8.4.5 Psychodramatic Group Therapy for Patients with Depression

Case example 66 (*Krüger, 1997*, pp. 86 f., 143, 226 f., Modified)
Mr. D., a 27-year-old social worker, was referred to a psychotherapist by a neurologist with the diagnosis of "endogenous depression". He suffered from severe depression and endogenous eczema on his hands and forearms. His breathing was slightly asthmatic. The therapist was shocked by the intensity of his conflict with his father when taking the patient's history and felt: "If Mr. D. realizes his authority issues with his father, he'll kill his father." After two years of psychodramatic group therapy, the patient's depression and physical complaints had disappeared. He had rebelled at work and made himself heard by his top boss. Moreover, he implemented a new way of distributing tasks to various professional groups. He also recognized the neurotic background of his depression and linked his depression with his pathogenic family dynamics.

Exercise 22
What do you think led to the success of Mr. D's treatment? *How often* has the patient dealt with present-day conflicts or with childhood problems in protagonist-centered psychodramatic plays? How often has he enacted in a fairytale or impromptu play in the 80 sessions of his group therapy? Before reading any further, please write down your responses on a piece of paper.

Case example 66 (continued)

The therapist asked these three questions to the psychodramatists present at a staff meeting of the Moreno Institute Überlingen. The co-workers of the institute organized themselves sociometrically according to their various answers. Thirty-three colleagues stood in place of 'protagonist-centered plays for childhood conflicts', three stood in place of 'fairytale and impromptu plays', and four stood for other therapeutic approaches. To everyone's astonishment, Mr. D. had worked with protagonist-centered plays only twice in his two-year treatment. He never switched to a childhood scene. In his first protagonist-centered play, he showed how he took the train home from Munich to Hannover three days before the group meeting. But he stopped the play and panicked. In his second protagonist-centered play, at the end of his treatment, he successfully dealt with a 'psychologist' from his current field of work.

But how could the patient's treatment success be explained if he had seldom dealt with his conflicts in a protagonist-centered manner? The therapist had written detailed group notes. They included insights such as (1) Mr. D. participated in impromptu plays several times. (2) He was elected to play the role of 'angry' or dominant male opponent 12 times by other group members in their own plays. At first, he maintained during the debrief: "I can't argue!" But, as an auxiliary ego, he played the male roles offered increasingly in more authentic and differentiated ways. In a role reversal, he also took on the roles of the inhibited and adapted protagonists. In doing so, he worked on his serious conflict of authority vicariously through the plays of other group members. (3) After the protagonist-centered plays of other group members, Mr. D. repeatedly complained about the egoism of their conflict partners and said to the protagonist: "It can't stay that way! You have to defend yourself more!" As a result, he became the action leader for the topic of 'self-actualization in the relationship with a dominant conflict partner'. (4) In such a situation, the therapist often asked Mr. D.: "Show Eva how you would behave in her place! Eva, you can take on the role of your husband!" In these plays, Mr. D. openly dealt with their authoritarian "conflict partners" as the protagonists' doppelganger.

The patient has differentiated his inner object images of 'angry' dominant men by frequently playing roles of 'angry' dominant males and, thus, loosened his defense through projection and denial. Additionally, as a doppelganger, he differentiated his self-image psychosomatically in authority conflicts. In doing so, he dissolved his own defense through introjection. Hence, he weakened his defense through identification with the aggressor by frequently playing roles in others' protagonist-centered plays. At the end of therapy, he spontaneously recognized the connection between his depression and childhood conflicts. He distanced himself from his father's patriarchal intent that he should have become a doctor. As a result, he gained significant recognition in his chosen profession. This development occurred even though Mr. D. had never once dealt with his father/authority conflict psychodramatically.

In psychodramatic group therapy, depressed patients defend through introjection and often remain stuck in their inferior position vis-à-vis their conflict partners in their protagonist-centered plays. The therapist then often unconsciously identifies with the protagonist's self and tries to empower the patient in his obstacles in the play. She then doubles the protagonist, for example, *suggestively*: "I'm angry!" "I am

sad and disappointed!" Or she works *cognitively psychodramatically* (see Sect. 2.14) and encourages him to adopt a more expansive role behavior.

Recommendation

In such a case, it is more appropriate to end the protagonist-centered play early and proceed to the debriefing. The more inappropriately the protagonist behaves in the play, the more likely the group members will protest against his way of resolving conflict in the debrief: "But that's not how it works! Defend yourself!" "I would speak my mind!" The therapist then asks the protesting group members to become the patient's doppelganger and deal with his "conflict partner" *on his behalf:* "Step into Klaus's role and show us how you would behave in his place!" (see Sect. 2.11)

Central idea

Each group is *a self-organizing system.* Inappropriately submissive behavior on the part of the protagonist in his play *always* provokes protest from the other group members (see Sect. 2.11). The therapist uses this protest therapeutically for the 6th and 7th steps of the psychodramatic dialogue (see Sect. 8.4.2). The protagonist *himself* always takes on the role *of his conflict partner* in such a play.

The group members and the patient collaboratively test whether and to what extent the patient's "conflict partner" would be willing to form a systemically just relationship. This process is therapeutically *successful in any case*, regardless of the result: (1) If the protest of the group participant were *inappropriate*, the group participant playing the role of the protagonist would fail in his interaction with the protagonist's "conflict partner", just like the protagonist himself. The group then recognizes, perhaps for the first time, the real drama of the protagonist's conflict and acknowledges his plight. (2) However, if the group participant's protest was *appropriate*, playing the alternative solution dissolves the protagonist's fixation in his defense through introjection, projection, and identification with the aggressor. The protagonist thus becomes internally free to look for a *new solution* to his conflict in everyday life. But, the group participants also learn in the process (see case example 66 above). This approach in the *treatment of patients with depression* surprisingly gives everyone involved considerable pleasure. There is a lot of laughter in the group.

In Moreno's tradition (1959, p. 238), some psychodramatists interpret the group participants' authentic and enjoyable experience in playing destructive counter-roles as the group member's *own* desire to be cruel and his *own* tendency for sadistic behavior. However, this interpretation assumes that the group participant cannot distinguish between play and reality.

Central idea

Anyone who can play *a destructive counter-role* well has *more* control over their destructive impulses than someone who strictly rejects this for ideological reasons or because of their own inhibition. Because they can *think* of evil in the *as-if mode* and do not act it out at the first opportunity in the *equivalence mode* (see Sect. 2.6). According to Gandhi: "Only those can offer non-violent resistance, who *can* use violence and then renounce it."

Some psychodramatists falsely assume that when playing the counter-role of a sadistic conflict partner in a role reversal, the protagonist "feels the inner energy of the perpetrator and then integrates it into his own role". But, the reason for the protagonist's increased courage is different. The role reversal helps the protagonist

liberate his object image from its fixation. In the counter-role of his conflict partner, the patient establishes a connection between his conflict partner's actions, physical sensations, affect, thinking, and speaking. For example, he psychosomatically perceives his indifference or lust for power. In this way, he breaks his defense through projection (see Sect. 2.4.2). He is outraged by *the opponent's* desire for power. That makes him more courageous in his interaction with the conflict partner.

8.4.6 Therapy for Depression in Separation Conflicts

Separation conflicts arise when a person leaves an old relationship system or when it breaks. For example, *adolescents* experience physical and emotional development spurts during puberty. They come together in peer groups and face challenges *outside* of the family. However, they can become depressed if they fail to separate from their original family. They are fixated on an old self-image, characterized *by defense through introjection.* For example, a 20-year-old woman discontinued her studies in a faraway city after six months and returned to her parents' house. One of the reasons she failed was that she couldn't go shopping at the supermarket in her place of study. This was because she had blindly adapted to her mother's addiction to control. If the young woman wanted to buy yogurt, she couldn't decide which was the healthiest option, and half an hour later, she would leave the shop without any yogurt. *Adults* are more likely to become depressed as a result of separation conflict *because of the defense through projection.* When a child leaves home, adults are fixated in an old beloved object image of their child. A separation conflict can be triggered by a divorce, loss of work, or when a close friendship ends. For example, from 1913 to 1918, Jung (1985) encountered a severe depressive crisis after separating from his teacher and friend, Sigmund Freud.

Central idea

A separation conflict in adolescents is the result of a change in inner self-image; in parents, it is the result of a change in the inner object image. In long-term separation conflicts, this change doesn't succeed spontaneously. The patient defends through introjection and projection. The defense through introjection stabilizes the defense through projection. Or the defense through projection stabilizes the defense through introjection. The fixation in an old *inner* self-image and an old *inner* object image must be resolved. Therefore, the psychodramatic dialogue with role reversal is indicated in disorder-specific approaches.

Case example 67

The 35-year-old Mr. E. sought group therapy because of reactive depression and a neurotic self-esteem problem. One day he reports: "I have problems with my mother. She called me six weeks ago. She also asked me if I was in a new relationship. I answered 'no'. But the truth is, I have had a new boyfriend for three months, and I feel very comfortable with him. I don't even know why I lied." Mr. E. clarifies the relationship with his mother in a psychodramatic dialogue (step 3 of the psychodramatic dialogue, see Sect. 8.4.2*). He sits on his chair during the play and looks at*

the mother. She looks dismissively at the window. Mr. E.: "We're so far apart, I don't understand!" Mr. E. reverses roles and steps into the role of his mother: "You don't come home like you used to. Everything has changed! The neighbors' children always come for a visit. They have grandchildren. It's different for us. I can't even imagine how it will be with us."

Mr. E. is gay. The therapist interviews Mr. E. in the role of his mother: "Mrs. E., have you ever dealt with the subject of homosexuality? Do you know what that is?" Mr. E. as the mother: "Yes, of course. But I want us to maintain the image of a 'normal' family, at least outwardly. I want Jörg to visit me and call me regularly." Again in his own role, Mr. E protests: "Actually, you don't want me to visit you with my boyfriend. I always have to be who you want me to be. That's why I always come to visit you alone. You distance yourself from me!" Mr. E. takes on the role of his mother again: "I have already read something on the subject of homosexuality. And I've seen films about it on TV. But it's hard for me to imagine that you are with a man like I am with dad. I cannot imagine that! And besides, children simply visit their parents!".

Mr. E. changes back to his own role. As an auxiliary ego, a group participant repeats the 'mother's' sentences. The therapist asks Mr. E: "What are you feeling physically and emotionally in your role?" Mr. E: "I feel distressed." The therapist: "Where in your body do you feel this? In the head, in the chest, or the stomach?" Mr. E.: "More in the throat, it's tight, I feel a lump." The therapist: "Can you tell your mother that the argument with her causes a lump in your throat?" Mr. E. to his 'mother': "I don't understand why you don't accept it. You've known that I'm gay for five years now. You always say you accept it. But I don't see it." In the debriefing session, one of the group participants tells Mr. E.: "Talk to your mother in plain language!" The therapist asks this group participant to take on the role of Mr. E. and to try it on his behalf (steps 6 and 7 of the psychodramatic dialogue). Mr. E. changes into the role of his mother and shows how she would react to it. The group participant in Mr. E's role: "When you talk about how I should be like others, I feel my throat tighten. I think the distance between us is quite right. I don't see any other possibility at the moment!" In the role of his mother, Mr. E. reacts surprisingly excessively: "But then why don't you tell me that you have a boyfriend! You know that I notice everything and know everything about you anyway! You are my son! And I am your mother! You can't hide anything from me anyway!".

In the debriefing, Mr. E. spontaneously says: "I have noticed that my mother wants me to be like I was as a child. She doesn't accept who I am today. She doesn't understand anything! I think the distance might be good for us." The group participant who took on the mother's role as an auxiliary ego: "As a mother, that was obvious to me. I was disappointed not to have any grandchildren!" The therapist: "I suspect your being gay has created an existential gap between the two of you that cannot be bridged! This concerns not only your identity but also your mother's! But one can only overcome an existential gap by recognizing it. Besides, I think it is important for you not to lie to your mother. Because lying often leads to feelings of inferiority and makes you depressed!" After two group sessions, Mr. E. spontaneously says: "I have thought about it, and I think I want to re-establish the relationship with my

sister. I want to have a conversation with her about our family. My sister lives five hundred kilometers away. She had a fallout with my mother a long time ago. I want to know how my sister is doing in relation to my mother now."

In a separation conflict, the patient expresses everything he feels and thinks toward his attachment figure in rehearsing a psychodramatic dialogue. In this way, he frees his inner self-image from fixation in the conflict, develops it further, and dissolves his *defense through introjection* (see Sect. 8.4.1). In the role of his mother, he psychosomatically experiences why the separation is so difficult for her. He psychosomatically learns something about her values and norms, her open or hidden contracts, her inner conflicts, and her defenses. He looks for answers to the questions: "Who *was* my mother really? Who would she have *wanted* to be? Who *could* she have *become* in other circumstances? *What* prevented that?" In doing this, the protagonist resolves his *defense through projection.* This helps him to refrain from automatically doing what his mother introject asks him to do. Instead, he asks himself: "Do I want what I want, or does my inner mother want that?" Then, he *can choose again* and is free to develop his *own* norms and ideal values (see case example 68 in Sect. 8.4.7).

Central idea

"True emancipation always requires a further development of the *inner* image of the conflict partner" (Krüger, 1997, p. 232).

The detachment from restrictive family relationships is easier if the person concerned knows any *family secrets* that may exist. He then no longer identifies himself, *unknowingly through introjection*, with the taboos, guilt complexes, and defensive patterns associated with the family secret. Awareness of a family secret often triggers a developmental boost in those concerned. For example, Bode (2009, p. 55 f.) reported on a man who had learned new information about his parents' life story: He "understood that the persistent feelings of guilt he felt came from his grandfather." The man had told the author, Mrs. Bode: "There is a saying in our family: 'If it is too good for you, life punishes you!'" The grandfather was a farmer in East Germany. In 1945 he hesitated to flee the Russian army because he had hoped the American military would advance. That "was the decisive mistake of his life. He lost everything he owned, and the Soviet soldiers also forced him to watch them raping his wife and mother. […] I know most people think: I don't want to burden myself with my parents' war experiences. But I was relieved when I finally knew the truth. It was a weight off my shoulders! […] It was only after I knew the secrets that I understood a lot: Why we were always so afraid, why my father behaved so well-adjusted, his extreme preoccupation with safety, his insistence on saving, saving, saving." Bode writes: "Since he can see his parents as people who were broken by the war, he is better able to endure his mother's strange behaviors, which used to upset him earlier." The man concerned reported: "Among other things, I have more respect for my parents' life achievements, and I no longer judge them for their fearfulness and adaptability. […] I can simply detach myself." According to Bode (2009, p. 56), this man's mother *learned much about herself* through her son's separation, and the confrontation with him. Now, unlike in the past, she can allow herself to enjoy some things in life.

