Chapter 9
Psychotic Disorders

The mentalization-oriented, disorder-specific psychodrama therapy helps *people experiencing psychosis*. However, it also expands *the psychotherapist's* experience and knowledge of fundamental questions, such as: How do people process conflicts? What is mentalizing? How does healing happen? What is therapeutic abstinence? What is creativity? What is resistance? What is the doppelganger technique? What is spontaneity? What does "meeting at eye level" between therapist and patient mean? The therapist enhances her flexibility and intuition when working with people with psychosis. She learns to ascribe positive meaning to what seems absurd and acts with the belief that *the patient's soul does nothing for free*. This skill is also helpful in the psychotherapy *of other* severe mental disorders: rigid defense patterns in personality disorders (see Sect. 4.8), suicidal fantasy (see Sect. 8.8), severe depression (see Sect. 8.6), anxiety and obsessive–compulsive disorders (see Sects. 9.6 and 9.7), non-substance-related addictions (see Chap. 10), or pathological deviant behavior (see Chap. 11).

9.1 The Historical Development of the Treatment of People with Psychosis

Psychiatrists use the term "psychosis" to refer to a *whole group* of severe mental disorders. The loss of touch with the reality of thought content is common in these disorders. The patient's thoughts and behaviors do not make sense in the context of their life history. The disorders contained in the term "psychosis" differ in their symptoms, cause, course, and need for therapy. The ICD-10 classifies them under the terms schizophrenia (F20), schizotypal disorder (F21), persistent delusional disorder (F22), acute transient psychotic disorders (F23), induced delusional disorder (F24), and schizoaffective disorders (F25). The disintegration of the systemic process of

R. T. Krüger, *Disorder-Specific Psychodrama Therapy in Theory and Practice*,
Psychodrama in Counselling, Coaching and Education 4,
https://doi.org/10.1007/978-981-99-7508-2_9

self-development, illusionary misjudgments, and the resulting disturbances in relationships are common to this group of disorders. The psychiatric treatment of people with schizophrenia is more successful than is often assumed. Ciompi et al. (2010) proved that the dictum "once a schizophrenic, always a schizophrenic" is wrong. In a follow-up examination of almost 300 patients, a good quarter of them had gradually healed, and another quarter had improved significantly after an average of *36.7 years post their first hospital admission.* More than 20 other follow-up studies worldwide have substantiated this finding (Ciompi, 2019, p. 100).

Unlike any other disorder, inadequate knowledge and violence characterized the treatment history of people with psychosis in Europe until the nineteenth and twentieth centuries. Working with people with psychosis in Germany again reached a terrible climax in the murder of many patients during the National Socialist era. Psychiatry only developed into a *scientifically based* discipline in the nineteenth and twentieth centuries. The development of many effective medications and modern social psychiatry has made the treatment of patients with psychosis more humane and successful over the past 60 years.

Central idea

Humane psychiatric treatment methods are a social achievement that must be secured and defended against the basic human fear of the "crazy" *at all times.* People who fall outside the societal norms and *cannot* protect themselves adequately are easily marginalized and disadvantaged.

Despite the equally severe consequential damage, society spends less money on people with mental health concerns than on those with physical illness. In 1971, the nursing rates in the psychiatric hospitals of Niedersachsen in Germany were half those in a general hospital with the most basic facilities. Nevertheless, the country made a profit of 4.7 million German marks with its psychiatric clinics that year. On the other hand, *other* medical hospitals received substantial grants (Krüger, 1974, p. 19). Furthermore, only 12 of the 25 medical posts at the psychiatric state hospital in Wunstorf were occupied. Today, 50 medical posts exist for only half as many patients.

The 1970s marked the beginning of modern social psychiatry in Germany. The state downsized large psychiatric hospitals and built new *community-based* clinics. In addition to pure psychiatric treatment, the patients in the clinics received group therapy and occupational therapy. The nurses, social workers, and pedagogues received further training in social therapy. Some clinics applied the therapeutic community principles in some of their wards. In addition, there was also a rise in day clinics, dormitories, and assisted living for people with mental disorders.

Beginning in 1936, Jacob Levy Moreno developed psychodrama as a method of psychotherapy at a private hospital with 12 beds in Beacon, New York. Even then, the clinic functioned according to the therapeutic community principles. About 8 of the 12 patients were experiencing psychosis. Beginning in 1948, Manfred Bleuler, Gustav Bally, Medard Boss, and Marguerite Séchehaye, together with Gaetano Benedetti from Italy, Christian Müller, Martti Siirala from Finland, and Norman Elrod from the USA, developed "psychoanalytic psychotherapy for schizophrenia"

in the Psychiatric University Clinic in Zurich (Red, 2018, p. 329 ff.). Benedetti's therapeutic approach is similar to that of Moreno. He lived with the patients wholeheartedly in their madness and, at the same time, maintained transmodal control over the therapeutic situation (Red, 2018, p. 336). Séchehaye rewrote her patient's delusional reality into a story of coping with the help of symbolic realization and wish fulfillment. This led "to changes in both the patient's and the analyst's life" (Red, 2018, p. 341). In Germany, there has been a working group for psychodynamically oriented psychotherapy for psychoses since 1975 (Nowack et al., 2018, p. 377). This group later became part of the German section of the "International Society for Psychological and Social Approaches to Psychosis" (ISPS).

Today, the most commonly used psychotherapy methods for psychoses are cognitive behavioral therapy (Lincoln & Heibach, 2017) and family therapy (Neraal, 2018a, 2018b, p. 29 ff. and 229 ff.). Since 2002, experts have increasingly recommended them in national guidelines in various countries. From 2014, health insurance companies will cover psychotherapy costs for patients with psychosis in Germany upon application. However, Lincoln and Heibach (2017, p. 2) state that the realization that one can treat symptoms such as delusions and hallucinations with psychotherapy has made little headway in psychotherapeutic practice. Many older psychotherapists do not have sufficient training for this. There are also false assumptions about the prerequisites for successful psychotherapy, for example, the idea that patients with schizophrenia have to have sufficient insight into the illness before starting treatment. The *psychotherapy* of people with psychoses still depends on the commitment of a few therapists on site. As a result, advances in the treatment of psychoses are repeatedly lost. The usual external organization of psychotherapies in Germany is often too rigid for the distinctive characteristics of patients with psychosis.

Psychotic disorders are expressions of *metacognitive disorders*. Therefore, the disorder-specific psychodrama therapy described in this book treats psychotic disorders *metacognitively*. The *two* qualitatively different processes of the patient's conflict processing—conflict processing in everyday life and conflict processing in delusion—are designed, differentiated, and executed *separately* in the as-if mode. The therapeutic conflict processing in a state of delusion is not centered on the *delusional content and insight into illness* but on the *change and expansion of the metacognitive process* with which the patient produces his delusional content. Moreno's psychodramatic methods and psychotherapy findings for psychosis (see Sects. 9.5 and 9.6) date back to 70 years ago. In the following text, I will demonstrate how they can also be used in today's therapy and develop them further.

9.2 Blockages in the Therapeutic Relationship in Psychiatric Treatment of Psychosis

In *conventional psychiatric treatment*, the therapist tries to make the patient's psychotic *symptoms* disappear, mainly with *psychotropic drugs*. However, a therapy process centered on drug treatment is "equivalent to an amputation" (Benedetti, 1983, p. 190). As soon as the ego of psychotic symptom production "is amputated, nothing remains but a defect, a shriveled ego that understands itself only insofar as it pays the high price of giving up any future-oriented possibility of growth."

Even in modern social psychiatry, the goal of therapy remains that the patients should accept their delusion *as an illness* and reduce their psychotic symptoms by taking the prescribed medication. They are supposed to learn *how to live*, structure their day, work, manage relationships, and spend their free time 'under the protection of the medication'. Ideally, their family and social environment will support them in doing so. Therapeutic communities in clinics, day clinics, leisure clubs, outpatient individual or group therapy, or assisted living are also helpful.

The fundamental problem in the treatment of patients with psychosis is that they *naturally* evoke disintegration-related countertransference (see Sect. 2.10) in their therapists. According to Hartwich (2018, p. 202), this is 'resistance by countertransference'. This countertransference leads to a block in the relationship between the patients and their therapists:

1. The patient tells the therapist about his problems. While listening, the therapist *internally* absorbs the patient's physical, psychic, and verbal information and tries to empathize with his internal conflict processing as an implicit doppelganger.
2. But at some point, the patient narrates bad influences, strange events, or harassment.
3. The therapist is confused and alienated by the patient's communication and feels afraid. Her emotion fixes her inner object image of the patient in the perception that 'he is crazy'. She unconsciously suppresses other actions of the patient and his suffering as a human being. Thus, she sticks to her biased perception. She asks skeptical questions and draws the patient's attention to contradictions in his descriptions.
4. The patient does not feel understood by the therapist and is irritated. As a result, he shuts himself off internally and distances himself. In this way, he acts out his existential dilemma in the therapeutic relationship between his desire for closeness and his refusal of intimacy (Mentzos, 2011, p. 223 ff.) due to his fear of disintegration. A vicious circle develops between the therapist's biased perception and the patient's distancing.
5. The *conventional psychiatric therapist* doesn't *use* her feelings of confusion and fear *psychotherapeutically*. She sticks to her biased inner object image 'he is crazy' and ascribes the label of "psychosis" to the patient. She inquires about the history *of his illness*: "Have you ever received psychiatric treatment? Do you take medication?" Then, she diagnostically records the patient's *psychotic symptoms*, classifies them using Bleuler's list of symptoms (1983), and documents them as

psychopathological findings: "The patient suffers from auditory hallucinations, derealization, depersonalization, and audible thoughts."

6. The patient feels that the therapist is not interested in his *actual suffering* and his fear of going insane *as a human being*. Or that the mafia is threatening him. Or that he will be poisoned. Or that his neighbors film him with a video camera. He is alone in his subjective suffering.
7. In this situation, he only has the choice between two evils: Either he sticks to his delusional experiences. However, this puts him in conflict with his social environment. Therefore, he withdraws from the therapeutic relationship and his other relationships. As a result, many people with psychosis become homeless. 15–30% of the homeless have psychosis. *Or* the patient blindly accepts the therapist's interpretations, adapts, and learns *the role of the patient*. As a "sick person", he takes the prescribed medication. He learns not to talk about his delusional experiences and trivializes them, even when interacting with the therapist.

Central idea

In a conventional psychiatric relationship, the patient is the ignorant one, and the therapist is the knowing one. The patient becomes the *object of treatment*. The therapist's authority blocks the therapeutic relationship. The therapist acts out a disintegration-related countertransference, a "countertransference resistance" (Hartwich, 2018, p. 202).

Modern social-psychiatric treatment of patients with psychosis is a significant advancement compared to the treatment eighty or a hundred years ago. At that time, therapists compensated their feelings of powerlessness and inadequacy toward their patients with psychosis with devaluation or grandiose feelings of helping or rescuing. They often used violent psychiatric treatment methods: insulin shocks, cold baths, or electroconvulsive therapies. Such therapeutic measures harmed not only the patients *but also the therapists themselves*. In 1941, for example, Boss (1979, quoted from Red, 2018, p. 339) examined 21 nocturnal dreams of 10 different shock therapists. In their dreams, they developed strong fear and intense feelings of guilt. The shock therapists suffered from "a threat to *their own* mental structure and the psychological imbalance caused by electroconvulsive applications".

Due to the therapist's *natural* disintegration-related countertransference, psychiatric clinics often tend to return to the mechanisms of the old institutional psychiatry even today. "The dynamics of acute psychotic disorder and the institutional behavior are mutually dependent and become a form of institutional defense" (Putzke, 2018, p. 300). The therapists unconsciously take over healthy adult thinking on behalf of the patients. In their desperation, they focus purely on pharmacological treatment, and otherwise only manage the patient's symptoms.

9.3 Mentalization Disorders as the Cause of Delusional Production

As a psychodramatist, I define mentalizing as the *creative inner process work* with which humans remember, with which they create an image of themselves and others in the current situation, control external actions, plan behaviors, and process conflicts. Humans use four tools for this purpose (see Fig. 2.3 in Sect. 2.2): representing, interacting, rehearsing, and integrating (see Sect. 2.2).

Exercise 23
Explore mentalizing for yourself. Please think about a relationship conflict of your own for 1–2 min. *What* did you think about? *How* did you think about it? Which metacognitive tools of mentalizing did you use? You will notice:

1. You *represented* the conflict in your imagination as an image,
2. You reconstructed memories internally and *interacted* with the conflict partner,
3. You may also have looked for a new way of behaving to resolve the conflict. This process is called *mental rehearsing*.
4. You may have even connected your conflict with other conflicts "I experience the same in relationships, as in my childhood." This process is referred to as *inner integrating*.

Defense is a protection against the disintegration of the self and needs a certain ego strength. If a person has insufficient ego strength when experiencing a high-energy affect, they experience a breakdown in the inner process of self-development. *The self* is a constant creative process of development. This process includes the development of the *inner* self-image and the *inner* object image in the current situation. The process of self-development is mediated through mentalizing.

Central idea

In psychotic decompensation, the patient loses ego control over his process of self-development. This disintegration is triggered by a high-energy affect that overwhelms the patient's processing system. The patient experiences dissociation in his psychosomatic resonance patterns (see Sect. 2.7). There is a split between the patient's cognitive ego (thoughts and linguistic concepts) and the psychosomatic ego (sensorimotor interaction patterns, physical sensations, affect) (see Fig. 2.4 in Sect. 2.2). The patient experiences a nameless horror and cannot find the appropriate words and thoughts. The disintegration of the systemic process of the self draws the tools of mentalization into the vortex of dissolution. As a result, the tools of mentalizing only work as *mechanisms of dream work* in emergency mode (Krüger, 1978, see Fig. 2.5 in Sect. 2.3) and produce delusional content.

There is a *metacognitive confusion* between the patient's delusional thinking shaped by the dream mode and their everyday thinking.

1. The tool of inner *representing* becomes the dream mechanism of '*perceiving inner thoughts as external reality*' (Freud, 1975, p. 177). Thus, patients with psychosis mix the *inner and outer* worlds in their delusional reality. Panic turns into paranoia (see case example 95 in Sect. 9.8.8). The feeling of losing control

over one's own life turns into the imagination: A thief has burgled my home. Desires become delusions of grandeur (see case example 86 in Sect. 9.7).

2. The tool of *interacting* becomes the dream mechanism of '*shifting*': The logic of the chronological interaction sequences in conflict processing is disintegrated. It keeps changing to match the high-energy affect. When interacting internally, the patient forgets interaction sequences and experiences that relieve feelings of guilt. In the case of delusions of grandeur, he ignores limiting factors. According to Freud (1966, p. 177), an element is "replaced by something remote, that is to say, the emotional emphasis is moved from an important element to an unimportant element, and the strange dream appears". Thus, the high-energy affect is moved to other inner images.
3. The inner *mental rehearsal* becomes the dream mechanism of '*reversal into the opposite*': "In the nocturnal dream, the rabbit often enough shoots the hunter" (Freud, 1966, p. 183). The relationship between inner self-images and inner object images disintegrates. The self-images and object images move freely in space and rearrange themselves into delusional relationship patterns. The self-deprecation (self-image) turns into the voices of neighbors (object image) talking about the patient (see case example 96 in Sect. 9.8.8). The desire for help and salvation from another person or God (object image) turns into the delusion (self-image) of "I am Jesus."
4. The tool of inner *integrating* becomes the dream mechanism of '*consolidation*'. This merges two inner images, that have something in common, into one (Freud, 1966, S. 174). For example, the patient wants to disrupt the petty-bourgeois thinking in his family. This wishful thinking merges with his image of TV stars who can do it. The patient then torments the family and therapist with his delusion that "soon he is "going to be the greatest entertainer in the world" (see case example 86 in Sect. 9.7).

Even healthy people can think, feel, and act in dream mode. However, they control their symbolizing in dream mode through mentalizing in the *as-if mode* (see Sect. 2.6). They *know* that their absurd fantasies are *only inner fantasies* and do not reflect the outside world's reality. Modern artists like Joseph Beuys, the composers of contemporary music, storytellers, some writers, and many theater directors could and can allow the dream mode of mentalizing *in the service of their ego* (Balint, 1970, p. 187 f.), thereby making them *particularly creative.*

Recent research suggests that *everyone* who *dreams at night* thinks, feels, and acts in the dream mode to process conflict. In dreaming, people integrate memories from everyday life with their previous experiences and memories stored in their brain. Dreamwork also expands the memory content *alogically,* leading to the freedom of thought necessary to create new solutions. Experiments show (Robert Stickgold and Erin Wamsley, quoted in "Die Zeit" No. 32, p. 27, August 4, 2011) "that dreams not only strengthen memories but can also offer varied new insights. As the brain replays the day's experiences, it looks for new solutions. At night we reenact what we experienced during the day. However, few dreams are true replicas of waking experiences. Instead, most pick up memory fragments and combine them into new, often bizarre

images to create nocturnal mental cinema. But why? […] The researchers' experiments are now pointing in a clear direction—the nocturnal mental cinema makes us fit for reality."

Central idea

In the case of patients experiencing psychosis, the deficits in their mentalizing ability and the disintegration of the systemic process of self-development are *indirectly* reflected in their reduced ability to act in the *as-if mode of play* (see Sect. 2.6).

When *people with psychosis* enact a fairy tale in group therapy, they usually stop after 5–10 min. They enact the contents of the fairy tale concretely and try to do everything right. *People with neurosis* or psychologically healthy people, on the other hand, spontaneously activate *their own inner conflicting relationship images* through their actions in the fairy tale play. These patterns become a part of their fairy tale, analogous or compensatory, and differentiate and expand their actions in the play. As a result, their enactment of a fairy tale usually lasts 45–90 min. It is fitting, that patients with psychosis often do not understand jokes or depth-psychological interpretations because of the deficits in their mentalization. They perceive symbolic images and metaphors in the equivalence mode as a *concrete* description of external reality. For example, healthy people often use the metaphor "I'm not here anymore" when they feel exhausted. People with psychosis, on the other hand, believe that they no longer exist *in reality* when feeling exhausted (see case example 82 below and continuation in Sect. 9.9).

Delusional patients secure their internal delusional construction by *thinking in the equivalence mode* (see Sect. 2.6). They do not differentiate between their *internal symbolic image of the conflict* and *the external reality*. *Patients* thinking in the equivalence mode assume that their *inner* construction of reality adequately reflects the *outer reality*. Thus, as Fonagy, Gergely, Jurist, and Target (2004, pp. 96ff.) say, "they confuse internal states (such as thoughts, fantasies, and feelings) with external reality and experience it *as reality* rather than as mere *internal representations of reality*."

Case example 82

As an officer on his ship, Mr. B. discovered that he was missing 100 marks in his cupboard. He suspected someone from the ship's crew had stolen his money. But at the same time, he was afraid of wrongly accusing someone. This dilemma caused him to panic. His mentalizing disintegrated. He feared being debarred from his crew if he made a false accusation. He was thinking in the equivalence mode, believing that the ship's crew members wanted to get rid of him. He jumped off the ship into the sea in the middle of the English Channel between France and England as a reaction to the suspected exclusion from the community. Luckily he was seen by a sailor. The crew rescued him and took him to a psychiatric hospital in the nearest port (continued in Sect. 9.9*).*

Similar to the nocturnal dream images, the contents of a patient's delusion are often a *symbolic* image of the patient's existential need in the conflict that triggered it: (1) The patient feels, for example, that his mother restraints and abuses him. But *he thinks in equivalence mode*. Therefore, he experiences this internal feeling as an

external reality and believes that his mother is *actually* poisoning him. (2) Another patient believes he is the real Jesus in the equivalence mode. He does not understand his thoughts *as a symbolic image* for his feeling in his current living environment: "*Like Jesus*, I make others' suffering my own and perish because of it." (3) People with psychosis *lose* control of their internal conflict processing and believe that their *social environment* controls their lives, watches them, and eavesdrops on them. (4) A 35-year-old patient (see case example 96 in Sect. 9.8.8) felt inferior because she hadn't gone to college and "didn't manage her life the way others do." In her delusion, she experienced her feelings of inferiority in the form of external voices of *"neighbors" who spoke negatively about her*.

9.4 The Psychodynamics of Psychotic Decompensation

There are *genetic and environmental* factors involved in the occurrence of psychosis. Twin research shows that if one parent experiences psychosis, there is a twenty percent chance that *one of their children* will also experience psychosis (Mentzos, 1999, only oral communication). However, the occurrence of a psychotic disorder *also depends on environmental factors*. Under advantageous circumstances, children of parents with psychosis can develop unique talents instead of becoming ill. This finding was possible with the help of Finland's highly differentiated population statistics. There are a hundred children of parents with psychosis who are *identical twins* and were each *adopted by different families*. If the relationships in the new families were *stable and flexible*, the children developed sufficient inner ego strength and unique talents.

About one percent of people *in all countries and societies on Earth* experience psychotic disorders. Therefore, unfavorable social and family conditions cannot solely explain the risk of developing psychosis. In the course of evolution, man has had to cultivate special cognitive abilities to survive and spread out all over the world. This ability is so complex that the mentalization of sensitive people with deficits or childhood trauma *worldwide* can implode in conflicts in adulthood. However, the risk of psychotic decompensation has not blocked the evolution of mentalization in humans. The advantage of saving energy by processing conflicts in the as-if mode was too great.

