The Spielzeit Method (SZM) in Dialogue with Psychodrama

Experience-Based, Systemically Synchronised Psychotherapy for Children and Adults with Intellectual Disabilities

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This paper is offered as a contribution to dialogue. Its aim is to introduce the Spielzeit Method (SZM) to practitioners of Psychodrama — not to claim equivalence, but to explore what the two approaches may recognize in each other. The SZM emerged from a specific clinical context: years of psychotherapeutic work with people with intellectual disabilities, for whom conventional verbal approaches are structurally insufficient. It is in that spirit — of shared curiosity across different traditions — that this paper is written.

1. Introduction

As far as I understand it, Psychodrama is grounded in the conviction that healing experiences arise through *action*, *role*, and *encounter*: through the embodiment of inner realities within the social field.

This fundamental intuition is shared in Spielzeit, even though it emerged independently — born of clinical necessity: working with children and adults for whom conventional verbal psychotherapy is insufficient, not because their inner world is less complex, but because the neurological channels of verbalisation and symbolic reflection are restricted. For over 30 years, our clinical work has focused primarily on people with intellectual and physical disabilities, neurodivergence, and severe illness. Over the course of this work, on an eclectic basis but with a depth-psychological foundation and in collaboration with various teams, I developed the Spielzeit approach (SZM).

The SZM is an **experience-based, systemically synchronised child psychotherapy** — explicitly situated within the framework of a general developmental concept that applies equally to people with and without intellectual disabilities (ID). Development, according to this basic assumption, is a self-organising, circular process in the dyad of individual and environment. What is specific to ID concerns neither the emotional depth nor the complexity of inner processes, but rather the *channels* through which these processes can be actualised and integrated.

1.1 Development as a Hero's Journey — and Trauma as the New Dragon

Before presenting the concrete interaction models, I will first outline our understanding of development — because it applies equally to people with and without intellectual disabilities.

The SZM is grounded in the conviction that **every human being, and thus every child, undergoes development as a hero's journey**. A biopsychic entity — the heroine — must, under biopsychosocial influences, endure and master various first- and second-order system transitions in order to unfold, at the phenotypic level, a structure inherently predisposed within her through maximal differentiation.

The decisive point: **The challenge is always greater than the heroine.** The child who says no for the first time is not facing a merely pedagogical task — they stand before an existential abyss. The mother, the first day of

school, puberty: each of these transitions requires the heroine to let her previous self die in order to become an expanded version of herself. From the perspective of Psychodrama, one might say: each developmental step requires a new exploration of role — and the roles offered by the environment help determine whether this new role can be rehearsed in surplus reality before becoming part of everyday identity.

Trauma interrupts this logic — but does not replace it. When a child or an adult with ID undergoes a traumatic experience, they are not catapulted out of the hero's journey. They remain on it — but the next challenge, the *new dragon*, now has a different quality. The injury leaves traces: restrictions in action, fears in relationships, and patterns of freezing that arise not from a developmental deficit but from a *protective function* of the psyche. The stuck behaviour is not a fault of the heroine — it is the last available shield against a dragon that was too large.

This has the following implication for the therapeutic perspective: **The question is not 'What is wrong with this person?', but rather 'At what point in their hero's journey are they — and which new dragon must they now overcome in order to move forward?'**

The SZM responds to this question by constructing specific experiential spaces in which heroic qualities — self-efficacy, strength of boundaries, and relational capacity — can be embodied in such a way that the heroine no longer faces the new dragon alone, but within the therapeutic alliance. What Psychodrama understands as *Tele*, as mutual perception within the play space, appears in the SZM as *systemically synchronised interaction* — allies are mobilised not only in the therapy room, but in every area of life.

The specificity of intellectual disability lies not in a different hero's journey, but in different conditions of that journey. The inner ordering force — the Self in the Jungian sense — sends out its signals. The basic emotional systems (SEEKING, CARE, FEAR, RAGE, PLAY, according to Panksepp) operate independently of cortical capacity. What is lacking is not the impulse toward transformation, but the neurological bridges that translate this impulse into consciousness and anchor it there. The SZM builds these bridges, among other means, through the use of four specific interaction models — external aids to actualisation for a journey that has already begun from within.

2. Interaction as Therapeutic Principle

Perhaps one could say that in Psychodrama, healing unfolds when the subject, with support, externalises inner conflicts and re-experiences them within the play space. Rather than interpreting unconscious contents, they are enacted — in the here and now, with the body, and in relationship.

