

© **Free Display Copy – for personal use only**

ANY DISTRIBUTION OF THIS ARTICLE WITHOUT WRITTEN CONSENT FROM S. KARGER GmbH, FREIBURG, IS A VIOLATION OF THE COPYRIGHT.

Written Permission to distribute the PDF will be granted against payment of a permission fee, which is based on the number of accesses required.

Please contact e.zimmermann@karger.de

Phantasy Therapy in Psychiatry: Rediscovering Reality in Phantasy

A Special Treatment for In- and Outpatients in General Psychiatry

G.B. Schmid R. Eisenhut A. Rausch K. Ito S. Dämpfle K. Frei

General Psychiatry ipw, Integrated Psychiatry Winterthur

Key Words

Fairy tales · Phantasy · Group therapy · Psychiatry · Psychosis therapy · Psychotherapy · Schizophrenia

Summary

Phantasy Therapy is an interdisciplinary depth-psychologically oriented group therapy form with focus on the treatment of psychoses in acute and remission phases. A different theme is presented to the patients every week on two consecutive days (90 min per session), coherently, via various sensory channels. On the first day, the theme is concretely and operationally introduced by means of an object, transformed into movement in the broadest sense of the word, and experienced directly with the body. The first session ends with a story, usually a fairy tale or parable, so that the body experiences can be further realized symbolically at the cognitive-emotional level. The second session treats the same theme via repetition of the chosen story with the deeper transformation of symbols into color and form. The first day is jointly led by a psychotherapist and a movement/dance therapist, the second day by a psychotherapist and an art therapist. Our approach understands therapy as a somatesthetic experience- and synesthetic expression-oriented encounter with the patient via the therapist's empathic imaginative identification with the patient by means of a progressively orchestrated, positivizing, cognitive-emotional, theme-centered rapport. In this connection six therapeutic elements are of importance: theme, object, movement, fairy tale, artwork, symbol. Phantasy Therapy offers the patient creative freedom in a humorous and playful way within a certain therapeutic security (Amae principle) and contradicts several classical prejudices concerning the treatment of psychotic patients.

Schlüsselwörter

Märchen · Phantasie · Gruppentherapie · Psychiatrie · Psychosentherapie · Psychotherapie · Schizophrenie

Zusammenfassung

Die Phantasietherapie ist eine interdisziplinäre, tiefenpsychologisch orientierte Gruppentherapieform mit Fokus auf der Behandlung von Psychosen in der Akut- und Remissionsphase. Den Patienten und Patientinnen wird jede Woche an zwei aufeinander folgenden Tagen ein neues Thema vorgestellt, das von ihnen kohärent über die verschiedenen Sinneskanäle aufgenommen wird (90 min pro Sitzung). Am ersten Tag wird das Thema anhand eines Objektes konkretisiert und anschliessend in Bewegung im weitesten Sinne umgesetzt und mit dem eigenen Körper erfahren. Schliesslich wird eine Geschichte vorgelesen, meistens ein Märchen oder eine Parabel, und das Erlebte symbolisch auf der kognitiv-emotionalen Ebene durchlebt. Am zweiten Tag wird dasselbe Thema durch Wiederholung der Geschichte wieder aufgegriffen und durch die gestalterische Umsetzung in Form und Farbe vertieft. Der erste Tag wird gemeinsam von einer Psycho- und einer Bewegungs-/TanztherapeutIn geleitet, der zweite Tag von einer Psycho- und einer KunsttherapeutIn. Unsere Methode versteht Therapie als eine somatästhetische erfahrungs- und synästhetische ausdrucksorientierte Begegnung mit dem Patienten durch die imaginative Identifikation des Therapeuten mit dem Patienten anhand eines progressiv orchestrierten, positivierenden, kognitiv-emotionalen und themenzentrierten Rappports. Hierbei kommen sechs therapeutische Elemente ins Spiel: Thema, Objekt, Bewegung, Märchen, gestalterische Tätigkeit, Symbol. Phantasietherapie bietet den Patienten auf eine humorvolle und spielerische Art und Weise schöpferische Freiheit innerhalb einer gewissen therapeutischen Geborgenheit (Amae-Prinzip). Darüber hinaus stellt sie einige klassische Vorbehalte gegenüber gewissen Behandlungsweisen von psychotischen Menschen in Frage.

Introduction

Entire treatises [29, 30, 67] and scholarly essays [13, 15, pp 341–353] have been devoted to the significance of Phantasy in human experience. Not only the distinction of normal Phantasy from daydreams, dreams and reality [3, 19, 31, 36, 47, 52, 72, 75] but also pathological Phantasy [1, 20] and proneness to Phantasy [17, 48, 49] have continued to interest the research community.

On the one hand, ‘too much’ Phantasy has since long been negatively associated with the confusion of reason, that is, with the workings of the psychotic [40, 56, 57], neurotic [39] or otherwise disturbed [38, 45] mind. The delusions of persons suffering from psychosis seem to be directly related to the usual kinds of daydream fantasies that these patients entertain in their normal, everyday lives [12, 62]. Indeed, it has been argued by some researchers that games of Phantasy and role playing can even have a negative impact on the milieu of a stationary psychiatric ward, at least with adolescents [4].

On the other hand, having ‘too little’ Phantasy is also apparently associated with mental problems [7, 51, 64] lending some support for an imagery deficit model for certain persons suffering from schizophrenia [60, 61].

That the power of imagination can even lead to death [55], but can just as well heal [37, 59], has also been well-established in the literature. Indeed, the knowledge that ‘Above all, Phantasy binds our various senses together ...’ [15, p 199] is important for the realization of Phantasy as a clinical therapy. For example, from the standpoint of ego psychology, fantasies are necessary for the construction of psychic structures [24].

Recently, the idea of Phantasy as a useful tool for improving mental health has gained increasing attention: active imagination [54], catathymic image experience [23], guided affective imagery [28, 34], hypnosis [66, 73] or narrative imagery [25, 46], to mention just a few applications of Phantasy in clinical practice.