8.4.7 Therapy for Prolonged Grief Reactions

The self-actualization and adaptation of an individual are entangled in a *long-lasting relationship* with the self-actualization and adaptation of his *reference person.* This happens through the diverse empathy, interaction, and agreement processes and the associated delegations, introjections, and projections.

Central idea

The death of a loved one changes the balance between one's self-actualization and adaptation in the *inner relationship image.* However, people usually hold on to the old relationship image to avoid losing the loved one internally. The loss must be integrated into the inner object image and the inner self-image (Krüger, 2003, p. 102 ff.).

In bereaved persons, depressive mood swings are still *appropriate* reactions *in the first year* after the death of a loved one and are not considered pathological. Signs of a pathological grief reaction are: (1) A bereaved person is unable to work for more than six weeks after the death of the loved one. (2) He withdraws from all his relationships, and/or (3) The grief reaction lasts longer than a year.

Prolonged or severe grief reactions occur when the bereaved cannot change their old inner relationship image with the deceased *on their own.* The patient reacts with guilt if he is doing well. He projects his own criticisms, resulting from the loss, onto the dead. But, he introjects his accusations. So he defends by identifying with the aggressor (see Sect. 2.4.3 and 8.4). This helps the patient to internally hold on to the relationship with the deceased. Therefore, the counselor or the therapist supports the change of the inner self-image and object image using the fictional psychodramatic dialogue. Blatner (2001, p. 41 ff.) suggested a structured method for counseling the bereaved, which he called the *"last encounter"*. This method consists of five steps:

1. In the psychodramatic dialogue, the therapist lets the patient remember the "dead person", and, *in his own role*, share his memories with them.
2. *By reversing roles with the deceased*, the mourner recollects *their* memories of the patient and shares these out loud to himself.
3. *In his role*, the patient formulates answers to the question: "What did the deceased mean *to me*?"
4. By reversing roles, he formulates *in the role of the deceased* an answer to the question: "What did I mean to the deceased in their lifetime?"
5. The patient deals with an unfinished business in the "last encounter". He asks or says, for example, what he has always wanted to ask or say to the deceased but didn't yet, and generates a coherent response from the loved one through role reversal.

The patient can no longer directly resolve conflicts with a deceased person *after their death.* The patient may feel guilty. Or he may have never told his mother that he loved her. Unfinished business can, in retrospect, weigh heavily on the memories of the deceased and color them negatively. In such a case, the bereaved should clarify the relationship with the deceased person in the as-if mode of psychodramatic play. The grief work in the as-if mode of play along with the last messages and questions

helps the patient to appropriately develop a new inner self-image in the relationship and to resolve his defense through introjection. In a role reversal, in the role of the deceased, the patient also resolves his inner object image from the fixation and, thus, resolves his defense through projection (see Sect. 8.4.2). In doing so, the therapist accompanies the patient in small steps. The inner transformation often takes more than one session. A 70-year-old man, for example, was deeply shaken when he imagined his 'wife', who had just died, in the empty chair in front of him. In the first session, he only looked at the empty chair and *shared his* memories of his wife *with the therapist*.

The five steps of the grief work do not have to be carried out *in precisely the same order* as described above. But, this process model can *help the therapist* check whether one or more steps of grief work are still missing.

Case example 68

The 50-year-old Mr. F. asks his father, who died four years ago (5th step of the grief work), in a fictional psychodramatic dialogue: "You have always been so distant from me. Why haven't you ever talked to me about personal matters?" Mr. F. in the role of the father: "I couldn't!" Mr. F. as the son (1st step of the grief work): "But I always tried so hard. For example, I always tried to do particularly well at school just to make you happy." Mr. F. as the father: "Yes, I noticed that. I was proud of you!" Mr. F. as the son, getting louder: "But why did you never tell me that!" Mr. F. answers in the role of his 'father' without any emotion but clearly suffering (2nd step of the grief work): "I couldn't; I'm different!" In his childhood, Mr. F. had always put his wishes for his father's recognition and affection on the back burner. He tells the therapist: "At first, I idealized my father for many years. Later I devalued him!".

The protagonist continues the psychodramatic dialogue and expresses anger toward his father through soliloquy. But he acts very cautiously in the game. Therefore, the therapist takes on Mr. F's role and moves on to step 6 of the psychodramatic dialogue. Mr. F. plays the role of his father. The therapist verbalizes his anger as a doppelganger (see Sect. 8.4.2*). Despite his 'son's' anger, Mr. F remains distant as the 'father'. In an interim debriefing, the therapist shares his experience as a doppelganger with the protagonist: "When you, as a father, said 'I can't do this!', my face went numb. Then I felt myself getting angry. Perhaps I felt something in myself that you do not allow yourself to feel?".*

In the continuation of the psychodramatic dialogue with the father, the therapist moves on to step 3 of the grief work and asks in the role of the protagonist: "What did I mean to you?" In his father's role, Mr. F. looks for an answer for a long time (4th step of the grief work). But then he says with a warm, intense look and a firm voice: "You are my son!" Mr. F. and the therapist reverse roles again. In the father's role, the therapist internally allows himself the high emotional intensity in the father's statement. He tries to express this when he responds to the son: "You are my son!" Mr. F. is very touched. He responds from the heart (3rd step of the grief work): "And you are my father!" He turns to the therapist and says: "I would love to hug you now!".

During the debriefing, the therapist asks the patient: "Do you know why your father was so distant?" Mr. F. talks about his father's life. He was a hard-working, well-respected man who kept a distance from everyone. The further report by Mr. F. suggests that his father was traumatized as a soldier in World War II. The therapist: "This is a common symptom in traumatized people: those affected can no longer allow themselves to feel their emotions. In the traumatizing situation, they learned to suppress their emotions in order to function and remain capable of acting. Even if they want to feel their emotions at a later stage, including positive feelings such as love, they suffer because, tragically, all unprocessed feelings from the trauma situation come to the surface along with the positive ones. If the traumatized person were to allow that, they would lose control of themselves. That might make them incapable of coping with the demands of everyday life. That is why many traumatized people unconsciously split off their feelings in the long run. They then suffer from numbness and cannot change that. This then leads to severe disturbances in their personal relationships."

The patient in the case example above introjected, in his childhood, his traumatized father's fear of closeness and his compensation through performance. In rehearsing the psychodramatic dialogue, however, he openly shared his unfulfilled need for closeness with his father. In this way, he further developed his inner self-image in the relationship with his father and resolved his defense through introjection. In the role of father, this rehearsal allowed him to *psychosomatically* feel his fear of closeness and loss of control. This expanded his inner object image and resolved his projection of rejection. The psychodramatic grief work helped him understand his father's distant behavior as *self-protection* against flashbacks of the war. Clarification of the relationship and 'joint' mourning over the joint fate made it possible for him to distance himself from his father's defense system four years after his father's death. He took the courage to live his own life in a more self-determined and relational manner.

In the "last encounter" of a patient with a 'deceased' in psychodramatic dialogue, the therapist or the auxiliary ego *also* takes on the patient's *counter-role* sensitively and carefully in gradations. She usually sits on an additional chair *next* to the deceased's empty chair. In doing so, she pays tribute to the existential level of the "last encounter". Sometimes the therapist 'only' steps behind the deceased's chair and repeats the protagonist's last sentences in the opposite role. However, the more intense the discussion between the protagonist and the 'deceased' becomes, the more critical it is that the therapist, as an auxiliary ego, actually plays the opposite role. The protagonist thus activates and integrates his actions, physical sensations, affect, and thinking *more holistically in his own role* (see Sect. 8.4.4).

The first two steps of the grief work with questions such as: "What did I experience and share with you?" and "What did you experience with me?" specifically open the reservoir of memories for the *old* relationship experiences with the deceased. In doing so, the patient processes his memories into a *relationship story*. He works out the mutual balance between self-actualization and adaptation, and the values and norms of *each* relationship partner. If necessary, he can specifically return expectations that the deceased has delegated to him in the play.

The 3rd and 4th steps of the grief work with questions such as "What did you mean to me?" and "What did I mean to you?" stimulate the protagonist to re-examine the *holistic meaning of the loved one* in his own life and development and also to grasp *one's own importance* in the life of the deceased. In both roles, the patient condenses all his relationship experiences into a symbolic image or sentence. As a doppelganger, the therapist helps him sensitively and creatively. The *existential* dimension of the subject of 'death' and the loss of a loved one usually leads to emotionally touching psychodramatic plays. The group members intuitively interact mindfully in a coherent and honest manner with themselves and others. They often respond with profound sharings, which offer support and security to the bereaved in the group.

If necessary, the therapist also uses therapeutic elements in the therapy for a *pathological grief reaction*, similar to those used in therapy for post-traumatic stress disorder (see Sect. 5.8). For example, she uses the *two-chair technique*: She places an empty chair next to the patient for his 'competent everyday ego', which is currently paralyzed by the death of a loved one. She names the chair on which the patient sits, 'the chair for the grieving Karl'. In the further conversation, she lets the patient switch back and forth between his 'competent everyday ego' and his 'grieving ego', depending on his current condition. This turns the 'either-or' between grief and coping with life into an 'as well as'. If necessary, the therapist also uses *self-stabilization techniques*. For example, the patient symbolizes his resources with stones and wooden blocks on the table stage. Or he develops a safe place with the therapist's help (see Sect. 5.10.5) where he can stabilize himself using transpersonal images. Unfortunately, we in the Western industrialized nations rarely take the necessary time to mourn and make appropriate internal changes after the death of our loved ones. This eventually hinders our own internal maturation process.

Case example 69

An 84-year-old patient reported that 'the subject of death is taboo' for old people in a retirement home she stays at. She had bought a place for her own casket in an old cemetery next to a beautiful old tree. When she told other residents about this, they fearfully changed the topic.

The grief work after the death of a loved one includes facing the fear of one's own death. The older the bereaved, the more one fears *one's own death*. The therapist will address this issue if necessary. Frede (2009, p. 35) suggests that, in such a case, the patient should engage in a psychodramatic 'dialogue with death'. The therapist turns to the patient and says: "I'm just imagining that death is sitting here with us—maybe on this chair. […] What would you want to say to death?" The therapist doubles the patient in this dialogue and invites him to reverse roles: "If death could answer, what would it say?".

According to Frede (2009, p. 36), everyone has "certain ideas about death. A dialogue with death helps define these ideas and contextualize them to one's own life situation". Frede (2009, p. 36) differentiated this work into the 'association sociogram' technique on the subject of death. The therapist asks the patient to draw a circle on a piece of paper: "Please write the word death in the center! When you

think about death, what comes to mind? […] Make a circle around each association and connect it to the center. […] Just imagine that death could join our conversation. […] Out of all these associations, what would death talk to you about?" Because "the protagonist familiarizes himself with the various aspects of his idea of death", "these lose some of their paralyzing power over him". By talking about his ideas of death, the patient gains "a certain distance, which makes it easier for him to observe his thoughts and feelings associated with one's own idea of death […] without judging them, holding onto them or evading them. […] The I is no longer identified with fear, sadness, or worry about the future: I *have* certain feelings, but *I am not* these feelings. […] Because there is a part of me that observes these feelings (Wilber, 2006, p. 113)." This work helps people develop "not only their own idea of death but also their personal reactions to it. One can at least partially counter some fears. […] The *open* discussion about death in therapy helps the bereaved at least lose the fear of these fears and learn to accept them as part of human existence: 'Everything that lives will one day cease to be—including me'. In dialogue, many patients no longer see death as an enemy, but as an ally for life […] who shows them what is really important" (Frede, 2009, p. 36).

8.5 Therapy for Masochism and a Pathological Superego

Masochistic thinking and behavior occur in various mental disorders, for example, severe depressive disorder, trauma disorder, obsessive–compulsive disorder, addiction disorder, or borderline personality disorder. Usually, persons with masochistic behavior were traumatized in childhood or secondarily traumatized in relationships with traumatized parents (see Sect. 5.2). The patients must have had to learn to block their self-actualization *through self-censorship* in their relationships as a child. Otherwise, they would have been beaten, rejected, devalued, or abandoned or they would have destroyed the equilibrium in their family leading to a family crisis. Self-censorship was a creative solution that helped the child to survive psychologically. It was therefore not possible for the child to develop healthy narcissism and the ability to self-actualize appropriately in relationships.

Patients with masochistic behavior block their self-actualization *even as adults*, although there is *no* external force to think self-injuriously. Rohde-Dachser (1976, only orally communicated) describes *masochism* as a "cry for empathy". People with masochistic, depressive, or dependent personality disorder (F.34.1, F60.7) are trapped in a defense system. This consists of self-protection through adaptation or grandiosity *and* masochistic self-censorship (see Sects. 4.7–4.10). The defense system creates a split in the process of self-development. Allowing the self to emerge would retraumatize the patient. Even the idea of a wish is taboo. Patients come into therapy when their defense system can no longer block their self-actualization adequately. The external pressure to conform becomes overwhelming. Or a favorable external situation allows one to live on their own terms.

Central idea

The masochistic self-censorship and the defense through grandiosity and perfectionism mutually stabilize each other. The patient's 'inner soul killer' is quiet only when the patient is grandiose and perfect. He is not allowed to be a normal human with emotions, strengths, and weaknesses.

Masochistic thinking and a pathological superego can be recognized by the following indicators: (1) The patient devalues himself and reacts prematurely with feelings of guilt. He experiences his inappropriate self-deprecation and self-accusations as *appropriate*, as they are part of his identity. (2) He cannot defend himself adequately and set boundaries in important relationships. (3) He strives to be a perfect or grandiose person in order to defend his inner masochistic self-censorship. If he didn't do that, he would get depressed. (4) Some patients become angry with themselves and bottle up their anger. But, at some point, the anger erupts. This eruption then confirms their inappropriate self-accusations and self-doubt in the process. (5) The patient may not be able to break free from the relationship with a damaging attachment figure. (6) He expects unreasonably serious personal and social problems in his future.

Case example 70

The 53-year-old Mrs. Z. has been retired for six years now due to depression and exhaustion as a consequence of a structural disorder. She suffers from migraines for about thirteen days a month (F34.-, G43.0). Mrs. Z. spends most of her life at home. Her social contacts are limited to a few activities with her husband. He suffers from stress syndrome, and high blood pressure, and is overweight due to his high-stress job and many hobbies. When he gets home from work at 10 p.m. or later, he first reads his e-mails before the couple 'sits together for an hour or two' and then goes to bed at 1.30 a.m. Mrs. Z. expresses indifferently: "That's just how it is." When the therapist draws the intelligent patient's attention to the absurdity of these systemically opposing lifestyles, Mrs. Z says: "I don't want to restrict my husband's activities. He is very popular everywhere." In another context, however, she says: "I feel out of breath when he comes home for lunch sometime for twenty minutes."