The SZM begins from the same fundamental conviction: healing does not arise through cognitive insight, but through *corrective relational experience in action*. It operationalises this conviction in four specific interaction models — POM, PMM, RMM, and TRM — which appear to be structurally closely related to psychodramatic principles of action:

Interaction Model	SZM Mechanism
POM Positive Modelling	Learning through imitation; therapist embodies healing behaviour
PMM Paradoxical Modelling	Controlled misrepresentation; patient corrects and teaches
RMM Reverse Modelling	Therapist enacts the problem behaviour; patient observes themselves from outside
TRM Triadic Reverse Modelling	Two therapists enact relational dynamics; patient as co-healer

Psychodrama employs role reversal as a central instrument: whoever places themselves in the other's position gains distance and perspective. The SZM achieves the same effect through implicit, experience-based learning — without the patient needing to cognitively grasp or verbally name the meta-level. This is the decisive difference for working with people with ID.

2.1 The Interaction Process: The Actual Therapeutic Medium

What both approaches seem to share is the idea that it is not the *what* (content, interpretation) that plays the central role, but rather the *how* of the encounter: the tempo, the quality of mutual attunement, the moment of responding to one another. Stern called these *moments of meeting* — brief but transformative moments in which the relationship is implicitly reorganised.

- The SZM systematically captures this interaction process in **Empirical-Regulatory Cycles**: through non-directive participant observation in the first 5–10 play sessions, the **basic interaction mode** of the child or adult is first assessed — that is, the spontaneously emerging modes of action, affect, and contact under safe, ritualised conditions.
- The basic interaction mode that emerges in spontaneous play is the grammar through which the subject speaks with both the inner and the outer world. Only on this basis are healing experiential spaces constructed and interaction models implemented.

3. Work with Children: Experience-Based, Systemically Synchronised Individual Psychotherapy

3.1 Structure and Particularity

Child psychotherapy according to the SZM combines **individual psychotherapy** within a non-directive play framework (ERC Phase I) with the systematic **systemic synchronisation** of all relevant contexts (family, school, residential setting). This distinguishes the SZM from classical play therapy, which focuses primarily on the dyadic therapy session: in ID, the deficit in generalisation is so pronounced that, without anchoring in everyday life, therapeutic gains often remain confined to the therapy room.

The four interaction models are applied purposefully in accordance with the inductive diagnostics (ERC Phase II):

- **POM — Positive Modelling**: Modelling emotional regulation, social skills, and personal hygiene; drawing on the intact mirror neuron system and implicit learning. Especially suitable for individuals who are able to imitate.
- **PMM — Paradoxical Modelling**: Competence and self-efficacy experience through intentional mistakes by the therapist; contraindicated for oppositional patterns or absent competence domain. Therapeutically especially valuable after experiences of powerlessness due to trauma.
- **RMM — Reverse Modelling**: Externalisation and mirroring of the problem pattern; implicitly activates Theory of Mind processes (caution with complex PTSD and severe disability!).
- **TRM — Triadic Reverse Modelling:** The TRM — triadic enactment of the problem pattern — unfolds its effect through three interlocking mechanisms:

  Firstly, the triadic constellation — one therapist as coach and mentor, the other as problem actor — makes possible **compassion for one's own wound**: the patient can allow themselves to be moved by the depicted problem (which is recognisably also their own) without at the same time needing to defend themselves or feel ashamed. The coaching therapist actively accompanies and supports this process of empathy.

  Secondly, the patient's identity position shifts decisively: no longer "I am the problem," but "I am the one who knows — the healer." **The experience of competence replaces fixation on deficit**.

Thirdly, a protected problem-solving space emerges: the patient can develop, test, and guide creative solutions without being placed under evaluative scrutiny. The solution belongs not to the therapist's judgment, but to the patient's competence — they stand on the "knowledge side" of the problem, not the "problem side."

(From a Psychodrama perspective, the sequence POM → PMM → RMM → TRM might perhaps be understood as an increase in role and relational complexity: from dyadic imitation to triadic enactment, from observation to co-authorship.)

3.2 The Hero's Journeys (the Developmental Process) as the Starting Point for Therapy

The SZM is explicitly conceived as a **Developmentally Oriented Therapeutic Intervention**. This means that it is oriented not toward normative developmental milestones, but toward the individual developmental pathway of a person (with or without disability): **the hero's journey**. Development — whether with or without ID — is understood as a self-organising process in which behaviour is always directed toward achieving fit with the environment. Seemingly meaningless stereotyped behaviour, aggressive outbursts, or sudden, rapturous bids for contact are therefore not read as deviations from a norm, but as *expressions of an active developmental task* on the journey — one that can be taken up therapeutically.

4. Work with Adults: CMI with POM, PMM, RMM, TRM

4.1 Caregiver-Mediated Interventions (CMI)

For adults with ID, for whom direct individual therapy is structurally impossible or insufficient, the SZM developed the **CMI model** (Caregiver-Mediated Interventions). Here, the psychotherapist functions primarily as an *architect of healing experiential spaces* and as supervisor of the care team within the institution, which carries out the actual interventions in everyday life, mainly through the four therapeutic interactions.