In general, creativity and induced imagination are proven, valuable tools for assessing [21, 71] and modifying [16, 35] consciousness [see also 41, 63] and for clinically treating people with mental problems [32, 41, 69, 70]. Here we might mention psychodrama, e.g., as a well-known application of Phantasy in the group therapy of psychiatric patients [9, 10]. Nevertheless, the literature shows most proven applications of Phantasy to take place in an individual setting and without simultaneous interplay between several different creative activities such as drawing/painting, movement/dance and playing music. Applications in group therapy involving several different creative disciplines at once are less widespread and, until now, seem to have been mostly represented by the school of Gaetano Benedetti and his coworker, Maurizio Peciccia [6, 44].

Phantasy Therapy is a form of group therapy for psychotic patients which was independently developed but, nevertheless,

shares the spirit of Prof. Benedetti’s and Dr. Peciccia’s Progressive Mirror Drawing Therapy for individuals and groups [6, 43]. Before we explain the details of Phantasy Therapy, we would like to explain what we understand under the concept of ‘Phantasy’ for the purpose of this work.

What Is Phantasy?

The Freudian school of thought postulates that unconscious Phantasy represents the conflicts, drives and wishes underlying human experiences, in particular those related to sexuality, birth, intrauterine existence, primal scene, castration and seduction and that these may be transformed into works of art through any kinds of artistic means [65]. Insofar as Phantasies are necessary for the formation of mental structures [e.g. 24], they can be understood as providing the very source of psychic life. From this point of view, the work of art is the integration of unconscious derivatives which are given artistic form [8] and, even in the case of psychiatric patients, is not necessarily regressive in nature [74]. Indeed, ego psychology sees even the most chthonic, unconscious Phantasies to be the consequence of active processing of experiences. Furthermore, insofar as ‘The ego is above all a body ego’ [14, p 255], ‘Phantasy’, i.e., normal Phantasy, can be understood to be the idealization of the body [27, 58].

Looking much further back into time, the Gnostic philosophers were perhaps the first universal scholars who tried to gain a differentiated understanding of Phantasy. Loosely speaking, one can update and summarize their mythopoetical body of knowledge with a hierarchy of four levels which, from the standpoint of modern psychology, can be thought of as four interrelated, extraordinary states of consciousness. At the ‘lowest’ level we find the state of *delusion or psychosis*, which, according to Christian and Islamic dogma, is a possession phenomenon ruled by the devil. Modern psychiatry identifies here several different pathological phenomena such as the hearing of voices. At the next ‘higher’ level we find the usual *daydreams or night dreams including nightmares*; they are all born of human fears and wishes, the stuff of which our neuroses are made. One step further we find the intermediate level of *imagination*, where images embody metaphysical ideas and envisage physical bodies. This is, for example, the spiritual realm of Christian and Islamic prayer and of Eastern meditation. This concept of imagination is the psychological realm of active imagination, of hypnosis etc. Finally, at the fourth and ‘highest’ mythopoetical level, we have the *inspiration* which, according to the Bible and the Koran, stems directly from the angels or from the godhead itself. This is the psychological realm of anticipation, divination, prophecy, vision etc.

In this work we don’t want to adhere to any special school of depth psychology or mysticism to understand the concept of Phantasy but, rather, choose to simply begin with an everyday idea about it, like the one you get from an ordinary lexicon: From this point of view, Phantasy can be creativity, imagina-

tion, ingenuity, inventiveness, originality, playfulness, resourcefulness, vision etc., in the common sense of these words [33, 42, 68, pp 173–176].

The most important implication of these simple definitions to our work is the following thought: Optimistically speaking, a cathartic, reality-based Phantasy could lead at best to an inspiring EUREKA! or AHA! effect with the fantasist. Being somewhat more modest in the actual demands on our method, we can make the following statement: Phantasy Therapy aims at an !AYA! effect, i.e., at a coherent, self-enhancing, positivising mental effect via a spontaneously induced, context- and reality-related insight in the sense of: 'Ah, yeah, now I get it!' *We understand Phantasy as that power of imagination which can progressively lead a mentally disturbed person, above all someone suffering from psychosis, to a more positive, coherent and reality-based, insightful relationship to the world in the sense of this !AYA! effect.*

Objective

The symptoms and behaviors usually accompanying the mental disorders leading to psychiatric hospitalization generally make it difficult to treat recently admitted patients: aggression, autism/mutism, distrust, negativism, restlessness etc. Accordingly, many persons in stationary psychiatric care, especially those suffering from psychosis, can be only conditionally treated by the usual creative, movement/dance or narrative methods during their first week after arrival. In addition to dealing with this difficulty inherent to the typical clinical picture, our method must be useful to a public clinic with an open policy of obligatory and often forced admittance, in particular with no patient selection. These practical conditions confront therapists with patients who also display numerous other barriers to compliance. Therefore we have developed our Phantasy Therapy from the very beginning with the following requirements in mind:

- (0) Suitable for the majority of patients under the difficult conditions of a public psychiatric clinic, namely,
 - (a) no refusal or selection of patients possible
 - (b) wide range of ages (about 18 – 60) for both sexes
 - (c) roughly 50% forced admissions
 - (d) short inpatient hospitalizations (on average 3 weeks)
- (1) Effectiveness already possible with only one session (!AYA! effect)
- (2) Suitable for a broad spectrum of disturbances, in particular acute psychosis.
- (3) Suitable for patients in very 'bad' states (autistic/mutistic, excited, strongly medicated or otherwise 'difficult')
- (4) Treatment of large groups (up to approximately 18, at most 22 patients with 3 therapists). One could argue that any group larger than approximately 10 persons can no longer be regarded to fulfill the clinical requirements of a *therapy* or that at least the term 'therapy' is questionable

under such conditions. We nevertheless hope to negate such claims with the approach to psychosis therapy presented here.

- (5) Motivation of negativistic patients via support of the group identity (= 'group ego')
- (6) Control of highly excited, disorganized patients via the ritualized, structured support of the 'group ego'
- (7) Openness to patient visitors and other interested members of a multidisciplinary team (e.g. medical doctors, nurses, therapists or practicants, and also for patients as visitors who initially don't want to participate.)
- (8) Therapy time of only 2 × 90 min.

An empirical, descriptive statistical evaluation of 226 patients during 63 treatment sessions (Day 1 only) during the 66 weeks between March 14, 1995 and June 30, 1996 demonstrated that our therapeutic concept successfully fulfills these practical requirements. Our experience since the end of July 1996 with the 2-day program (table 1) shows that acceptance of Day 2 tends to be even slightly higher than that of Day 1. Regular quality assessment of our therapy from August 1996 to date continues to support this initial success.