As a child, Mrs. Z. had to stabilize her traumatized parents. She was brought up with strict rules. Her own feelings and needs were not seen. As a result, when she was six months old, she was hospitalized for an eating disorder for three weeks. Even now, at over fifty years of age, Mrs. Z. immediately associates her own emotions and wishes with a feeling of senselessness and helplessness. She often cries desperately in therapy sessions when she realizes that she here actually has time and space for herself but cannot express herself verbally.

The therapist wanted to help Mrs. Z improve her self-development (see Chap. 1*). He asked Mrs. Z to write a coping fairy tale about her childhood trauma (see* Sect. 5.14*). In the following therapy session, Mrs. Z complained: "It was incredibly difficult to even remember events from my childhood. I experienced a mental block. As if a doorman was standing in front of the door and said: 'You can't come in!'" The therapist represents the 'doorman' with the hand puppet of a sadistic laughing devil on a chair three meters away from the patient.*

Patients with a depressive personality disorder are, as it were, under the spell of the evil mountain spirit from the fairy tale "The Traveling Companion" by Hans Christian Andersen. Many princes have wooed the beautiful princess in an attempt to marry her. She promises marriage to the suitors if they solve her three riddles. If a suitor fails to do this, he will be beheaded. When the hero of the fairy tale comes to the princess's castle, he sees ninety-nine male heads impaled on the bars of the fence surrounding the castle. Verena Kast (1980, p. 52 ff.) interpreted this fairy tale as a tale of masochism. Like the hero of the fairy tale does with the princess, the therapist strives for a good relationship with her masochistic patient. But she is repeatedly left feeling puzzled. She fails in *all her attempts* to help him. The many heads of the suitors in the fairy tale symbolize the therapist's failed attempts to resolve the patient's masochistic self-censorship. The patient keeps beheading his therapist through his masochism, so to speak.

The diagnosis of a depressive or masochistic personality disorder often only results from the shared experience of the therapist and patient in the therapeutic relationship:

1. The more a patient accepts an imbalance between self-adaptation and self-actualization *and* the less aware he is of this imbalance, the more likely he is to suffer from masochism and a pathological superego (see case example 70 above).
2. The patient's childhood trauma is recognized and named. However, without realizing it, the *therapist* does not give sufficient meaning to his trauma.
3. The therapist attempts to encourage the patient's self-actualization in relational conflicts, for example using the seven steps of the psychodramatic dialogue (see Sect. 8.4.2). But, she fails because of the patient's inability to reverse roles. Or the patient had improved his self-actualization only *for a short time*. There is no progress in therapy over time.
4. The patient defends himself through *projective identification* (see Sect. 2.4.4). This defense leads to a *disturbance in the therapeutic relationship*: (i) The patient thinks and acts in a self-injurious manner. (ii). The therapist identifies with his repressed self and contradicts him. (iii) A latent power struggle develops between the hopeless patient and the therapist, who protests against his hopelessness. iv. The therapist feels strained, annoyed, and thwarted in her efforts. She thus *feels* what the patient represses, on the patient's behalf.
5. The therapist often takes over the systemic role assigned to her by the patient and represses her feelings of disappointment, sadness, helplessness, and anger. She acts out her *countertransference* (see Sect. 2.10) and continues to be *only* the good, supportive mother.
6. The therapist repeatedly represents the patient's self-injurious thinking and inner child as chairs and puppets (see Sect. 4.8). However, the work on the self-injurious thinking (see Fig. 4.1 in Sect. 4.2) encourages the patient *only briefly* because of his rigid defenses. The therapist is drawn into the conflict between the patient's self-actualization and pathological superego. She *unilaterally* identifies with the patient's repressed self and tries to strengthen it. However, she "forgets" to deal with the patient's defense system and feels frustrated.

7. The therapist finds it increasingly difficult to endure the patient's self-blockage. She feels tormented by the patient because he keeps repeating his old defense pattern and reporting new failures. In the end, the patient even wants to work through some relationship conflicts *that have already been dealt with*. The therapist is disappointed with the lack of success in therapy.

Central idea

Patients with masochistic disorder tempt the therapist into being therapeutically *inconsistent*. The lack of progress in therapy then alerts the therapist that the patient continues to be fixated on his defense of self-protection through adaption or grandiosity and masochistic self-censorship.

Patients with a depressive personality disorder or masochism suffer from *metacognitive confusion* between their healthy adult thinking, their self-protection through adaption or grandiosity, and their self-injurious, masochistic self-censorship. They must therefore also be treated *metacognitively* (see Sect. 4.8).

Central idea

It is *part of being a therapist* to allow yourself to be tormented once in a while. However, the constant willingness to do so leads to the therapist and the patient *jointly* denying the reality and truth of their relationship. Then they both act masochistically. The patient torments *the therapist* as he torments himself in everyday life. The therapist then reacts by openly or latently devaluing the patient. Transference and countertransference block progress in therapy. The therapist must again self-actualize in the therapeutic relationship in order to resolve her countertransference. In the therapy of people with masochism, the *new beginning begins with the therapist*.

Therefore, the therapist takes the *following* therapeutic *steps*:

1. The therapist engages in *psychodramatic self-supervision* with steps 1–17 (see Sects. 2.9 and 4.8). In the *fictional* psychodramatic dialogue, she names *her feelings* of resignation, tiredness, annoyance, anger, listlessness, and helplessness. She attributes the "patient's" external actions, which trigger these feelings in her, to the patient's "self-injurious thinking" (see Sect. 4.8). She symbolizes it externally with a chair for the 'blind soul killer' or 'tormentor' and places this chair opposite the patient. As a result, she perceives the "patient" as *a victim of his "inner soul killer"* in self-supervision and can empathize with him internally again. Her resignation and anger disappear.
2. The therapist names the patient's unfavorable approach to himself as "self-injurious" in the real encounter and sets up a chair in the room opposite him on the object level for his inner "blind tormentor" or "blind soul killer" (see Fig. 4.1 in Sect. 4.2).
3. The therapist explains to the patient the meaning of the terms "self-injurious" or "masochistic". She describes the *positive function* his self-censorship had in his childhood: "Your self-injurious thinking was a wise *solution in childhood*. Both your parents were traumatized and addicted. You were creative as a child and *censored your own desires* to cope with the unbearable situation."

Central idea

The therapist additionally represents the two other metacognitive processes involved in the defense system, namely self-protection through adaption or perfectionism and the rejected

negative emotions (the inner child). The masochistic self-censorship is stabilized by self-protection through perfectionism, which helps to avoid a flashback.

4. The therapist places the chair representing the adaption near the patient (see Sect. 4.8 and Fig. 4.1 in Sect. 4.2): "This chair symbolizes your self-protection through adaptation. You try to meet the expressed and unspoken expectations of your significant others most perfectly. You always have to be a good person, know everything, and present everything calmly. I will place this hand puppet of a white knight onto the chair, representing your high expectations of yourself." Or: "You control the current situation because you can't stand it if something bad happens to someone near you."
5. The therapist points at the chair of 'self-injurious thinking': "Self-censorship has helped you to adapt and to *not* amplify the chaos in the family with your feelings and problems. However, the problem is that you censor yourself *even now*." The therapist places another chair behind the chair of self-protection through adaption: "You have to devalue yourself and perfectly meet the expectations of others, otherwise you are not able to deal with the negative emotions evoked in you. Feeling insecure, exhausted, annoyed, or resigned is taboo. In such a case you would experience a flashback." The therapist positions the chair representing the negative feelings far away in the corner of the therapy room."

Central idea

The therapist must explain to the patient the *positive function of his defense system* in his holistic process of self-regulation.

6. The therapist *steps next to the chair* for the soul killer and lends him a voice as an auxiliary ego. She converts the patient's many *self*-reproaches, *self*-accusations, or *self*-denigration into you-statements for the soul killer. As a result, "I'm worth nothing" becomes: "You're worth nothing, look at you!"
7. The therapist also symbolizes the self-injurious thinking with an *additional* matching hand puppet on the chair. Thus, the patient looks at his own self-injurious thinking *as an interaction* partner from the outside. He experiences himself anew *as* a *victim* of his inner soul killer.
8. She works with the patient to find an *appropriate name* for the character that will represent his self-injurious thinking. This name is intended to consolidate the patient's personal self-injurious statements into one symbolic concept: the blind sadistic critic; the blind prosecutor who mocks the patient's feelings; the blind judge; the blind soul killer who denies the patient's right to exist if he doesn't conform to external expectations; the blind cold-hearted governess; the blind accuser; the child wrecker.
9. Patients with severe structural disturbances are often internally paralyzed by the external appearance of the 'sadistic critic' as an interaction partner. The empathic therapist is paralyzed too. In such a case, the therapist defends herself, *as an interacting doppelganger* (see Sects. 2.4.1, 7.2 and 9.8.8) for the patient, against the patient's 'blind inner prosecutor'. For example, she screams directly at the chair and the puppet (Arntz and van Genderen, 2010, p. 53 ff.) and

puts him in his place: "Don't you see how Christa is suffering? Why are you tormenting her then? Stop that! She has suffered enough as a child. She doesn't need it anymore! Just go!" If necessary, the therapist even turns the sadistic prosecutor's chair such that the puppet faces the wall. Or she carries him out of the room with his chair. Often, the patient wonders about such *direct* help from the therapist against his 'self-injurious thinking'. He is irritated and laughs a little. During debrief, however, he reports that he suddenly could 'breathe more freely'. The patient *shouldn't put away* his inner 'soul killer' *on his own* because that would activate his sadistic superego.

10. The therapist and patient make *a list* of the patient's self-injurious statements and number them. To do this, they convert the patient's various self-deprecating thoughts into *statements made by the blind accuser* or the soul killer. The "I" should always become a "you". "I can't do it" becomes "You can't do it!" Some patients self-injuriously write down the statements of their 'soul killer' as I-statements. They then tell the therapist: "I didn't feel well with the list at home." In such a case, the patient should definitely convert the statements of the 'soul killer' into "You" statements. One patient reported: "It was very exhausting for me. But it helps. Once I felt like I was in a stupor. Then I took the list out and I thought, 'What is the soul killer's voice saying right now? What do you hear him saying?' My head suddenly cleared up."
11. For six months, the patient collects statements from his soul killer and makes a list. He reads them out to the therapist. One patient collected 42 self-injurious accusations from his sadistic superego. Some of these contradicted each other. He read them out in group therapy. Another group member, a writer, exclaimed enthusiastically: "That's literature, what you wrote there!" Three weeks later, the patient drove with that list to his childhood hometown. As a 50-year-old well-dressed gentleman, he crawled between trees alongside a small river in the forest. He had always played there as a child. He took out the list of his self-devaluations from his pocket, lit them with a match stick, and burned them in a ritualistic manner.

Central idea

In patients with narcissistic personality disorder, grandiosity is the dominant defense pattern (see Sect. 4.2). This is stabilized through masochistic self-censorship. In patients with masochism, the dominant defense pattern is the masochistic self-censorship. This is stabilized through self-protection through adaption and perfectionism. In each case, the therapist first works to resolve the dominant defense pattern. In doing this the therapist gets therapeutic access to the other defense patterns as well (see Sect. 4.10)

Masochistic thinking patients act out their self-injurious thinking in equivalence mode (see Sect. 2.6). The patient doesn't consider *whether* he is inferior. He *knows he is*. He knows that his friend will break up with him if he said: "I can't listen to your complaints any longer." In metacognitive therapy, the patient learns to integrate the as-if mode in equivalence mode (see Sect. 2.6): (1) He *names* his defense pattern 'inner soul killer'. Thus, he neuronally connects his self-injurious thoughts with the generic term 'masochism'. (2) He *represents* his defense pattern *externally*

as a puppet on another chair. (3) He curiously *collects the statements* of the 'soul killer'. In this way, he tracks down the soul killer's presence like a detective looking for a murderer. (4) He reveals his masochism by reading aloud the statements of his soul killer to other people. In doing so, he notices the grotesque, contradicting, *sadistic pleasure* of the soul killer in the statements. Thus, he resolves the feelings of helpfulness he projected on his soul killer. This loosens his defense through introjection and frees his self-development from fixation in masochistic self-devaluing. (5) As an *interactional doppelganger,* the therapist helps the patient to free his self-development. Thus, over time the patient develops *ego control* over his self-injurious thinking. He doesn't think self-injuriously as often and for as long and can sometimes even laugh about it (see case example 8 in Sect. 2.6).

Central idea

The patient recognizes the *general metacognitive principle* that gives rise to *many of his different* self-reproaches and self-deprecations. He, along with the therapist's help, gives this general principle a name: "This is my self-injurious thinking." Naming the general metacognitive principle helps him to stop his self-injurious thoughts. He *no longer* has to speculate *over every single* self-injurious thought.

12. The therapist asks the patient about *the age of his self-injurious thinking*: "Since when have you been thinking that you are worthless and that you have no right to live? When was the first time?" She then sets up a chair for the internal 'traumatized child' and places the puppet of a four to eight-year-old boy on it (see Fig. 4.1 in Sect. 4.2). The sight of the puppet can retraumatize the patient. The therapist therefore immediately asks the patient what the sight of the 'little boy' triggers in him. If necessary, the therapist takes the chair for the traumatized child out of the room and puts it in the hallway (see Sect. 4.8).
13. The therapist uses elements from trauma therapy (see Sect. 5.6), if necessary.
14. Associating the patient's masochistic thinking with his childhood helps him to understand himself better. In the next 15–30 sessions, however, the therapist works on the patient's core problem in the present, his *current* masochistic self-censorship.
15. The therapist tells the patient: "Your self-censorship is allowed to die. You are a moral person even without the self-injurious self-censorship and you have a conscience even without it." This message frightens some patients. They experience the disappearance of the 'soul killer' as a loss. The therapist understands this fear as fear of *a loss of identity*. Although this identity is *negative*, it gives the patient a sense of identity. The patient has lived with this self-censorship since childhood. He doesn't know how to be without it. He has to learn that first.
16. The therapist places an *extra chair behind* the 'soul killer' chair for the *harmful attachment figure from childhood* (see Fig. 4.1 in Sect. 4.2): "I want you to separate the inner soul killer's self-censorship from your parents' images. The internal images of your inadequate parents will continue to live on in you." The therapist soon removes the chair for the "alcoholic father" to avoid retraumatizing the patient. In metacognitive therapy, the therapist does not work

on the relationship with the *pathological introject*, but rather on the patient's *old self-censorship,* developed in childhood, in the encounter with his harmful attachment figure.