The decompensation into psychosis can be explained as follows: People with psychosis react more *sensitively* to stress and conflicts than other people (Zubin & Spring, 1977): "People at risk of psychosis often have a history of emotionally difficult experiences such as sexual trauma, neglect, or serious discontinuities" (Ciompi, 2019, p. 105). They have developed rigid defensive patterns due to childhood deficits or traumatic experiences. It is, therefore, difficult for them to withstand conflicts and psychological stress. For example, they adapt to the family system (see case example 87 in Sect. 9.8.1) and take on the role assigned to them by others. Such self-protective behavior spares them the intrapsychic conflict between their *systemic role* in the family and their *inner self* in conflict situations (see Sect. 2.4.4). In doing

so, however, they do *not* learn to process internal and external conflicts *adequately*. Psychotic decompensations are then triggered by traumatic crises, physical illnesses, or challenging situations in life, for example, the first romantic relationship. The old, functional role that provides support is lost. The old defense system collapses. The loss of a *negative* identity can also trigger decompensation, for example, the loss of the eccentric role or the role of the 'difficult child' (Mentzos, 2011, p. 206). People with psychosis decompensate when their emotional stress exceeds a critical level in an identity conflict (Ciompi, 2019, p. 104). Drug abuse or retraumatizing situations are often involved in the breakdown.

Neraal (2018a, 2018b, pp. 29 and 38) suggests a *significant relationship dynamic* in the context of psychotic symptoms: "The person with psychosis represents the *family's* 'overflowing vessel of emotions, so to speak." The psychotic thought content is often symbolic images of *conflicts* hidden *in the family or by society*. The example of Greta Thunberg's family helps us understand the significance of a relationship dynamic in severe psychological symptoms. Greta Thunberg didn't experience psychosis. But she was autistic and severely anorexic for two years, from the age of 12–14. Thus, she acted out the meaninglessness of her own life in the face of the climate crisis and unconsciously protested from the omega position against the high energy consumption in her family's lifestyle: Her mother is a world-famous opera singer. As a result, the family lived alternately in Japan for a few months, then again in New York or Paris in the past. At one point, they *sought family therapy*. As a result, the family members learned to take Greta's feelings and fears seriously and listened to her. Greta Thunberg is a sensitive person with Asperger Syndrome. She heard about climate change and let it impact her emotionally and existentially. However, due to her mental strength, she developed a *transpersonal conscience* during therapy *instead of* experiencing psychosis.

Anyone with a *childlike conscience* is afraid of punishment from their parents. Those with a *community conscience* are afraid of being excluded from the community. But a person with a *transpersonal conscience* follows the greater truth (Dürckheim, 1976, p. 110) and protests against the community's norms when necessary, even if it means breaking the law and being penalized. Greta Thunberg drew new strength from her transpersonal conscience. For the first time at 16, she demonstrated, *against her parents' will*, in front of the Swedish parliament in Stockholm against the inaction of politicians concerning the climate crisis. The family members continued to listen to Greta. They integrated Greta's fears into their *own* lives *as a complementary truth*. Her father now lives a vegan life. As an opera singer, her mother only accepts invitations to places she can reach by train. With her inner mental change, Greta Thunberg gave *a positive meaning* to her *denial* of the world, expressed through her symptoms. She became a role model for hundreds of thousands of people.

In social relationships of people with psychosis, Mentzos (1992, p. 10 f.) observed "pronounced dramatic escalations of the clash of opposing intrapsychic tendencies […] in people with schizophrenia, for example, the bipolarity between the *self-related* and the *object-related* […] tendencies. The resulting […] conflict only allows for two […] 'solutions': extreme narcissistic withdrawal or the dissolution of ego boundaries and the fusion with the object. Affective psychoses […] are characterized by

the bipolarity of (normally by no means mutually exclusive) self-worth and object worth. Even here, there are only two possible […] 'solutions' to the resulting frozen conflict: absolute domination of the archaic, […] overpowering superego (depression) or the superego being 'thrown overboard', i.e., the dominance of grandiose self (mania)." The dilemmas described by Mentzos reflect the *existential quality* of the inner conflicts of a patient experiencing psychosis. It is a matter of existence/non-existence, being/not being oneself, or dignity/indignation.

In people who decompensate into *psychosis,* the process of self-development disintegrates due to excessive emotional tensions (see Sect. 9.3). Thus, the tools of mentalizing work as mechanisms of dream work in emergency mode. The process qualities (Plassmann, 1999) of space, time, logic, and sense (see Fig. 2.5 in Sect. 2.3) dissolve in the internal construction of reality. In Moreno's words (1939, p. 4f.), "a break-up and distortion of the tele-relations (internal images, added by the author) take place, a breaking up of the auto-tele (relation to oneself, added by the author). The sense of time and space may also become blurred." In response, the self constructs the *auxiliary reality* of delusion to stabilize the systemic process of self-development.

"What we consider as disease production is, in reality, the attempt at healing, the reconstruction" (Freud, 1910, quoted in Hartwich, 2018, p. 180) and Grube (2018, p. 167 f.) speak of hallucinations as "paralogical constructions". They are "to be interpreted as counter-regulation patterns to disintegration, ego threat, and risk of decompensation". As early as 1847, Ideler (quoted from Hartwich, 2018, p. 180) understood delusion as "hard work on the reorganization of consciousness". Scharfetter (1986, only *as being quoted* in Hartwich, 2018, p. 180) understood delusion as an "autotherapeutic endeavor". In 1992, Benedetti also recognized delusions as "attempts at recompensation and reconstruction".

But the inner auxiliary reality of delusion is *not positively confirmed* in everyday life. The patient notices it and develops an *existential fear of becoming* insane. The relationship partners distance themselves from the patient's perception of reality. The patient is existentially afraid of being excluded from the community. The secondary existential fears *traumatize* his soul. He *cannot flee* from his voices or the "persecutors" or *fight* them. A traumatizing situation (see Sect. 5.2) causes tremendous stress to the human brain. Old neural connections dissolve. The processes of conflict management disintegrate even more. As a result, the inner conflict processing repeatedly produces new bizarre inner auxiliary realities—the delusional content. A vicious circle develops between (1) the production of delusions, (2) the lack of positive confirmation of the delusional reality from outside, (3) the existential fear of becoming insane and/or being excluded from the community, and (4) the disintegration of mentalizing.

Imaging procedures can demonstrate the neurophysiological consequences of decompensation into psychosis as *dysfunction of the brain structures relevant to the working memory* (Frith, 1992; Goldman-Rakic, 1994). For example, in examining patients after the first appearance of schizophrenia, Schneider, Habel, Reske, Kellerman et al. (2007) found: *The less* the working memory structures were activated in patients with psychosis, *the more* their illness deteriorated in the following year.

Despite their delusion, many people experiencing psychosis want to continue functioning in their everyday lives and try to cope with their tasks. They act as if nothing is wrong and separate their delusional life from their daily experience. They develop a *secondary defense by splitting the* self into an "everyday ego" and a "dream ego" (see Sect. 9.8.1). The patients can still meet many of their everyday needs as healthy adults. However, their ego is trapped in the production of delusional content.

In the event of an *unfavorable development*, the disintegration of the process of self-development and the psychosomatic resonance patterns in the brain's memory centers continues to spread. Patients cannot adequately process their high-energy affect. In this way, patients develop chronic schizophrenia from *acute* psychosis. However, people with acute psychosis are *seemingly less likely to develop* chronic schizophrenia with intensive and adequate psychotherapy (Aaltonen et al., 2011, p. 179). In psychotherapy, the patient's problems in conflict processing are taken seriously. This experience equalizes their narcissistic deficits and stabilizes their soul. They possibly develop a new identity.

In the early 1940s and 1950s, Moreno (1939, p. 3 ff.) described the psychodynamic processes involved in psychotic decompensation as follows: "In the case of a hallucinatory psychosis … a break-up and distortion of the tele-relation take place, a breaking up of the auto-tele…The sense of time and space may also become blurred…As the psychological organization of time and space are disorganized, the spontaneity states, instead of following one another in rapid frequency, producing the sense of time with the dimensions of a past and future, flow freely into space since there is no barrier to prohibit this." Sigmund Freud (Freud, 1917, p. 423, only quoted from Böker, 1992, p. 146) understood the processes involved in psychotic decompensation similarly: "The ego reacts to an unbearable loss by denying it with the psychotic symptoms: the ego breaks off the relationship with reality, it withdraws the cathexis from the system […] and disintegrates."

9.5 Moreno's Secret in the Psychotherapy of Psychoses

In 1936, Moreno founded a 12-bed sanatorium in Beacon, New York. Eight of these beds were usually occupied by people with psychosis. There were no neuroleptics for treating psychoses in the 1930s and 1940s. So Moreno had to develop *psychotherapeutic* approaches if the symptoms of his patients with psychosis were to improve. In the therapy of his patients, Moreno used his experiences from the treatment of an actress in his improvisational theater from 1921 (see case example 15 in Sect. 2.6). He summarized this experience in the sentence: "Every true second time is a liberation from the first" (Moreno, 1970, p. 77). Moreno concluded from these experiences: The patients had to gain ego control over their deviant thinking and feeling through *acting* in the as-if mode of play (see Sect. 2.6). Thus, they learn to distance themselves from their dysfunctional thinking and feeling and modify or stop it.

Moreno's clinic functioned based on the therapeutic community principles (Straub, 2002, only oral communicated). For example, the therapists ate their meals

together with the patients. They also accompanied them to the hairdresser. Moreno arranged for his patients to enact their delusions in *role-plays*. He had auxiliary therapists take on complementary roles in the patient's delusional system. The auxiliary therapists acted out the delusion with the patients. As a result, the patient's symptoms improved. This experience fascinated Moreno so much that he asked to have his tombstone written before his death: "Here lies the one who brought laughter to psychiatry." Moreno (1939, p. 5 f.; 1945a, p. 3 ff.) called the form of *psychodramatic individual therapy* he developed for people with psychosis "the auxiliary world method". In the following case example, Moreno & Moreno (1975a, p. 193 ff.) treated a man with psychosis who believed he was Adolf Hitler *at the beginning of the Second World War in 1939*. The patient had emigrated from Germany to the USA.

Case example 83

The patient came to Moreno for a consultation. He had a trimmed mustache on his upper lip. Moreno asked him his name. Then the man got angry: "Don't you know who I am?" Moreno was startled. But then he remembered: the patient's wife had called him on the phone and said that her husband believed he was Adolf Hitler. Moreno promptly touched upon the patient's delusion: "Of course, now I recognize you, Mr. Hitler!" In response to Moreno's accepting attitude, the patient complained that the man in Germany who called himself Hitler was taking everything from him. "He took my name… he took everything I have, my inspiration, my brainpower, my energy. This other man also claims to have written the book 'Mein Kampf'. I wrote 'Mein Kampf'." Moreno picked up the phone and called two nurses. When they arrived, he introduced them to the patient as "Mr. Goering" and "Mr. Goebbels." The patient had actually come at an inappropriate time. Moreno was about to speak to his students in a lecture hall. He, therefore, seized the opportunity and informed those present: "Mr. Hitler wishes to make an announcement to his people." The patient promptly followed the request.

In this case report, Moreno describes how he treated the patient in individual therapy for three months. The two nurses who played Goering and Goebbels maintained their doppelganger roles in their everyday interactions with the patient. They also interacted with him in the as-if mode of play. They didn't reverse roles with him. There was also no debriefing of the psychodramatic play. Initially, the patient "Hitler" behaved aloof towards his "comrades," but then he began to become more familiar: "During an intermission of one session, he said to Goering: 'Hello Goering, what do you think of the joke I made on stage today?', and they laughed together. But suddenly, Hitler swatted Goering. Goering responded similarly, and a regular fistfight took place on the spot, during which Hitler took a bad beating. Later they enjoyed a glass of beer together. From then on, the ice between them gradually began to melt." The patient slowly changed as a result of the treatment. Finally, he shaved off his mustache and, at the same time, began to cry bitterly. Later, he also requested that people call him Karl and no longer Adolf. The patient, a master butcher, could reintegrate well socially after the treatment. He returned to Germany a few years later.

During my training as a psychodrama therapist, I read various case examples of Moreno's therapy of people with psychosis (Moreno, 1939, 1945a, 1959, pp. 253–317; Moreno, 1975a, pp. 191–206). I found the descriptions fascinating. But I didn't want to pretend to my patients at first that I shared their delusional reality and then distance myself from their psychotic experience. I didn't want to lie to them. I would have been helpless if they had asked me if I believed their delusional reality.

Central idea

Today I know: It counts as therapeutic *malpractice* to tell patients, directly or indirectly, *after a joint psychodramatic enactment* of their delusion, that their delusions do *not* correspond to reality. This disrupts *the stabilization* of the patient's inner process of self-development in the as-if mode of play (see Sect. 9.6). The patient feels even more alone than before the enactment. The high-energy affect that led to their decompensation into psychosis is actualized, thereby aggravating the patient's symptoms, because their stabilizing auxiliary reality has been called into question (see Sect. 9.4).

***Case example 84* (Bender & Stadler, 2012, *p. 89*)**
A patient recently admitted to the clinic talked about his paranoia in group therapy and partially enacted it psychodramatically. In the debriefing, the group "expressed, with shock and tact, that the story actually sounds fantastic and improbable." None of the therapists in this situation supported the protagonist's experience of reality as a doppelganger. They didn't follow the basic principle "Be with your protagonist" (Dean Eleftery, 1973, verbal communication). The group members wanted to help the patient improve his insight into the illness through their feedback. However, their distancing from the patient's reality experience intensified his psychotic symptoms. The patient "fled from the clinic that same evening […]. Two days later, he was found drenched in the rain and brought back by the police in an agitated and confused state."

9.6 Moreno's Metacognitive Approach in the Psychotherapy of Psychoses

Central idea

Many therapists focus their work on changing the *inappropriate thought content* in the delusion of patients experiencing psychosis. They address the *cognitions*. *Metacognitively oriented* therapists try to free the patient's creative inner process, which *produces* their *inappropriate thought content*, from its blockage and halt the whirlpool of disintegration of the systemic process of self-development.

Like most psychodrama therapists, I did not dare to use Moreno's auxiliary world method in the treatment of my patients for many years. An experienced psychiatrist and trainer in psychodrama (Wolfgang Gerstenberg, 1974, verbal communication) once told me: "I tried it, but it did not help my patients. Moreno could do that because he was a special person. That is not me. That's why I don't need to be able to do

that either." But in his psychodramatic approach, Gerstenberg empathically followed the fleeting psychotic *thoughts* of his patients with frequent psychodramatic scene changes. He did *not* work *metacognitively.* He did not treat the everyday conflict processing *and* the conflict processing in delusional conflicts *separate from each other.* He did not try to construct *individual delusional scenes* together with the patient and transform them into a story of coping (see case examples 85 in Sect. 9.6, 88 in Sect. 9.8.1, and 96 in Sect. 9.8.8).

Central idea

The ability to provide psychodrama therapy to people experiencing psychosis does *not* depend *only* on the therapist's personality. In my opinion, Moreno did *not fully describe* his *practical approach* in his case examples 70 years ago. Therefore, one *cannot successfully imitate* his approach as a therapist. The description of the doppelganger's dialogue is missing (see case examples 85 in Sect. 9.6 and 86 in Sect. 9.7).

Moreno's disorder-specific approach in the psychotherapy of psychoses contradicts contemporary *psychiatric* thought. *Not every* psychodrama therapist is so spontaneous and self-assured that he can and wants to flexibly accompany his patients *in their delusional world*. *Psychodynamic psychotherapists* have the same problem in working with people with psychoses. Psychoanalysts also make little use of the practical disorder-specific approach of Benedetti and Séchehaye today.

As a psychodrama therapist, I initially limited my work to treating my patients "only" from a *social-psychiatric* perspective. I used *practice role-play* in group therapy (see Sect. 9.12), and the patients made progress. Many of them stabilized mentally, socially, and in their family lives. What irritated me, however, was the poor sustainability of the therapy. The accompanying pharmacological treatment made the psychotic symptoms of the patients disappear. However, after stopping the neuroleptics, the symptoms usually returned after 4–8 weeks, sometimes even after three days.

It wasn't until 1998 that I understood Moreno's 'auxiliary world' method in the therapy of people with psychosis. It was a creative leap in my therapeutic approach to the experience of people with psychosis and Moreno's theory of 'spontaneity'. At that time, I met with some psychodramatists from the German Professional Association for Psychodrama (DFP) in a working group on "Psychodrama in Therapy for Psychosis". We exchanged our experiences and experimented. For the first time, we recognized how Moreno proceeded *practically* in the psychotherapy of patients with psychosis and why his disorder-specific approach has a *healing* effect. The new insight came when we role-played a report by Schindler (1996, p. 9).

Exercise 24

Try to reenact the following case example in small steps together with a colleague in a role play. Then you will understand the secret to healing psychosis *psychosomatically*.

Case example 85

In the early 1950s, Moreno came to the University Psychiatric Clinic in Vienna to demonstrate his therapy method in practice. He had been asked if he wanted to speak

to the patient beforehand. Moreno renounced it. The clinicians then selected a patient with a depressive stupor for the demonstration. As a result of her severe mental illness, this woman "did not respond to the doctors' questions. She was mentally absent and lost." Schindler reports: When the patient was led into the lecture hall, she "stopped after a few steps. But then Moreno approached her, greeted her loudly, and took her hand. Then he stood next to her and explained that the doctors in the auditorium were like students. And that they should learn about her situation from her perspective […]" (continued below).

Central idea

In the therapeutic conversation with the patient, Moreno shifted from the usual face-to-face position to the shoulder-to-shoulder position. I imagine he grabbed her left hand with his right hand, stood at her side, and turned his gaze, *together with her*, toward the auditorium. Together, they looked at the doctors sitting in rows in the lecture hall. The audience probably looked at the two expectantly. Moreno then explained the situation *to the patient* shoulder to shoulder. *As her metacognitive doppelganger,* he verbalized what he perceived in the identification with her. He thus activated and structured the mute patient's inner thinking. Schindler further reports:

Case example 85 (continued)

Moreno asked her name almost casually. To our amazement, she told him her name without any inhibitions. Moreno repeated the name slowly and found it was nice. He made an association that I've now forgotten, which didn't fit either. The patient corrected him, and he immediately accepted her perspective and offered an extension. This is how a thoroughly trivial conversation developed between the two, emphasizing the importance, supported by an expression of personal interest and without any objective justification. The patient's stupor seemed to have fallen off, and a conversation about their life situation developed. Moreno rarely asked any questions. He offered her his ideas and let her guide him through corrections. So the patient was actually helping him. She imagined some family members who wanted to withdraw. Moreno wouldn't tolerate that.

We then practiced applying Moreno's practical approach to *our own patients'* treatment through role-plays in our working group. One of us played the role of our own patient, and another tried being a therapist. Like Moreno, we stood *shoulder to shoulder next to the "patient"*. As doppelgangers, we tried together with the "patient" to playfully participate in her *internal production* of delusion and actively develop it beyond reality. In the therapeutic relationship, we had to think, feel and act *transmodally in the equivalence mode*, as if the patient's delusions were reality (see Sect. 9.7). I call this method "Doppelganger Dialogue" (Krüger, 2001a, p. 257 ff., see Sects. 9.8.2–9.8.5). Moreno (1959, p. 85) once described the *doppelganger method* in his poetic language with the words: Due to psychosis, the patient is "in such a mental state that communication is challenging, and neither the doctor nor the nurse can establish contact with her. […] But if she could talk to herself, to the person closest to her and who knows her best, she would have someone to form a connection with. In order to enable her to do this, we reproduce her 'doppelganger' for her on stage, with whom she can identify most easily and with whom she can talk

and act together. That is the purpose of the doppelganger method in psychodrama." Moreno's definition seems like he was thinking of this patient with a stupor in the Vienna University Clinic.

9.7 The Transmodal Relationship with Patients Experiencing Psychosis

Schindler's report (see case example 85 in Sect. 9.6) *fills a gap in Moreno's description* of his practical approach to the therapy of people with psychosis. Moreno understood the psychotic symptoms of his patients as an invitation to *encounter.* Plassmann (2019, S. 55ff.) calls such an offer the "present moment". The patient acts out a dysfunctional thought and behavior and, thus, *unconsciously asks* the therapist for help to resolve this dysfunctionality. The encounter with patients suffering from psychoses fails by definition. If the encounter is to be successful, the therapist has to enter the patient's delusional world as a metacognitive doppelganger (Moreno & Moreno, 1975a, p. 193 ff.). In case example 83 (see Sect. 9.5), Moreno called two nurses and introduced them to the patient "Hitler" as "Mr. Goering" and "Mr. Göbbels". I suspect that, *as a doppelganger*, Moreno immediately turned to the two nurses and addressed them: "Mr. Goering, we're waiting for you! Why are you so late?—Ah, yes, Mr. Göbbels, nice to have you here! I hope you bring good news to Mr. Hitler!" The two nurses immediately accepted this role assignment as trained auxiliary egos *without asking* any questions and went transmodally into the delusional reality of the patient "Hitler". Therefore, the patient had no choice. He had to get wholly involved *in his own delusional reality*, taken over by Moreno, and act as "Hitler". Otherwise, he would have betrayed his *own* delusional reality.

Central idea

The *doppelganger dialogue* (see Sects. 9.8.2–9.8.5) is the basis of the disorder-specific psychodrama therapy of people with psychosis. Through doppelganger dialogue, the therapist helps the patient to gain ego control over the work of his mentalizing tools. As a metacognitive doppelganger, the therapist actively affirms the *positive stabilizing function* of the patient's delusional production in the holistic process of his inner systemic self-regulation (see Sect. 9.8.5).

The therapist steps *shoulder to shoulder* with the patient *transmodally* into the patient's delusional scene and actively shapes it.