Quality Assurance

The requirements under which Phantasy Therapy has been developed and empirically optimized show that our approach is

- practical:
 - Suitable for all diagnostic groups with patients of both sexes and all ages, in particular for negativistic, aggressive or psychotic patients under the difficult conditions of a public psychiatric clinic including nonselective and forced admissions. We have even been able to successfully include patients in wheelchairs or in bed(!) during therapy.
- therapeutically effective:
 - !AYA! effect possible in only 1 or 2 90-min sessions.
- cost-effective:

18 patients – 1.5 h/3 therapists = 9 patient-hours per therapist. Accordingly, Phantasy Therapy fulfills the 3 major quality assurance criteria of the Swiss National Health Office (Schweizer Bundesamt für Gesundheitwesen): It is practical, effective and economical.

In addition, the fact that our approach is open for visitors, whether patient or therapist, shows that our therapy form is also robust.

Method

Our method was developed with certain requirements in mind. First of all, it should fulfill all the above-mentioned practical requirements of a public clinic with an obligatory admission policy and a high percentage of forced admissions. Secondly, it should successfully combine verbal psychotherapy with several different nonverbal methods in order to provide the psychotic

patient as well as possible with an integrative, many-channeled sensory experience (balancing, hearing, seeing, smelling, tasting, touching) and also enable the patient to express himself integrationally via sensory-cognitive-emotional-intuitive channels (somatesthetic experience- and synesthetic expression-oriented psychotherapy). Finally, it should be capable of building up a group identity (not the same as point 4 under 'Objective').

Depth-psychological verbal therapy can be meaningfully combined with nonverbal methods [2]. This is well-known from child therapy which successfully integrates multifarious play methods simultaneously with verbalization and dialog. Nevertheless, the usual treatment approach in a clinic with a complex palette of adult therapies is less integrative and more sequential in nature: Generally, the focus is first placed upon nonverbal therapies like art therapy and movement/dance therapy; only later, as the patient's condition stabilizes, are verbal psychotherapies brought into play. Such a 'domino approach' doesn't adequately match the actual synesthetic, sensual-cognitive-emotional-intuitive therapeutic requirements optimally suitable for the treatment of the mind-brain in a psychotic state. The therapeutic method which we call Phantasy Therapy was developed with these requirements in mind.

Although it is not unusual for art, movement/dance, music therapists and psychotherapists to lead group sessions involving several psychotic persons, that is, to work with psychotic patients in a group setting, it is quite another thing to involve psychotic patients in a therapy session whereby the group encounter itself plays a central role. Accordingly, the development of a group therapy for persons suffering from psychosis with the ambition of constructing a group identity or group ego during each session, i.e., a feeling of 'us', presented an especially difficult challenge for us. To get an idea of how unusual and novel such an approach is, we mention that out of the roughly 290 contributions to the '13th International Symposium for the Psychological Treatment of Schizophrenia and other Psychoses' in Stavanger, Norway, June 5-8, 2000, only about 35 contributions were more or less related to the treatment of psychotic patients in an overall group setting and only perhaps 4 of these were actually concerned with building up a group ego during the session ($4/290 = 1.4\%$) [26]: 'My doing something in a group with others' is not the same thing as 'Our group doing something together'.

What Is Phantasy Therapy?

Phantasy Therapy is an interdisciplinary, depth-psychologically oriented therapy form integrating elements of art-, hypno-, movement/dance- and psychotherapy with focus on the treatment of psychoses in the acute and remission phases. It was developed at the Clinic Rheinau/Switzerland over an intense period of 1 1/2 years (1995-1997) as a cooperative effort between several therapists from unrelated professions under detailed consideration of patient feedback.

This approach encompasses at the *perceptual-apperceptual symbolic level* various different domains of first-person experience and expression by which sensory- and self-awareness are progressively orchestrated, positivized and expanded. The approach is in several ways diametrically opposed to certain classical prejudices regarding the treatment of persons suffering from psychotic disorders.

Patients are offered a new theme weekly on two consecutive days in the form of two 90-minute sessions. This theme is presented to and experienced by patients coherently via virtually all sensory channels, that is, somatesthetically, in a structured, ritualized manner with focus on the progressive positivization of the patients' expressions (table 1). The latter are given multifarious esthetic outlets such as color, form, movement, music and word, simultaneously via virtually all artistic media, that is, synesthetically.

Realization of the Method

Three professionals are generally involved in the realization of Phantasy Therapy: Day 1 is lead by a psychotherapist together with a movement/dance therapist. Day 2 is lead by a psychotherapist together with an art therapist. Usually, one therapist in training also serves in the background on both days.

Three therapeutic elements work to lead the psychotic patients out of their 'spiritual wasteland' ('Todeslandschaft der Seele', [5]) while, at the same time, they protect the patients from their fear of fusion while experiencing a feeling of closeness in the group:

(1) *Theme*: Experience has shown that intellectually abstract themes, e.g. mirroring, are more suitable for acute inpatients, whereas more concrete themes, e.g. vanity, gain better acceptance by remitting outpatients.

(2) *Object*: The respective transitional object mediates the theme between patient and therapist. This object is often quite complex and not very easy to manipulate, e.g. a gyroscope (for the theme 'Twisting/Rolling').

(3) *Fairy tale*: Probably because of their chthonic archetypal nature, fairy tales seem to find more favor with acute inpatients [50] and, due to their evident relevance to everyday life, parables [46] seem to be better received by remitting outpatients.

A different *theme-object-fairy-tale triad* is chosen each week from a clinically proven sequence of triads leading to a cycle which repeats itself approximately every 4 months. Our inpatient program includes the following themes:

Chaos = » Mirroring = » Balancing = » Opening/Closing = » Nearness/Distance = » Labyrinth = » ambivalence = » Polarity = » Twisting/Rolling = » Transformation = » Sensing (hearing/listening, looking/seeing, touching/sensing) = » Dialogue = » Harmony = » Music (with emphasis upon rhythm, melody and dance) = » Active Imagination = » Passive Activity.

= » Chaos = » Mirroring = » etc.