17. The patient should buy a puppet for his 'blind soul killer' or his 'blind governess' who controls him. He puts this puppet *in a closet* at home and locks it. The soul killer belongs "in jail" so to speak. He should 'not be able to get out again *at any point in time'*. The patient should not put his inner soul killer on his desk and then always see it in front of him. The therapist interprets this as masochistic: "You have to constantly expend energy to block out the sight of the soul killer while you work!"
18. The patient should take his "soul killer" out of the cupboard *once a day*, look at it for five minutes, and feel when the soul killer devalued him again that day. He adds *new* statements from the soul killer to his list. He then puts the soul killer back in the closet and locks it. This ritual in the as-if mode of play helps the patient to *neurally connect the external distancing* from their self-injurious thinking in their memory. One patient had symbolized her 'inner soul killer' with the hand puppet of a robber. If she struggled to sleep in the evening, she would place the puppet in front of her and let the sight sink in. Then she would grab her 'inner soul killer' and carry it out of the room. She locked it in a closet in the farthest corner of her apartment. She would then go back to her bedroom and lay down in her bed. This ritual helped her to alleviate her nocturnal psychosomatic crises.
19. In the course of the therapy, at the beginning of a therapy session, the therapist always sets up the two chairs for the *symptom scene* in her room (see Fig. 2.9 in Sect. 2.8). It is only when the patient in the therapy session thinks and acts in a self-injurious manner, that she places a second chair opposite him for his blind sadistic critic, persecutor or soul killer. She then points to this chair with her hand and rephrases the patient's statement. The patient's statement "*I* can't do anything!" becomes the soul killer's statement "*You* can't do anything anyway!"
20. If necessary, the *therapist* verbalizes *her negative affect*, triggered by the patient's self-injurious thoughts and actions. She gestures at the "blind soul killer": "I feel sad and annoyed because you are blocking all my efforts with your self-injurious thinking. You keep biting my head off, so to speak. I think I feel within myself the feelings that you are repressing in yourself." The patient does *not* feel devalued by this feedback because the therapist is standing *shoulder to shoulder* with him and looking *at his "inner blind soul killer"*. He feels seen and validated. The therapist must *repeatedly* justify her own negative feelings in the therapeutic relationship and make them beneficial for the therapy.
21. Sometimes, when the therapist verbalizes her negative affect, the patient responds with a *negative transference*. In such a case, the therapist places a chair next to her for the transference figure from childhood and actively works out the difference between herself and the transference figure (see Sect. 2.10): "I'm annoyed with you, as your mother often was. It's true. But then your mother always cut off from you and didn't speak to you for days. I *don't want*

to end therapy with you. My motivation for sharing my feelings with you is that I want to be honest and take you seriously as a person. Would you rather have a therapist who pretends nothing is wrong? We have a therapy contract for another 28 sessions. We're in the same boat and must get along somehow. I make sure I'm okay. Otherwise, you can't learn anything from me. Now that I've expressed my feeling, I feel better immediately."

22. Patients who repeatedly act masochistically often project their own sadistic superego or soul killer onto those they relate to (see Sect. 8.4.2). The therapist, therefore, teaches the patient *psychodramatic self-supervision* (see Sect. 2.9). The patient should use this method alone at home in order to distinguish the *real person* of his conflict partner from the figure of his inner soul killer in current relationship conflicts. In the role of his respective conflict partner, the patient repeatedly explores his true thoughts and feelings and thus dissolves any existing projection of devaluation. Thus, some patients learn, for the first time, how different people are and how differently they tick.

Central idea

There is a close connection between the patient's self-actualization and the actualization of his masochistic thinking. If the patient dares to take a small step forward in self-actualization, the patient's inner soul killer or prosecutor also becomes active again and pushes him back into adaption. The devil doesn't care about the souls roasting in the fire. But when a soul tries to escape from the underworld to go to heaven, he chases after it.

23. The therapist tries to relate the patient's *emerging* depressive moods in therapy to small advances in self-actualization: "Your soul killer is active again *because you dared to be* yourself, and not only to function well as a father / because you moved in with your partner / because you are successful / because you took it easy." One day a patient wanted to break up with his partner, a pretty young woman, "just like that". The therapist was taken aback. But he recognized, "You're not used to just enjoying when you're feeling good. If you have these thoughts again, please try to simply let yourself enjoy for three more hours!" In the next session, the patient reported with shining eyes: "It worked. It was beautiful!"
24. Some patients use a form of self-stabilization technique *at the end of their therapy* when the soul killer or inner prosecutor emerges. They list out loud to themselves everything positive they have done recently—first, second, third… Even small things count. One patient always patted himself on the back. Visualizing the real positive small victories can help push the self-injurious thoughts aside.

Central idea

The therapist cannot gift the patient his self-actualization. The patient has to acquire it himself, laboriously and in small steps. An inner transformation of masochistic thinking and acting therefore usually requires a long-term therapy of 50 sessions or more.

25. When the patient defends through grandiosity, the therapist points to his self-image in the symptom scene (see Sect. 2.8 and Fig. 2.9) and draws his attention

to the contrast between self-protection through grandiosity and *being normal in everyday life*: "To be normal means to allow oneself to be how you are. Normal people are allowed to feel *insecure* in an *unsettling* situation. Normal people get angry when there is a reason to be angry and feel sad when there is a reason to be sad. It says so already in the Psalms in the Bible. But your blind inner soul killer forbids you from being a person with *normal* feelings, a person who has strengths but also makes mistakes. Maybe you don't even know what it's like to be normal. How would a normal father react to the situation at the parents' conference? Do you know what I mean by 'normal person'?" Many masochistically fixated patients are puzzled by this question: "No, actually I don't. I always think I am wrong, instead!"

26. The patient consciously practices being a "normal person" in his everyday life and also gives permission to his blocked feelings. This can be a long journey of practice because "being normal" means allowing oneself to be. However, doing this often actualizes the patient's self-injurious thinking.
27. The therapist explains to the patient that his therapy is so lengthy because of the deficits and trauma in his family of origin: "You feel guilty in the present because you violate a *rigid defense from your family of origin* with your completely normal wishes. There was a taboo on talking about feelings in your family. No one was allowed to address problems and expect others to deal with them. So now you are the first in your family to break the taboo. It's a big, tough job."
28. *Masochism also gives something.* Masochism is a prison, but the rules in this prison are simple. The patient *always* only thinks: "I am nothing, I can do nothing, I am good for nothing." If necessary, the therapist informs the patient: "It is also comfortable to think masochistically. Because you know your way around. If you omit perfectionism and self-injurious thinking, you have to reassess what the *respective* conflict partner *really* means in his statement, how he *really* ticks, and what he *really* wants in *every* conflict situation. That's exhausting. If that is too exhausting for you, you can of course remain in your masochistic thinking and acting."
29. As patients make progress in therapy, they sometimes feel that they are missing something *without* the masochistic self-censorship: "Life has become dull and boring! I don't have to maintain balance all the time anymore." The patient misses his constant state of hyperarousal, the rigid fixation on grandiose or perfect goals, and his failure to meet these demands. The therapist re-interprets this message positively: "Previously, you were trapped in your self-injurious thinking and your adaption to the assigned systemic role. If you let go of your masochistic self-censorship you are spontaneous and free to seek an appropriate solution in the respective situation. In the beginning, it is exhausting to be free. But you will learn it through practice."
30. The patient often only realizes during therapy that, contrary to his original assessment, he did not have a "beautiful childhood". He also recognizes that his problem with his inner killer or prosecutor shows up in *all* his relationships, even with his beloved children. The therapist appreciates the patient's strenuous work: "You're dealing with a *character change*. It takes at least two years for

the new solutions to be neurally wired in your brain. If you think this work shouldn't be exhausting, write that expectation on the list of what your inner killer says, 'This is far too exhausting for you. You can't do it anyway!'"

31. Some patients develop grandiose abilities as fathers, husbands, or co-workers *by adapting* to the accusations of their 'blind soul killer'. They are narcissistically abused, humiliated, and devalued by caregivers and *still try to function perfectly* in the assigned systemic roles in the present. In this case, the therapist has the patient engage in a psychodramatic dialogue with their damaging caregiver in the present. As a doppelganger in the 6th and 7th steps (see Sect. 8.4.2), she tells the caregiver, who is played by the patient: "I don't need this anymore. I have experienced enough humiliation, loneliness, and abandonment in my childhood. I'm traumatized by it. I don't need this again. Stop! Stop doing that. I am allergic to it. I want you to be mindful of my vulnerabilities. Let's agree on how you can tell me something in peace. But I can't take it anymore if you react emotionally to me! Stop!" In the role of his attachment figure, the patient often feels that this is the first time that he has respect for him. This experience *completes* his inner picture of his conflict partner. In the *next real encounter* with him, he will therefore behave differently on his own (see case example 15 in Sect. 2.14).
32. It is not uncommon for patients or clients who act masochistically to try to have their unfulfilled childish needs fulfilled by their *elderly* parents in the *present*. But they keep getting a bloody nose, break off contact from time to time and then try again and again: "I want to improve the relationship with my mother!" In such a case, the patient is not really separated from the parent concerned. The therapist, therefore, allows him to integrate his progress and findings from the therapy *in psychodramatic dialogues* with role reversals *into his inner relationship with the childhood attachment figure.* True detachment only succeeds if the patient develops his inner self-image and *also the inner object image* of his attachment figure through rehearsal with role reversal (see Sect. 8.4.6): Who was the mother really? How does she tick in the relationship? What were her values and norms that determined her actions in my childhood? What defense am I running into against her at the moment? When did her defenses arise? Who could she have become if she had grown up differently? If necessary, the patient can also write a coping fairy tale *for his mother* (see Sect. 5.14). In this process, he recognizes the familial defense structures of his family of origin and can then break away from them more easily.
33. Some therapists identify with the patient's inner abandoned or traumatized child in therapy without realizing it. They become impatient or can no longer stand the extent of the patient's masochistic self-censorship. They then introduce a fictional helpful doppelganger to aid in the patient's self-actualization against his inner 'soul killer'. It is usually more appropriate to apply the described procedure *more consistently,* to adequately appreciate the severity of the patient's childhood trauma experiences, and to integrate elements of trauma therapy into the work (see Sect. 5.8).

8.6 Therapy for Severe Depression Bordering on Psychosis

A severe depression bordering on psychosis (ICD F31.4, F32.2, F33.2) occurs when an old defense system has collapsed. The patient's inner fantasy space collapses, and their mentalization is profoundly paralyzed or deficient. They cannot connect their depressive affect with past or present conflicts because they can no longer represent their conflicts internally (Krüger, 2012, p. 301). Therefore, they do not understand themselves or *any depth psychological interpretations*. It is difficult to connect with these patients psychotherapeutically because of the severity of their depression.

Case example 71 (*Krüger, 2004a*, p. 257 ff., Revised)
A 48-year-old social worker, Ms. H., seeks outpatient therapy fourteen days after a seven-month long (!) treatment in a psychiatric clinic with a discharge diagnosis of 'Severe depression with psychotic symptoms' (F32.3). She is, she says, "doing just as bad as she was before the inpatient treatment". She takes antidepressants, sedatives, and neuroleptics as medication. The year before, Ms. H. had had a mental breakdown triggered due to harassment at her workplace (current conflict). She slowly enters the therapy room with small steps and sagging shoulders. She is startled by the smallest of external irritations. Ms. H. fell ill after obeying her boss's unreasonable instructions for a long time. Her boss seemed to have a noticeable disturbance in her own personality. However, despite her intelligence, Ms. H. is unable to relate her depression to the harassment at her workplace internally. Despite her severe depression, she wants to go back to work immediately.

In reality, Ms. H. was creatively gifted. As a child, she had a good intuitive sense of discrepancies in her family of origin and was, as she later said, "always curious, open, and honest". Tragically, this led to her being considered "the difficult one" in her family. She was repeatedly devalued and shamed in her family. As a child, Ms. H. unintentionally identified with this role of being the difficult one in a family where the perception of emotions and conflicts was taboo. Her father was traumatized by the war. Her mother had ulcerative colitis. Empirically, these two diseases are known to be accompanied by a splitting-off of emotions. The family suppressed emotions by assigning roles and ideological rationalizing with the help of a Christian justification of love. Her father worked in a Christian community. He once wrote to her in a letter: "There is always a black sheep in every four or five siblings. But one can also love a black sheep." Ms. H. was therefore not excluded in her family as long as she was at home. In fact, she received narcissistic gratification from taking on the role of the 'difficult one".

At the age of nineteen, the patient decided, as part of her separation from her parents' home, "to no longer be difficult" because she hated being 'funny' and 'dramatic'. As a result, later in life, she was always left feeling that she was 'not right'. She said: "I doubt myself so often. But others seem to feel so safe with themselves. This is my deepest question." Ms. H. learned a profession in which she helped children with mental and physical disabilities. She also married a widower with a difficult family. These two areas of conflict triggered the patient's intrapsychic

conflicts due to the external pressure to adapt. She had psychosomatic complaints for many years before she broke down mentally at the age of 47.

The therapist and the patient could not agree on the cause of her depression in the first two therapy sessions. The patient fought against the role of the 'difficult one'. She completely ignored the cause of her breakdown and workplace harassment and went back to work immediately, severely depressed, against the therapist's advice. However, her boss immediately sent her home because of her severe depression. (For continuations, see Sects. 8.6.1–8.6.6*).*

Central idea

The ability to mentalize collapses in patients with severe depression (see case examples 71 above and 89 in Sect. 9.8.1). Life happens to these patients. There is no inner self that could oppose the conflict partner in a conflict. Unfortunately, the ego is busy regulating the symptoms of depression. Therefore the therapist does *not* initially focus his work on the patient's interpersonal conflicts. Instead, he should validate the patient's *suffering from her depression* and, as a doppelganger, actively accompany her in her attempt to regulate the symptoms of depression. This activates her sense of self and authority *in regulating her symptoms*.

In case example 71, the therapist used six intervention techniques: (1) He exchanged roles with the patient and *mentalized* her thinking and feeling in the therapeutic relationship *on her behalf*. (2) Together with the patient, he implemented the process of self-regulation in her suicidal fantasies and asked her to think through her suicidal fantasies *right up to the end*, with all the consequences included. (3) Together with her, he implemented the process of *self-regulation* in her everyday life and thus activated her sense of self and authority in her actions. (4) He used the power of symbolizing in *nocturnal dreams* as an amplification to understand the patient's self-regulation during the day. (5) He symbolized *the sadistic superego* of the patient with an object and fought against it as her doppelganger. (6) He helped her to integrate her self-actualization, which improved in therapy, *into her inner relationship images*.