Case example 86 (*Krüger, 2001b*, p. 49 f., changed)

A 40-year-old patient, Mr. A., had been in outpatient psychiatric-psychotherapeutic treatment since the onset of his illness eleven years ago. During this time, he decompensated into acute psychosis and was hospitalized seven times. In eleven years, he spent a total of 350 days in hospitals. He was forcibly admitted six times. He had graduated from high school, was a skilled craftsman, and was on early retirement for five years. He had had a legal guardian for six years to manage his financial affairs. Mr. A. was overweight and diabetic and consumed a lot of alcohol when ill.

In January 2000, the patient's father came to see the therapist and reported: "My son has changed again. He has spent 1,000 marks in the last three days." The therapist telephoned the patient and asked if he could come and talk to him. Mr. A. answers the phone and replies cheerfully: "I can swing by sometime." The therapist is treating another patient when a staff member calls him out into the hallway to see Mr. A. Meanwhile, Mr. A. is standing there, comfortably resting his arm on the counter, and greets the doctor in a friendly and cheerful manner: "Hello, Mr. Krüger!" Therapist: "Hello, Mr. A. Nice that you have come!" Mr. A.: "Yes, it's good to meet you again!" Therapist: "Yes, your father is worried!" Mr. A.: "Oh! the old man, he's being stingy with the money again!" The therapist does not admonish the patient that he must also understand his father. Instead, as a doppelganger, he enters the patient's delusional world and shapes his delusional reality with the doppelganger dialogue: "You seem to be fine!" Mr. A.: "Yes, no reason to complain!" Therapist: "So it's starting now, yes?" Mr. A.: "Yes, because I am chosen!" Therapist: "Oh, you are going to be great!" Mr. A. teasingly: "Yes, I am about to become the greatest entertainer in the world!" Therapist: "You will come on TV." Mr. A.: "Yes, it is only a matter of time. They chose me." Therapist: "It's like winning the lottery! You received a letter confirming that." Mr. A.: "Yes, it's going to start soon!" Therapist: "And when you watch the news on TV, the newsreader has already announced: 'Arthur A. is the new entertainer for TV! It's still unclear who Arthur A. is, but it'll start soon!'" Mr. A.: "They're eavesdropping at the moment!" The therapist: "The TV people!" Mr. A. laughs cheerfully and underlines his statement with a hand gesture: "No, all people in the world." Therapist: "And then you will be free of all your worries! You have money! You are the greatest entertainer in the world! You make music and jokes, and you make people laugh!" Mr. A. somewhat arrogantly: "No more problems, Mr. Krüger." He adds hesitantly: "I just have to be careful not to slip and become sick!".

At this point, the patient unexpectedly shifts from the equivalence mode to the as-if mode in thinking about his identity as the world's greatest entertainer and recalls his earlier decompensation into psychosis. The therapist follows this change immediately without commenting on it. He thinks, feels, and acts "normally" as a psychiatrist: "Shall I give you an injection?—I can do that." Mr. A.: "Well, maybe that's better!" Therapist: "Okay, come with me!" Mr. A. accompanies the therapist into the examination room and gets injected with a depot neuroleptic. He doesn't pay attention to the dosage. The therapist and the patient schedule another appointment to see how the depot injection works and whether he experiences any side effects.

In the doppelganger dialogue, the therapist and the patient internally *represented* the delusion scene between the patient and his future employer as if writing a film script. They *interacted* with his interaction partners and developed his delusion into a holistic story of coping through *mental rehearsal*. However, a story of coping with a delusion is always absurd by definition. Thus, the patient psychosomatically felt the absurdity of his coping story. He noticed that his identity as the world's greatest entertainer is only *an inner representation* and probably cannot be realized in the external reality (see Sect. 2.6). In doing so, he thought of his desire in the as-if mode and no longer in the equivalence mode. Thus, he developed an insight into his illness (see Sect. 9.8.5).

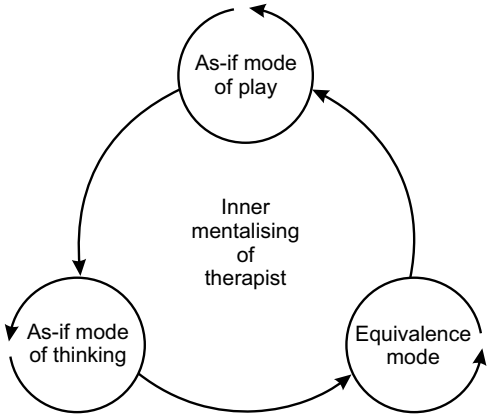

Fig. 9.1 The therapist's transmodal thinking and acting as a doppelganger

Important definition

The therapist *freely switches* between three modes of mentalizing—the *equivalence mode*, the *as-if mode of thinking,* and, if necessary, the *as-if mode of play—without* integrating them (see Fig. 9.1 below) in the *transmodal relationship* with patients experiencing psychosis (see Sect. 2.6). As the patient's metacognitive doppelganger, she does *not* draw the patient's attention to the contradictions between his various thought contents.

Central idea

The patient's high-energy affect in the current conflict disrupts the systemic process of his self-development. His ego control over the work of his tools of mentalizing breaks down. Therefore, the therapist *enters his delusional world* as a doppelganger. As a metacognitive doppelganger, he works together with the patient to restore his ego control over his mentalization. In the doppelganger dialogue, the therapist carries out the patient's representing, interacting, and rehearsing in the patient's delusional world shoulder to shoulder with him, or implements it anew, using *her own* mentalizing (see Sect. 2.2). In doing so, she helps *the patient* organize his mentalization process spatially, chronologically, and logically in his delusional production and, thus, stops the disintegration of his inner systemic self-development (see Sect. 9.8.5).

Relating to the patient transmodally does *not* mean the therapist *only avoids* contradicting the patient. The therapist does *not* announce in advance that she "now wants to address his delusion". She does *not* ask the patient's *permission* to talk to him differently. She does *not debrief* the joint shaping of the delusion with the patient. These actions would *indirectly* define the patient's delusional reality as mere *fantasy*, and the collaborative transmodal relationship and encounter would fail.

Moreno's approach to the *psychotherapy of psychoses*, which he developed since 1936, seems strange to us "rational" people today. However, his unique way of dealing with people with psychosis is well-known in other contexts. As early as 1788, *Goethe* described the "healing of insanity through a psychic cure" in his "Lila" using a very similar procedure (Diener, 1971). In the story, a healer lets the family and the domestic staff of a woman experiencing psychosis act out the characters that appear in her delusional world for three days. Thus, the woman is no longer alone in her delusional experience and is no longer afraid of going crazy. This stabilizes her

systemic process of self-development and halts its disintegration. For the first time, she can *externally* perceive her delusional figures in the as-if mode of play, actively *interact* with them, and *rehearse* relating to them and influencing their actions. Thus, she re-establishes ego control over her representing, interacting, and rehearsing in her delusional world. In Goethe's story, she gains insight into her illness and is healed.

Transmodal communication in doppelganger dialogue and the auxiliary world method have long been practiced as therapy methods even *in other cultures*. For example, a medical student from Africa once told me (Krüger, 1997, p. 112) that he had witnessed how a medicine man in his homeland treated and healed a tribesman with psychosis: the tribesman believed that other members of his tribe had stolen from him. Together with the "victim" and the other villagers, the medicine man staged a major search for the "stolen" objects. The whole village and the patient went shouting from hut to hut with great effort. They looked for the stolen objects in all corners. In doing so, the healer did not distance himself from the apparent absurdity of the patient's delusional fantasies. Instead, he *thought transmodally with him in the equivalence mode* and acted with him and others as doppelgangers in the as-if mode of play, as if the patient's delusions were real.

The transmodal relationship with patients suffering from psychosis can be found under different names and with modifications in *other psychotherapy methods* for psychosis, for example, Sechehaye (1956) or Benedetti. According to Séchehaye (Elrod, 1991, quoted by Red, 2018, p. 341), the psychotherapy of psychoses is *not* only about "helping the patient with schizophrenia face social reality but also about creating a new reality together with him…through symbolic realization, leading to changes in existence in both the patient and the analyst."

9.8 Why Metacognitive Psychodrama Therapy Can Causally Stop the Delusional Production

Question
Why are early psychodynamic interpretations of delusions as symbolic images therapeutically ineffective or even harmful?

Before I understood Moreno's approach (see Sect. 9.5), I treated a 40-year-old patient with chronic paranoid psychosis (ICD10: F20.0) in 160 sessions over three years *without participating in her delusional world* (see case example 87 in Sect. 9.8.1). I tried to interpret the delusional content with a depth psychology lens. This approach stabilized the patient in her family and social life. She *did not need hospital treatment*. However, despite continuous treatment with neuroleptics, the patient's core disturbance, her delusions, did not disappear. Other therapists have had similar experiences. Schwarz (2018, p. 107 ff.) stabilized a patient with psychosis in 20-year psychoanalytic *psychotherapy* and "saved his life". However, after the end of therapy, the patient made two serious suicide attempts and was hospitalized several times. He stabilized later and lived with his partner as an early retiree.

Depth-psychological interpretations aren't wrong. But, they don't help the patients Often, delusions are a *symbolic expression* of an existential conflict in the patient's family or social environment. If the patient believes he is poisoned by his mother, it may be that his mother restricts him with excessive care. Early depth-psychological interpretations follow the theoretic idea: As far as possible, the patient should recognize that his delusion is "only" a symbolic image of his everyday conflict. Thus, he should distance himself from his delusion. The problem is that *a patient experiencing psychosis* finds *no* resemblance between the mother who threatens him in his delusion and the mother who worries about him in everyday life. *He cannot understand symbolic images* and metaphors as figurative. He thinks of his delusion in the equivalence mode and considers it real. If the patient *were to understand* the symbolic meaning of his delusional content, it *would* actually harm him. This is because it would trigger his negative affect toward his mother which has disrupted his ego control over his mentalizing and caused him to decompensate into psychosis in the first place (see case example 31, Sect. 4.14).

For the same reason, *a psychodramatic relationship clarification* with role reversal with important attachment figures is contraindicated in the treatment of patients with psychosis. Better self-actualization in the as-if mode of play actualizes the patient's desire for distance and aggression that had led to the breakdown of his ego.

Central idea

According to Winnicott (1985, p. 63), "People who cannot play must first learn to play. They don't understand interpretations. […] Premature interpretations, therefore […] sound like instructions and lead to adaptation." According to Auchter (1995), it is important for a psychotherapist to "develop the ability *not knowing*, not knowing immediately, and not knowing everything."

People decompensate into psychosis when a high-energy affect in the triggering conflict situation traumatizes their souls (see Sect. 9.4). They are afraid of going insane. This existential fear disintegrates the systemic process of self-development. As a result, the tools of mentalizing work in emergency mode as mechanisms of dreamwork (see Sect. 9.3) and produce delusions. Thus the tools of mentalizing become mechanisms of dreamwork (see Sect. 9.3) and produce delusional production. The cause of the disorder is not the delusional *content* but the dysfunctional *metacognitive processes that produce* the delusional content. In metacognitive psychodrama therapy, the therapist and the patient convert the mechanisms of dreamwork back into tools of mentalization by mentalizing together in the doppelganger dialogue and using them appropriately in the delusional scene. This stops the current delusional production or reduces it (see case examples 94 in Sects. 9.8.6 and 9.8.8 and 95 and 96 in Sect. 9.8.8).

In doing so, the therapist uses the following steps:

1. The therapist and the patient construct *a delusional scene* from the patient's most important delusional content and *represent* it externally with the help of chairs and hand puppets. This *differentiates* the subject and object in the delusion (see Sect. 9.8.4). The *object* can be, for example, a voice heard by the patient. he feeling of threat gets a suitable conflict partner as the object, the 'persecutor'

(see case example 95 in Sect. 9.8.8). Or *the object image* of the voice gets the appropriate *self-image*.

2. The therapist and the patient psychodramatically play an *individual delusion scene*. They both *interact* in the conflict as the doppelganger and protagonist. Thus, through their actions, they expand their respective inner psychosomatic resonance patterns between the memory centers of sensorimotor interaction patterns, physical sensations, affect, linguistic concepts, and thoughts. Moreno says (1959, p. 98): "Talking is important. But acting precedes and includes talking."
3. If necessary, the therapist *rehearses* as a metacognitive doppelganger on the patient's behalf without being daunted by the contradiction between delusion and reality. For example, she loudly berates the 'mother', symbolized with an empty chair, as a 'bad mother who wants to kill her son', and forbids it explicitly (see case example 95 in Sect. 9.8.8). In doing this, the patient feels *psychosomatically* relieved through the acting of the doppelganger. But, he also remembers that his mother loves him and cares for him. He experiences his inner object image of his mother in everyday life *differently* than the therapist's cruel image of his mother. Therefore, he begins to doubt his delusion of being *poisoned* by his mother.

Central idea

The repeated interruption of the current delusional production precedes the development of insight into the illness. It is not to be equated with insight into illness (see Sect. 9.8.5).

Question

Why does the joint therapeutic development of delusion also improve the patient's ability to deal with conflicts *in his everyday life*?

Metacognitive therapy reduces or stops the current production of delusion (see case examples 94 in Sects. 9.8.6 and 9.8.8, and 95 and 96 in Sect. 9.8.8) thereby improving the patient's ego strength. A 40-year-old patient had been planning to leave home for three years. Together, the therapist and the patient developed her delusion metacognitively in a therapy session. The patient then left home *without* discussing her desire to move with the therapist again. The therapeutic stabilization of the systemic process of self-development in delusion production *automatically* improves the patient's ability to deal with *everyday conflicts*. The therapeutic principle of strengthening the ego through self-development is also practiced in the psychotherapy of children. In their *free symbolic play*, the children shift their high-energy affect onto roles in a story and help the heroine to overcome danger: the cat, who is being treated cruelly, must be saved. The conflict is further developed into a story of coping in the symbolic play. Free play promotes the children's ego strength and self-healing (see Sect. 5.13). At the beginning of group therapy, they often only play for a few minutes and are otherwise standing outside the scene of the play. By the end of therapy, if they can play along for the whole session, their symptoms of illness will have disappeared in everyday life.

9.8.1 The Separation of the 'Dream Ego' from the 'Everyday Ego' Using the Two-Chair Technique

Mentalization-oriented metacognitive psychodrama therapy is more successful in new patients with a *first* psychotic episode than chronically ill patients. Therefore, new patients may even heal. Their delusional world is still fresh and not yet branded into their memories. They have *not yet* identified with the role of the sick person or the diagnosis assigned to them in the psychiatric system. The *secondary* damages caused by treatment traumata and medication are still minimal. But the *chronically ill also* benefit from metacognitive therapy.

Patients with *acute psychosis* often confuse the therapist with rapid changes in the topic of discussion and the chaos in their delusional life. In such a case, the therapist should justify her own feelings of disorientation and actively orient herself by using empty chairs in the therapy room. In doing this, she *also helps her patient*. When working with the table stage, she represents the dream ego and the everyday ego side by side with two stones. Together with the patient, she represents everything that currently makes up his life with stones and wood blocks, namely *his feelings*, his friends, family members, and other significant things. In the *case of acute psychosis*, the work with the table stage slows down and relaxes the interaction in the therapeutic relationship.

Case example 87 (*Krüger, 1997*, p. 44 f., abridged)
40-year-old Mrs. E. came to the initial consultation in a severe state of psychosis. She spoke about magicians stealing her aura at night, raping her, and sending her back. These magicians would influence her over the radio. She suffered from physical discomfort and much more. The therapist was truly confused with all the information. He agreed with her to start a drug treatment with neuroleptics. In the second therapy session, he asked the patient: "Could you please represent the important elements of your life by using different stones and placing them on the table? Take a stone for yourself as well!' Mrs. E. placed a small I-stone on the table. Next, she put two larger stones at some distance for two 'evil magicians', one for a man and one for her former professor. She had fallen in love with her before her mental illness. Then she placed a stone for their partner behind these two stones. The therapist asked: "Is that all?" Mrs. E.: "Yes, that's all!" But, the therapist also had her represent her everyday ego on the table stage: "Mrs. E., but you still exist in everyday life. You function as if nothing happened! You have children and a business too. Please add a stone for your everyday ego!" The patient placed a second stone next to her first "I-stone", symbolizing her "everyday ego". She then completed the symbolic image by adding stones to represent her husband and two children.

Together, the therapist and the patient looked at the symbolic life image of the patient on the table. Mrs. E. referred to the dream ego as her "feeling ego" and the everyday ego as her "functioning ego". As she saw the two stones, she suddenly fell silent and burst into tears: "Actually, I've only functioned my whole life!" Despite chaotic family circumstances, Mrs. E. had energetically mastered her life during her

childhood. But she had married a man who was not very good with people. He now had an alcohol problem. Mrs. E. had split off her feelings in her marital relationship in a similar way as in her childhood. However, after a gynecological illness, she fell in love with her professor. When the professor did not reciprocate her love, she decompensated into psychosis. Mrs. E reported in the following therapy session: "I just cried for three days after the last session."

Case example 88

A 32-year-old craftsman, Mr. F., had been delusional for six months. He believed he was being bugged and filmed in his apartment. In the first session, the therapist succeeded in convincing the patient that he should take one neuroleptic tablet every evening for four days for "his excessive sensitivity". The therapist used the doppelganger dialogue to communicate with the patient and, in doing this, recommended that he file a complaint with the police. In the second therapy session, Mr. F. reported: "It has become much calmer now. By the way, I also went to the police. But they said they needed evidence or a witness." The therapist: "Oh, yes, of course. That makes sense!" Mr. F: "But I don't have that!" The therapist: "Oh, what a pity!" Four weeks later Mr. F began to have doubts: "Perhaps I just imagined it all." The therapist deliberately ignored the patient's growing insight into the illness. But he represented the contrary psychotic logic of the patient next to him with an empty chair: "You say you may have only imagined it. But I think what you experienced with your neighbors remains valid and significant. So I am placing this empty chair here next to you for the part of you that experienced the filming and bugging. You can call it your dream ego if you want. Our nocturnal dreams appear unreal during the day but true during the night." The patient then spontaneously decided to write down a list of his everyday experiences for the next four weeks. He divided these experiences into two groups and titled one group "real" and the other group "just imagined."

In the two-chair technique, the chair on which the patient sits represents his 'everyday ego,' and the chair next to him represents his 'dream ego'. The therapist gives the patient's dream ego a personally appropriate name: "This is the part of you that is being bugged," or "This is the part of you that the neighbors harass," or "This is your entertainer self" (see case example 86 in Sect. 9.7). Then in the therapeutic conversation, the therapist actively assigns topics to his everyday ego *or* his dream ego *by pointing to the respective chair*.

The *two-chair technique* with the "everyday ego" and the "dream ego" is helpful in the psychotherapy of people with psychosis for the following reasons:

1. The external spatial separation of the psychotic experience from healthy adult thinking restores the patient's dignity as a human being. She is not only "a psychotic" but a woman, who *among other things, also* thinks psychotically. As with the chair work of patients with personality disorders (see Sect. 4.8), the psychotic experience is "only" *an individual character trait* of the patient. The therapist gives the patient's delusional life in the as-if mode of play a right to exist through the *external* representation of the "dream ego". A delusional life is allowed. The patient develops self-empathy for her pain.

2. The *external juxtaposition* of the "dream ego" and the "everyday ego" dissolves the patient's *secondary* defense through the splitting of the self and denial of the delusional content (see Sect. 9.4). Together, the therapist and the patient look at her disturbing psychotic experience from the meta-perspective. The place and time of the current therapeutic relationship and that of the occurrence of the psychotic experience is externally separated in a psychosomatically perceptible way. Thus the therapist and the patient deliberate on psychotic thinking and, in doing so, think concretely metacognitively.
3. In communicating with each other, the therapist and the patient sort out what belongs to the patient's everyday reality and her delusional reality. In doing so, they *internally* delegate all of the patient's *psychotic* experiences with their high-energy affect to *the chair of the "dream ego" outside.* They thus reduce the pressure of conflict in the therapeutic relationship. In doing so, the patient's everyday ego is indirectly defined as 'healthy'.

Central idea

In patients with psychosis, the tools of mentalizing work in emergency mode as mechanisms of dream work. Therefore, they aren't able to *appropriately* represent their delusional experience *internally* as a scene and to process the delusional conflict (see Sect. 9.3): Who with whom, how, and why. This results in *metacognitive confusion* between their delusion and external reality. But, the separation between the imaginary world and the external reality is the basis for inner conflict processing. The two-chair technique implements the necessary separation of the imaginary world and the everyday world *externally* in the as-if mode of play. This strengthens the patient's cognition and ego control over her psychotic thinking because she can choose freely. She can change chairs internally and think psychotically, but she can also remain seated on her chair internally. Thus, the two-chair technique untangles the patient's metacognitive confusion between his everyday thinking and his delusion production *also internally.*

4. The *therapist* develops *two opposing parallel* empathy processes without resolving their opposition and alternates between them. As a metacognitive doppelganger, he empathizes with the patient's suffering as a victim of her persecutor or her voice in the delusion. He actively carries out her delusional production consistently until she says: "Yes… but…" and spontaneously shifts back to her everyday thinking (see case example 86 in Sect. 9.7). But as a *doppelganger* of her healthy adult thinking, he also develops compassion for her suffering from her symptoms of illness in her everyday life thinking. Alternating between the two empathy processes resolves the block in the psychiatric relationship and the metacognitive countertransference (see Sect. 9.2). The therapist feels *free* to switch between thinking with the patient in her delusion as well as in her everyday conflicts and remains creative, if necessary.
5. Collaborative therapy planning becomes more manageable. The 'everyday ego' represents the *working space of social-psychiatric therapy*. The second chair for the 'dream ego' represents the *psychotherapeutic work on the delusion scene.* The actual *external* co-existence of the dream ego and the everyday ego makes it easier for the therapist and the patient to realize *both therapeutic approaches on an equal footing* side by side (see below).