Other empirically proven outpatient theme sequences are, e.g.:

Dreams = » Reality Testing = » Illusions = » Honesty = » ...

Juggling = » Acrobatics = » Mimicry = » Theater = » ...

Trust = » Suspicion = » Humor = » Sadness = » ...

The examples can be easily extended or modified.

An additional set of three therapeutic elements, namely *movement*, *artwork* and *symbol*, are intrinsically defined by any given theme-object-fairy-tale triad.

Conclusions

Our approach understands therapy as a somatesthetic experience- and synesthetic expression-oriented encounter with the patient via the therapist's empathic imaginative identification with the patient (as opposed to psychoanalysis which is more characterized by encountering the patient through guided introspection) by means of a progressively orchestrated, positivizing, cognitive-emotional thematic rapport. In this connection the above-mentioned 6 therapeutic elements are of importance. Phantasy Therapy offers the patient creative freedom in a humorous and playful way within a certain therapeutic security (Amae principle, [11]).

Human understanding for the person suffering from psychosis is, in our method and within a somato-synesthetic setting, as important as the explanation and even the analysis of the disorder or of its psychogenesis. Indeed, the empathic-identificatory and progressively positivizing rapport with the psychotic person is already therapy.

As opposed to analytical therapeutic work with neurotic patients, which is basically anti-identificational and regressive in nature, guiding the patients from the here-and-now world of collective reality into the magical mythopoetical world of their own subjective unconscious, psychosis therapy is basically *identificational and antiregressive*, empathically finding the person in the magical, mythopoetical depths of the collective unconscious and leading him back into the here-and-now world of collective reality. It is important to mention that a certain amount of regression is often necessary in the psychotherapy of psychotic patients in order to meet up with them on common grounds at the very basis/origin of their disturbance in the 'wasteland' of their unconscious. Antiregressive is the work ultimately 'leading them back' to collective reality. Whereas neurosis therapy focuses on the *self-understanding* of the patient, psychosis therapy focuses on the patient's *self-experience* and *self-expression*.

Phantasy Therapy, like most other forms of depth-psychologically oriented psychosis therapies, has an especially close relationship to the modern

Table 1. Summary of the two sequential sessions

Duration, min	Day 1	Day 2
20	<ul style="list-style-type: none"> – A new theme is introduced by the psychotherapist and cognitive-emotionally discussed in the group. – A corresponding object, concrete-operationally representative of the theme, is presented by the psychotherapist and passed around in the group allowing the patient firsthand auditory-tactile-visual and sensory-motor confrontation with the theme. 	<ul style="list-style-type: none"> – The course of Day 1 is summarized by the psychotherapist. The experiences of the patients relevant to the theme are cognitive-emotionally discussed. – The fairy tale is read by the patients in tandem providing them with a coherent auditive-cognitive experience under supervision of the psychotherapist. The patients are asked to volunteer and share their thoughts and feelings about the fairy tale pictures and symbols.
50	<ul style="list-style-type: none"> – The theme is kinesthetically transformed under supervision of the movement/dance therapist into corresponding movement exercises at 3 sequential levels of experience: the experience of myself in the circle of others, of you in the partner exercise and of us in the group. 	<ul style="list-style-type: none"> – The theme is synesthetically transformed into color and form under supervision of the art therapist and the fairy tale scenes are represented by pictures and symbols ('Gestalt').
20	<ul style="list-style-type: none"> – A fairy tale, symbolically related to the theme and object, is read to the group as a coherent auditive-cognitive experience by the psychotherapist. The patients thereupon volunteer and share their impressions as to which pictures and symbols have had the strongest emotional impact on them; their comments are progressively positivized in the discussion. 	<p>The patients' graphic creations are not elaborated with individual patients. Spontaneously arising discussions between patients and therapists focus upon the coherent progressive positivization of the self-symbolic content.</p>

Suggested time order in the presentation of 6 therapeutic elements on 2 sequential days:

Day 1: theme > object > movement > fairy tale (read to the group by the therapist).

Day 2: theme > fairy tale (read in tandem by the patients themselves) > artwork > symbol.

Phantasy Therapy has a fixed structure with a ritualized course of presentation:

- The direction of the group in a circle during the respective introduction of theme, object, movement, fairy tale, artwork and symbol has proven to be very important for support of the group ego.
- The following 'I-You-We' temporal order (= progressive orchestration) has also proven very effective and has become standard in the course of therapy:

- (1) Encounter with myself in movement within the circle of others (I-experience)
- (2) Encounter with my partner in synchronized partner exercises (You-experience)
- (3) Concluding collective-movement exercises in our group (We-experience).

hypnotherapy of psychotic persons. This therapy allows a metaphoric comparison to the ancient tradition of shamanism:

The 'healer' – i.e. the therapist – puts himself into an 'ecstatic healing trance' ('Counter Trance') enabling him to 'travel directly into' – i.e. identifiably empathize with – the 'fantastic and supernatural' – i.e. subjective – world of his patient in order to meet up there with the patient's soul ('pacing') and ultimately 'bring it back' – i.e. antiregressively positivize it – into the 'healthy' – i.e. coherently, cognitive-emotionally balanced – realm of collective reality ('leading').

Another modern, scientific transformation of this shamanistic tradition within the context of psychoanalytical reflection is Gaetano Benedetti's multistep, therapeutic process of visio-motor graphic drawing, involving symbolic creation, symmetrisation, imaginative forming and progressively positive, symbolic reconstitution [5]. As already mentioned above, this process has been further developed by his colleague Maurizio Peciccia into their method of Progressive Mirror Drawing, which is closely related to our Phantasy Therapy.

Clinical Indications and Contraindications of Phantasy Therapy

Phantasy Therapy is especially suitable for agitated patients with acute psychotic disturbances.

To date we have found no clinical contraindications. It has turned out, however, that patients suffering from substance abuse generally tend to

find this playful form of therapy too 'childish', i.e., they generally have a strong unconscious resistance to partake of the group identity.

Phantasy Therapy in the Day Clinic

We have also successfully implemented Phantasy Therapy in our day clinic. Because these patients have greater cognitive-emotional abilities than stationary patients, we have been able to somewhat intensify the basis program: less abstract, more concrete, day-to-day themes; more complex treatment of objects; longer, more intense discussions of themes; more difficult movement exercises; longer, more complicated texts (essays, fairy tales, literary anecdotes, parables etc.); longer, more intense discussions of the symbolic content of the texts with more emphasis on personal emotional impact and commitment.