8.6.1 Vicarious Mentalization in the Therapeutic Relationship

Case example 71 (1st continuation, see* Sect. 8.6*)

At first, the therapist could not get in touch with Mrs. H. because of her severe depression. In order to better understand her internally, he asked her: "May I change into your role? I want to know what it is like to be, feel, and think like you." The patient and the therapist changed places. The therapist assumed her slumped posture and re-enacted her role. He verbally repeated what she had said. As her doppelganger, he allowed himself to experience her role physically, mentally, and cognitively vicariously and expressed it verbally. In doing so, he recognized that the grave 'feelings of panic' Mrs. H expressed were actually 'feelings of guilt' for not functioning adequately' in his own subjective experience: "I feel the guilt and panic go through

my arms and chest down to my navel." Mrs. H corrected: "I feel it as a cramp that goes down to the lower abdomen."

During vicarious mentalization, the patient realized that her physical and mental experiences could be put into words and understood by someone else. This process indicated to the patient: She is allowed to be difficult in the therapeutic relationship. This dissolved the blockage in the therapeutic relationship. In the next therapy session, Mrs. H. was able to report her suicidal thoughts openly for the first time. These had already existed for several weeks (continued in Sects. 8.6.2–8.6.6*).*

8.6.2 The Activation of a Sense of Self-regulation in the Symptom of Suicidal Fantasies

Mrs. H. was experiencing a pre-suicidal syndrome (see Sect. 8.8.3) due to her suicide fantasies. She thought in the equivalence mode (see Sect. 2.6) and was experiencing her *external circumstances* as depressing as *she felt within.*

Central idea

The patient's mentalizing and her inner fantasy space had collapsed. The patient experienced herself as someone to whom life happens. She felt she was at the mercy of her depression and could only react. The therapist, therefore, retraced her process of self-regulation, with her, in the symptom of suicidality. The aim was for her to develop a sense of self-regulation (thinking, feeling, and perception) in her actions and restore her inner fantasy space.

In doing this, the therapist asked her to think of her plan for suicide step by step, including the time, place, *and all the consequences.* In this way, the patient integrated the as-if mode of play into her thinking in the equivalence mode (see Sect. 2.6). That resolved her pre-suicidal syndrome. She could internally connect with her self-actualization in the symptom of suicidality.

Case example 71 (2nd continuation, see Sects. 8.6 and 8.6.1)
After Mrs. H. had reported her suicidal ideation, the therapist asked her to imagine the course of her potential act of suicide with all the consequences. Mrs. H's fantasy was to jump out of her friend's apartment window, which she regularly cleaned without pay, to structure her everyday life'. The apartment was on the 23rd floor of a high-rise building. Together, the therapist and the patient imagined how she would think and feel and what she would experience in her body during the act of suicide moment by moment. The patient and therapist recognized that it was about flying for her. Flying would allow her to leave the suffering behind and 'feel freedom'. The therapist asked the patient to go even further in her imagination of the suicide: "And when you come down on earth, what will happen? What do you think?" It was only then that Mrs. H. realized how this act of suicide would completely destroy her physically. She would also emotionally hurt her friend and her loved ones. This horrifying imagination terrified her to the depths of her soul (continued in Sects. 8.6.3–8.6.6*).*

The imaginative realization of the suicide fantasy helped the therapist to *diagnose* the patient's suicidal risk. If the patient hadn't felt terrified in the end, the therapist would have had to admit her to a psychiatric clinic in an emergency. Thinking through to the end of the suicide fantasy *in the as-if mode* helped Mrs. H. to recognize the difference between her wishful fantasy and the horrible reality of the act of suicide *with its real consequences*. She developed internal distance from her suicidal ideation and her pre-suicidal syndrome was resolved.

8.6.3 Rebuilding the Inner Fantasy Space in Everyday Life

Case example 71 (3rd continuation)

From the sixth therapy session onwards, the therapist would ask the severely depressed patient to report specifically about her present everyday life. In doing so, he walked through, together with her, her actions, physical sensations, affect, and thoughts in the process of her self-regulation in depression, step by step: "What did you do after you woke up in the morning? What did you think? What did you feel? Then what did you do?…" The therapist and the patient represented everything that she reported with stones and blocks of wood on the table: her own self, her feelings of guilt, her sense of duty, her bed, her husband, and other relatives. Like a naive, curious child, he let Mrs. H show him the way of her self-regulation today. He doubled her verbally and helped her put her feelings and thoughts into words. In doing so, he always pointed out to her when she had made a choice. For example, he stated: "Ah yes, you drank tea for breakfast but didn't eat anything." Once, Mrs. H. lay in bed for two days until her husband persuaded her to get up. The patient felt that she was an imposition on others. She was living in the role of the 'difficult one' in her present family, even though this role was initially created for her survival in her family of origin. The bed had become a cave for her, in which she felt safe with her cuddle pillow. The therapist commented: "If it felt more comfortable for you to turn on your left side in bed, then that was the best solution for you!".

Retracing the chronological sequence of interactions in depression, resolved the defense through denial (see Sect. 2.4.2*). It revealed that Mrs. H. had been suicidal in the car on her way to the therapy session. She had had the idea of crashing into a truck. The therapist was startled. But he saw Mrs. H. sitting in front of him alive. He, therefore, asked her to tell him exactly how she had regulated her suicidal tendencies: "What did you think and feel after the thought of crashing into a truck? Something must have caused you to distance yourself from this idea!" Mrs. H.: "I thought that you were waiting for me." At that moment, the therapist experienced Mrs. H. as naively trusting as a child. He felt connected to her. That calmed him down a little. However, he increased the number of therapy sessions to twice weekly and thus made the therapeutic setting more stable than before. He did not admit the patient to a psychiatric clinic because she had recently been hospitalized for seven months without any improvement in her condition (continued in* Sects. 8.6.4–8.6.6*).*

Central idea

The patient's inner fantasy space had collapsed. Life happened to her. The patient first had to develop a sense of self-regulation in her actions. So this work was not about the content of her thinking, but about reviving her mentalizing ability.

During this work, the therapist met the patient with an inner attitude: *When it's about living*, there is no right or wrong. *Every* action the patient takes is a solution. The patient's current solution may not be a *good* solution, but it is the best possible solution for her *right now* because *the patient's soul doesn't do anything for free.* The therapist accompanies the patient in understanding her actions in everyday life as an implicit doppelganger shoulder to shoulder. He interviews her: "What do you feel and think when you do that?" And he verbalizes *his own* actions, feelings, affect, and thinking *as her doppelganger*. In this way, he fills gaps in *her* inner psychosomatic resonance (see Sect. 2.7) and marks meaningful thought contents. The collaborative mentalization of the patients' experiences in their everyday life has an ego-strengthening effect.

Working with the table stage helps the therapist to get an overview of the patient's psychological crisis together with the patient.

Recommendation

The more distressed a patient is, the more likely it is that the therapist *himself,* as a doppelganger, has to represent and re-enact the patient's experience externally with stones on the table when working with the table stage.

The patient's ego stone in her soul landscape represents the center of her self-regulation: "It is your ego that feels guilty". The *external* play in the as-if mode with the stones on the table stage improves the patient's *inner* capacity to think in the as-if mode via the feedback loop between the external psychodramatic play production and inner mentalization (see Sect. 2.3). The patient looks at *the symbolic image of her self-regulation* in her crisis from the meta-perspective. This sets up her inner fantasy space again and strengthens her cognition. At the end of therapy, Mrs. H. paid tribute to the *small-step* therapeutic work on the process of her self-regulation with the comment: "Whenever I said that I wasn't doing so well, you would always ask me pointedly. That's when I noticed what I really *felt*."

8.6.4 Symbolizing in Nocturnal Dreams as an Amplification for Understanding the Patient's Self-regulation in Everyday Life

Some patients with severe depression continue to process their conflicts in nocturnal dreams *despite their mental breakdown.* However, the dream work must not be severely impaired by a high dosage of psychotropic medication. The therapist uses the power of symbolic images in the nocturnal dreams *therapeutically* as a resource for self-regulation in mentalizing. He appreciates the *inner creativity* of the patient

that may be recognizable in the dreams. This activates the patient's inner ability to mentalize in everyday life.

Case example 71 (4th continuation, see Sects. 8.6–8.6.3)
*The first sign of progress in Mrs. H's therapy was visible in the 10th session. She narrated a dream in which a house had collapsed above her. The debris had fallen on her. A week later, she even dreamt of a large church that had collapsed above her. She resignedly interpreted these dream images as symbols for the collapse of her hope for healing. The therapist knew, however, that if a patient symbolically converts their clinical symptom into a scenic dream image, it is to be seen as progress in psychotherapy (*Plassmann, 1999*). Therefore, the nightmares described by Mrs. H. gave him confidence that Mrs. H. could benefit from psychotherapeutic treatment. He communicated this assessment to the patient through a 'space interpretation' (*Plassmann, 1999*): "I think your creative powers are gaining some strength, at least in your unconscious. Because your unconscious is able to symbolically represent your mental breakdown through images and deal with it."*

The appreciation of the creative powers of her unconscious brought about further progress in the patient. However, this was demonstrated in the following therapy session in a somewhat grotesque manner. Mrs. H. reported a new dream: "My brother-in-law put a pistol in my hand. In the dream, I held it to my head and pulled the trigger. But nothing happened. I felt very disappointed in the dream and said: 'That doesn't work!'".

In contrast to the dream images of the collapse of the house and the church, death in this dream no longer 'simply' fell upon the patient as a matter of fate. She was now trying to kill herself in the dream. This indicates that, at an unconscious level, she was now feeling in control of her suicidal fantasies. At the same time, however, similar to real life, she did not succeed in putting this into practice. The therapist interpreted the dream: "In the dream, your unconscious gave you a pistol without any bullets, and the suicide attempt failed. Perhaps this indicates that there is a part in you that wants to live?" Mrs. H. found this dream interpretation to be true but also restrictive. She groaned, "If committing suicide is not possible anymore, what then? Then it will be really difficult!" The possibility of suicide had given the patient a feeling of freedom and the ability to act, which has now disappeared. (Continued in Sects. 8.6.5 *and* 8.6.6*).*

8.6.5 The Doppelganger Technique in Self-injurious Thinking

Case example 71 (5th continuation)
*At the beginning of the 14th therapy session, Mrs. H said: "It was challenging for me to come here today. Just thinking about it as I lay in bed was a nightmare. But my husband made sure that I got up and came here." The patient radiated deep suffering. As with focusing (*Gendlin, 1998*), the therapist asked the patient to exactly describe*

her experience of the 'nightmare': "Where do you feel the nightmare? What color does it have? Which shape? What consistency?" Mrs. H. experienced her nightmare as a square, a brown-black stone weighing about ten kilograms lying on her chest. The therapist remembered a similar stone lying in a closet behind him. He turned around, picked up the stone, and placed it on the table: "Is the stone like that?" Mrs. H. turned completely white in the face and stared at the stone: "You have such a stone!—I can't even look at it!" The therapist: "Would you like to do something?" The patient: "I would rather take it and throw it away." Therapist: "Do that!" Mrs. H hesitates: "No, it does not work like that. I'd have to throw it through the window."

The therapist seriously considered doing this on behalf of the patient. But then he dreaded the effort of having to repair the window. He saw the stone on the table in front of the patient and hesitated. Then he felt: He couldn't stand the sight of this threatening stone in front of him on the table. As a doppelganger, he took the stone on behalf of the patient and held it in his hands: "We can also take the stone away. How far away does it have to be?" He got up, took the stone to the far corner of the room, and laid it on the floor: "Is that okay? Mrs. H: "Yes, that's fine. I can't see it now!" The therapist went back to his chair. He sat down. He felt that the situation had eased for him.

But, a short while later, he felt blocked again: The nightmare stone was still threatening him from the corner of the room and paralyzing his inner contact with the patient. So he followed his impulse to act as a doppelganger and stood up: "I can't stand it!" He fetched the stone from the corner of the room and carried it out of the room through the corridor into the examination room of his practice. There, he placed it on the floor in the furthest corner. Then he went back to the therapy room. He explained his actions to the patient: "It's not just about working, but also about feeling good." The therapist sat down on his chair and felt differently in the changed situation: "Yes, that's better for me." A deep, long-lasting silence emerged in the therapeutic relationship.

The therapist felt more comfortable. Suddenly he saw that Mrs. H. was beginning to cry cathartically from deep inside her body. Her breathing was restricted like in an asthma attack, and she groaned: "I feel so empty from within, so empty, so empty!" The therapist told her what he had experienced: "I have great respect for the depth of your feelings. You do a lot of work when you allow your feelings here." Mrs. H: "I always feel so guilty that I don't do anything here during the session!" The therapist gave the patient plenty of time. She slowly relaxed. Then she spontaneously said: "I have always lived against my feelings in my relationship with my stepdaughter. I've always tried to fix everything and do everything. But my stepdaughter didn't like me. She always only wanted her dead mother. I have never been able to talk to my husband about these feelings." For the first time, the patient internally linked her suffering with her own relationship conflict through these statements. The therapist affirmed this as a therapeutically significant step: "Linking your feeling of emptiness with the knowledge that you have always acted against your own feelings makes a lot of sense." (6th continuation below).

Recommendation

The therapist should constantly *positively affirm new solutions* that *appear spontaneously* in the patient's crisis. This helps those affected to integrate the new solution into their self-organization and to stabilize it over time. If a new solution is not positively affirmed from inside or outside, it is mostly lost again in the chaos of the crisis (Schacht, 1992, p. 125). This is a finding from the chaos theory (see Fig. 2.1 in Sect. 2.1).

Central idea

Improving one's sense of self in acting can *worsen* severe depression. In such a case, the improved sense of self intrapsychically triggers an internal pathological introject or a sadistic superego. In such a case, *the therapist* must not be confused in assessing the patient's progress.