6. As a metacognitive doppelganger, the therapist tries together with the patient to liberate the patient's internal process of self-development from the whirlpool of disintegration. He lets the patient switch to the chair of her "dream ego" and tries to integrate individual elements of her delusional world into a *delusion scene* with the help of the auxiliary world and develops it into a holistic history. The chair for her realistic "everyday ego" remains noticeable in the therapy room. The *external* psychosomatic presence of the 'everyday ego' as a chair gives the therapist and the patient a feeling of security when using the auxiliary world technique. The external 'everyday ego' is an anchor in reality for both of them. Because *after* the collaborative work in the auxiliary reality of the delusion, the patient can switch back to the other chair of her 'everyday ego' at any time.

Recommendation

In disorder-specific psychodrama therapy for people with psychosis, the therapist acts bifocal. She treats the patient's conflict processing in everyday life *separately* from the conflict processing in his delusional experience.

Psychotherapy of patients with psychosis comprises the following successive steps: (1) the doppelganger dialogue (see Sect. 9.8.2) and mentalizing in dream ego, (2) separation of the patient's 'dream ego' from his 'everyday ego' with the help of the two-chair technique, (3) support for the 'everyday ego' through psychopharmacological treatment and social-psychiatric measures, (4) collaborative therapy planning, (5) constructing the patient's delusional content into a delusion scene and developing it into a story of coping with the help of the auxiliary world technique (see Sect. 9.8.8). (6) *Thereafter,* if necessary, the therapist interprets the symbolic meaning of the delusional contents in the context of the patient's life history and (7) helps the patient improve his ability to deal with conflicts in everyday relationships in the present directly. (8) *Chronically* ill psychotic patients often need to be stabilized through monthly therapy sessions for many years.

The *social-psychiatric interventions* help the patient find his way in his social relationships and cope with *everyday life* appropriately. For example, the therapist prescribes medication (see Sect. 9.8.6). She includes family members in the therapy process. She refers the patient to a clinic if they are at risk of hurting themselves or others. However, in social-psychiatric therapy, the patient's ego remains trapped in its delusional production. *Only metacognitive* psychotherapeutic interventions can liberate the patient's ego from its delusional production (see Sect. 9.8.1–9.8.9).

9.8.2 The Doppelganger Dialogue in the Initial Psychotherapeutic Consultation

In the first meeting, the therapist engages in a routine diagnostic and counseling conversation with the patient. In doing so, she usually represents the patient's symptoms and conflicts in his everyday life from a few days or weeks ago externally with two additional empty chairs in the therapy room (see Sect. 2.8 and Fig. 2.9).

She waits until the conversation with the patient reveals a window to his delusional world. She notices that the patient's thought content appears strange or she feels confused (see case example 86 in Sect. 9.7). For example, the patient may say: "I hear voices!" or "The neighbors are watching me!" If the patient does *not* share *any* psychotic thoughts of his own accord, the therapist *herself* directs the conversation toward such a window. For example, she asks the patient, "Can you sleep at night?" If the patient has not been able to sleep *two nights in a row*, this is often an indication of nocturnal delusions. The therapist then switches to the doppelganger dialogue *without* giving any reason. She points to the empty chair of the patient's *self-image* in the symptom scene (see Fig. 2.9 in Sect. 2.8): "Then you lie in bed and want to sleep!" She then points to the opposite chair of his *interaction partner*: "But then you hear your neighbors gossiping about you." Depending on the content of the conversation, the therapist uses the second chair for the patient's problems in his everyday life or his psychotic experiences.

Case example 89

54-year-old Mrs. K. comes for the initial consultation. She reports that she cannot sleep at night. Therapist: "It's too loud; the neighbors are talking about you." Mrs. K.: "No, I'm afraid." Therapist: "You're being threatened by strangers." Mrs. K.: "Yes, when I went home yesterday, many things in my apartment were in a completely different space than usual." Therapist: "There was someone in your apartment." Mrs. K.: "Yes." Therapist: "A man who wanted to steal things from you." The therapist points to the chair for her inner object image in the delusional world. Mrs. K.: No, I think it was a woman. Therapist: "The woman came into your apartment but didn't steal anything. She just took everything in her hands and looked at it." Mrs. K.: "Maybe she wanted to see if there was anything valuable." Therapist: "And then she went away again and planned a burglary." Mrs. K.: "But I don't have anything valuable in my apartment." Therapist: "You don't have any jewelry or money." Mrs. K.: "Yes, I've been unemployed for a long time." Therapist: "So you only have a television. Of course, one can also sell that. Perhaps it fetches around 100 euros at the flea market." The therapist takes the chair representing the object image of "the other woman" and places it four meters away: "The chair is too close for me. That feels spooky. Slightly further away is better for me. So the woman left and will come back soon." Mrs. K.: "No, I think she told a man." Therapist: "And then the man comes at some point and breaks into your apartment." Mrs. K.: "Yes." Therapist: "Then he will steal your TV and maybe other things from your kitchen." Mrs. K.: "I don't know. Maybe he'll attack me too."

Therapist: "You are scared of being attacked. I suggest you ask your neighbor if you can give her a call at night if you hear something at your front door." Mrs. K.: "No, I can't. She is already annoyed with my stories." Therapist: "But you have other friends or relatives you can call in an emergency." Mrs. K.: "Yes, my son. But he's sick. He has enough on his plate already." Therapist: "But if you are in trouble. What illness does he have?" Mrs. K., in a somber tone: "He has prostate cancer." Therapist: "But your son is still young. He'll survive." Mrs. K.: "No, he already has

metastases in his shoulder." Therapist: "Oh, I'm sorry to hear that. That's terrible for him. And for you. Do you have any other children?" Mrs. K.: "No."

The therapist feels shocked and paralyzed on behalf of the patient. In her questions about the patient's everyday reality, she switches from the equivalence mode back to the normal psychiatric relationship. She understands the patient's symptoms indicate acute transient psychotic disorder (F23.8) and traumatic crisis (F 43.1). In her delusion, she experiences that the order of things in her apartment has changed. This experience symbolically expresses the inner fragmentation of her soul due to the impending death of her son.

In the as-if mode of play, the therapist and the patient (1) *represented* the delusion scene, (2) transformed its *interaction sequences* into a logical story, (3) redesigned it into a copying story through *rehearsal* and (4) *integrated* it with the patients's serious everyday conflict. Thus, they stopped the patient's delusion production.

Central idea

Even short doppelganger dialogues improve the therapeutic relationship. The patient is no longer lonely in his delusional reality. In the distress of his delusional reality, he feels seen, taken seriously, and understood by the therapist *as his doppelganger* even though he doesn't understand himself. The patient's delusion *usually* ruins the encounter between the patient and his therapist. However, the encounter succeeds in the doppelganger dialogue. The doppelganger dialogue is the basis for Encounter Focused Therapy in the treatment of people experiencing psychosis.

In doppelganger dialogue, the patient carefully develops trust in the therapist. Trust also facilitates the patient's *social-psychiatric* treatment.

Case example 90

Mr. D is a patient with chronic psychosis and emotional rigidity. Mr. D. had sent in an early application for a promotion at his office. However, when he didn't receive the expected promotion, he developed delusions of grandeur (ICD F22). He thought he had been appointed head of the office. A few weeks later, he assumed he had been appointed head of a state office and even the CSU chairman, a great political party in Germany. Mr. D. went to work in a black suit every day. He worked at his job there, constantly waiting to receive the appropriate certificate of appointment. The therapist placed one stone on the table in front of him for his 'everyday ego' and another for his' dream ego': "On the one hand, you have received the information that you will be appointed today. So you go to your office in a black suit! I am placing this round stone here to represent this experience. We can call it 'the promotion stone'. On the other hand, when in office, you have to act as if nothing has happened and as if you know nothing. I represent this experience with this squared stone here. You then try to go about everyday work in your office in a black suit. That must be very tiring!" The otherwise unemotional man suddenly began to cry and groaned: "You can believe me!" He felt deeply understood by the therapist. His cooperation with the therapist greatly improved in his social-psychiatric treatment.

9.8.3 The Doppelganger Dialogue for Crisis Intervention in Patients with Acute Psychosis

Question

In the doppelganger dialogue, the therapist *himself enters* the patient's delusional world and, together with the patient, develops it further. Why doesn't that *reinforce the patient's delusion production*?

In *crisis intervention* for patients with acute psychosis, the doppelganger dialogue transforms the mechanisms of dream work back into tools of mentalizing (see Sect. 9.8). This halts the current delusion production thereby improving *the emotional contact* with the patient. The transmodal relationship helps, for example, to execute involuntary admissions to a psychiatric clinic *without* traumatizing violent measures by the police.

Recommendation

The therapist does *not* use the two-chair technique in the crisis intervention (see Sect. 9.8.1). Instead, *as a metacognitive doppelganger*, as in the auxiliary world, she directly enters the patient's delusional world through *psychosomatic action* (see Sect. 9.8.8). Doing this, she actively tries to support him in fulfilling his supposed task in his *delusional scene* or to protect him from a supposed threat.

Case example 91 (Gudrun Runge, 2014, only orally communicated)

A general practitioner had learned the technique of doppelganger dialogue in a seminar. During supervision, she shared how she used this technique for crisis intervention with a patient: She was called to a patient's home for an emergency at night. There was an ambulance and a police car in front of the patient's house. In Germany, only police officers are allowed to touch a sick person physically and, if necessary, force them into the ambulance against their will. Nurses are not allowed to do that.

The nurses and police officers provide the doctor with all the necessary information while standing in front of the patient's house. Then the doctor goes through the house to the patio behind it. She sees a 50-year-old man standing there. He is looking up at the sky and intently watching something. The doctor stands to his left shoulder to shoulder with him. She also looks up into the sky: "There are a lot of stars today!" The man: "Yes." The doctor: "You have to pay attention!" The man: "Yes." He makes a big arm movement from the top left to the bottom right toward the ground. The doctor imitates the movement as a doppelganger. She thinks and feels transmodally in the equivalence mode and boldly gives meaning to the arm movement: "Ah, you have to pay attention to ensure that the celestial bodies there" she points to the stars visible in the sky, "do not hit us directly here on Earth!" The man: "No, that's where UFOs land." The doctor: "Oh yes, you show the UFOs where they should land." The man: "Yes, I'll instruct them." The doctor is startled. She thinks for a moment. Then she says empathetically: "You have a huge responsibility. That must be exhausting!" The man groans: "That's right!" The doctor seriously engages with the patient's delusional reality internally and externally. She continues to watch the sky with him. Then she has a creative idea: She points to the left with

her hand: "There, there's another UFO. You forgot that one!" The man: "Oh!" With his right arm, he again shows the "UFO" the way to the "landing pad" with a big movement.

The doctor keeps looking at the sky. After a while, she says rehearsing mentally: "I don't see any UFOs anymore. Do you see another one?" The man: "No!" At that moment, the doctor flexibly switches from thinking in delusional logic to thinking in everyday logic without being bothered by the contradiction between the two logics: "Can we go then?" The man: "Yes." As if naturally, he goes through his house to the ambulance together with the doctor and sits in it without protesting. The police officers do not have to intervene violently. The patient's nosy neighbors do not see the patient screaming and punching when the police put him in the ambulance. The patient is not additionally traumatized by the involuntary admission. The joint interaction with the UFOs and the joint rehearsing in the delusion scene stopped the current production of delusion (see case example 88 in Sect. 9.8.1).

Case example 92 (Luzia Amrein, 2020, oral communication)
A 45-year-old patient with severe exhaustion and paranoia refused his family doctor's advice to get admitted to a psychiatric clinic. The family doctor asked a psychotherapist for help. The patient came to her office. He immediately began drawing the curtains in the therapy room. The therapist immediately switched to the doppelganger dialogue and helped him do it: "Yes, they have to be closed!" Patient: "Otherwise, they can look in here!" Therapist: "Yes, otherwise, they can see us here. That would be dangerous." The therapist also helped the patient to carefully close the shutters. They both could no longer see outside. Therapist: "It must be exhausting for you, constantly hiding from the Islamic State people." Patient: "No, they are people from my place of work." Therapist: "Oh, I understand. The people from your workplace are after you and want to spy on you. And it's been like this for one week now." Patient: "No, for three weeks." Therapist: "They've been after you for three weeks. Then you are probably having trouble sleeping at night." Patient: "That's right, I'm completely exhausted." The therapist: "Then it would be good for you to go to a clinic! You will be protected from your colleagues' influence. You could take a week or two to rest well and recuperate." The patient: "Yes, I think that would be best. I can't stand it any longer at home." The therapist switches to everyday logic: "Then I'll call the clinic immediately and ask if there's a bed available for you." Patient: "Yes, that would be great."

The father-in-law had come along with the patient and sat in the waiting room. The patient, the therapist, and the father-in-law left the practice together. The therapist locked the practice door behind her. She checked again with her hand whether the door was closed. The patient laughed, "Yes, that's good if you protect yourself from them. Not that they are going to steal your documents." The patient allowed his father-in-law to drive him to the clinic without resistance. After an extended stay in the hospital, he contacted the psychotherapist and thanked her for her understanding. He then engaged in intensive psychotherapeutic work with her and successfully reintegrated into his workplace.

The therapist and the patient represented the delusion scene between the patient and his persecutors in the therapy room and interacted together with his persecutors in the as-if mode. This reduced the patient's panic and strengthened his cognition. He gained psychosomatic awareness of his distress.

The doppelganger dialogue also makes it easier to diagnose obscure clinical pictures. The therapist and the patient's attempts in constructing a delusional scene together help to discover or rule out psychosis.

Case example 93

During supervision, an experienced psychiatrist described the case of a 25-year-old patient "with severe depression, anxiety, and borderline syndrome." Her patient had already made many severe suicide attempts. She has been in psychiatric inpatient treatment for 24 months in the last five years. Despite the intensive treatment, her symptoms had not improved. The supervisor, therefore, recommended that the therapist review the diagnosis: "But please use the doppelganger dialogue method for this!" The therapist and the supervisor practiced the doppelganger dialogue together in a role play. The psychiatrist herself took on the role of her patient, and the supervisor played the role of the therapist.

The psychiatrist felt amazed, happy, and relieved in the next supervision session. She reported: "I used the doppelganger dialogue with my patient. It turned out that the patient was hallucinating and had an extremely destructive delusional system." The doppelganger dialogue revealed that the patient suffered from chronic paranoid-hallucinatory psychosis (ICD: F20.0). Thanks to the new diagnosis, the psychiatrist could treat her patient appropriately with medication for the first time after five years of therapy.

After that, the therapist sometimes visited the patient at home for crisis intervention during outpatient treatment. Each time she would find the patient sitting on the floor in the corner of the room in a state of severe psychosis. The therapist would then place a chair in the other corner of the room, representing the voice of Satan molesting the patient. As an interacting doppelganger, the therapist yelled at him: "Leave Mrs. Krämer alone! She can't take it anymore!" Representing the persecutor and interacting with him relaxed the patient and helped re-establish contact in the therapeutic relationship.

9.8.4 Practical Implementation of the Doppelganger Dialogue

The doppelganger dialogue technique is the basis of the metacognitive psychotherapy of psychoses, because patients with psychosis cannot process the conflicts in their *delusion* due to the breakdown of their ego control over their tools of mentalizing (see Sect. 9.3). Together with the patient, the therapist can lead the doppelganger dialogue purely verbally in the as-if mode of thinking (see case example 86 in Sect. 9.7). Or

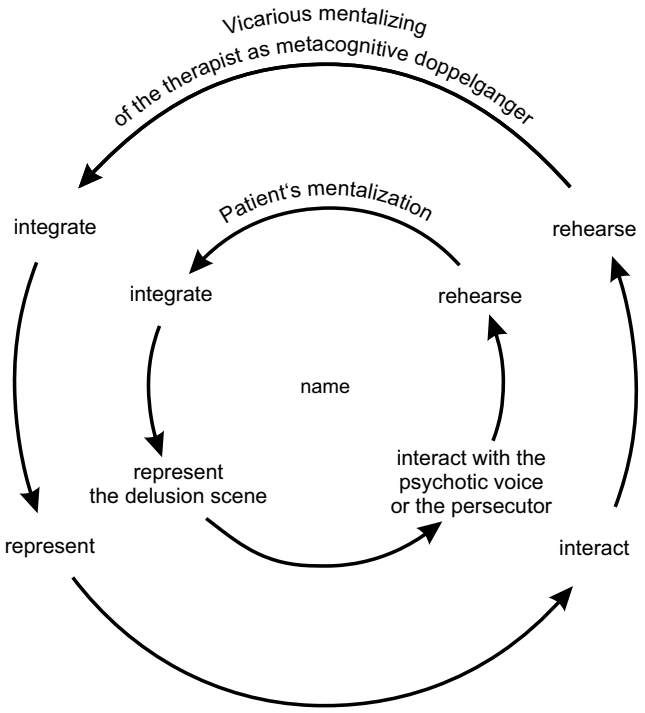

Fig. 9.2 Vicarious mentalizing of the therapist as a metacognitive doppelganger

she combines it with the auxiliary world method and uses it in the as-if mode of play (see case examples 91–96 in Sects. 9.8.3 to 9.8.8).

Central idea

During the conversation, the therapist feels confused on behalf of the patient experiencing psychosis. Therefore, together with him, she orients herself to his chaotic delusional thoughts in a doppelganger dialogue. *Acting* as a metacognitive doppelganger, she realizes *her* tools of mentalizing in his delusional production. Together with him, she *represents* individual delusion scenes, creates the chronological sequence of *interactions* in them, and tries to *develop* logic and meaning in them.

The doppelganger dialogue method *looks quite simple from the outside*. In truth, however, the therapist thinks and acts in a very complex way (see Fig. 9.2):

1. The therapist waits until the conversation with the patient reveals a window into his delusional world. She then goes *inward* with the patient into his *delusional life* and stops at an emotionally charged delusion content.

Important definition

Together with the patient, the therapist *verbally* reconstructs important content from his delusional reality into a *delusion scene* (see Fig. 9.3). They develop a conflict space where the patient's self-image and object image interact with one another. As a victim, the patient

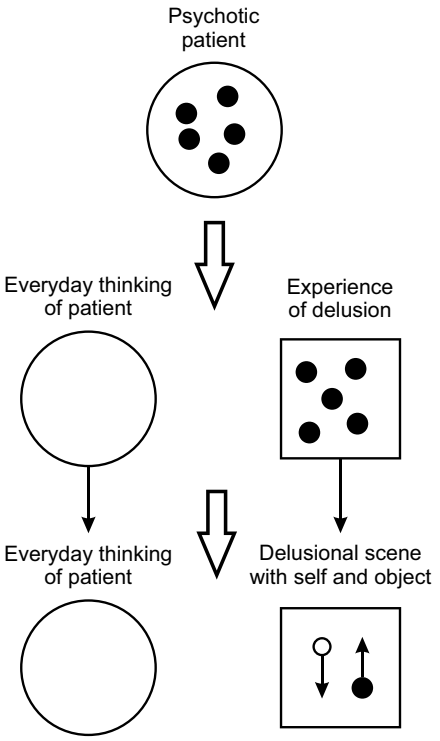

Fig. 9.3 Construction of a delusion scene using the two-chair technique

feels he is being followed, watched, spied on, or hears voices talking about him. The delusion scene then includes the patient's self-image as a victim and, the object image of an interaction partner who persecutes or observes him, or spies on him. The co-construction of a delusion scene is the first step in the patient regaining ego control over the work of the mentalizing tools in the delusional production.

2. Together, the therapist, as a doppelganger, and the patient describe the people interacting in the delusion scene and retrace the *chronological sequence* of actions and reactions *step-by-step*. Action and reaction should interlock like the hooks of a zipper.

Central idea

The therapist and the patient write a script for a film, so to speak. Together, shoulder to shoulder, they always implement only the next logical step in the chronological interaction *sequences* in the delusion scene. In this way, the patient *himself* notices that he *cannot remember* many concrete actions in his delusion scene. As a result, he wonders whether he has merely imagined the psychotic events and gets *insight into his illness*. The *step-by-step* approach helps the therapist, *as a metacognitive doppelganger,* to individually determine the patient's dysfunctional logic and avoid 'false' assumptions.

3. The therapist *only* makes *statements* in the doppelganger dialogue. Unlike other times, she *doesn't ask* any *questions*. It is very unusual for a therapist only to

make statements and not ask questions. Even experienced psychodramatists have to practice the doppelganger dialogue in the beginning.

Central idea

People must process a question in the as-if mode of thinking to answer it *appropriately*. However, patients with psychosis think, act, and feel *in the equivalence mode*. They experience their internal thinking as external reality (see Sect. 2.6). *If asked a question*, a patient with psychosis would feel insecure and shut down. Internally, he would shift from the shoulder-to-shoulder position to the face-to-face position. The joint transmodal construction of delusion wouldn't succeed. In contrast, however, when thinking in equivalence mode, the patient understands the therapist's *statements* as descriptions of 'external delusional reality'. This allows him to agree or disagree with the therapist's statements. He becomes the person who knows, and the therapist becomes the one who doesn't know.