To date the practicality, effectiveness, economy and robustness of Phantasy Therapy is similar in both ambulatory and stationary settings.

Demands on Phantasy Therapists

In general, Phantasy Therapists should share a broad, empathic-identificatory understanding of – i.e. a good human feeling for – psychotic persons. To this end, it is helpful for them to have had sufficient professional experience with acute psychotic patients in order to already have developed a personal practiced routine in patient rapport. Personality characteristics like openness, genuineness, concern and humor help Phantasy Therapists support a cognitively transparent and emotionally warm and playful communication with a minimum of transference effects clouding the issue. It is important that Phantasy Therapists be capable of anticipatorily understanding their patients allowing them to enter together with their patients into a shared mental state of mutual feeling and respect ('Counter-Trance') without losing their own identity and therapeutic relation to the central theme of the therapy session at hand ('professionalism').

Phantasy Therapists should, in the sense of the individual 'pacing' known from hypnotherapy, be in the position to objectively judge the psychopathological symptoms as well as the emotional sensibilities and psychological vulnerabilities of each and every patient during a relatively short time (2 × 1.5 h), e.g., patients' delusions and formal thought disturbances etc., their feelings of well- or of unwell-being, or patients' resources and weaknesses etc. Furthermore, Phantasy Therapists should be well able to 'tune into' or 'contain' the countertransferences induced in them by the patients' pathologies and to 'digest', within their own psyche, the uncomfortable feelings induced by these countertransferences. This can help Phantasy Therapists to be better capable of guiding patients through the exercises in the sense of the individual 'leading' known from hypnotherapy.

Phantasy Therapists should also be able to quickly estimate the mental state of the group as a whole in the hypnotherapeutic sense of 'group pacing' – again, using their countertransferences as a 'barometer' of the patients' emotional situation – and be able to spontaneously react adequately in order to guide the group ('group leading') along the given thematic path set out upon at the beginning of the session. Finally, the interdisciplinary communication and team ability of the different individual therapists involved in each session cannot be overlooked.

Theoretical Basis of Phantasy Therapy

In principle at least, one is free to decide at what level one might attempt to understand and treat psychosis:

- at the spiritual level (shamanism/spiritual healing)
- at the linguistic-analytical level (psychotherapy)
- at the perceptual-apperceptual-symbolic level (Phantasy Therapy / Progressive Mirror Drawing or hypnotherapy)
- at the bioneurological level (biochemotherapy).

Our therapeutic approach encompasses at the *perceptual-apperceptual-symbolic level* various different domains of first-person experience and expression, by which sensory- and self-awareness should be progressively orchestrated, positivized and expanded:

- body perception/apperception, e.g., sensory, psychomotoric, artistic transformation of verbal content etc.
- self- or cognitive-emotional/magical-mythopoetical symbolic perception/apperception, e.g., cognitive-affective expression, psychological symbolic self-expression etc.
- social perception/apperception, e.g., nearness/distance, symbiosis/separation etc.

Our therapeutic approach bases on a theoretical empirically-founded hypothesis of psychosis.

Evidence-Based Psychosis Hypothesis

One of the authors of this article (GBS) has suggested that psychosis is a consequence of a disturbance in the nonlinear information processing ('hand-shaking') between various cell ensembles in the mind-brain. This results in pathologies of associated coherence and synchronization, also called 'binding' or 'connectivity' in the mind-brain: Afferent and efferent signals, in particular those corresponding to the usual sensory and apperceptual channels, become confusingly disorganized [53, 54].

Starting out from this hypothesis, what we recognize to be the patient's psychopathology is actually their coping behavior in a desperate attempt to make sense out of their sensorial-cognitive-emotional-intuitive deficits. What we don't know, however, is whether the associated disturbance in the information processing is located essentially in the human 'hardware' (brain anatomy) or 'software' (mind set).

Corresponding Psychosis Therapy

According to this hypothesis, a form of psychosis therapy is needed which

- (1) neuro-psychologically induces and supports the orchestration of different sensory-awareness channels by progressively stimulating, simultaneously, several sensory inputs and by synergetically bundling ('binding' or 'connecting') them into meaningful somatesthetic images ('Gestalt', 'qualia');
- (2) depth-psychologically increases the patient's feeling of understanding himself and of being understood by others (!AYA! effect) via the therapist's empathic-identificatory communication and progressive synesthetic orchestration and positivization of the often distorted and destructive images expressed from within the patient's mythopoetical world of imagination.

Such a somatesthetic therapy of neural synchrony and coherence, on the one hand, and of empathic identification with and progressive, synesthetic orchestration and positivation of the patient's inner mythology, on the other hand, helps the patient suffering from psychosis gradually relearn a collective context-related understanding of his sensory inputs and apperceptions by practical experience and self-expression in the therapeutic setting. He is enabled to gradually build up his own symbol of Self and, consequently, to balance the otherwise ambivalent, uncontrolled psychological switching between symbiosis and separation from the outer world, so characteristic of psychosis [5]).

Thus, and in contrast to spiritual, analytical or biochemical approaches, this form of therapy is not goal- or learning-oriented but, rather, experiential and expressive ('!AYA!') in nature.

Therapeutically Effective Factors

In our opinion, the neuropsychological therapeutic effect of Phantasy Therapy lies in the progressively repeated, simultaneously and coherently channeled activation of different and separate areas of the brain, thus inducing the context-related orchestration (so-called binding or connectivity) of the many different subjective and 'Gestalt'-forming sensory impressions (so-called qualia) neurologically correlated to these areas and providing the patient with an overall somatesthetic experience.

Essential for the depth-psychological therapeutic effect of the guided, positivizing, subjective 'Gestalt'-forming is an integratively channeled imagination which is progressively stimulated, supported and focused by the respective therapeutic exercises, encouraging and enabling the patient to express himself synesthetically.

In nonpsychotic individuals, the processes of imagination and action are in continuous, cyclic interaction with one another.