Case example 71 (6th continuation, see Sects. 8.6–8.6.4)

At the beginning of the next therapy session, Mrs. H. was in a completely unexpected state, depressed and by no means relieved. She groaned: "I feel so bad and guilty because I portrayed my husband so negatively here in therapy." She defended through projective identification (see Sect. 2.4.4*). She identified with the role of the good mother ascribed to her in her current family. The therapist should help her be a good mother and not cause trouble for her family. By acting out this defense, she delegated her own sense of self to the therapist. The therapist felt internally blocked, resigned, and lost on the patient's behalf. In this situation, however, he made his own emotional reaction fruitful for therapy. He symbolized the patient's self-accusation and his inner protest against it with two stones in a symbolic image. He placed the five-kilogram nightmare stone from the 14th therapy session on the table in front of him and clamped a cherry-sized, green semi-precious stone underneath it: "The big stone here is your feeling of guilt, which is depressing you. The small stone is you!" (7th continuation see Sect.* 8.6.6*).*

The *interpersonal* conflict between the patient and the therapist was transformed into an *intrapsychic* conflict of the patient through the external representation of her interacting self-parts. From the meta-perspective, they both perceived the patient's conflict *as an intrapsychic conflict* outside on the table stage. The patient's 'self' was the victim of the big stone of guilt. In this way, she was able to admit her will to exist, suppressed by her large, sadistic superego.

Recommendation

When symbolizing a sadistic superego on the table stage, the therapist should keep replacing the object symbolizing the superego with a *larger* object until the patient protests: "No, the previous stone is big enough!" The following rule applies: the larger and more powerful the superego stone looks in relation to the small ego stone, the more likely it is that *the patient* will develop compassion for her suppressed and frightened self and empathize with herself.

The treatment of Mrs. H. took place more than 30 years ago. At that time, I had not yet developed the models of disorder-specific therapy for people with trauma-related disorders and structural disorders presented in Chaps. 4 and 5 of this book. Today I would treat the patient's dysfunctional metacognitive processes with the *chair work* on the room stage instead of stones on the table stage (see Sects. 4.7 and 4.8) *from*

the point at which Mrs. H. was able to relate her depressive affect on her own with her current relationship conflicts.

8.6.6 The Integration of Improved Self-actualization into the Inner Relationship Images

Case example 71 (7th continuation, see Sects. 8.6–8.6.5)
The therapist symbolized Mrs. H.'s intrapsychic guilt conflict in the following twelve therapy sessions patiently and consistently with the same two stones on the table. This helped to center the therapeutic conversations thematically on the intrapsychic conflict. When the patient talked about her current negative feelings and body sensations, she saw her 'sadistic superego' lying heavily on her 'little self' on the table and spontaneously associated various relationship problems from her life story in which she had felt guilty. Unlike at the beginning of the therapy, the patient now linked her depressive affect with inner relationship images. She redefined herself in her thinking as "someone who dares to be difficult for the other, at least in her thinking, and then feels guilty toward the other".

In this therapy, the therapist learned that an internal structural change takes a lot of time. The new paths must permanently interconnect and nestle in the memory structures of the human being in order to become part of a new dynamic balance of the soul (*see* Fig. 2.1 in Sect. 2.1). *Mrs. H. needed another twelve therapy sessions with consequent 'linking work' (Fuhr, 1994, verbal communication). It was only after six weeks, in the 25th therapy session, that she explicitly confirmed to the therapist that her condition had improved: "In the last session when I went out, I felt something light inside me for the first time."*

The sight of the small suppressed ego stone under the large 'guilt-stone' helped the patient justify her feelings in relation to her conflict partners. She spontaneously linked her feelings of powerlessness and helplessness with the traumatizing workplace conflict that had triggered it. She no longer wanted to be 'the difficult one'. She had, therefore, not spoken to anyone about the harassment at her workplace. But now she told the therapist: "Back then, as a social pedagogue, I failed in my creative style of work with differently-abled people. I had to re-dress them whenever they would wet themselves. Some youngsters have beaten me on several occasions. My colleague, who was part of the group, would run to the toilet for an hour whenever it got difficult." Mrs. H had asked her boss for help in this emergency. But the boss had obviously been overwhelmed with this situation herself. So in response to Mrs. H, she had given absurd suggestions to practice specific exercises in arithmetic, biology, and other subjects with the youth. Each exercise should last a quarter of an hour. Mrs. H. had been asked to record her work and its successes in detail and submit these records to the boss for supervision every day. Mrs. H. resignedly said: "The others in the facility didn't bother the boss. They just went along with it somehow! But I was constantly afraid!" 19-year-old Mrs. H.'s plan to 'no longer be difficult' was a disaster in this situation. She should have been difficult with her boss in order

to protect herself mentally. It is fitting, that a few years later, Mrs. H's boss took early retirement due to a mental disorder.

After three months of explicit metacognitive work on the intrapsychic conflict between herself and sadistic superego, Mrs. H. named the small green stone that was so unbearably burdened by the big guilt-stone on the table stage, 'my feeling ego': "It is my own will, which was buried in me." She added a third stone to the outer symbolic image of the two stones for her 'adapted ego' and said: "I hadn't even noticed it before. I just did everything all the time." Mrs. H. tried to find out in which of the three ego states she was in her relationship conflicts respectively, whether in her punishing superego, in her 'adapted ego', or in her own feeling as a healthy adult woman (see Sect. 4.7*). The external image of her ego states on the table helped her work through her relationship conflicts. As a result, she learned to assert herself better in everyday conflicts.*

For example, in the 81st therapy session, Mrs. H. reported that her husband had advised her "to go back to work because of her self-esteem problems". But she immediately protested: "I'm not bored at all. I am fulfilled. I am rediscovering a lot of things for myself right now. I paint. I am learning English. And for the first time, I am also enjoying the household chores. I have developed interests! I don't want anyone telling me what to do!" The therapist appreciated her new self-determination in the conflict with her husband as 'personal progress'. Mrs. H. appeared quite distressed upon hearing this positive appreciation and said: "The work in the institution for differently abled had left me with a lot of self-doubts!" She started weeping cathartically and groaned: "I am never enough! I do not want to feel like that anymore! I don't want to be determined by idiots anymore!" This sentence became the focus of her further development in psychotherapy: "I don't want it anymore! I don't want to be determined by idiots anymore!" (8th continuation below).

Over time, the patient developed awareness of her defense through identification with the system (see Sect. 2.4.4), and through the explicit metacognitive work on her intrapsychic conflict (see Sect. 4.8). She realized that even as an adult, she was still identifying with the role of the 'difficult one' from her childhood. Over time, by working on her identity conflict, she learned to justify *her feelings* even more and relativized the power of her sadistic superego. In doing so, she dared to feel what she is feeling. She no longer had to ignore the 'evil' in her loved ones. At the end of therapy, Mrs. H. stated: "My husband always said that he would like to have a *normal* family. I had tried everything to achieve this goal. But the family *was not* normal. It was difficult. The daughter always wanted her dead mother back. I should have said to my husband: 'But this is not a normal family, this is a *difficult family*!'".

Case example 71 (8th continuation)

At the end of her therapy, the patient dreamt of a newly built house she had moved into. This indicates that she had established a new inner self after her old adjusted self had collapsed. Mrs. H. had retired for three years due to her severe depression. However, two years before the end of her five-year therapy, she decided to return to work in her old institution. She fought against all opposition and ensured that she only worked with individuals and no longer in groups. At the end of therapy,

Mrs. H. shared a dream: She is standing with her 'therapist' on a mountain meadow and talking. Then she says goodbye of her own accord and "drives away in her Triumph sports car". In the 1950s, there was a sports car called "Triumph". Mrs. H. herself was driving the car in the dream. So she could now steer herself and leave the therapist figuratively 'in triumph'. In the continuation of the dream, she then switched to a bicycle and thought: "But now you need a lot of time!" Mrs. H. then decided: "Now I want to take my time in my everyday life, too". Ten years after the end of her psychotherapeutic treatment, the patient informed the therapist that she had not been mentally ill ever again in the last ten years.

The *psychotherapeutic treatment* of a patient with severe depression with structural conflicts should proceed in small steps and offer stability, in the beginning, considering the patient's internal blockages and inner chaos. We, therefore, recommend two 50-min sessions per week for the first 3–6 months. The frequency of the sessions can be reduced to one session per week once the patient's condition has improved. The treatment for *severe depression with structural conflicts* can last for five years. However, it can be phased out at a lower frequency in the last two years. In the case of *chronic disorders*, the therapist must continue to accompany the patient for many years after the end of the intensive phase of psychotherapy. A 50-min session once every four weeks is sufficient for this. The stability in the therapeutic relationship often stabilizes the patient in their professional life, personal relationships, and in dealing with themselves. Many therapists underestimate the therapeutic effect of a long-term, stable therapeutic relationship with their patients. During these subsequent years, the patients sometimes take important developmental steps despite the limited therapy hours.

8.6.7 Limitations in the Therapy of People with Depression

In the psychotherapy of patients with severe depression, everything that helps alleviate their *suffering* is ultimately good. Sometimes it helps if the therapist firmly asks the patient to take an absurdly small step in the right direction.

Case example 72
A 48-year-old housewife, for example, had been suffering from severe depression and schizoaffective psychosis (F25.1) for a long time and had developed a helplessness syndrome. Her husband was very caring and did all of the household chores for her. The therapist witnessed this absolute protection of the patient during a home visit and experienced it as exaggerated and absurd. Therefore, he asked the patient to carry at least one spoon from the dining room into the kitchen after lunch every day from that day onwards. The patient gradually emerged from her depression from the moment she did as told by the therapist.

The clinical symptoms in patients with severe depression are sometimes difficult to influence psychotherapeutically. Nevertheless, the therapist should *continue* to provide psychiatric and psychotherapeutic support to the patient. Sometimes the

symptoms improve surprisingly. It can help, for example, if the therapist answers psychodramatically (see Sect. 4.13) and expresses his feelings openly *after having endured the patient's suffering for a long time*: "I feel helpless in my relationship with you as a person. That doesn't mean that, as a therapist, I want to stop therapy. You are in therapy with me, and we are in the same boat. I just want to tell you honestly how I am doing with you."

Case example 73

Mrs. I., a middle-aged nurse, was severely depressed. She sought outpatient psychotherapy after several admissions to psychiatric and psychosomatic clinics. After two operations, she was sick for three years and was thus unable to work. During these three years, all her therapists in inpatient and outpatient care were in despair due to her repetitive sentence: "I can't think, I have become stupid!" The therapist willingly tried out various therapeutic approaches for six months. In his desperation, he even gave her a foot massage for 30 min. But, the patient did not start again until the therapist gave up his helper attitude and took her 'saying' seriously. He told the patient openly: "I don't know what to do next. I think it's true: Maybe you do have brain damage!" The therapist's surrender led to an inner turning point in the patient and a new beginning in her ability to think. The therapist only realized much later that her statement was true in a figurative sense! The patient had almost died in two emergency operations due to medical errors and was only saved by the mindfulness of her life partner. In addition, she was also psychologically traumatized due to a subsequent chronic physical illness. The patient's statement, "I can't think, I have become stupid!" was an accurate description of the frozen state of her traumatized mentalization.

This book does not describe psychotherapy for depression in the context of bipolar affective disorder (ICD-10 F31.-). In bipolar disorder, the patient experiences episodes of mania and depression alternatingly. According to Mentzos (2011, p. 213), mania is to be understood "as an antidepressive defense. […] The sequence of depression and mania corresponds, on the one hand, to repetitive sequences of a self-degrading submission to the superego and fate and, on the other hand, to the illusory, manic denial and excessive self-overestimation, which can only last for a short time." Depressive and manic psychoses "often don't break out of the blue, they are at least partially triggered by difficult breakups, illnesses, or losses" (Mentzos, 2011, p. 312). Even before this disorder is diagnosed, patients experience fragile disturbances in their self-esteem regulation. "Traumas, disappointments, and frustrations experienced by these patients in childhood have made them hypersensitive to the triggers mentioned above." This hypersensitivity leads to the onset of depressive or manic phases in the presence of new triggers. According to Mentzos (2011, pp. 212 and 214), a certain organically induced over-excitation or biological instability can be assumed in bipolar patients.

In my experience, psychiatrists diagnose 'bipolar disorder' too often. One reason for this may be that the therapist's time and professional resources are limited. If the doctor assumes a biological psychotic condition, it is easier for him to justify to himself that he is largely confining himself to the administration of medication.

Severe depression in the context of 'bipolar disorder' (F31.-) is often depression in the context of a borderline personality disorder, a dissociative disorder, or a trauma-related disorder (see case example 71 in Sects. 8.6–8.6.6). For example, the manic decompensation of Mrs. H's husband (see case example 71) occurred 15 years after her treatment, after he heard gunshots in a war zone in Syria outside his hotel. His manic decompensation served the function of countering a flashback from childhood trauma.

8.7 Treatment with Psychopharmacology

When patients with *severe* depression are discharged from a psychiatric clinic and come to outpatient psychotherapy, they are often found to be consuming very high dosages of psychotropic drugs. Psychiatrists often *combine* antidepressants, sedatives, and neuroleptics. They may then supplement these medications with antiepileptic drugs "to prevent bipolar mood swings". For example, the patients in case examples 71 (see Sects. 8.6–8.6.6) and 73 (see Sect. 8.6.6) were more or less rigid in their facial expressions and gestures, had swollen faces, and walked in small steps without moving their arms when they came to their first psychotherapeutic interview. Psychotherapists, even if they are psychologists, are *jointly responsible* for their patient's medication. When in doubt, a psychotherapist should follow their intuition and communicate their doubts to the prescribing doctor. A high dosage of psychotropic medication should be *reduced to an appropriate level* as early as possible in cooperation with a psychiatrist. The reasons for this are: (1) A psychotherapeutic relationship giving a sense of security replaces a part of the medication. (2) Patients may not be able to make adequate use of psychotherapy due to the effects and side effects of the medication. For example, psychotropic drugs often limit one's cognitive abilities. However, the patient needs his cognitive abilities in order to process his experience *in psychotherapy*. (3) The pathological mental states of the patient must be acted out in the relationship with the therapist so that they are accessible for psychotherapeutic interventions.

Recommendation

When prescribing psychotropic drugs, the general rule applies: the closer the therapeutic relationship, the lesser the amount and dosage of drugs required. For example, if a patient is in twice-weekly therapy, his medication can be decreased even more than if he were in *once*-weekly therapy.

Psychotherapy sessions save a lot of money when compared to the often very expensive psychotropic drugs. Medicines mainly 'only' improve the symptoms. But psychotherapy heals at a deeper level. It often prevents illnesses from becoming chronic, resulting in extended sick leave and early retirement. Even if *all* complementary economic costs are included, psychotherapy is probably no more expensive than a purely biomedical treatment over many years. In Germany, health insurance companies cover the costs of psychotherapeutic treatments at the therapist's request because it helps them save money. This was an outcome of a scientific study by

Dührsen (1962). This study indicated that patients who had engaged in psychoanalytic psychotherapy were sick and *incapable of working for fewer days every year* than the average population. The number of sick days also included all physical illnesses. The financial expenditures of the health insurance companies for medical care had therefore decreased.