The CMI model repeatedly employs all four interaction models — now, however, in the hands of caregivers and teachers:

- **POM in everyday life**: Caregivers model emotional regulation, boundary setting, conflict resolution explicitly and repeatedly. *'I am now saying out loud that I am angry'* — visibly, physically, consistently.
- **PMM in everyday life**: Intentional small mistakes by the caregiver that place the adult with ID into the correcting role. *'That's mine!'* — the experience of being right, of teaching, of being able to set limits.
- **RMM in everyday life**: Caregivers demonstrate helplessness (e.g. *'I don't know what to do when someone reaches into my plate'*) and invite the person with ID to show solutions.
- **TRM in everyday life**: Two caregivers jointly enact a scene; the person receiving care becomes the co-healer. This is particularly effective in cases of aggression and relational problems that arise in direct face-to-face contact.

5. Trauma-Informed Action: Action and Interaction Restrictions in ID

5.1 PTSD Prevalence and Atypical Presentation

People with ID are disproportionately affected by trauma: the international 12-month prevalence of all forms of violence is 31.7%, and the lifetime prevalence of traumatic experiences ranges between 65% and 86%. In clinical samples, 85.1% of people with ID in psychological settings have trauma in their history.

Crucial for therapeutic practice is the fact that PTSD presents atypically in ID. *Aggressive-disruptive behaviour*, self-harm, extreme social withdrawal, and regression are often attributed to the disability rather than recognised as trauma sequelae — the phenomenon known as *Diagnostic Overshadowing*.

5.2 Action and Interaction Restrictions Due to Trauma in ID

From the clinical findings, specific restrictions can be derived that may be addressed therapeutically:

Trauma-Related Injury (PTSD)	Restriction in Action/Interaction in ID	Therapeutic Consequence within the Experiential Space
Ego-centre fragmentation (Loss of *I am safe, I am stable*)	Fragmentation of identity; incoherent self-image; no stable sense of self	POM: the therapist models stable self-regulation; rituals serve as anchors of identity
Flooding / lack of boundary (Sensory stimuli explode without filter)	Sensory overload; meltdowns; sensory trauma; lack of impulse control	A low-stimulus experiential space; gradual exposure structure; safety rituals
Time loss / absent classification function (The past is not stored as concluded)	Flashbacks appearing as seemingly causeless behavioural outbursts; inability to attribute causality	Chronological structure in everyday life; narrative accompaniment by caregivers; POM in transition rituals
Defence failure (Uncontrolled surfacing of images and impulses)	Pseudo-memories; self-talk; hearing voices as a defensive mechanism	Differentiated assessment (not psychosis!); containing interaction; PMM to strengthen self-efficacy
Powerlessness / loss of control (Helplessness, being at the mercy of others)	Disorganised attachment behaviour; approach-avoidance sequences; aggression as contact-seeking	RMM/PMM: self-efficacy as a counterweight; rituals of power reversal
Relational incapacity (Trust destroyed, fear of closeness)	Disorganised attachment patterns; borderline features; oppositional dynamics	TRM: safe relational experience through triangulation; activation of empathy through observation
Absence of protection and boundaries (porous limits, total submission)	Lack of personal boundaries; compliance; risk of re-victimisation	PMM: boundary-protection training; practising “Stop!” within a safe framework

The task of therapy is the restoration of this freedom — in the SZM through experience-based role formation, not through verbal interpretation.

5.3 Interactions, PTSD Injuries, and Healing Processes

The therapeutic logic of the interaction models in the aftermath of trauma can be condensed as follows:

POM primarily addresses **ego fragmentation and dysregulation**: through consistent, physically visible modelling of emotional regulation, the nervous system is conditioned — not through cognitive insight, but through the intact mirror neuron system. The body learns what cognition cannot process. Insight emerges through doing, not through explanation.

PMM primarily addresses **powerlessness and low self-worth**: the cautious, supported, and controlled boundary transgression (for example, taking a piece of cake from a plate) within a safe and familiar space elicits the response *'That's mine!'* — and the experience that 'my no has power' becomes the neurobiological antidote to the helplessness conditioning of trauma. Agency is restored. Dopamine release following successful correction stabilises the self-efficacy system that trauma has dysregulated.

RMM primarily addresses **perspective rigidity**: seeing and experiencing one's own behaviour from the outside — the therapist enacts the outburst, the freezing, the withdrawal — makes possible both distance and competence, and thereby self-acceptance. At this point, the SZM deliberately refrains from verbal commentary.

TRM addresses a threefold logic of action.