An accomplished artist, for example, commonly begins his painting process by imagining something in his mind; the further development of this idea/image depends, amongst other things, on the results gradually taking form on the canvas in front of him during the actual physical process of painting and which are continuously being fed back into the results of the previous steps ('feedback looping'): Via the nonlinear recursivity of this process [54] of planning and doing, the nonpsychotic artist is both doer and observer at the same time.

In psychotic individuals, the continuous, cyclic interaction between the processes of imagination and action typical of the nonpsychotic person is cut through. In marked contrast to the above-mentioned accomplished artist, plan and action seem to be more or less isolated during the linear painting process of the schizophrenic artist: Imagining and doing hardly seem to recursively interact, i.e., to feed back, with one another. This could explain the strong reduction and painstaking repro-

duction of figures, forms and symbols which the works of schizophrenic painters are usually crammed with and which commonly mark the artistic style of such so-called Art-Brut artists.

Cognitive Deficits

The practical realization of Phantasy Therapy according to the therapeutic elements and steps outlined above progressively activates, via the above-mentioned therapeutic effects, those mental attributes generally known to be considerably disturbed by psychosis (so-called cognitive deficits) [18, 22]:

- motor coordination, mannerisms, posturing and speed of performance
- working memory which enables the simultaneous processing of information from different sensory channels
- orientation, attention and expectant attention (vigilance)
- abstract thinking, planning ability and problem-solving ability (executive function)
- speech and conceptual organization.

We have already discussed [54] the extent to which these cognitive deficits could be consequences of linear information processing in the mind-brain.

Defying Prejudices

How can it be that activating the Phantasy of mentally disturbed persons – in defiance of a widespread prejudice – doesn't actually aggravate an already existing psychosis or cause prepsychotic patients to decompensate? The answer lies in the progressively positivizing and basically antiregressive focus of our approach within the ritualized structure of each session as discussed above:

Patients are empathically-identificationally encountered from the very beginning there, where they already can be found, in the unconscious. In hypnotherapy, this process is called 'pacing'. Although a certain amount of regression may also necessarily take place here (another assumed 'taboo!') in order to help the patient find his symbol of Self at the basis/origin of his disturbance in the 'wasteland' of his unconscious, the basic attitude is one of antiregression, i.e., of ultimately 'leading the patient back' to collective reality.

The disorganized or deluded Phantasy of the patient is guided by the theme-centered, structured and ritualized approach and not overloaded. On the contrary and speaking in metaphors, the patient's imagination is steered for a single theme and then integratively channeled within our sheltered and supportive methodological framework to a 'safe' location in the unconscious where the patient's inner pictures may be positively transformed. In hypnotherapy, this process of progressive positivation is called 'leading'. For the therapy of psy-

chotic persons this process is perhaps initially regressive, but ultimately antiregressive.

The patient should actively somatesthetically experience and synesthetically express his Phantasy and live it out under the guidance of our approach. The patient should progressively adapt his Phantasy to the outside world, namely, to the therapy session, in a humorous and playful manner, instead of fighting against it. As a result, it becomes time and again possible for the patient to develop his own feeling for the difference between his own personal world of imagination and our world of collective reality.

Phantasy Therapy does not compete with or fight against the patient's delusions. Through the progressively positivizing suggestive influence of the therapeutic process, the patient can experience his Phantasy as a beneficial possibility of expression. With this experience, he can relive his 'world of delusion' as a 'domain of personal imagination' within the therapeutic framework and compare it with our 'world of reality' as a 'domain of collective perception and apperception'. By means of such a playful, humorous and creative approach to 'reality testing' – individually, pairwise and socially in the group (= progressive orchestration) – the patient gradually acquires the freedom to decide for himself in which of these two worlds he might prefer to linger.

Finally, to our own surprise and in defiance of widespread prejudices, we have also discovered that our patients tolerate amazingly well a great deal of closeness, touching and sensory flooding and that they seem to be able to well integrate these experiences mentally without amplification of their disturbance. In particular, Phantasy Therapy defies, amongst others, the following well-known prejudices:

'Imaginative work with psychotic persons is contraindicated.'

'Closeness and touching is taboo for psychotic persons.'

'Reduced stimulation of psychotic persons more or less means their isolation and the reduction of their sensory input.'

'Groups larger than roughly 10 persons can no longer sustain therapy.'

'One cannot already speak of therapy after only one session.'

References

- 1 Akhtar S: 'Someday ...' and 'if only ...' fantasies: pathological optimism and inordinate nostalgia as related forms of idealization. *J Am Psychoanal Assoc* 1996;44:723–753.
- 2 Ammon M: Dynamic-psychiatric treatment of schizophrenia – an integrated verbal and non-verbal approach. *Acta Psychiatr Scand* 2000;102:31.
- 3 Arlow JA: Phantasy, memory and reality testing. *Psyche* 1969;23:881–899.
- 4 Ascherman LI: The impact of unstructured games of Phantasy and role playing on an inpatient unit for adolescents. *Int J Group Psychother* 1993;43:335–344.
- 5 Benedetti G: Todelandschaften der Seele: Psychopathologie, Psychodynamik und Psychotherapie der Schizophrenie, 4. Aufl. Göttingen, Vandenhoeck & Ruprecht, 1994.
- 6 Benedetti G, Peciccia M: Symbol und Schizophrenie; in Schottenloher G (Hrsg): Wenn Worte fehlen, sprechen Bilder: Bildnerisches Gestalten und Therapie II / Reflexionen. Göttingen, Kösel, 1992, pp 107–118.
- 7 Bermond B, Vorst HC, Vingerhoets AJ, Gerritsen W: The Amsterdam Alexithymia Scale: Its psychometric values and correlations with other personality traits. *Psychother Psychosom* 1999;68:241–251.
- 8 Breuer H: Freud's psychological methods in art. *Psyche* 1985;39:577–591.
- 9 Cabral CA, Garcia D: Psychodramatic experiences with psychotic patients. *Acta Psiquiatr Psicol Am Lat* 1977;23:44–49.
- 10 De Neuter P: Notes concerning two psychodrama treatments in a psychiatric institution. *Acta Psychiatr Belg* 1977;77:399–409.
- 11 Doi T: Amae: Freiheit in Geborgenheit: Zur Struktur japanischer Psyche. Frankfurt a. M., Suhrkamp, 1982.
- 12 El Sendiony MF: Cultural aspects of delusions: A psychiatric study of Egypt. *Aust N Z J Psychiatry* 1976;10:201–207.
- 13 Freud S: Der Dichter und das Phantasieren; in Anna Freud EB, Hoffer W, Kris E, Isakower O (Hrsg): Gesammelte Werke, chronologisch geordnet. Frankfurt/M., S. Fischer, 1941, pp 213–223.
- 14 Freud S: Das Ich und das Es. Gesammelte Werke, 6. Aufl. Frankfurt/M., S. Fischer, 1969, pp 235–289.
- 15 Gehlen A: Der Mensch: Seine Natur und seine Stellung in der Welt. Bonn, Athenäum, 1950.
- 16 Gehring H: «Die Phantasie ist ein Platz, in den es hineinregnet». *Schweiz Arch Neurol Psychiatr* 1996;147:77–81.