8.8 Suicidal Crises

8.8.1 Fundamentals of Suicidal Crises

Suicidal tendencies are scary because healthy people find it absurd to seek the great, real death instead of dreading it. A successful suicide always indirectly hurts other people in the social environment. This is because suicide is a breach of taboo and a violation of the deeper meaning of the human community. One of the tasks of a community is to ensure the survival of the *individual* members of the community. A community can be the family, the employees at work, a circle of friends, or the neighbors. A suicide attempt is often an *unspoken* message from the individual to the community that it has failed or is about to fail in an important task. A successful suicide always calls the community's identity into question. Many families break apart after a family member kills themselves.

In exceptional cases, suicide can be an *appropriate* solution to a conflict, for example, in a serious, incurable disease. Suicide is perhaps the only way for those affected to maintain their *dignity* (see Sect. 8.8.4). Paragraph 1 of the German constitution also applies here: "Human dignity is unimpeachable." In most cases, however, the prerequisite for suicide with dignity does not exist.

Everyone has the right to kill themselves. But only a few people attempt suicide even when in full possession of their mental and emotional powers. A good example of suicide with dignity is Moreno himself, the father of psychodrama: "In late April of 1974, a series of minor strokes had weakened him. At the age of 85, he was bedridden, he could […] only speak slowly […]. Because he was in pain from eating solid foods and knew he would die soon anyway, he decided to hasten the end and die with dignity. He decided not to eat anymore and to live only on water" (Yablonsky, 1986, p. 247 f.). His family and many of his students from around the world said goodbye to him one by one in his home. He died after about six weeks of fasting.

8.8.2 Constricted Thinking in the Pre-suicidal Syndrome

In a *pre-suicidal syndrome,* people at risk of suicide are usually in a psychological state of emergency through the encounter with the great real death.

Important definition

A pre-suicidal syndrome involves the following (Ringel 1953, quoted from Reimer, 2007, p. 599): (1) The individual's thinking is fixated on death fantasies up to and including the longing for death, *without* thinking through the consequences of the imagined suicidal act. (2) The inner mentalization, the self-actualization tendency, and the ability to imagine or fantasize are constricted. The closer in time suicidal patients come to their suicidal act, the more they think in equivalence mode (see Sect. 2.6). They then see their outer world as negatively as their inner construction of reality suggests. They, therefore, see no other way out except for suicide, even if there was a way out. They can no longer feel the relationship with those close to them.

Sometimes an unplanned event pulls a suicidal person out of their pre-suicidal syndrome.

Case example 74

One patient told his psychiatrist, "I went into the woods with a rope to hang myself. There I met a man with a big black dog. The dog suddenly barked terribly at me. The man couldn't calm him down and kept apologizing to me: 'My dog is not usually like that. I didn't even know that he could be so aggressive! I'm sorry!' This other man, unsuspectingly, engaged me in a conversation. We talked for twenty minutes. I didn't tell him about my plan. But after that, I could no longer carry out my plan. I went home and talked to my wife. She then made this appointment for me with you."

Some suicidal people delay their suicidal act *on their own* initiative until the pre-suicidal syndrome and the suicide fantasy dissolve.

Case example 75

A 50-year-old patient had been traumatized in the first year of his life by being hospitalized for six months in the post-war period. As a funeral director, he always became suicidal when he was exhausted and happened to have a "suicide" coffin as well. In four years of therapy, he had secretly gone into the cellar at night a total of twenty times with a rope to kill himself. But he would always take his time there. He would sit on the cellar stairs and wait. He always waited until he thought of his daughter. Sometimes this would take up to three hours. Then he would curse himself: "You are a pig! You just want to slip away!" Then he would put the rope aside, go upstairs to his apartment, and resume his daily chores. The therapist only realized much later that the patient began the act of suicide whenever he found himself feeling empty and senseless. The encounter with the great death helped him wake up from a flashback and the pre-suicidal syndrome. Then he would feel his body again and could enjoy the little things in life until the next crisis.

8.8.3 Criteria for Assessing the Risk of Suicide and the Need for Therapy

There are many reasons why someone attempts suicide. The therapist can evaluate the risk of suicide and why one needs therapy by examining two questions *after a patient has attempted suicide*:

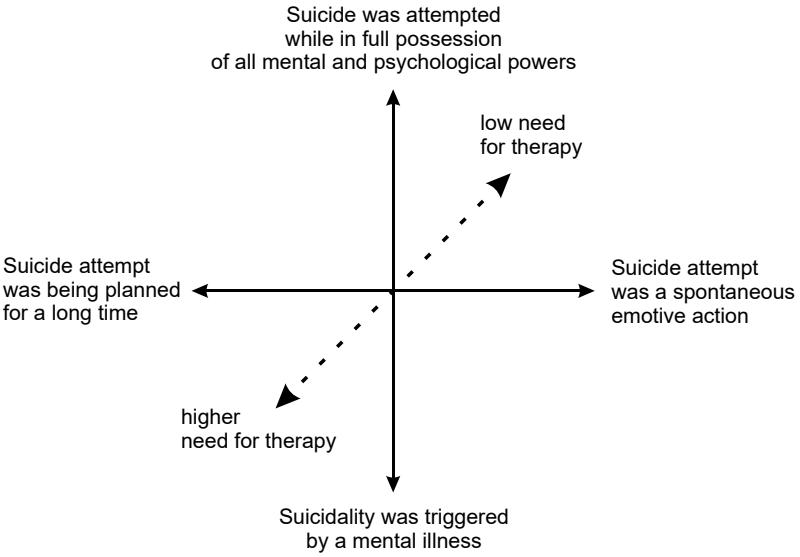

Fig. 8.3 Criteria for the risk of suicide and the assessment of the need for therapy after a suicide attempt

1. Is the attempt at suicide more of an 'emotional act' or a 'long-planned attempt to end one's own life'?
2. Is it a suicide attempt with the individual being "in full possession of all mental and emotional powers" or a "suicidal act caused by mental illness"? (See Fig. 8.3).

The risk of death of a suicidal patient and their need for therapy is generally more significant when they have been planning the act of suicide for a long time, and the individual is severely distressed. People with suicidal thoughts must be taken seriously because of the mortal danger associated with their suffering and considered at risk, *even if* a suicidal act appears to be 'simply' demonstrative. Because even a 'simply' demonstrative attempt at suicide can lead to death. The therapist, together with the patient, looks for answers to the following questions during diagnosis and crisis intervention (see Sect. 8.8.5):

1. When did the patient *first think about* ending their life before attempting suicide? The longer it has been, the more dangerous the suicide fantasies. The greater the time interval, the more time the patient has had to reconsider his suicidal intention and examine it based on what has been happening in his everyday life. But the shorter the time interval, the more likely it is a question of a poorly thought-through emotional act.
2. *In which context did the suicidal thoughts arise for the first time?* How did the crisis develop *over time*? The greater the patient's external distress in his *real* everyday life, the less likely his suicidality is due to an already existing

mental disorder. The risk of suicide is exceptionally high for those whose therapists *cannot* establish an understandable reason for their suicidal act or suicidal intention *during therapy*. Young adult males, for example, are more likely to kill themselves without a suicide note and seemingly for no reason. These young men have the following factors in common: (1) They are going through a transition internally and externally. For example, they have just finished school. (2) They hide their loneliness behind a facade that appears to be perfect on the outside. (3) Their families never talked about feelings and problems. As a result, they lack the imagination and spontaneity required to find *another* solution to their conflict. Seemingly random suicide attempts are very dangerous. If the therapist can empathize with the patient's conflict, she can act and find ways out of this particular conflict with the patient. However, this possibility does not exist if the patient does not know the reason for his suicide attempt. The triggering conflict situation then remains latent and can reoccur or even intensify *at any point in time*.

3. *When did the patient start planning their suicidal act?* What ideas had he developed about this? A cruel suicide plan indicates a severe mental disorder in the patient. The more the patient thinks about the threat to *others*, the less likely it is a mere emotional act.
4. *What did the patient think and feel when he began his suicidal act?* And then when he did it? And before he passed out? The answers to these questions provide insight into the patient's self-regulation process in the symptom (see case example 71 in Sects. 8.6-8.6.6) and his internal conflict processing.
5. What did the patient *feel shortly after stopping their suicidal act*? What did he think next? Then what did he do? The answer "It didn't work, there was a barrier" has a *high therapeutic value*. Because the patient suddenly recognizes that he is about to confront *real* death. The constriction in his thinking *spontaneously* dissolves when faced with the choice of whether to live or die. He is potentially ready to 'capitulate' and challenge his old intrapsychic equilibrium for the sake of his own life.
6. What did the patient *think and feel when he regained consciousness after attempting suicide*? What if he could think clearly again after taking the tablets? The response "Luckily, it didn't work!" indicates that the patient has found a way out of his constricted thinking *after* his suicide attempt and is ready to rethink.
7. Sometimes, during crisis intervention *immediately after a drug overdose*, the therapist feels that she is having a 'normal' therapeutic conversation with the patient. However, often, the patient can *hardly remember anything* when they meet again because his ability to think and short-term memory had been severely impaired chemically due to the drug overdose. The therapist didn't notice it in the first conversation.
8. *Does the patient have a supportive network of personal and social relationships?* How did people in his network react to the information about suicidality or his suicide attempt? The more close-knit the network of friends and family, the easier it is for people to cope with crises.

9. *Has the patient already spoken to at least one person about their attempted suicide?* The less a patient talks about his crisis to others, the less likely he will deal with it internally. And the more likely he continues to be at risk.

Case example 76

The 45-year-old Mr. N. sought initial psychotherapeutic consultation after his admission to a psychiatric clinic. He had suddenly been fired from his job after a prosperous professional career. For two years after that, Mr. N. had lied to his family that he had a new job. He pretended to drive to work every day but spent his time somewhere no one saw him, for example, in a parking lot on the highway. The patient had resolved to kill himself if his family discovered his lie: "I knew that my web of white lies would break at some point! I longed for some peace and quiet." After two years, his wife discovered that his previously well-stocked bank account was now empty, and she confronted him. Mr. N. decided that the time had come to act: "I took the rope, went into the forest, and threw it over a tree there. The rope was hanging there. I took my time. At some point, I realized: 'I can't do it!' I was surprised. Afterward, I accused myself of being a coward! I didn't know that in my life. I had always been a courageous man at work, especially during a crisis. I would be extremely cool there. I was a doer. I would always step in and connect with people!—I stayed in the forest for three days. My family believed I was dead." When Mr. N. returned home from the forest, his daughter greeted him with relief with the words: "You are my father! I'm glad you're not dead!" Mr. N: "I'm proud of my daughter!" The therapist interpreted the patient's feeling, "I can't do it!" radically positively: "That wasn't cowardice! You discovered your will to live there in the wood! All living beings have this natural will to live! The desire to live is an existential right. The right to life is a law in the United Nations Charter of Human Rights. It is free from all external norms."

8.8.4 The Encounter with Death as a Wake-Up Call and an Impetus for a New Beginning

Recommendation

In crisis intervention with suicidal people, the therapist should use the patient's encounter with the real great death as a wake-up call and an impetus for the patient's inner change. The thought, "He just wants attention!" is therapeutically unproductive. The therapist must not adapt to the patient and join him in trivializing his suffering: "No, it's not that serious!" That would potentially increase the patient's risk.

A person with thoughts of suicide is in *real* danger of death. But a suicidal crisis is also an opportunity. The *existential* character of the situation can present him with the freedom to let go of old ways and try new ones. He has the chance to develop a new kind of conscience.

Central idea

According to Dürckheim (1976, p. 110), there are three types of conscience: (1) The child's conscience, (2) The community conscience, and (3) The absolute conscience. If an individual obeys the child's conscience, he is afraid of punishment. If he obeys the community's

conscience, he is afraid of being different from the others, breaking the community's laws, and being cast out for inappropriate behavior. But there is also a transpersonal conscience: "Here I stand, I can't help it!" The person concerned then sometimes *consciously* violates familial or institutional norms for the sake of *transpersonal truth* and accepts the consequences of his actions.

Case example 77

In the United States, a Catholic priest climbed the fence of a nuclear missile depot in the presence of press reporters and hit the silo of a missile with a hammer. Naturally, he was arrested by the police, sentenced by a judge, and sent to prison. But the priest wanted to set an example. He had stood up for a transpersonal truth greater than his parents' truth and more comprehensive than the state law.

Similarly, people with suicidal fantasies have the right to review the rules of their community and break them to sustain their own life, if necessary, in an attempt to defend or restore their human dignity.

Case example 78

The 17-year-old Lisa, an outwardly attractive student, comes to the counseling center because she has refused to attend school. The accompanying mother complains: "At home, she is just lying in her bed." The therapist uses the table stage for her therapeutic work with the girl. On the table stage, she uses stones to symbolize a timeline for the development of the girl's psychological crisis. For the last three years, Lisa has thought about killing herself over and over again. Her suicide fantasies intensified after an abortion six months ago: "I hate my boyfriend for doing this to me!" The student adds: "My mother advised me to have the abortion. My mother had her first child when she was fifteen and wanted to protect me from going through the same experience." At present, Lisa is severely depressed and remains indoors all the time. In her bed, she dreams of her relationship with her former boyfriend. Everything seems pointless and empty to her: "I just want to die."

While looking at the table stage, she also mentions a new friend: "If I go out with him, then I don't think about dying. I'd like to have a child from him someday! But my mother forbids me to contact him!" The therapist places a stone for the new friend and another one for the child she wants. She positions the stone for the child further away from the stone for the present on the timeline. The small black stone for "suicide" is very close to the stone that marks the present. The therapist is concerned for the girl's life. She feels helpless. But then, as an implicit doppelganger, she consistently thinks ahead of the girl's suicide fantasy along the timeline. She points with her hand at the stones for the friend and the child: "If you kill yourself, you have to say goodbye to your future, to your new friend and the child you want! That's how you want it to be, isn't it?—However, there might be another option: You run away from home and try to live with your boyfriend. If that doesn't work then, you can still kill yourself. Ultimately, nobody can stop you from dying. But once you are dead, you can no longer try what it would be like to live with the new boyfriend and your own child! You know, it's really about your life! I think: your life is more important than you obeying your mother!" The therapist then narrates the fairy tale

of Rapunzel as an amplification interpretation. Rapunzel had also been locked in a tower by her 'mother'. The mother wanted to save her from the evil world. But then a prince climbed up to join her in the tower. Rapunzel became pregnant by the prince. Her 'mother' found the prince, and pushed him down from the high tower. He injured himself gravely. She shunned the pregnant girl. Rapunzel and her two children searched for the prince for two years, and then she found him again. Her tears fell on his blind eyes and he regained his sight."