4. The patient's mentalizing disintegrates in his delusional production and works in emergency mode as dreamwork (see Sect. 9.3). As a result, he mostly knows little about his delusion scene. Therefore, the therapist often goes one step ahead of the patient *in the joint orientation* in the delusion scene. For example, when the therapist wishes to ask if the voice is male or female, she turns the question into a statement, "The voice is male." The patient hesitates, then states, "I don't know. No, I think it is female." In another case, the therapist suspects, "The one blessing you is an enlightened one." The patient: "No, a ghost!" Therapist: "Then he is like a Jinn, a blue Jinn." The patient: "No, it's red." The therapist: "Ah, yes. His color is not blue but dark red."

Central idea

In the doppelganger dialogue, the more specific and action-oriented the interactions and logic in the patient's delusion scene, the more likely the patient notices that his delusional reality *doesn't match* his everyday reality and is therefore 'only' a fantasy.

5. As a metacognitive doppelganger, the therapist consciously thinks a little *more absurdly than the patient* in the joint development of the delusion scene. This 'false' presentation motivates the patient to correct the therapist and narrate his own delusional reality. Naturally, he is better acquainted with the action sequences, bodily sensations, emotions, linguistic concepts, and thoughts related to his delusion than the therapist. Thus, the patient completes the psychosomatic resonance pattern associated with his delusion (see Sect. 2.7) between his different memory centers. By distancing himself from the therapist's statement, the patient feels he is separate from the therapist as a doppelganger. The *patient* becomes the one who knows, and *the therapist* is the one who doesn't know. The result is *an encounter on an equal footing*. The therapist always immediately integrates the patient's corrections into the joint construction of his delusion scene.

Central idea

The doppelganger dialogue realizes the patient's longing for a supportive relationship. However, it *also* protects the patient from the dilemma of seeking intimacy and avoiding it

simultaneously, as described by Mentzos (see Sect. 9.4). By slightly exaggerating his delusional reality willfully, the therapist repeatedly allows the patient to contradict her and thus *distance himself from her.*

6. In the doppelganger dialogue, the therapist does *not empathetically* verbalize the *patient's affect alone*, as in Rogerian psychotherapy: "You felt threatened and powerless." *Empathic doubling* or mirroring of the affect amplifies the patient's fear of symbiotic closeness with the therapist. The therapist, therefore, *always immediately* and willingly describes the interactional frame that *she suspects* belongs to the emotion in his delusion scene: "You felt threatened *by the rays* that came out of the socket and hit you." This description gives the patient the opportunity to distance himself from the therapist's statements, correct them, and further develop the interactions in the delusion scene beyond reality.
7. The therapist *does not ask* the patient *diagnostic questions*: "Do you think other people can hear your thoughts?" Instead, she transforms these questions into an appropriate interactional scene from the patient's life, in which the patient *might* experience the psychotic symptom she suspects: "And when you were waiting at the tram stop, you felt that other people around you could hear your thoughts!".
8. Some of the therapist's ideas in the doppelganger dialogue are new to the patient. He *needs time* to internally fit them into his thinking and feeling in his delusional reality and correct them if necessary. The therapist, therefore, repeatedly pauses in the doppelganger dialogue.
9. The therapist herself is often unsure and doesn't know what to do next in the doppelganger dialogue. In such a case, she conducts a soliloquy in the patient's presence: "I'm confused right now, and I need to think a little. It's hard feeling threatened like that. I'm just thinking about what I can do against the danger. Give me some time. I am thinking!' Such communication humanizes the therapist in the patient's eyes because she feels at a loss, too. In such a soliloquy, the therapist often vicariously verbalizes the patient's feelings.
10. Patients with psychosis often ask the therapist at some point if they share their delusional perception of reality: "Do you believe what I told you?" In such a case, the therapist does *not* answer with a yes or no. Instead, she remains in the role of the metacognitive doppelganger in his delusional reality: "But you yourself told me." Then she reframes his feeling of insecurity *in the context of his delusion scene* and immediately elaborates on the scene: "You are insecure. Everyone is pretending! You feel unsettled and scared. You don't know who is behind it and pulling the strings. Maybe it's the secret service!".
11. The therapist avoids *symbolic images and metaphors* in her statements. For example, she does *not* say, "Your husband's negligence was a slap in the face!" Patients with psychosis comprehend metaphors concretely in equivalence mode. So they interpret the above metaphor as "Your husband slapped you in the face!" Metaphors and symbolic imagery unsettle patients unnecessarily. Therefore, the therapist formulates her empathetic comments *as a scenic interaction*: "Your husband did not keep his promise. You were very disappointed."

12. Patients with psychosis experience their delusional world as reality. Time and again, they try to accommodate the demands of their delusional reality, such as obeying the voices or fulfilling their delusions of grandeur. But they don't succeed; otherwise, it wouldn't be a delusion. Nevertheless, the patient feels threatened. Or he is completely overwhelmed when, for example, he believes he is Jesus. In such a case, the therapist expresses her sympathy for the patient's suffering *in his delusion* scene: "Yes, really, you have a huge responsibility!" "But it is very exhausting to have to pretend as if nothing is wrong!" (see case example 90 in Sect. 9.8.2) Expressing compassion for the suffering in the delusional world improves the patient's trust in the therapist.
13. In the last third of the doppelganger dialogue, together with the patient, the therapist derives a logical consequence from his delusional reality *for his mental rehearsal in his everyday reality*: "You surely have already inspected everything in your living room for bugs!—No? Then do that!" "Maybe you should go to the police and report your neighbors because they are making videos of you! That violates your privacy rights." One patient actually went to the police and later told the therapist, feeling very disappointed: "The police officers asked if I had any evidence of my suspicion that the neighbors were spying on me and filming me in my apartment. But I don't have any evidence!" The therapist replied empathically: "Yes, that's right. This must be hard for you." The integration of delusional reality into everyday reality *cannot succeed*. Because if it were to succeed, the delusional reality would indeed not be *a delusion.* The patient recognizes the *difference* between his delusional world and everyday reality through external rehearsal in his delusional world.
14. In the doppelganger dialogue, the therapist does not make false promises to the patient about his everyday reality and does not lie to him. She is his metacognitive doppelganger in mentalizing the delusion scene, but *not his active helper in everyday life*. For example, she doesn't promise him that she will go to the police *with him* and file a complaint against the mafia.
15. At the end of the conversation, the therapist returns from the doppelganger dialogue to everyday reality (see Fig. 9.1 in Sect. 9.7) and assumes responsibility for her role as therapist, psychologist, or psychiatrist. She plans, for example, appropriate drug treatment and socio-psychiatric aid. Or she motivates him to go to a hospital or a day clinic. The patient feels taken seriously and understood by the therapist because of the previous encounter in the doppelganger dialogue. The therapist did not leave him alone in his suffering. He is, therefore, often more willing to accept the therapist's recommendations. The transmodal relating to the patient is not folie à deux (a delusional disorder shared by two).

Exercise 25

Experience the doppelganger dialogue technique through *psychosomatic acting*. You cannot understand it just by reading about it because your impulses to act therapeutically arise *from your psychosomatic experience* in the direct encounter with your patient. Try to do a role-play with a colleague and, as a "therapist", go into the

delusional production of a "patient" with psychosis and verbally develop a delusion scene, together with the "patient", in the doppelganger dialogue. The colleague is supposed to play the role of one of his patients with psychosis.

You will notice (1) As a therapist, you initially fail at making statements instead of *questions.* You have to practice this first. (2) The doppelganger dialogue requires courage, spontaneity, good intuition, and, last but not least, also humility. As a therapist, you are *spontaneous* when you live in the moment and try to act appropriately in the current situation without prejudice, interpretation, prior determination, and expectations. (3) Firstly, you will fail at this goal. Many therapists feel insecure when they accompany their "patient" as a doppelganger and "falsely" describe the delusion. But you don't have *to succeed* in the doppelganger dialogue. All that matters is that *you make an effort* to succeed. (4) Even if you make "mistakes" in the doppelganger dialogue, your "patient" will react positively *to your efforts alone.* As a result, the therapeutic relationship begins to flow again. Patients with psychosis feel incredibly lonely in their delusions. But the doppelganger dialogue eliminates this loneliness. An existential encounter takes place. Sometimes this encounter is a sacred moment for the patient and the therapist (Luzia Amrein, verbal communication 2020). (5) The doppelganger dialogue reduces the "patient's" mistrust of the therapist. For the first time, the patient experiences that someone is genuinely interested in the content of his delusion.

Central idea

The therapist should *allow and accept* her own feelings of insecurity. This is the only way for her to remain capable of acting in the therapeutic relationship. She should not personalize it and conclude: "I am incapable of psychotherapeutically treating people with psychosis," because the insecurity is a justified, *appropriate* reaction to the patient's behavior.

When the therapist *herself* is part of the patient's delusional system, it is much more challenging to communicate with the patient in doppelganger dialogue. For example, the patient may be delusional and believe the therapist loves him. In such a case, the patient wants to engage in a *real* partnership with the therapist. He would like a concrete answer about how should their romantic relationship continue *in everyday reality.* The shoulder-to-shoulder position of the doppelganger dialogue automatically turns into a *face-to-face position.* In such a case, the therapist can try to tell the patient that she does not want a relationship with him *in everyday life.* But then, she should *immediately* shift to *another delusion* in the doppelganger dialogue and actively work on it with him. In this way, she once more encounters the patient as his doppelganger *shoulder to shoulder*. Or she can refer the patient to another therapist.

The therapist can use the metacognitive therapy with the help of the doppelganger dialogue in many formats, such as the initial consultation (see case examples 88, 89, 90 in Sects. 9.8.1 and 9.8.2), crisis intervention, for diagnosis (see case example 93 in Sect. 9.8.3), during hospital admission (see case examples 91 and 92 in Sect. 9.8.3), home visits, doctor's visits in the hospital, and long-term psychotherapy. The doppelganger dialogue is indicated for people with *acute* psychosis, *chronic* psychosis, and in the state of remission *after* psychotic decompensation.

Encountering patients with psychosis in doppelganger dialogue improves the patient's ego strength and the *therapeutic relationship* and, thus, makes *socio-psychiatric therapy* more successful. Patients are less likely to be admitted as inpatients, or even when they are, the duration is shorter. Disorder-specific psychotherapy of delusional disorder reduces the *treatment costs* through fewer and shorter hospital stays and reduced intake of medications.

9.8.5 The Theory of the Therapeutic Effect of Doppelganger Dialogue

A psychiatrist reported in a working group for psychosis therapy: "I tried the method with a patient with psychosis in my outpatient clinic. I represented her voice with a chair across from her and then, as her doppelganger, loudly berated the 'voice': "Stop it! Don't you see that Mrs. E. is already exhausted? I forbid you from talking to her. 'Stop tormenting her!' Then I carried the chair out of the therapy room, came back in, and closed the door. The patient's delusional voices disappeared over the next weeks."

Question
Could the therapist do magic? Explain theoretically: Why did the patient stop hearing voices without additional medication? (see case example 95 in Sect. 9.8.8).

Psychotic experiences traumatize the human soul. In a delusion, the patient cannot fight against his persecutors or against those whose voices he hears. But he can't flee from them either. His *action* is blocked. Even a patient experiencing delusions of grandeur fails in his grandiose task repeatedly. At the same time, patients experience existential fears. Patients with psychosis are at the mercy of basic human fears: the fear of being left out, the fear of absolute loneliness, the fear of going crazy, and the fear of losing their dignity as human beings. The resulting panic blocks the work of their tools of mentalizing, allowing them to work in emergency mode as mechanisms of dreamwork.

The doppelganger dialogue reduces these fears to a tolerable level. The patient no longer feels incredibly lonely. He has someone to talk to, someone who doesn't question his perception of reality and, if necessary, fights his adversary on his behalf. The therapist acts on the patient's behalf (see case example 95 in Sect. 9.8.8) and defends his dignity, his right to live, and his right to mental and physical health care. Thus, the patient internally regains his capacity to act in his traumatizing situation. The traumatizing quality of the situation is thus resolved thereby stabilizing the patient's self-development. The patient's hyperarousal subsides, and he becomes calmer. His panic reduces. As a metacognitive doppelganger, the therapist *freely and actively* uses the tools of *her* mentalizing in *his* delusion production. Thus, she helps the patient to convert his mechanisms of dream work to tools of mentalizing

and in doing so, reduce or stop his current production of delusion (see Sects. 9.8.2–9.8.4). Therefore, even *an inept* attempt improves the patient's ego strength and the therapeutic relationship.

Question

Why does the patient develop *insight into his illness* through the doppelganger dialogue? Why doesn't it reinforce the patient's delusion when the therapist enters their delusion world?

The *free interaction* with the persecutor or the voices activates a psychosomatic resonance between the memory centers of his sensorimotor interaction patterns, physical sensations, affect, linguistic concepts, and thoughts (see Sect. 2.7). As a result, the patient's associations in the delusion scene become more complex. This process makes it easier for him to find a new solution in a targeted or consistent manner *or* to give up this search (Moreno, 1939, p. 25). The doppelganger dialogue implements the as-if mode into the patient's thinking in the equivalence mode. In this way, over time, he regains ego control over his delusional production (Moreno, 1945a, p. 3f). Interacting and rehearsing in a delusion scene reduces or stops the current production of delusion. The mechanisms of dreamwork function freely as mentalizing tools again (see Sect. 9.8). The patient *independently* notices that, *despite intensive collaborative efforts*, there is *no* logic in the delusional events or that the jointly developed reason also *seems absurd to himself*. Initial insight into the condition emerges. For example, Mr. A. (case example 86 in Sect. 9.7) noticed the absurdity of his delusion of grandeur through the doppelganger dialogue and suddenly said: "But I have to be careful not to veer off."

Recommendation

The therapist remains in the transmodal relationship mode *until the end of therapy*. As a metacognitive doppelganger, she actively confirms, if necessary, the *need for* the existence of the patient's two opposing realities *side by side* (see Sect. 9.8.1).

Important definition

In the metacognitive doppelganger technique, the therapist activates within herself the sensorimotor interaction pattern, physical sensation, affect, linguistic concepts, and thoughts that belong to the development of the patient's inner self-image in his delusional scene. She completes this psychosomatic resonance pattern *internally* on behalf of the patient to form *a holistic psychosomatic resonance pattern*. This makes the therapist flexible in the doppelganger dialogue and gives the patient stability in his delusional scene.

Central idea

The transmodal relationship mode is necessary until the patient has developed the psychosomatic resonance pattern associated with his delusional scene into *a holistic resonance pattern* with sensorimotor interaction pattern, physical sensation, affect, linguistic concept, and thoughts (see Sect. 2.7). If the delusion is interpreted as a fantasy too quickly, the neuronal connections in the psychosomatic resonance pattern of the delusional scene break down once again. The completion of the neurophysiological interconnection between the corresponding five memory centers makes it more likely that the patient will, at some point, *autonomously* link the delusion with similar psychosomatic resonance patterns from his life history (see Sect. 2.7). Through this integration, the patient then experiences his delusion as an *inner representation* of reality and not directly as the outer reality itself.

The therapist continues to talk to the patient about the delusional content in equivalence mode, *even when* the *patient himself* begins to doubt the reality of his delusion (see case examples 86 in Sect. 9.7, 88 in 9.8.1, and 95 in Sect. 8.8.8). She reinforces the work of his mentalizing tools in his *current* delusional production in order to stop it. The patient's insight into his illness is *a result* of the end of delusion production and *not* a prerequisite. As a metacognitive doppelganger, the therapist strengthens the patient's ego until the patient gains ego control over his delusional production and insight into his illness all by himself.

Important definition

Ego control means that the patient can think of his delusion in the as-if mode and experience it as his inner representation of reality, but not external reality itself. So it doesn't have to be 'normal'. He is free to think and behave in strange ways if he has accepted his traits only as his *personal idiosyncrasies.*

The therapist's acting in the doppelganger dialogue may seem directive from the outside. In truth, however, the therapist develops a profoundly abstinent attitude. Her abstinence is more genuine than, for example, early psychodynamic interpretations (see Sect. 9.8) or cognitive behavior therapy (see below).

Patients with psychosis need at least one year of disorder-specific metacognitive psychotherapy to develop *long-term* insight into their illness (see case examples 94 and 96 in Sects. 9.8.6 and 9.8.8). There are many minor setbacks along the way. That's because of new crises the patient's delusional life can actualize again, *despite* a brief insight into the illness. In case of another decompensation, the patient would remember that the therapist had questioned the reality of his delusion. That would be proof that the therapist doesn't believe him after all. Loneliness and existential fears of going insane would nullify the stabilization of his process of self-development. His process of self-development would disintegrate further. *In retrospect*, he would feel betrayed and humiliated. His relationship of trust with the therapist would suffer *permanent* damage.

Central idea

The patient *himself* has to gain insight into the illness again and again if it is lost. The *lack* of insight into one's condition is an indication that the patient's mentalizing still works in emergency mode as dream work. The patient needs the auxiliary reality of the delusion for stabilizing the systemic process of his self-development. The patient must learn to think about his delusional world in the as-if mode and understand it as an *inner representation* (see Sect. 2.6). Then, he can differentiate his delusional reality from his everyday reality *all by himself*.

In psychotherapy of people with psychosis, the doppelganger dialogue *helps therapists* transform *their feelings* of powerlessness and helplessness into *action* in a therapeutically effective way. The *theory of metacognitive interventions* described here gives the therapist security and is a map for orientation in her practical work.

The practical implementation of the doppelganger dialogue is full of surprises. When using the doppelganger dialogue, the therapist acts in the here and now *without prejudice, interpretation, prior determination, and expectations*. Her acting is similar to the famous Zen Buddhist parable: the therapist sees the patient with delusion like

someone catching fish *with a wicker basket* in the river. But she *doesn't* say: "That won't work!" Instead, she grabs a second wicker basket, steps into the river, and "catches trout" too. She comments on her actions: "There, a shadow! Heck, the trout is gone; it just took off!—It probably saw me.—The water is pretty cold.—The trout probably just swam to the other trout and warned them about us!—I wonder if trout communicate with each other like whales?" In metacognitive psychodrama therapy of people experiencing psychosis, the therapist learns the art of failure. As a doppelganger, she actively tries to successfully develop the reality and logic in the delusional story together with the patient. But, she fails. Otherwise, the story wouldn't have been a delusion.

As a psychodynamic psychotherapist, Benedetti (1983, p. 199 f.) *also* designed the therapeutic relationship with patients with psychosis transmodally. His statements seem to explain the *psychodramatic doppelganger dialogue.* He recommended that the therapist must consciously absorb his patient's delusional symptom and, *by acting together in the symptom*, "enrich it with feelings and ideas of his own, which continue and modify the patient's suffering simultaneously. […] The therapist's fantasy transforms the patient's self-image […] into a new one that does not negate the first, but rather connects with what is creative in the therapist's experience." Benedetti (1983, p. 297 f.) thought that "the *therapeutic identity confusion* can be a way to overcome the identity confusion in which the psychosis is grounded. The first is the reversal of the second." The doppelganger function of the therapist in the patient's delusional production results in a *"dualization of the patient's autistic psychopathology"*: "The resulting relationship, in turn, develops a dynamic based on the ability to transpose the patient's psychopathological experiences into a dialogue without at the same time negating them or dismissing them as 'abnormal'. But then the patient may open up to the therapist and let him peek into his inner world. This breakthrough is made possible precisely through the therapeutic experience of and participation in the preceding autistic isolation." The therapist should be able "to incorporate the patient's identity and shelter it without losing herself in the process" (Benedetti, 1983, p. 194). The psychodramatic doppelganger dialogue and its theory could help psychodynamic psychotherapists apply Benedetti's recommendations more frequently.

Cognitive-behavioral therapists stop halfway in their treatment of people with psychosis. They also have their patients describe the interactions in their delusional world scenically and playfully identify with the patient's ego in his delusional production. They also verbalize the patient's feelings and construct an interactional delusion scene with self-image and object image: "You feel persecuted. The person up there is certainly one of the persecutors." However, the therapists *do not* enter the patient's delusion production in the doppelganger dialogue to develop it and, thus, stop it (see Sect. 9.8). Instead, together with the patient, they patiently and paradoxically search for evidence of reality in the delusion. However, by definition, this is not possible. They, therefore, offer *alternative* explanations to replace delusional thoughts (Lincoln & Heibach, 2017, p. 53). In cognitive behavioral therapy, the patients should "question their dysfunctional assumptions about reality" (Lincoln & Heibach, 2017, p. 47). The therapist hope that the *insight into illness* would reduce or stop the production of delusion over time. The therapist tries to improve the patient's

ability to distinguish between reality and delusion from a position of maternal acceptance.

Central idea

In psychotic decompensation, the tools of mentalizing work in emergency mode as mechanisms of dreamwork (see Sects. 9.3 and 9.6) and, therefore produce delusions. Cognitive-behavioral therapy does not treat this *cause* of delusion production. On the contrary, *metacognitive psychodrama therapy* for psychosis tries to change the patient's *metacognitive process* which produces his dysfunctional delusional thought content. The psychodramatic conversion of mechanisms of dreamwork into tools of mentalizing stops or reduces *the current production* of delusional content. Patients regain ego control over the function of their mentalizing tools. In doing so, the patient *autonomously* develops *an insight* into his illness and *searches* for new solutions in dealing with his conflicts.