Taboo Themes

Our experience has shown that, within the context of our approach, patients seem to have no pronounced problems dealing with the emotional impact of highly charged themes ('high expressed emotions') characteristic of fairy tales as long as the respective pictures are empathically introduced before reading.

The value of the possible emotional 'provocations' inherent to fairy tales lies in the fact that the patient has the opportunity to confront personal and societal taboos like murder, incest, etc. at the archetypal, symbolic level in the protective framework of a therapeutic setting and that he has the chance to talk about these things in an open, sheltered situation under beneficial, positivizing circumstances.

Conclusion

We would like to sum up the special features of Phantasy Therapy.

Phantasy Therapy

– is suitable for virtually all acute patients: It is effective, practical, economical and robust.

– comprises an integral interdisciplinary interplay between psychotherapists, movement/dance therapists, hypnotherapists and art therapists.

– represents in principle a more experience-/expression- and a less goal-/solution-oriented approach (!AYA! effect) to psychosis therapy.

– contradicts certain classical prejudices concerning the therapy of acute psychotic patients.

In closing, we would like to point out that, with certain supplementary exercises, in particular with the additional collaboration of a music therapist, an extension of our method to cover a full 5-day weekly program (1.5 h per day) is also possible.

- 17 Giambra LM: A laboratory method for investigating influences on switching attention to task-unrelated imagery and thought. *Conscious Cogn* 1995; 4:1–21.
- 18 Goldberg TE, Gold JM: Neurocognitive functioning in patients with schizophrenia: An overview; in Bloom FE, Kupfer DJ (eds): *Psychopharmacology: The Fourth Generation of Progress*. New York, Raven Press, 1995, pp 1245–1257.
- 19 Greenwald DF, Harder DW: Sustaining fantasies, daydreams, and psychopathology. *J Clin Psychol* 1995;51:719–726.
- 20 Gur'eva VA, Vandyshev VV, Shilana ZM: Comparative-nosologic characteristics of the fantasizing syndrome in the pubertal crisis period (forensic-psychiatric aspect). *Zh Nevropatol Psikhiatr Im S S Korsakova* 1986;86:81–86.
- 21 Hanggi D, Schedle A: Induced imagination as a methodologic paradigm in assessing stress perception and stress processing. *Z Klin Psychol Psychother Psychother* 1988;36:245–254.
- 22 Heinrichs RW, Zakzanis KK: Neurocognitive deficit in schizophrenia: a quantitative review of the evidence. *Neuropsychology* 1998;12:426–445.
- 23 Hennig H: Cathartic image experience as a psychotherapeutic imagination procedure – principles and practical approach. *Psychiatr Neurol Med Psychol* 1982;34:738–744.
- 24 Hohage R: Die Funktion der Phantasie in der Psychoanalyse: Struktur- und Strukturveränderung. *Prax Psychother Psychosom* 1993;38:22–31.
- 25 Holmes J: Can narrative approaches help in our understanding and management of psychosis? *Acta Psychiatr Scand* 2000;102:1.
- 26 Johannessen JO: Abstract book 13th International Symposium for the Psychological Treatment of Schizophrenia and other Psychoses. ISPS 2000, Stavanger, June 5–8, 2000. *Acta Psychiatr Scand* 2000; 102:1–81.
- 27 Kafka JS: Körperphantasien. *Prax Psychother Psychosom* 1992;37:81–91.
- 28 Kulessa C, Jung F: The efficiency of 20 hours of brief psychotherapy with Guided Affective Imagery. Examination with psychological tests. *Z Psychosom Med Psychoanal* 1979;25:274–293.
- 29 Kunz H: Die anthropologische Bedeutung der Phantasie. I. Teil: Die psychologische Analyse und Theorie der Phantasie. Basel, Verlag für Recht und Gesellschaft, 1946.
- 30 Kunz H: Die anthropologische Bedeutung der Phantasie. II. Teil: Die anthropologische Deutung der Phantasie und ihre Voraussetzungen. Basel, Verlag für Recht und Gesellschaft, 1946.
- 31 Langs RJ: Day residues, recall residues, and dreams: reality and the psyche. *J Am Psychoanal Assoc* 1971;19:499–523.
- 32 Lazarus A: *In the Mind's Eye. The Power of Imagery Therapy to Give You Control over Your Life*. New York, Rawson, 1977.
- 33 Lersch P: *Aufbau der Person*. München, JA Barth, 1952.
- 34 Leuner HC: Guided affective imagery (GAI). A method of intensive psychotherapy. *Am J Psychother* 1969;23:4–21.
- 35 Leuner HC: Creativity and modification of consciousness. *Confin Psychiatr* 1973;16:141–158.
- 36 Loch W, Jappe G: Construction of reality and Phantasy. Comments on Freud's case report 'little Hans'. *Psyche* 1974;28:1–31.
- 37 Marks I, Marsset P, Boulougouris J, Huson J: Physiological accompaniments of neutral and phobic imagery. *Psychol Med* 1971;1:299–307.
- 38 Merritt RD, Waldo TG: MMPI code types and the Phantasy prone personality. *Assessment* 2000;7: 87–95.
- 39 Newmark N, Adityanjee KJ: Pseudologia fantastica and factitious disorder: Review of the literature and case report. *Compr Psychiatry* 1999;40:89–95.