In the case example, the therapist strongly represented the belief that the girl could and should find new solutions in her encounter *with real death.* If it helps her live, she should leave her family and 'sin' against her mother's rules. A community's laws, values, and rules exist to protect the community members from hardships. But they have to fulfill their function. They lose their meaning when they lead to the loss of human dignity and death. Therefore, the therapist aggressively represented the transpersonal quality of conscience for the 17-year-old girl to dissolve *the block in her fantasy through adaptation.*

Patients with thoughts of suicide often get stuck in an old, rigid defense system. Suicide becomes the way to avoid having to change one's old intrapsychic equilibrium.

Case example 79

An artist committed suicide six months after the end of his psychotherapeutic treatment. He was unable to accept the failure of his grandiose ideas about himself in therapy. Despite all his friends' efforts, he couldn't capitulate. He 'preferred' the real great death to the small death of inner change. After his real death, however, it was too late for him to break out of his old intrapsychic equilibrium and find a more humble path for his life.

Case example 80

*A 50-year-old patient, Ms. K, was traumatized in childhood. She only found a new beginning after five years of psychotherapy through a suicidal crisis in her life (*Balint, 1970*). She had long resisted an inner change with the help of her grandiose self-image. In the end, she had a mental and physical breakdown due to psychosomatic fever attacks. Nothing seemed to work anymore. She was filled with despair and, thus, considered suicide. However, during the crisis, Ms. K. spontaneously found a new solution to end her suffering. She just did what was good for her, following the motto of the Bremen Town Musicians: "You will definitely find something better than death!" After a long time, she called her former partner again. Unlike before, she spoke to him openly about her feelings. To her astonishment, she spontaneously felt understood by him. Her inner 'blind sadistic governess', with traits similar to her birth mother, lost her power over Ms. K in her encounter with the real death. The 'blind governess' disappeared in the following years, apart from a few 'relapses.'*

Many suicidal people only begin to look for a new way of living *after a crisis.* "Avoiding or combating suffering is natural. But when we are suffering, the point is to accept it and use it to create something beyond suffering. […] We have to accept defeat and not pretend as if nothing has happened. We must overcome our resistance"

(Dürckheim, 1982, p. 88 f.). The fear of the real great death can help to let go of an overwhelming life principle, and we can humbly try to *live* a simple life. This is, for example, the core experience of Alcoholics Anonymous at their mental and physical 'rock bottom' (see Sect. 10.7). People with alcohol addiction cannot imagine a life without alcohol. But if they are at risk of confronting the real great death because of alcohol, it often helps them become abstinent and 'simply' stop drinking. One day and another and another. And so on.

Case example 81
A 45-year-old patient, Mrs. L., sought therapy for a year after her 18-year-old son's suicide. She was always dressed in black and wanted nothing more than 'to go to her son's grave'. Her son had been differently-abled right from childhood. At the age of 18, he poured gasoline over himself, lit fire to it, and died a brutal death. Mrs. L made no noticeable progress during the one-year treatment and discontinued therapy. A year later, she was diagnosed with breast cancer. In this situation, she suddenly had to decide whether she really wanted to die. She chose the operation. She then made sure that her mother-in-law moved out of her home. She also motivated her alcoholic husband to face his illness and become abstinent. She even co-founded a self-help group for people with addiction disorders, along with her husband.

8.8.5 Therapeutic Interventions in the Event of Risk of Suicide

A therapist who treats or counsels people at risk of suicide *cannot* save them *all* from dying. Their experience is similar to cardiologists who treat patients after a heart attack. *Not every* patient survives a heart attack. Nevertheless, the death of a patient by suicide is always a shock for the therapist. The therapist intuitively rethinks her therapeutic actions in retrospect. I drew the following conclusion from the suicide of some of my patients: "In the future, I would like to act more courageously and unconventionally with those at risk of suicide because of their *existential* threat. If necessary, I would like to offer them help *even outside of the customary pathways*." Treating patients at risk of suicide includes admitting them to a psychiatric facility against their will if their life is otherwise at risk. For example, a young patient, Ms. J., acutely decompensated in a psychotherapy group and was psychotic. She appeared suicidal, and no one could reach her. Finally, the therapist forcibly sent her to a psychiatric clinic directly from the group. The police carried the struggling, screaming young woman from the therapy room down the doorway to the street and used reasonable physical force to get her into the ambulance. Twenty years later, Mrs. J. is still alive today. She is working and regularly comes for therapy along with her husband. She is always happy to see the therapist. Her husband also smiles at the therapist.

It is a matter of life and death for people in suicidal crises. The therapy process demands empathy from the therapist and, at the same time, also requires them to

call things by their names and speak clearly. *Crisis intervention* for people at risk of suicide involves diagnosis and therapy simultaneously. Together with the patient, the therapist retraced his *self-regulation process in the development* of his suicidal thoughts (see Sects. 8.6.2 and 8.6.3). As a *doppelganger*, she helps him to understand his self-regulation in his crisis. She verbalizes his actions, physical sensations, affect, and thoughts (see case example 71 in Sect. 8.6.3). She does not *oppose* the patient's suicidal impulses with her interventions. Instead, she retraces *shoulder to shoulder* with him, step by step the chronological sequence of interactions, to find out how his suicidal thoughts came about and how he dealt with them. In doing so, she resolves the suppression of interaction sequences (see Sect. 2.4.2). She works according to the principle: "The patient's soul doesn't do anything for free." She draws the patient's attention to the point in time when he decided on his way through the crisis. She searches without prejudice for why his solution has always been the best solution for him. This process expands his equivalence mode by thinking in the as-if mode (see Sect. 2.6). The patient no longer blindly concludes from his *inner* despair that *the outer world is also* full of despair. He can once again distinguish between his *inner* despair and the *outer* world, which simply goes on. He experiences anew that his suicide would be an act of his *own free will*.

Central idea

During the crisis intervention, the therapist understands the patient as a person who in his inner conflict processing, consciously or unconsciously, concluded: "I cannot live like this!" But she completes the sentence internally in the as-if mode: "I cannot live like this, but maybe *I can live differently*!"

This therapeutic attitude helps the therapist protect their spontaneity and fantasy from the patient's constricted thinking. The following rules and techniques have proven effective in crisis intervention for patients at risk of suicide:

1. Whenever the therapist has the idea or an indication that a patient *may be* secretly thinking about suicide, she should *immediately ask about suicidal thoughts.* This applies even if, when treating a patient, she 'only' has the intuitive idea: "He *can't* live like that in the long run." It is better to ask one too many questions than too few. This is therapeutically important for the following reasons: (1) It helps evaluate the extent of the risk of suicide. Or it relieves the therapist of possibly unfounded fears. (2) The therapist marks the danger of the situation and makes it accessible for therapeutic communication. (3) Inquiring about suicide fantasy dissolves the patient's constricted mentalization in the pre-suicidal syndrome. As a result, his death fantasies lose their possibly illusory character (see case example 71 in Sect. 8.6.2). (4) The open therapeutic conversation about suicidal fantasies often integrates the patient's suicidal impulse with the associated conflict. (5) The patient is no longer alone in the space of his suicidal fantasy. (6) The patient's existential suffering is appreciated.
2. The therapist sets up a timeline with three chairs in the therapy room in conversation with the patient. She places the first chair in one corner of the room to represent the patient's birth time, the second chair in the opposite corner of the room for his likely natural death at around 80 years of age, and the third chair

between these two chairs for his present life (see Sect. 8.8.4). She points to the respective chair with her hand: "You are now 50 years old and are still physically healthy. Statistically speaking, you still have 30 years to live. That's about 10,000 days. Every day your lifespan reduces by one day." The patient and the therapist look at the timeline from the meta-perspective. The patient becomes aware of the natural finiteness of his life and realizes that if he were to kill himself, he would be giving away 30 years of his life. The therapist can also symbolize this timeline with three stones on the table stage. In his film 'Guide to Happiness', Yalom said that he often illustrated the *existential dimension of his patients' lives* for them in a similar manner. First, he would draw a line on a piece of paper and mark the patient's time of birth and the possible time for his natural death. Then he would ask the patient to mark the point in time where he could see himself right now. In doing so, the patient would recognize the finiteness of his life and feel encouraged to *evaluate whether he really wanted to live the way he lives in the present*.

3. When working with the table stage, the therapist can add to the lifeline between birth and natural death stones for (1) The time of the initial *arrangements* for the suicide attempt, for example, the date on which the patient bought the tablets, (2) The *beginning* of the suicidal act, (3) *Waking up* from unconsciousness or *stopping* the suicidal act, and (4) The time at which the patient met his loved ones again. The therapist asks the patient to describe their thinking, affect, physical sensation, behavior, and wishes *for each of these points in time* in detail. Together they trace his thoughts, feelings, actions, and sensations along the timeline. They look at each bead on a string of beads, as if they wanted to write a film script together. Then, the therapist re-enacts the crisis concretely with the stones on the table stage. For example, she takes the stone for the patient's ego and lets him 'go to the train tracks': "What did you think and feel on the way?" In this work, the therapist works shoulder to shoulder with the patient in implementing his self-regulation process in his development of suicidality (see Sect. 8.6.3). She makes the patient aware of his decisions and calls things by their names. If necessary, she represents the patient's rigid defense patterns with empty chairs (see Sect. 4.8).

Central idea

In doing this, the therapist implicitly assumes that the patient's suicidal thoughts result from *subjectively coherent* conflict processing. Therefore, together with him, she searches for the meaning that his suicidal thoughts have *for him* in his life.w

4. Some patients stop their suicidal actions. They may then interpret their actions with the words: "I was too cowardly" (see case example 76 in Sect. 8.8.3). The therapist re-interprets such an interpretation in a radically positive way: "Maybe *your body* didn't want to die and signaled to you: 'But I want to live!'"
5. While the patient is processing his self-regulation in the crisis, the therapist points to *alternative options for action*: "You have always been a strong, independent woman. If your partner worries about you after you attempted suicide, it may indicate that he loves you. Admit it! Enjoy his attention! You've always

longed for love!" *In rare cases*, an act of suicide is part of a macabre game with own life and, as it were, Russian roulette. In such a case, the life-threatening acts are *masochistic* or addictive. Those affected obtain the existential *feeling of being alive* through the emotionally intense kick of the *danger to life*. In doing so, however, they often self-injuriously and ignorantly repeat old destructive relationship patterns from childhood.

6. In the case of suicide fantasies, the therapist works with the patient consistently to identify *the possible consequences of his planned suicide act* (see case example 71 in Sect. 8.6.2). Nowadays, driving your car into a tree is no longer lethal. However, it can lead to a lifelong disability or harm other drivers. If the patient throws himself in front of a train, it often traumatizes the train driver. Thinking *about the consequences* of one's actions activates the patient's sense of self in its restricted conflict processing. It dissolves the constriction of thinking in the pre-suicidal syndrome. The patient can now consider whether or not he wants to accept the identified negative consequences of his actions (see case examples 71 in Sects. 8.6–8.6.6, 75 in Sect. 8.8.2, and 78 in Sect. 8.8.4).
7. Many patients come to therapy only *after attempting suicide*. The therapist then works with the patient to identify the potential risk of death in his type of suicide attempt. Ten headache pills are not going to kill a person. Most people know this. On the other hand, it is life-threatening to drive off in a car when intoxicated and suicidal. Intoxication with alcohol and tablets *together* is more dangerous than a suicide attempt with alcohol or pills *alone*. The therapist informs the patient of the *real* risk of dying they were taking. The higher the risk, the more likely it is that the act of suicide will be a wake-up call to life. The lower the risk, the more the therapist can positively re-interpret the failure of the patient's suicide attempt: "You are intelligent. I think a part of you didn't want to die! It would have been quite easy for you to plan the suicide attempt more precisely if you had wanted to."
8. The therapist uses the basic human fear of death and her own insight into the value of life as *an impetus* for a possible inner change in the patient (see case example 78 in Sect. 8.8.4): "Life is too short. What comes after that takes a long time. It would be a shame if you *just happened* to be dead without really thinking about what death is!" The patient should take himself seriously when he feels, "I can't live like this". He should take his time to think about *whether he could live differently*.
9. The therapist does not allow the patient to go home *after* a suicide attempt *until* they have worked together to develop an appropriate plan for continuing therapy. For example, she proactively books another appointment for him. Or she arranges a consultation with a professional in a counseling center or with another psychotherapist. If the patient refuses to come for future appointments without a plausible reason, it may be a *diagnostic* indication that he is still at risk of suicide. The *patient's decision* to continue with therapy gives him *inner* support in the event of future risk. The offer of help may encourage the patient to look for a way out of his crisis.

10. The therapist develops ideas for a therapy plan together with the patient. She defines the causes for his suicidal thought and shows him how he can continue to work on his problems if necessary. For example, she justifies the suicidal thoughts of an alcohol-dependent person with his alcohol problem and tells him what to do about his alcohol addiction. If necessary, she informs him about inpatient treatments, health resorts, short-term outpatient treatments, outpatient psychiatric or psychotherapeutic treatments, or the possibilities of drug therapy.

    About 80% of patients who have attempted suicide need further psychotherapy or psychiatric treatment. But some people *do not need any aftercare*. These are people to whom *each of the following three points applies*: (1) The suicide attempt was 'only' related to an actual conflict. (2) The person has a reliable family and social environment. (3) The patient *spontaneously* became afraid for his own life upon encountering real death. *In another case*, the therapist advises the patient of therapy options.
11. Many therapists have the patient sign a contract to ensure that the patient *will not* attempt suicide until a point in time specified therein. The consultation about the planned contract helps *the therapist* protect himself *legally*, assess the suicidal risk diagnostically, and talk about the subject of life and death with the patient. However, such a contract does not relieve the therapist of their responsibility for the patient's life. Therefore, the therapist should also decide *for herself* whether she considers the patient to be at risk. If she is unsure, she must find reliable help.
12. Sometimes the therapist has to admit a patient to a psychiatric clinic *against* his will. If necessary, she can motivate the patient with the following sentence: "Give yourself a chance by staying in the clinic! If you still want to die *after your stay in the clinic*, nobody can stop you!" The patient then has time to reflect on his conflicts during his inpatient treatment. He can consider whether suicide is the appropriate solution to his conflicts. He can look for alternative solutions and life options in discussions with fellow patients, therapists, and family members or friends.

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