9.8.6 *Psychopharmacological Treatment and Personal Emergency Plan*

Drug treatment with neuroleptics helps people with psychosis reduce their *sensitivity* to conflicts and, thus, *indirectly* strengthens their ego in everyday life. The problem, however, is that after stopping the neuroleptics, they often decompensate into psychosis again within a few days or weeks. Neuroleptic drugs do *not* 'glue' self fragments of patients with psychosis, as Hartwich assumes (2018, p. 179). They only paralyze the *dysfunctional* metacognitive processes producing the delusion. But, *mentalization-oriented, metacognitive action methods* develop Hartwich's desired "bonding qualities between the self-fragments" (Hartwich, 2018, p. 179) in the psychotherapy of psychoses. Constructing the delusion scene and joint interacting and rehearsing in the delusion scene bind the self-fragments to each other. For this purpose, in psychodrama, we use the doppelganger dialogue, the symbolizing of the dream ego alongside the everyday ego (see Sect. 9.8.1), the auxiliary world method (see Sect. 9.8.8), and hand puppetry (see Sect. 9.10).

In mentalization-oriented therapy, the therapist offers drug treatment from a transmodal attitude as it implicitly questions the patient's delusional reality. Otherwise, there will be a struggle for reality between her and the patient. Medication should make sense for the patient *within his subjective experience of reality*. Therefore, the therapist looks for a symptom of distress in the patient's *everyday life* that is treatable with neuroleptics. For example, insomnia or the inner agitation and stress caused by the voices: "It must be difficult for you to hear your neighbors talk about you incessantly and still go on with your life as if nothing is wrong. Especially when you are sensitive to conflicts. However, there is the option of taking medication, for example, one tablet of Amisulprid 100 mg daily. This drug makes you less sensitive

to conflict. Then you wouldn't feel so agitated when your neighbors talk about you. Anyhow you would still be able to drive a car."

Case example 94

A 20-year-old student, Mr. C., comes for an initial consultation because of drug-induced psychosis (ICD F12.5). He keeps hearing voices, although he says it's been six months since he last used illegal drugs. When asked, he confirmed that he had consumed excessive hashish for five years. He considers himself an addict. But he is now abstinent and never wants to use illegal drugs again. The patient has superficial insight into his illness concerning his psychotic experience. However, after being discharged from the clinic, he had not taken the prescribed psychotropic drugs for three months. As a result, he has decompensated again. In the second therapy session, the therapist explains to the strong rational young man: "Your psychosis probably came about because your ego strength has weakened through years of heavy hashish consumption. The drugs have diminished your ability to process conflict internally. That's how hashish work. My approach in psychotherapy aims to improve your ego strength again. In psychotherapy, we rebuild your ego strength together. But when you hear voices, you are torn between your delusional world and your everyday world. Your laboriously improved ego strength keeps collapsing and is unable to grow. I, therefore, make it a condition of psychotherapy that you take a small dose of neuroleptics, at least in the first phase of treatment. The dosage should be high enough that your voices disappear. The medication should have little or no side effects. First, you can try the tablets for three days. Tablets are not the same as depot injections. So you can simply stop taking the tablets if you experience any side effects. Come back after three days and then tell me whether you noticed any positive effects of the medication and, if so, what those were!" (continued in Sect. 9.8.8*).*

Recommendation

The therapist should *only* begin long-term outpatient psychotherapy with a *patient with psychosis if* the patient has at least attempted low-dose drug treatment with neuroleptics in tablet form within the first five sessions of psychotherapy.

If the patient takes neuroleptics *in tablet form* during the initial phase of treatment, he is *involved* in the decision-making process about the type and amount of medication (see case example 94 see above). In patients with an initial psychotic decompensation, the fourteen-day depot injection is used *only in acute crises* because many patients do not know the consequences of their consent to depot injections. It can temporarily lead to severe side effects. *Side effects* of neuroleptics include muscle cramps, movement disorders, visual disturbances, fatigue, sexual disturbances, hand cramps when writing, and cognitive impairment, among others. Therapists, including psychologists, should *actively look* for such side effects and ask about them during treatment with psychotropic drugs. Psychiatrists should reduce the medication as much as possible in the event of side effects. In the psychotherapy of psychoses, Benedetti and other therapists from the Zurich School have "always advocated that, depending on the situation, drug treatment can very well support and promote psychotherapeutic care" (Red, 2018, p. 347).

Treatment with neuroleptics *reduces the patients' sensitivity to conflicts.* That is the goal of taking the medication. But *excessive medication* paralyzes the patient's inner conflict processing *in psychotherapy*. As a result, psychotherapy is then less effective. However, *too little medication* also impedes progress in psychotherapy. The patient's working memory is overwhelmed with strong emotions and unresolved conflicts. The patient's mentalization ability, which had improved in psychotherapy, breaks down time and again.

Recommendation

Neuroleptics should be prescribed in adequate amounts to stop auditory hallucinations *largely* because continuous hearing of voices traumatizes the patient's soul. Hearing voices indicates that the patient's psychological process structures *are still disintegrating in the present*. On the other hand, it is advantageous if the patient hears one or more voices once every two to four weeks. The therapist and the patient can then *enter into the acute delusional production together* and work through the conflict in the delusion scene. In this way, the patient learns to deal actively with his current voices. He can also practice this directly in his everyday life (see case examples 94 and 96 in Sects. 9.8.6 and 9.8.8). At the end of psychotherapy, patients with psychosis should have lived *without psychotropic drugs* for six months if possible. Or the patient takes the smallest possible amount for him in the long run.

In exceptional cases, patients must be admitted to a psychiatric clinic. In the case of self-harm or danger to others, even *involuntary admission is crucial*. *After the hospital stay,* the therapist should discuss with the patient the shared experience of the process of involuntary admission in *psychotherapy*: She asks him what he experienced during the admission and how he judges the admission retrospectively. She justifies her actions once again. She openly names the fear she had for him as a person and acknowledges her limits: "I would like to be a grandiose therapist. But I've realized that I've failed whenever I tried to be grandiose."

People with psychosis often have difficulty remembering their *therapy experiences* because of their mentalizing disorder. The therapist thus becomes the patient's memory *vicariously*. She actively reminds him of such shared experiences when needed. Additionally, she invites the patient to draw up a *written crisis plan* collaboratively as her *own* memory aid. This crisis plan should include the following information: (1) What specific signs can help the patient recognize that he is beginning to decompensate? If he doesn't sleep *one* night, it may be a coincidence. However, the danger is imminent if the patient cannot sleep *two nights in a row*. The patient is also at risk when other people "can hear the patient's thoughts again" or when "the neighbors are talking about him again". (2) Which medications will help him in *crisis*, and what dosage? (3) What will he do if he feels unwell again? For example, the patient can decide that if a particular event occurs, he will immediately consult a doctor and tell him that he is afraid of experiencing psychosis again. (4) Patients who have advanced in therapy can plan to feel angry toward their voices, interact with them internally, and influence them suggestively (see case examples 94 in Sects. 9.8.6 and 9.8.8, and 96 in Sect. 9.8.8). The therapist recommends that the patient *always carry* his crisis plan in his wallet.

9.8.7 Collaborative Therapy Planning

After the initial five sessions of therapy, the therapist decides if she wants to work psychotherapeutically with the patient on a long-term basis. In the first session, she uses the doppelganger dialogue for diagnosis and crisis intervention, or 'only' for the improvement of the psychiatric relationship. A crisis intervention needs 1–2 sessions, short-term psychotherapy or trial therapy includes 25 sessions, and long-term psychotherapy needs 100 sessions or more.

Central idea

In making this decision, the therapist *also* relies on her feelings for guidance: "Do I connect with the patient? Does the patient's suffering touch me? Do I have the courage to engage with the patient despite all the insecurities?" These are indications that the therapy could go well. Sometimes, the therapist's intuition is wiser than her mind.

The severity of illness experienced by patients with psychosis varies greatly. While a single hospital stay or brief disorder-specific therapy is sufficient for some patients, others need 100 to 200 therapy sessions or longer. The therapist *can't make* the patient heal. It happens autonomously. But the therapist can create good external conditions which promote healing. How healing occurs is ultimately a mystery. An excess of something good doesn't always heal more. The disorder-specific therapeutic techniques must be subordinate to the therapist's intuition. The therapist must be patient and intervene in the right place at the right time. In doing this, the theory *extends* the therapist's stability. The *spontaneity and creativity in the therapeutic relationship* between the patient and the therapist and the stability and flexibility in the therapeutic relationship are central to the healing process. Appropriate therapeutic techniques must be used *for the specific person in the current moment.* Only then they are therapeutically effective.

The goal of psychotherapy for psychoses is not always *total* healing. However, it means a lot for people with psychosis, their families, and society, (1) if hospital admissions can be avoided or shortened, (2) if the amount of psychotropic drugs is low, which in turn results in fewer long-term side effects, (3) if a person can avoid a decade-long career as a psychiatric patient, (4) if the patient remains part of his family, (5) if he does not have to retire, and (6) if he does not kill himself.

Central idea

Psychotherapy for psychoses is emotionally exhausting for therapists because of the patient's metacognitive confusion. But the therapist gains a lot. In her existential encounter with the patient, the therapist develops her intuition, her inner flexibility, her creativity, and her sensitivity to the truth of the soul. She learns anew to attribute a radical positive meaning to the absurd. These skills are also helpful in the therapy of less severely disturbed patients. For example, they are fundamental in dealing with defense and resistance therapeutically and in the therapy of patients with personality disorders (see Sect. 9.4) or addiction disorders (see Sect. 9.10).

The therapist should initially treat only one or two patients with psychosis in long-term psychotherapy, preferably with accompanying supervision. In inpatient treatment, the therapist should discuss the psychotherapeutic approach with her superiors

and the team. The team must want to support the psychotherapy process. Otherwise, the therapist and her patient will attract projections that are likely to burden the treatment.

9.8.8 *Moreno's Auxiliary World Method in Contemporary Form*

Question
Why does a patient with psychosis also have to *act psychodramatically* in his auxiliary world and not just verbally in the double dialogue?

Moreno's auxiliary world method was a form of individual therapy. Assistant therapists, as auxiliary egos, would enter the patient's *delusional reality* for several weeks and realize it in the as-if mode of play together with the patient *in the everyday reality of the clinic* (see case example 83 in Sect. 9.5) as if the delusion were real. Today, the auxiliary world method would strain most clinics' human and time resources because of the tremendous effort involved. However, one can implement it with less effort, even in outpatient therapy. Today we use *chairs and hand puppets* instead of the assistant therapists to represent and enact the interaction system of the delusion outside in the therapy room.

Central idea

The core disturbance in people experiencing psychosis is the disintegration of the inner systemic process of self-development and the dissociation of internal psychosomatic resonance patterns (see Sect. 9.3). Thus, the tools of mentalizing work in emergency mode as mechanisms of dream work and produce delusion content (see Sect. 9.4). Patients with psychosis even fail in the first step of mentalizing—the *internal representing* of self-image and object image in the delusion scene.

For example, patients who feel persecuted *cannot* perceive the persecutor as a *real* person in the external world. Therefore, as reasonable persons, they do not *interact* with him. Their conflict processing is blocked. The therapist, therefore, *represents* the patient's 'ego which is persecuted' with a chair next to him *and* the 'persecutor' as an interaction partner facing him, with a chair and a hand puppet. Thus, the patient sees his 'persecutor' externally and can *interact* with him *psychosomatically* in the as-if mode of play. The therapist accompanies him as a metacognitive doppelganger. This interaction can also happen in the initial interview (see case example 95).

Case example 95 (Alfons Rothfeld, 2018, only communicated as E-Mail)

After the psychosis seminar, I soon had the unexpected opportunity to use the auxiliary world method on a patient. This patient felt watched and controlled by signals. I placed two chairs in the therapy room, one for herself and one across from her, for the unknown person watching and controlling her. I actively turned to this unknown person and spoke clearly and distinctly as a doppelganger: 'I, Dr. Rothfeld, disapprove of your behavior towards Mrs. G. You are violating Mrs. G.'s human dignity! I want you to stop that!' The patient

looked at me in disbelief for a moment. Then she started laughing out loud. At the end of the session, she said: 'I'm curious if this will stop now!' As she was leaving, she looked back to the persecutor's chair and said: 'And you stay here now!' In the next therapy session, the patient spontaneously expressed: 'I didn't think that yelling at a chair would be so effective!' From this point on, the patient questioned her delusion of persecution.

The therapist and the patient *represented* the delusion scene with the persecutor externally in the therapy room and *interacted* with the persecutor in the as-if mode of play. Thus, the patient's tools of mentalizing were liberated from working in emergency mode as mechanisms of dreamwork. This stopped the delusional production and promoted insight into the illness.

Central idea

The auxiliary world method stabilizes the inner systemic process of self-development (see Sect. 9.4) and, thus, stops the disintegration of self-development.

When using the auxiliary world method, the therapist completes the following steps:

1. The therapist *represents* the patient's self-image in the delusional reality with a second chair next to the patient. She gives it a personally appropriate name or calls it his "dream ego" (see Sect. 9.8.1).
2. She *switches to* the *doppelganger dialogue* and represents (see Sects. 9.8.4 and 9.8.5) the patient's interaction partners involved in the delusion scene with empty chairs and hand puppets as inner object images externally in the therapy room (see Fig. 2.9 in Sect. 2.8): 'These are the two demons whose voices you heard. I'll place these two chairs to represent these demons." Or: "Ah, there were *three* police cars. I represent them here with these three chairs. The three police cars drove up behind you and chased you!" The persons or figures who do good to the patient in his delusion reality should *look at* his 'persecutor' or the 'voices' shoulder to shoulder together with him.
3. In the as-if mode of play, the therapist and the patient collaborate to recreate the recalled interactions in the patient's delusion scene and even develop them further beyond reality through rehearsal. For example, the *patient* tells the therapist what the voice he hears says to him. *The therapist* lets change the patient to the chair of his 'dream ego'. She then represents the 'voice' with a chair opposite him. She steps behind the chair of the 'voice' and repeats as an auxiliary ego: "The voice says to you: I know the company where you work. The story about your boyfriend is also a wild one." The therapist waits for the patient's reaction. Again she steps next to the patient and asks: "What are you thinking and feeling right now? Please, tell that to the man?"
4. The therapist then works with the patient to develop the interaction sequences in the delusion scene into a meaningful story. Action and reaction in the delusion scene should interlock like the hooks of a zipper. In this way, the patient shapes the reality and causality in the delusion scene *with self-determination.* In doing this, the patient needs time to mentalize. Then, he shall become "the creator of his own life" (Moreno, 1970, p. 78).

5. The patient can and should correct the therapist's statements continually. She then takes what was said and immediately integrates it into the delusional co-production.
6. The therapist lets the patient also switch to the role of his interaction partner *for a short while* if necessary. But he is only supposed to *show* how his dead grandmother or the "persecutor" *would* react to his actions. He should *not* clarify the relationship with the conflict partner in a psychodramatic dialogue with repeated role reversal (see Sect. 9.12).
7. Often a delusional figure *endangers the patient's life* or *violates his dignity*. In such a case, the therapist supports him by acting as a doppelganger, similar to his approach in the therapy of persons diagnosed with a masochistic personality disorder (Sects. 4.8 and 8.5). She consciously notices the emotions triggered *in her* in the external presence of the "persecutor" as a chair and allows herself to experience the feeling in the as-if mode of play. Then as the patient's doppelganger, the therapist actively opposes the "persecutor" or the "voice" by *interacting* psychosomatically on the patient's behalf. She speaks clearly with the "conflict partner". She yells at the "voice" when necessary (see case example 95 in Sect. 9.8.8) and angrily tells it to stop its destructive behavior. In doing so, she justifies her request appropriately: "You are Ms. H.'s grandparents. But you are already dead! You can't want your granddaughter to join you in the world of the dead! She will die for sure! As a grandparent, you must want your granddaughter to live!" Or: "I'm outraged. You are Mrs. D.'s boss! How dare you watch Mrs. D. on the toilet! It is violating! As the boss, you surely want Mrs. D. to do her job well. Then please stop bothering Mrs. D. at work too!"

Recommendation

If necessary, the therapist grabs *the chair* for the persecutor or the voice and moves it 3 or 4 meters away by the window. Or she even takes him out of the room. In doing so, she explains her actions to the patient: "I can't think when I feel threatened. The secret service man is too close for me. That's why I'm putting the chair for him over there!" She sits down on her own chair again and feels her emotions: "Yes, that's better!"

Central idea

As a doppelganger, the therapist *stabilizes* the patient's internal process of self-development through vicarious acting *and mentalizing in the as-if mode of play* (see Fig. 9.2 in Sect. 9.8.4). Thus, she supports the patient's inner process of self-development.

8. In the case of patients with *delusions of grandeur* (ICD: F25.0), the therapist uses empty chairs to place one or more supporting *fictional 'helpers'* beside them. For example, "Jesus" needs "several disciples" who support him. A patient who is "preparing to be a prophet" needs an "angel" to tell him whether he "should make his religious announcements *now* or wait."
9. The therapist can try to conclude a contract with the patient's conflict partner in his delusion scene *on his behalf*, for example, the "voice". Romme and Escher (1997, p. 73, p. 75 ff.) have found that patients can also do this *on their own*: "It has helped others who have experienced something similar to you. Ask the

voices not to bother you until after 8 p.m. Tell the voices you first need to focus on your work in your company!"

10. In the auxiliary world method, the therapist and the patient try to rewrite what happened in the delusion scene in the as-if mode of play into a coping story (see Sect. 9.8.4).
11. Together, the therapist and the patient try to integrate the logical consequence following the delusional reality into everyday reality.

Case example 96 (Krüger, 2013a, 2013b, 2013c, p. 184 f.)
The 35-year-old, attractive, intelligent Ms. G. had been suffering from a chronic delusional disorder (F22.0) for three years. She kept hearing the voices of her neighbors in her apartment. The "neighbors" complained she was too loud or snoring at night. She had already moved four times in the last three years because of "intense sound absorption" in her apartments. The patient was friendly and overadjusted in everyday life. However, in intimate relationships, she could not maintain this attitude in the long term and often reacted uncontrollably and angrily. That irritated her. The therapist represented the angry inner ego state, similar to working with a patient with a borderline organization (see Sect. 4.9*), with an empty chair next to her: "On the one hand, you are the kind, needy Renate. The other chair next to you represents what you call the 'disgusting Renate'."*

In the 28th therapy session, the patient reported that she was doing well. She no longer heard the "neighbors" speak, even without medication. For the first time, she had been open with her boyfriend about her tendency to over-adapt and even found new, less perfect solutions with him. The therapist was pleased with her progress. Ms. G.: "I also use earplugs now because Robert snores very loudly. Therefore, I hear no more voices. It's not even possible."

The therapist was startled. He noticed that the intelligent patient was still mixing her delusional reality with her everyday reality. As a metacognitive doppelganger, he immediately modified the therapeutic relationship into a transmodal encounter. He pointed to the empty chair of her dream ego next to her: "Now you put earplugs in your ears at night." He set up two additional empty chairs three meters away from the patient for "the female neighbor" and "the male neighbor": "You can no longer hear the two neighbors because of your earplugs. But what do they say about that? They want to complain to you that you are too loud! The neighbors will surely think that these earplugs are mean." Ms. G.: "No, they don't complain directly to me. They only gossip about me!" The therapist turned the two chairs for the "neighbors" around such that they looked at each other: "So they talk to each other. They're an old married couple. They're bored and always pay attention to what's happening in the house." Ms. G.: "No, they're my age. But they are successful, intelligent, and good-looking. They don't have any problems!" Ms. G. added: "Ever since I was in secondary school, I've often felt inferior to people who have a good education, have their lives under control, and everything is fine with them." The direct psychodramatic encounter with the "neighboring couple" in the as-if mode of play on the room stage, allowed the patient to spontaneously integrate a problem from her everyday life in

her delusion scene. At the end of the session, Ms. G. said: "Today you hit a weak spot in me!" (continued below).

Central idea

People with psychosis experience the voices they hear or their persecutor as *external reality*. But, they *cannot see them and interact with them.* Therefore, they don't know *who with whom, how, and why*. Moreno (1939, p. 2) has already recognized the significance of psychosomatic acting in the therapy of psychoses: The therapist asks the patient to "throw himself back into the hallucinatory experience when it is still most vivid in his mind. He is not asked to describe it: he must act it out."

The following reasons explain the therapeutic effect of the auxiliary world method:

1. The joint *construction* of the delusion scene creates the patient's inner self-image and inner object image in the delusion and answers the question: Who with whom? The conflict partners can be represented *only* with chairs and hand puppets. The auxiliary world method helps the patient *to encounter* their conflict partner *psychosomatically* in the delusion scene in the as-if mode of play. The joint psychosomatic *interaction* of the therapist and the patient creates chronological interaction sequences in the delusionary world and answers the question: How? The joint *rehearsal* in the delusion scene answers the question: Why? The joint *action* stabilizes the inner systemic process of self-development in the delusion scene. The joint mentalizing in the delusion scene frees the tools of mentalizing from their function as mechanisms of dream work and, thus, stops or reduces the current delusional production (see Sects. 9.4 and 9.8).
2. In contrast to the purely verbal doppelganger dialogue, the therapist and the patient enter the delusional scene *psychosomatically.* Thus, the patient experiences his doppelganger as *physically* present beside her in the delusion scene. This *psychosomatically* eliminates the patient's existential loneliness in his delusional reality (see case examples 88 and 90 in Sects. 9.8.1 and 9.8.2).
3. The patient represents her conflict partner in the as-if mode of play with a chair opposite her and gives him a name. Representing and naming the conflict partner is an act of self-empowerment. It gives the patient a sense of self-efficacy.
4. The patient *directly interacts* with her "persecutors" in the as-if mode of play. The chronological order of the *interaction sequences* in the delusion scene constellates the *reality* contained in the delusion scene.
5. The therapist and the patient work together to create *cause and effect* in the delusion scene through rehearsing. They attempt to *rewrite* the traumatizing delusional experiences into individual coping stories, activating the patient's self-healing system (see Sects. 5.13 and 5.14).
6. The patient's *internal systemic process of self-development* starts anew (see Sect. 9.4). Through their joint action, the patient and the therapist integrate the *free-floating elements* of delusion production into a new psychosomatic resonance pattern that is separate from the patient's everyday reality. A psychosomatic resonance pattern interconnects five different memory centers of the brain, namely sensorimotor interaction patterns, physical sensations, affect, linguistic

concepts, and thoughts. The new holistic psychosomatic resonance pattern integrates the high-energy affect which had triggered the decompensation into psychosis.