- 40 Nicolai EA: *Gedanken von der Verwirrung des Verstandes, dem Rasen und Phantasiren*. Kopenhagen, Rothenische Buchhandlung, 1758.
- 41 Niederland WG: Clinical aspects of creativity. *Psyche* 1969;23:900–928.
- 42 Olbricht I: Männliche Phantasien – Weibliche Phantasien: Gestaltung von Wirklichkeit und Therapie. *Prax Psychother Psychosom* 1993;38:42–51.
- 43 Peciccia M, Benedetti G: Das progressive therapeutische Spiegelbild; in Schottenloher G (Hrsg): *Wenn Worte fehlen, sprechen Bilder: Bildnerisches Gestalten und Therapie II / Reflexionen*. Göttingen, Kösel, 1992, pp 91–94.
- 44 Peciccia M, Benedetti G: The splitting between separate and symbiotic states of the self in the psychodynamic of schizophrenia. *Int Forum Psychoanal* 1996;5:23–38.
- 45 Person ES, Klar H: Trauma diagnosis: difficulty in differentiating between recall and Phantasy. *Psychother Psychosom Med Psychol* 1997;47:97–107.
- 46 Peseschkian N: Fantasies and parables as media in psychotherapy) Diskussionsforum *Med Ethik* 1991;11:LXIII-LXVI.
- 47 Rand N, Torok M: Questions on Freudian psychoanalysis: dream interpretation, reality, Phantasy. *Psyche* 1996;50:289–320.
- 48 Rauschenberger SL, Lynn SJ: Phantasy proneness, DSM-III-R axis I psychopathology, and dissociation. *J Abnorm Psychol* 1995;104:373–380.
- 49 Rhue JW, Lynn SJ: Phantasy proneness and psychopathology. *J Pers Soc Psychol* 1987;53:327–336.
- 50 Rosenkotter RM: The fairy tale – a prescientific developmental psychology. *Psyche* 1980;34:168–205.
- 51 Rubino IA, Grasso S, Sonnino A, Pezzarossa B: Is alexithymia a non-neurotic personality dimension? *Br J Med Psychol* 1991;64:385–391.
- 52 Sandler J: Dreams, unconscious fantasies, and perceived identity. *Psyche* 1976;30:769–785.
- 53 Schmid GB: Chaostheoretische Betrachtungen zu Psychiatrie, Psychologie und Psychotherapie. Teil 1: Die sechs Grundeigenschaften des Chaos und eine Prozess-Orientierte Psychiatrie (POPSY). *Forsch Komplementärmed* 1997;4:146–163.
- 54 Schmid GB: Chaostheoretische Betrachtungen zu Psychiatrie, Psychologie und Psychotherapie. Teil 2: Neue Hypothese zur Natur der Psychose. *Forsch Komplementärmed* 1997;4:194–208.
- 55 Schmid GB: *Tod durch Vorstellungskraft: Das Geheimnis psychogener Todesfälle*, 1. Aufl. Wien, Springer, 2000.
- 56 Schmidt-Degenhard M: *Die oneiroide Erlebnisform: Zur Problemgeschichte und Psychopathologie des Erlebens fiktiver Wirklichkeiten*. Berlin, Springer, 1992.
- 57 Schmidt-Degenhard M: Imaginary aspects of Phantasy experience correlations. Comments on a little regarded aspect of the delusion problem. *Nervenarzt* 1994;65:293–295.
- 58 Senf W: Die Funktion der Phantasie in der Psychosomatik. *Prax Psychother Psychosom* 1993;38: 32–41.
- 59 Simonton OC, Matthews Simonton S, Creighton J: Wieder gesund werden – Eine Anleitung zur Aktivierung der Selbstheilkräfte für Krebspatienten und ihre Angehörigen. Reinbeck, Rowohlt, 1998.
- 60 Starker S: Phantasy in psychiatric patients: Exploring a myth. *Hosp Community Psychiatry* 1979;30: 25–30.
- 61 Starker S, Jolin A: Imagery and hallucination in schizophrenic patients. *J Nerv Ment Dis* 1982;170: 448–451.
- 62 Starker S, Singer JL: Daydreaming and symptom patterns of psychiatric patients: A factor-analytic study. *J Abnorm Psychol* 1975;84:567–570.
- 63 Stein M: Bild, Traum und Phantasie. *Prax Psychother Psychosom* 1993;38:1–9.
- 64 Taylor GJ: Alexithymia: concept, measurement, and implications for treatment. *Am J Psychiatry* 1984;141:725–732.
- 65 Trosman H: Transformations of unconscious Phantasy in art. *J Am Psychoanal Assoc* 1990;38:47–59.
- 66 Vas J: Hypnose bei Psychosen: Eigenschaften der hypnotischen Beziehung bei der Psychotherapie schwer gestörter Patienten. München, Quintessenz Bibliothek, 1993.
- 67 Vetter A: *Die Erlebnisbedeutung der Phantasie*. Stuttgart, Ernst Klett, 1950.
- 68 Welck A: *Die Polarität im Aufbau des Charakters: System der Charakterkunde*. Bern, A. Francke, 1950.
- 69 Wendt H: *Gestalttherapeutische Methoden in der Sexualtherapie. Partnerberatung* 1982;1:27–34.
- 70 Wilmer HA: Origins of a Jungian-oriented therapeutic community for schizophrenic patients. *Hosp Community Psychiatry* 1976;27:338–342.
- 71 Zelin ML, Bernstein SB, Heijn C, Jampel RM, Myerson PG, Adler G, B DH, Rizzuto AM: The Sustaining Phantasy Questionnaire: Measurement of sustaining functions of fantasies in psychiatric patients. *J Pers Assess* 1983;47:427–439.
- 72 Zepf S, Weidenhammer B, Baur-Morlock J: Reality and Phantasy. Remarks on the dream concept of Sigmund Freud. *Psyche* 1986;40:124–144.
- 73 Zindel JP: Was kann die Hypnose zur Behandlung psychotischer Patienten beitragen? *CH-Hypnose* 1992;2:11–16.
- 74 Zinggl W, Chlubna P: Regression in the artistic creations of psychiatric patients. *Z Klin Psychol Psychother Psychother* 1990;38:21–36.
- 75 Zutt J: *Auf dem Wege zu einer anthropologischen Psychiatrie: Gesammelte Aufsätze*. Berlin, Springer, 1963.