7. The high-energy conflict image of the delusional scene contained in the psychosomatic resonance pattern links itself with the patient's current everyday conflict after it has been *fully mentalized*. For example, the patient in case example 96 (see above and below) spontaneously understood her feeling of inferiority in relation to the 'voices' of her neighbors as a symbolic image of the inferiority she feels in her everyday life when comparing herself to people who are well-educated and have no problems. Her spontaneous integration was an indication that she had adequate ego strength to complete this integration with biographical conflicts without negative side effects (see Sect. 9.6).
8. The joint development of delusion stabilizes the process of self-development thereby improving the patient's ego strength. The vicious circle between being delusional and being traumatized by the fear of going insane is broken. The patient is, therefore, better able to cope with some conflicts in her everyday life *even without discussing them in therapy.*
9. Over time, the patient learns to *autonomously* reduce or stop her current delusion production by interacting in her delusion scene. In doing this, she integrates the as-if mode of play into her delusional thinking and thus becomes the "creator of her own life" (Moreno, 1970, p. 77).

Case example 96 (1st continuation)
In the 35th therapy session, Ms. G. returned exhausted from a 14-day vacation. She said, feeling disappointed: "I was on holiday with my boyfriend in Tenerife. All hell broke loose in two days. The voices were back. I thought I would have to admit myself to a Spanish hospital. I had forgotten my pills. I haven't used them here at home for a long time. But I panicked on the island. On the fourth night, I heard the neighbors talking again. The neighbor said to his wife: 'I know the company where she works. It's a wild story with her boyfriend too!' At first, I was shocked and scared. But then I thought: 'It can't be that someone from my company is here!' I got angry. I consciously thought of a lie and thought: 'And I'm sure you were with me at the kindergarten in Celle!' I kept repeating this sentence to myself. And then the neighbor really said to his wife: 'And you know, I used to go to the kindergarten in Celle with her!' Then I deliberately added something crazy and thought intensively: 'Yes! And my mother was on vacation with your mother in Turkey last year too!' Then I heard the neighbor's voice again, who said: 'And by the way, my mother was on vacation with her mother in Turkey last year!' Then I realized: 'I have control over what happens.' That was very relieving!".

The therapist: "And then the neighbor was quiet." The patient: "Yes, I didn't hear the neighbors from then on." Ms. G. did not take any psychotropic drugs in the last two years of her therapy. She didn't have any psychotic symptoms, even three years after the end of treatment.

During therapy, the patient developed a permanent insight into her illness and spontaneously integrated her delusional conflict with an important life conflict. She,

therefore, became angry at the voices when they bothered her again. She *internally represented* the delusion scene between herself and the 'voices', *interacted* with the voices, and tried to influence them through *mental rehearsing*. Internally, she suggested to her "neighbors" what they should think and say. Her "neighbors" reacted to her inner actions like puppets. The patient realized that she could control the 'voices' *through her own actions*. She developed ego control over her internal object image—the 'neighbor's voices'—in the delusion scene. Her representing, interacting, and rehearsing liberated her tools of mentalizing from their function as mechanisms of dreamwork in emergency mode. Thus, she stopped her current delusional production.

10. Patients with psychosis are often not aware of their new ability to stop or reduce their delusion production. This is because they *don't* detach their experience from the concrete situation and view it from a meta-perspective. They act in the as-if mode of play, but cannot yet detach the self-healing technique from the delusion scene. Therefore, the therapist must help them to internally represent their healing experience as a 'self-healing technique' *in the as-if mode of thinking*. In doing so, the therapist looks *at the two chairs* representing the "dream ego" and the "voice" in the delusion scene (see Sect. 9.8.1) and asks the patient: "Remember your experience with your voice! Try to use this experience as a self-help technique in other situations as well!" The therapist encourages the patient to include this self-help technique in their crisis plan.

Case example 94 (continued from* Sect. 9.8.6*)

In the 7th therapy session, the therapist recommended a 20-year-old student, Mr. C., to directly ask his "voices" to behave differently. He told him how the patient in case example 96 (see above) had done this. In the next therapy session, Mr. C. reported spontaneously: "What you suggested didn't work! I heard my friend's voice. So I thought of a certain sentence that I wanted him to say. I suggested this sentence: 'What I am saying here has no purpose; it makes no sense!' There was a voice that said what I said. But it wasn't my friend's voice!" The therapist: "And how did it continue?" Mr. C.: "Then the voices were gone for four to five days. That was positive. But it wasn't my friend's voice that said what I wanted!' Therapist: 'I don't think you can always dictate everything exactly to your voices. They have their own right to exist. However, I am pleased that you addressed your friend's voice directly. You achieved what you wanted! You found a way to make a voice you hear disappear for four days!" Mr. C. is still dissatisfied: "But the voice came back after five days!".

In this situation, the therapist uses the doppelganger dialogue to have the patient describe the exact situation in which the voice spoke to him again: Mr. C. went to a party in the evening. It was a farewell party for the man he used to buy drugs from when he was a hash addict. This man has now gone abroad as a soldier in the federal armed forces. When the patient arrived at the drug dealer's house, he heard a girl's voice. He knew her voice from earlier "psychotic fantasies." Mr. C.: "I was shocked to hear a voice again after five days. Then I thought with all my might: 'Get out, get out!' Then the voice said: 'Oh, yes, yes!' Then I got angry. I thought: 'I can think whatever I want in my head, nobody cares!' So I said to the voice: 'Speak

more clearly!'" Therapist: "And then the voice asked you: 'Why should I speak more clearly!'" Mr. C.: "No, then the voice was gone!" Therapist: "You have now made one of your voices disappear for the second time!".

Therapist: "Maybe it's not a good idea for you to go to your former drug dealer's party as a clean hash addict! That stresses you internally." Mr. C.: "Actually, I didn't want to go there. But a friend took me. He also has cannabis-induced psychosis. Unlike me, however, he has not taken any medication for five years. He has only been sitting at the computer and playing for five years. He hasn't worked in five years!' Therapist: 'Well, maybe your way is better after all. At least you've got your high school diploma!".

Central idea

The patient's *self-determined* representation and interaction with his object image in the delusion scene is therapeutically a leap in quality that reduces or stops the current delusion production (see Sect. 9.8). Therefore, even small actions dealing with delusional figures have a tremendous therapeutic effect (see case example 101 in Sect. 9.12).

Recommendation

The therapist can stop *only the current* delusional production with the help of the doppelganger dialogue and the auxiliary world technique. Therefore, the disappearance of voices happens differently in each patient over days, weeks, or months (see case example 94 in Sects. 9.8.6 and 9.8.8, and 96 in Sect. 9.8.8). Moreno already said that the frequency of therapy sessions should depend on the extent of the current delusional production. In the acute stage, the frequency should be higher (Moreno, 1945a, p. 5 f.) (see Sect. 9.11).

Case example 97

A young patient, Ms. H., had regularly heard the voice of a monster and rapist during the night. During the doppelganger dialogue, the therapist placed an empty chair for this perpetrator in the therapy room opposite the patient. The patient and therapist looked at this "man" in the chair. Then, the therapist spoke directly to Ms. H.'s "persecutor" and loudly demanded that the monster respects the patient's right to integrity and her dignity as a human being. He called him a "rapist". Two sessions later, Ms. H. said: "It was important that I realized that I could talk about him here and that nothing happened! Because the rapist threatened to kill me if I told anyone else about him."

The auxiliary world technique *also helps the therapist*. The therapist transforms her own natural resistance against the patient's current delusion production into therapeutically fruitful interventions when using the auxiliary world method. In doing so, she resolves her natural disintegration-related countertransference (see Sect. 2.10) and finds her way back to her inner spontaneity in the therapeutic relationship.

9.8.9 Application of the Auxiliary World Method to Delusions of Grandeur

The doppelganger dialogue is also the primary psychotherapy intervention in patients with delusions of grandeur. Patients with delusions of grandeur (see case example 86 in Sect. 9.7) fail by definition to assert their own perception of reality in the external world. They end up in a vicious circle. The feeling of failure reactivates old traumas in them. As a result, they have to compensate for their feelings of failure again with delusions of grandeur. In the doppelganger dialogue, the therapist and the patient construct the delusion scene externally in the therapy room and interact with the interaction partners in the scene. In doing so, they paradoxically *try to convert* the patient's delusions of grandeur into reality (see case examples 83 in Sect. 9.5 and 86 in Sect. 9.7). For this purpose, the therapist places fictional helpers on the patient's side. They help him to enforce his ideas of grandeur. The therapist represents them with chairs, hand puppets, or real auxiliary therapists in the therapy room.

Case example 98

The 22-year-old Mr. I. smashed furniture in the hospital ward during his inpatient psychiatric treatment. During supervision, his therapist asked about the possibilities of psychodramatic intervention in such a situation. The supervisor let the therapist enact her patient's role, and he took on the 'therapist' role. As a 'therapist' in conversation with the 'patient', he summoned a 'ward staff member' with some psychodrama experience: 'Nurse Birgit, could you please come here? You have some experience with meditation. Mr. I. here is enlightened. I would like you to have him as your teacher for half an hour every day and talk to him about his enlightenment experiences." The therapist turns to the "patient": "I also have a request of you: Your enlightened spirits have commissioned you to make a mark in the world. These spirits will surely contact you again. If they get in touch, please connect with Nurse Birgit to discuss how you can best carry out the spirits' mission here on the ward. By the way, I would also like to speak to your spirits! There are three of them, right." The therapist places three chairs across from the patient and, as a doppelganger, addresses the "spirits" as fictional helpers: "You want Mr. I. to make a mark in this world. You want people to reflect on themselves and be less destructive. I ask you to stop Mr. I's mission for the time being as he is currently overwhelmed by this endeavor. He's here for treatment in a psychiatric hospital! He smashed the furniture in the ward on your behalf. As a result, as an enlightened person, he must stay here longer in the psychiatric clinic. His medication has also increased. As spirits, you can't want that! I think you are asking too much of Mr. I. As Mr. I.'s doctor, I urgently ask you to let Mr. I. calm down! He needs to recover!" The supervisor then explains this method to the supervision group.

The fictional helpers enter the patient's delusion scene, interact with him and try to support him in the as-if mode of play in realizing his delusions of grandeur in everyday life. For example, "Hitler" needs his "aides," Goering and Goebbels. Similarly, "Jesus" is dependent on his "disciples". It often takes the therapist a day

or two to think of a creative way to appropriately use the auxiliary world technique with this particular patient experiencing delusions of grandeur.

The fictional helpers should *interactively* support the "summoned" in gaining appropriate external recognition and position in the world or at least create suitable conditions for success (see case examples 83 in Sect. 9.5, 86 in Sect. 9.7, and 91 in Sect. 9.8.3). Of course, the fictional helpers *also* fail in this project. If they didn't fail, it wouldn't be a delusion. However, the patient is not lonely and does not fail alone; he fails *together with the therapist* as his doppelganger. Thus the patient learns that his feelings of failure and being overwhelmed could be justified and appropriate in this situation. He is comforted and witnessed in his suffering. As a result, his old traumas are not *as strongly* triggered. He doesn't have to continue compensating for them with his delusion of grandeur. The repeated interruption in the delusional production makes the patient autonomously aware of his illness over time (see case examples 83 in Sect. 9.5 and 86 in Sect. 9.7).

The auxiliary world technique breaks the vicious circle of negative transference and disintegration-related countertransference between the therapist and the patient. The patient feels taken seriously because of the *collaborative, serious effort* to realize his delusions, *even if their effort fails to produce tangible results*. It is precisely the paradoxical, absolutely authentic seriousness of the joint effort to convert the delusion into a reality that helps the patient notice that his *inner* construction of reality doesn't match his *external* reality.

9.9 Transforming a Depersonalization Process into a Creative Process of Self-direction

Central idea

In the case of depersonalization, there is a split between the patient's acting ego and observing ego (Wurmser, 1998, p. 425f.) (see Sect. 5.10.2). In therapy, the therapist represents the patient's split-off 'acting-ego' *externally* with a second chair in the therapy room and lets the patient *interact* and *rehearse* a dialogue between his two ego states using role reversal. Thus, the patient carries out his splitting *as a psychodramatic process* in the as-if mode of play. He resolves the defense through splitting and *integrates* his experience of mental decompensation with a triggering everyday conflict.

Case example 82 (continued, see Sect. 9.3) (*Krüger, 2001a*, p. 263 ff., modified)
A 54-year-old patient, Mr. B., had repeatedly suffered from psychotic decompensation since he became a young adult. He has been participating in outpatient group therapy for patients with psychosis for twelve years now. In today's group session, he turns to the therapist right at the beginning and complains: "It's happening again. I'm not here anymore!" The group members and the therapist are shocked. After a brief group discussion, the therapist addresses the patient: "You are Mr. B., sitting there and feeling that you are no longer there." The therapist takes a second chair and places it in the other corner of the room, representing the patient's acting ego: "You

lost yourself? Your lost Bernd is sitting in that chair back there." The therapist stands next to the patient as a doppelganger and addresses the missing Bernd's empty chair (the acting ego) in the other corner of the room: "What is this? You just took off!" Then he addresses the patient directly: "Could you swap roles and respond to me as Bernd, who has disappeared?" Mr. B. sits in the second chair of "Bernd" (in the role of his acting ego) and spontaneously recommends to the 'patient' in the first chair (of his observing ego): "You must remember how it was a year ago when you got sick! You took breaks at work. That did you good!" The therapist lets Mr. B. switch back to his first role of his observing ego. Mr. B. suddenly talks about his current conflicts at work without any confusion: "I have to make payments that would otherwise be forfeited. I have five urgent files on the table. Earlier I used to take breaks in between and tidy up in peace. Or I would do some photocopying. I can't do that anymore!" The play suddenly turns into a group discussion. Some participants urge Mr. B. to resolve the conflict differently: "Can't you tell your manager that? You are severely disabled!" The group wants Mr. B. to be different from what he is. He should assert himself when speaking to his boss! Mr. B. replies, "My boss knows it is impossible."

At this point, the therapist intervenes in a disorder-specific manner in the group discussion. He reinterprets the patient's depersonalization process radically positively and evaluates it as appropriate self-protective behavior: "I don't think it's good for you if you openly resolve the conflict with the boss. You are someone who, like everyone else in this group, is easily overwhelmed by conflicts. Otherwise, you would not experience psychosis. You are more sensitive than others. This is a common characteristic in people with psychosis. Therefore I like your solution better! If you can't withstand the demands of your job anymore, just split off your feelings and block them! It's not the best solution, but it's a solution!" The therapist steps up next to the patient and speaks to him in the role of his observing ego: "Mr. B., allow me to throw Bernd (the acting ego) out along with his feeling of being overwhelmed! He'll only cause you problems!" The therapist, acting as the patient's doppelganger, turns to the imaginary Bernd (his acting ego) in the other corner of the room: "Sit down and shut up! I'll close the door now, then you're gone and can't disturb me anymore. I can't stand your feelings of being overwhelmed! I have to work!" The therapist holds two imaginary door handles and locks the "door" between the patient and the missing Bernd (the acting ego). Mr. B. laughs uncertainly: "No, you can't do that!" Some group members protest indignantly: "That's impossible!' The grotesque solution causes astonishment and laughter in the group. However, the therapist defends his approach: "But what if Mr. B. can't stand the conflict!" A lively group discussion follows. Two participants share similar situations of feeling overwhelmed at work.

In the further group sessions, Mr. B. clearly describes his boss as a "workaholic" for the first time after twelve years of participation in the group: "He had a heart attack five years ago. And now he's saying—and he really said that—that one is serious about their work only if they eventually have a heart attack. There is no praise or recognition! He doesn't understand if you tell him something about stress or psychosis!" The therapist advises the patient: "So your boss knows everything, but he doesn't understand anything! Mr. B., please be careful! Don't get into a conflict

with your boss. You can't withstand it! Just do your work, one step at a time, as well as possible."

A week later, in the group session, Mr. B spontaneously reported: "Last time's role play was good for me. However, the workload hasn't decreased. Out of six people, only three of us are currently on duty. A colleague who is ten years junior can not cope with the stress either. But I can organize my work better again. I also met my boss on Tuesday. He rode the elevator with me to grab a bite. He asked me how I was doing. I said: 'There's a lot to do!' Then he said: 'You'll manage it!' That's how he always reacts! I could have strangled him when he said that!" The therapist: "Be careful! Don't get into a conflict with your boss! You can't withstand the stress of a conflict." Finally, the therapist asked him about his emotional numbness. Mr. B says: "It went away after the last session. I can feel again." Unlike before, the patient only decompensated into a psychotic episode three years later. He felt better again after one day with the help of a similar therapeutic procedure.

In this case example, the therapist worked *explicitly metacognitively* (see Sects. 2.4 and 2.14). He had the patient resolve the *defensive* split between his acting ego and his observing ego by reconstructing the *process* of splitting in the as-if mode of play and working out its *positive function* in the holistic process of the patient's self-regulation. It turned out that the patient's masochistic defense through identification with the aggressor and his massive feeling of failure had led to the disintegration of his inner process of self-development. His inner representation of the conflict thus became the mechanism of the dream work 'Inner thoughts are perceived as outer reality' (see Sect. 9.3). Representing the split *psychodramatically* and interacting and rehearsing in the dysfunctional process of his self-development stopped his current delusional production and transformed his external perception of "I'm not here anymore" back into a metaphor. The dysfunctional perception "I'm not here anymore" turned out to be a *symbolic expression of* his feeling of being overwhelmed at work: "It's *as if* I'm not here anymore!".

9.10 Healing Psychotic Disintegration of Self Through Psychodramatic Play with Hand Puppets

Some patients with psychosis, experience a disintegration of the internal process of self-development and their psychosomatic resonance patterns *without* delusional production (ICD-10 F23.8). They have sufficient ego strength to prevent their tools of mentalizing from turning into mechanisms of dream work. But, they dissociate and split off their psychosomatic ego (sensorimotor interaction patterns, physical sensations, and affect) from their cognitive ego (linguistic concepts and thoughts) (see Sect. 2.7). Patients who split off their cognitive ego tend to become depressed (see case example 99 below). Patients who split off their psychosomatic ego tend to become rather manic (see case example 100 below). The patients experience metacognitive confusion between internal self-images or object images, ego states,

emotions, interaction patterns, and internal symbols. The spatial and temporal organization in conflict processing is lost. People can experience psychoses *without delusions* in the case of post-traumatic stress disorder (F43.1), emotionally unstable personality disorder (F60.3), or dissociative disorder (F44.-).

Non-delusional psychotic patients evoke feelings of chaos and helplessness in the therapist. The therapist himself feels the confusion that the patient *would* feel if she *could* internally admit and label her feelings. In such a case, the therapist and the patient orient themselves together and grasp the patient's *current feelings* and internal images in the *current* situation. They *name* and *represent* the feelings with stones on the table stage or with chairs and hand puppets. First, they play them out *individually* and then let them interact *with each other*. Together, the patient and the therapist try to shape these interaction sequences into a holistic story with the process qualities of space, time, and logic using mental rehearsing with role reversal (see Fig. 2.5 in Sect. 2.3, Plassmann, 1999).

Case example 99

The 48-year-old, Ms. J., was experiencing chronic psychosis and retired early. She had been traumatized several times during her childhood, including being an unwanted child. At the beginning of each new phase of the illness, she developed paranoid delusions of grandeur (F25.0). Subsequently, she became severely depressed (F25.1). One day Ms. J. comes to the therapy session severely depressed. She reports: "I've only been at home for a fortnight. I just sit there and do nothing!" The patient finds it difficult to talk about herself and her feelings. The therapist feels a tenacious heaviness in the encounter. In coordination with Ms. J, he represents her feelings in the current situation with hand puppets and enacts the roles to some extent: the slightly worn-out hand puppet of a girl is sitting in the armchair as 'the depressive girl'. She wants to read a book but can't concentrate. She has a sack filled with "emptiness." The therapist introduces a fictitious, helpful doppelganger into the patient's play. It is a hand puppet of a little boy. The 'little boy' wants to play with the 'depressive girl' girl. However, the patient reacts with displeasure. She finds the little boy to be "annoying". The therapist lets him go away: "Okay, I can come back tomorrow and ask you to play with me!".

In the next session, the patient reports emotionally: "I haven't been depressed in the last week. I felt the fragility of my soul. That was very nice!" The therapist asks her: 'Buy yourself a hand puppet that looks like the 'depressive girl' here and put it on the table at home in plain sight!' The patient protests: "That is unreasonable! The feeling that arises in me is far too intense!" In the following session, the patient does not speak; she refuses. Finally, when asked, she says: "I'm angry. You don't take my feelings seriously." The therapist does not allow himself to be irritated: "You are not doing well. I'm trying to understand you." He chooses a hand puppet of a magician to represent himself and puts it on the table: "That's me as a therapist." He lets the "therapist" engage in a monologue: "I know, I still have to orientate myself; it's not that easy! I think I still have to learn. I hope Ms. J. will help me with this!" The therapist takes another puppet and turns to the patient: "That's you as the angry one." He also lets the 'angry one' engage in a monologue. In doing this,

he integrates Ms. J's earlier communications: "I feel like I'm in school here, dumb and stupid!" Ms. J. nods in confirmation.

In the following session, the patient says, "I haven't been scared for the last week. I no longer feel inferior; instead, I feel alone!" The therapist takes a different hand puppet 'for the lonely one'. This puppet is "a four-year-old child. The mother has gone away". Once again, the therapist invites a helpful doppelganger, a penguin hand puppet. The penguin wants to play with the lonely child. However, Ms. J. rejects the penguin again: "I want to be alone!" The therapist introduces another helpful doppelganger into the play, a "prince". Ms. J. turns him away too. However, rejecting the fictional helpers stabilizes the patient's self. She spontaneously talks about her work and plans at the Red Cross. The therapist takes the puppet of a princess: "I am the lively one. I want to experience the world!" The "lively one" wonders about "the girl who is alone". Ms. J. protests: "But I also want to be able to hibernate sometimes. Being alone is not bad! I feel safe when I am alone!".

In the following session, Ms. J. says: "I had a good week! I have now experienced 40% of my feelings instead of 10%." The therapist has the patient symbolize her current feelings with stones on the table: "the lively one who is sometimes even happy", "the anxious one who is afraid of everything new", the "depressive one", the "angry one," and "the lonely one". The therapist and the patient concretize these affective states as hand puppets and let them interact: the anxious and the lively ones talk to each other about the sad one etc. *It reveals that "the anxious one" represents the patient's healthy adult thinking and mediates between the other affective states. Ms. J.: "The lively one is much too bold. But I don't want to just sit there like the depressed one either!" The therapist plays the anxious hand puppet's role, says goodbye to the cheerful one, and turns to the sad one. Both sit there quietly for a long time. Ms. J. keeps crying a little during the "play". She is very touched. In the debriefing, she shares: "I have experienced a variety of emotional states in the last few weeks. At first, I was afraid to accept my mixed feelings. I didn't want to feel any of them." The therapist symbolizes the "fear" and the "mixed feelings" with small stones. He playfully places them next to the corresponding hand puppets, the "fear" next to the "anxious one," and the "mixed feelings" next to the "depressive one".*

In a joint review of the patient's experiences over the past few weeks, the patient and the therapist determined that the more time the "depressive" patient took, the lighter her feelings became. But the less time she had, the darker the feelings. Therapist: "I know it's hard for you to grasp your feelings. But our joint work has helped me to understand you better." Two weeks later, Ms. J. says: "Working with hand puppets was quite exhausting. But it also helped me feel relieved! I realized that I have feelings! I haven't felt too overwhelmed in the last few weeks. I've been more true to myself than I used to be."

The freely floating fragments of the patient's self thus develop relationships with one another, thereby strengthening the patient's sense of coherence.

In such a mentalization-oriented approach, the therapist, *as a doppelganger*, *verbalizes* the patient's *current feelings*, *names* them, and *represents* them externally with hand puppets on the table. The patient and therapist then have the hand puppets interact with each other. In this way, every emotion has a right to exist

with its unique identity in the interaction system. The self-fragments, which previously existed side by side without being connected, develop relationships with each other and with associated affect by naming, representing, interacting, and rehearsing with role reversal in the as-if mode of play. The patient creates cause and effect in a holistic story. In this way, puppetry stops the disintegration of the inner process of self-development. The internal systemic process of self-development becomes coherent. The new *relationships between* the different self-fragments coordinate the patient's inner conflict processing in the further course of therapy.

Case example 100 (*Krüger, 1997*, p. 44 f., slightly modified)

A 40-year-old female patient, Ms. K., repeatedly decompensated psychotically. Her individual psychotherapy involved the use of symbolic images and metaphors such as the 13-year-old boy "Peter", "Sleeping Beauty", the "Buddha Child," and the "Black Fairy". The patient repeatedly associated these figures with her bodily sensations. For instance, when she felt her spleen, she would say that "Sleeping Beauty had contacted her again." One day, Ms. K. happily surprised the therapist with the message: "The 13-year-old boy 'Peter' and the 'Buddha Child' have now integrated. I'm very happy." The therapist was pleased but unsure. He sensed that the "integration" she was referring to might just be a cognitive construction.

The therapist did not want to take away the patient's joy and confront her with his doubts. But he didn't want to pretend that he shared her opinion either. So he went transmodally into the patient's thought process in the equivalence mode. He asked her to "show and enact" the "path of integration" between her inner characters. He let her choose a puppet for each of her internal characters and produce a puppetry between them (continued below).

Puppetry in the therapy of patients with psychosis follows Straub's (1972) model of *therapeutic hand puppet play* developed in the therapy of children and the treatment of patients with obsessive–compulsive disorders. The patient selects a variety of hand puppets that interest her from a box. She plays with them individually at first. In this process, the therapist interviews each puppet. The patient and therapist then *verbally* connect the actions of each puppet into a logical story. The therapist makes sure that the story has a happy ending and thus becomes a coping story. The patient and therapist then enact the story together using hand puppets. The patient begins. When the therapist has learned enough about the actions and intentions of a puppet chosen and played out by the patient, he exchanges the puppet with the patient. He exaggerates the puppet's emotional expression in the play by about twenty percent when re-enacting. By reversing roles, the patient remains the author and director in the interaction space of her mental processes. In the reenactment of the story, the characters relate to each other and develop their own identities. The play should end as planned.

Case example 100 (continued)

Ms. K.'s hand puppet show was lively and unobtrusive. Her inner figures related to each other in the play and developed their own identities. The therapist actively

participated in the interacting and rehearsing with role reversal between the characters. Later he felt that he now better understood the patient's internal self-regulation. He was, therefore, surprised that Ms. K. suddenly said, deeply shaken, in the debriefing of the play: "I'm shocked at how fragmented my soul is." She later said that she had read that the principle of "integration" was healing in the therapy of psychoses. The effort of representing, interacting, and rehearsing with role reversal between her self-fragments in the as-if mode of play allowed the patient to experience her soul's 'fragmentation'. Her autonomous attempt at "integration" was just an associative cognitive construction.

Over the next six months, the patient worked through her inner identity conflicts in her everyday life with hand puppets. Then, one day, she surprised the therapist with the message: "I've made my decision: I'll give up trying to integrate everything." The therapist felt deeply touched. Ms. K. had recognized the true meaning of the word "integration". Six months later, the patient ended her therapy and no longer took any medication. She had not decompensated into psychosis again, even after five more years. She led an active, social life in her family and her workplace.

Central idea

Integration is the last step of mentalizing in conflict. Integration of the delusion with personal everyday conflicts requires successful naming, representing, interacting, and rehearsing in the delusion scene (see Sect. 2.2).

9.11 Moreno and Casson's Theoretical and Practical Insights

Moreno first described his disorder-specific psychodrama therapy for people with psychosis in 1939 and 1945. Many of his theoretical explanations are still valid. They only need to be translated into today's customary language: By acting playfully, the patient shall bodily and mentally experience the relationship images that are "outside spontaneous controls" in psychosis (Moreno, 1939, p. 5) (i.e., cannot be thought of in the as-if mode—ed. by the author). As early as 1945, Moreno spoke of an "imaginary reality" (Moreno, 1945a, p. 3 f.) created by the auxiliary world technique when the auto-tele (the relationship to oneself, ed. by the author) has dissolved: "In this imaginary reality on the psychodramatic stage, the patient finds a concrete setting in which all his hallucinatory and delusionary thoughts, feelings, and roles are valid … On the therapeutic stage … she finds a new 'reality' that was tailored just for her." By "being normal and 'as if' psychotic, at the same time, she develops spontaneous controls (the ability to consciously expand and thereby also control the delusional experience in the as-if mode of play, ed. by the author). The outside event becomes a part of herself" (Moreno, 1939, p. 13 f.). With this approach, the patient controls the process of her delusion: "She has found a tie to her existence." "Through the *performance of insanity,* she could return to herself and become the center of events" (Moreno, 1939, p. 25). Enacting the delusion produces "a higher frequency and a wider range of associations when compared to the course of her illness." It enables the

patient "to take action and activates her core conflicts physically and mentally. She thus senses all possible solutions more clearly and, of her own free will, seeks a new path that will lead her out of her impotent and perverse struggles […]. Psychodrama embraces the mind and the body […] and brings them to a new synthesis" (Moreno, 1939, p. 28 f.).

Moreno gained four important experiences in his practical approach to the psychotherapy of people with psychosis:

1. The patients should *act out* their delusions during therapy and *not just report* them. They should develop their *delusional scene* further and try to rewrite it as a coping story through interacting and rehearsing with the help of the therapist in the as-if mode of play. (see Sects. 9.5 and 9.8.8): "From the point of view of a fully integrated personality, the tele formations (the relational pictures, ed. by the author) existing *during the psychotic phase* have to be brought back into the common reality. […] In psychodrama, production is creation in its complete sense" (Moreno, 1939, p. 5ff.).
2. The external representing of and interacting in the auxiliary world is the basis for the patient's processing of his delusional conflict. It is necessary for the patients "as an anchor if their experiences are not to be permanently reduced to the level of false signals and symbols" (Moreno, 1945a, p. 4). According to Moreno (1945a, p. 6), patients do not require a *continuity* of "reality" in their psychodramatic auxiliary world created for them appropriately. "It appears to be sufficient if they are placed within this imaginary world at certain crucial times, to establish certain *points of coordination*" of the delusion to a corresponding reality.
3. The more acute the delusional disorder, the shorter must be the *time between* therapy sessions in which the auxiliary world technique is used (Moreno, 1945a, p. 5 f.). "The pauses between one psychodramatic session and the next must remain flexible and carefully coordinated with the patient's inner activities. In psychodramatic work, patients can just as easily be undertreated as overtreated."
4. The therapist must not be satisfied with the spontaneous remission of his patient's delusion. In Moreno's experience, people with psychosis try to remain free from symptoms by anxious adjustment. However, as long as "unintegrated elements persist in some manner near the individual or are scattered […] outside of the patient's *spontaneous controls*, similar occurrences can always trigger the patient and upset his balance" (Moreno, 1939, pp. 5 f.). Therefore, the therapist should go transmodally into past delusional experiences and work through them with the patient *even if he is not experiencing psychosis at the moment*.

In his first essay on therapy for psychosis in 1939, Moreno called his method "psychodramatic shock therapy". With "psychodramatic shock therapy," the patient can "gradually integrate the psychotic contents and gain control of the roles she played during the psychotic decompensation" (Moreno, 1939, p. 3). The therapeutic shocks, "which follow one another, prevent the patient from ridding herself of her psychosis prematurely. We artificially prolong the experience, thereby keeping the psychosis alive in her."

Central idea

Patients experiencing psychosis can split off unprocessed psychotic content or suppress it with medication, similar to how traumatized people deal with their flashbacks. But then the high-energetic psychotic images continue to smolder beneath the surface like the embers in a fire that has not been fully extinguished and are actualized by suitable triggers. That is why, when people with psychosis decompensate *again*, they produce the same delusions over and over. Similar to flashbacks in trauma therapy, the delusional content must be processed into a coping story so that it can *no longer* be triggered.

Over time, individual delusions are burned into memory like chronic nightmares (Spoormaker, 2008). If a patient once believed that he was "a chip" during psychosis, then he is also convinced of it in his next psychotic decompensation. Therefore, it is crucial that patients who *decompensate into psychosis for the first time,* gain ego control over their psychotic processes as quickly as possible in the as-if mode of play. Then the subsequent disorders that arise from the trauma of "going mad" and possible traumatizing psychiatric treatments do not have to be compensated for in therapy.

Casson (2004) has shown in a research paper that psychodrama is more successful and financially affordable for people with psychosis than conventional inpatient or drug treatment. He used a special type of psychodrama, called *drama therapy.* From 1996 to 2000, he treated forty-two psychotic patients in group and individual therapy. In doing so, he also communicated transmodally with his patients. He used hand puppets, masks, drums, dollhouses, tangram stones, buttons, ribbons, perfumes, make-up, babushka dolls, and animal figures to further develop the delusion content. He worked on a four-level glass table and used role-playing games.

Casson described his method in detail in two case examples from the individual setting: The therapy of a 40-year-old woman with psychosis comprised 156 sessions (Casson, 2004, p. 126 ff.), and that of a 34-year-old man only 44 sessions (Casson, 2004, p. 182 ff.). Both experienced severe psychosis and were symptom-free at the end of their therapy. Casson (2004, p. 139 f., 143, 190) also described how he dealt with the patients' severely destructive impulses and problems in the therapeutic relationship. According to Casson, the therapist and patient must go *through the heart of their delusion* together to succeed. Casson (2004, p. 187) experienced that auditory hallucinations often express feelings that the patient *cannot directly experience in the current situation.* People with psychosis have mostly had traumatic experiences. They would now have to learn to change themselves and their attitude toward their voices. They should try to interact with their own voices and guide them so that they are less threatening. According to Casson, patients can understand themselves better through this method, thereby reducing their serious relationship problems.

9.12 Group Psychotherapy for People with Psychosis

Psychodramatic group therapy for people with psychosis is usually oriented to *social psychiatry*. Patients should learn to *live with their psychosis* in the group. They must take enough medication to improve their psychological well-being. Inpatient stays should become unnecessary or shorter. Social and professional integration is encouraged. The relationship between the group members and the therapist is based on the traditional psychiatrical framework (see Sect. 9.2). The psychotic symptoms are viewed as a *deficit* and not understood as a paralogical expression of personality (see Sect. 9.4).

A disorder-specific approach according to the therapy model described in Sect. 9.8 with transmodal relationship design is *possible in the group* only in exceptional cases. In doing this, the therapist should proceed with tiny steps, according to the motto: "Less is more." Simply *representing* the delusion (see Sects. 9.8.4 and 9.8.8) can stop the current delusion production.

Case example 101 (*Matthias Ewald, 1997*, only orally communicated)
In a therapy group for people with psychosis at a day clinic, the therapist noticed that a patient was withdrawing. It was apparent that he was hearing voices again. The therapist addressed the patient. The patient confirmed the assumption that he had just heard voices. The therapist then had the patient line up all the voices in the room in front of him. There were five of them. His fellow group members took over the roles of the voices. Each of the auxiliary egos was assigned a typical sentence as a "voice". In their role as voices, the fellow members repeated their respective sentences to the patient. The therapist saw the patient's suffering and expressed compassion. This seemingly simple technique of representing and interacting with 'voices' resulted in the prompt disappearance of the protagonist's auditory hallucinations. His medication did not need to be increased. The patient did not decompensate again until six months later when he heard voices in the group again. The therapist wanted to proceed therapeutically in the same way as before. This time, however, the group members were unwilling to take on the role of the voices in embodying the patient's hallucinations in the group room. Therefore, the patient's medication was increased.

In this crisis intervention, the therapist let the group members *represent* the object images in the patient's delusion externally in the therapy room and *interact* with the patient as his 'voices'. This process liberated his tools of mentalizing from the maelstrom of disintegration of the inner systemic process of self-development and their emergency mode as mechanisms of dream work (see Sects. 9.3 and 9.6). This transformation of mentalization stabilized his process of self-development and stopped the disintegration of his internal self-development and current delusion production. Perhaps in the patient's second crisis, the psychotherapeutic work *with empty chairs* in individual therapy (see Sect. 9.8.8) would have been just as helpful as the voices played out by other group members.

Recommendation

In the group therapy of people experiencing psychosis or hearing voices, *the therapist himself* should not apply the doppelganger dialogue and enter the delusion transmodally because it confuses *the other group members* in their social-psychiatric learning goal of understanding their delusional experience *as an illness.*

The group members may become afraid of losing touch with reality and distance themselves from the protagonist's delusional reality: "That's very unlikely after all." Such feedback destroys the stabilization of the patient's inner process of self-development through transmodal therapy and *often intensifies* the protagonist's psychotic symptoms (see case example 84 in Sect. 9.5). Therefore, some therapists (Bender & Stadler, 2012, p. 85) proposed including only those patients with psychosis in the group "who are able to work in groups, form a psychotherapeutic working alliance, and are willing to get involved with the method of psychodrama". However, these *selection criteria* exclude many patients with psychosis from group therapy.

Central idea

In his sanatorium in Beacon, Moreno worked with patients with psychosis *only in individual settings* (Straub, 2010, p. 28). He certainly knew that the *transmodal relationship formation* in group therapy was difficult to sustain. In group psychotherapy *with patients experiencing psychosis*, psychodrama therapists should not try to do what Moreno himself wasn't able to do. They should not overwhelm *the group members or themselves.*

Some therapists simplify Psychodrama in group therapy and use it as a *pedagogical role play* (Arbeitskreis Pedagogical Role Play eV, APR, 1989). In doing so, they forego the central psychodrama techniques of doubling, mirroring, role reversal, and scene changes. But, they do *not* go transmodally into the patient's delusion. Instead, the group participants work on *current* conflicts with *protagonist-centered* plays without reversing roles. For example, they review their behavior in dealing with their superiors at work, with work colleagues, or with flatmates in their residential group and try to improve it.

The *social-psychiatry oriented psychodramatic group therapy* does *not* change the core *metacognitive* disorder of patients with psychosis. However, it promotes communication between group members and enhances their ability to play and their role flexibility. The therapist can, for example, proceed in a *topic-centered* manner. He can place a rope on the floor as a *"lifeline"* and ask the patients to "place symbols for the important events in their lives" along the rope. The beginning of the rope represents the patient's birth, and the end represents their current age. In this way, patients indicate the good times in their lives as well as the phases of illness. In another group session, they can each develop their *personal emergency plan* (see Sect. 9.8.6). They write down the plan, put it in their wallet, and try to use it when needed. In the *"doctor's visit" exercise* (Moreno, 1945a, p. 9), the therapist asks a patient to play the role of her own doctor. The patient should inform the therapist about the course of her illness *from the role of the doctor*. She describes her current condition from a meta-perspective and, as a "professional", makes recommendations for her own therapy. The group participants share and empathize with the others during the *topic-centered group work*. They recognize themselves in the other as in a mirror and, in doing so, learn to understand themselves and others better.

Improv games are also helpful in group therapy. The therapist lets the group participants formulate a common group theme and translate this into a symbolic image. The participants then enact the theme with distributed roles as a group play. For example, the statement "I am listless in my free time" is converted into the symbolic image of "the family is sitting at the breakfast table on Sunday morning and thinking about what they could do". The therapist encourages the group members to find a role in this picture and act it out: "Who will play the father? Who will play the mother? Who would like to play one of the children?" The participants can enjoy the listlessness in the symbol play. Or they develop unconventional wishes. Taking *on the roles of other people* in improv games makes it easier for the patients to establish relationships with their fellow patients, to set themselves apart, or to argue*, all while being in the safety of these fictitious roles.*

The therapist is generally more active in the group therapy of patients with psychosis than in the treatment of people suffering from neurosis. He structures the group sessions more firmly. He also evaluates imperfect solutions as solutions. Patients with psychosis are more clumsy in group work than those with neurosis. However, group therapy still has therapeutic effects. In a scientific study, Bender et al. (1991) demonstrated that patients with psychosis in psychodramatic group psychotherapy achieved significantly better therapeutic results than patients who only visited leisure clubs for mentally ill people.

Recommendation

Resolving a relational conflict with an important attachment figure using psychodramatic dialogue with role reversal is *contraindicated* in group therapy. This is because an open conflict with an important attachment figure may actualize the patient's self and trigger an inner pathologic introject or old trauma experiences (see case example 31 in Sect. 4.14). Clarifying the relationship can thus lead to psychotic decompensation. *A spontaneously occurring open* conflict *with a close reference person in everyday life* is often an indication of the beginning of a new psychotic decompensation in the case of patients with psychosis.

Garde et al. (1987) have developed a unique psychodrama format for *work in an acute psychiatric ward* called the *"fairytale drama"*. Siebel (1998, verbal communication) used this group method successfully for fifteen years in the acute psychiatric ward of the Medical University of Lübeck. She described the steps of the procedure as follows: A "fairy tale group" takes place on the ward once a week. All patients *and therapists* on the ward take part. They come up with a fairytale together. A therapist begins. Another therapist goes from one group member to the next with a tape recorder and records what is said. In this way, the group develops *a continuous* story. *Everyone* contributes a part to the story. The group takes a short break when the story is finished and recorded on tape. Two or three group members and two therapists summarize the story as "dramatic advisors". They determine which roles appear in the fairy tale. Then the group gets back together. The "dramatic advisors" narrate the story again in summary. They name the roles and ask the group members to choose one of the roles for the fairy tale play. The patients and therapists then act out the fairy tale *together* from start to finish. Ute Siebel said that as a ward doctor, "she once played Gretel, a highly psychotic patient played Hansel, and the ward nurse played

the wolf". As Hansel, the patient protected her, "Gretel", the ward doctor, from the "big bad wolf", the ward nurse.

Inpatient fairytale drama can help expand, structure, and coordinate the inner images of relationships between the patients and therapists on a ward. In the fairytale play, the participants experience each other differently. New *shared* inner relationships emerge in which good triumphs over evil. The development of mutually complex inner relationships impacts everyday life in the acute care unit. Thus, it can be assumed that a fairy tale drama group reduces drug treatment costs in an acute psychiatric ward.

Conclusion

Interested psychotherapists should each treat at least one or two patients experiencing psychosis in long-term therapy. This allows them to practice and stabilize *their own ability* to reverse logic. They get to know the heart of psychosis therapy, which is the development of the self, and absorb this knowledge into their intuition. The systemic process of self-development is *also* the basis *for* the therapy of other mental disorders.

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