- First, the triadic structure enables compassion for one's own wound: Therapist B depicts the problem (for example, helplessness in the face of boundary violations), while Therapist A actively accompanies and coaches the patient in responding to this depiction with empathy. The patient comes to feel compassion for the suffering portrayed — which is recognisably also their own — *without simultaneously having to defend themselves or feel ashamed*. This process of empathy becomes possible from within, because the patient is not placed at the focal point.
- Moreover, the identity position shifts fundamentally: the patient experiences themselves not as "the problem," but as the one who knows — the healer. They stand on the side of competence, not on the side of the problem. This reversal interrupts the cycle of victimisation that so often dominates self-perception after trauma.
- Finally, the TRM offers a non-evaluative space for creative problem-solving: the patient can develop, propose, and guide solutions without being judged. The knowledge of the solution belongs to them, not to the therapist. The person experiences themselves as part of a relational field and as an active co-creator of healing, rather than as an isolated symptom.

6. Experiential Space Concept and Systemic Synchronisation

The **experiential space concept** is at the center of the SZM— and perhaps also constitutes its closest point of connection with Psychodrama. The therapeutic space is not the therapy room; it is *everywhere that healing interactions can take place*.

Was not Psychodrama, for Moreno, a communal event? The group is the carrier, not the dyadic relationship. The SZM sees this in a similar way, especially in institutional and familial contexts: residential homes, schools, and families become stages for healing action. *'Every professional is an everyday therapist; every encounter is an opportunity for healing'* — this is the systemic formula of the SZM.

Systemic synchronisation means that all actors speak a similar therapeutic language, use comparable interaction patterns, and reinforce the same experiences of competence and safety. Without such synchronisation, the gains of individual therapy dissipate — in ID this is structurally inevitable, because the generalisation deficit greatly impedes transfer beyond the therapeutic context.

7. Development as a Universal Framework

The SZM is explicitly not a specialised method for people with intellectual disabilities only, but a developmentally oriented method grounded in a universal understanding of development. Development is a non-linear, self-organising process. ID modifies the channels of actualisation, not the ordering force of the psyche itself. The subcortical emotional systems[1] remain largely intact in ID; what is impaired are the cortical, especially prefrontal, capacities for integration.

The prefrontal cortex, as the primary seat of executive function, impulse regulation, working memory, temporal sequencing, and metacognitive reflection, is structurally and functionally limited in ID. The consequences for psychotherapy are substantial: reduced capacity for symbolic representation means that inner experiences cannot readily be translated into language or abstraction; diminished working memory limits the consolidation of new relational experiences across sessions; impaired temporal integration makes it difficult to connect past experience with present behaviour or future consequence. As a result, there is reduced spontaneous actualisation, less cumulative learning, and a developmental tendency to remain organised at first-order states — that is, states that are immediate, sensorimotor, relational, and affect-regulated, rather than second-order states involving reflection, narrative, and symbolic elaboration.

[1] The neuropsychological framing used throughout this paper is not intended as a reductionist account of the psyche, but reflects a clinical necessity: working with intellectual disability requires a differentiated understanding of which cortical capacities are structurally different or limited — precisely because these limitations define which therapeutic channels remain open, and which do not.

This is not a deficit of the psyche, but a structural condition of its expression — and it precisely defines the therapeutic task of the SZM: to provide the external scaffolding that the prefrontal cortex cannot yet — or cannot fully — supply from within.

Does this perhaps correspond to Moreno's fundamental conviction regarding the universality of spontaneous and creative energy? For Moreno, spontaneity is not a cognitive achievement — it is a primary vital force, independent of symbolic capacity. The human being is, regardless of cognitive capacity, a role-fluid being that strives for encounter, self-expression, and co-creation. Where the prefrontal cortex cannot readily supply the bridge between inner impulse and outer expression, the SZM attempts to provide it — through action, structured encounter, and the relational field, rather than through language.

8. Summary

The Spielzeit Method stands in clear dialogue with Psychodrama:

- Neuropsychological Classification: The method identifies the cognitive bottlenecks — absent symbol formation, deficits in metacognition, impaired prefrontal integration, and slowed neuroplasticity — that inhibit the spontaneous actualisation of inner patterns, and seeks to provide methodological compensations for them.

- Experience-Based Interaction Models: Rather than verbal interpretation, the SZM works through four structured interaction models (POM, PMM, RMM, TRM) that create corrective relational experiences in action — directly paralleling psychodramatic principles of role, encounter, and surplus reality, but accessible where language and symbolic reflection are limited.

- Systemic Scaling: Healing experiences are not confined to the therapy room, but extended into all relevant everyday contexts through the training and synchronisation of all involved actors — caregivers, teachers, and families. Every encounter becomes a potential site of healing.

- Developmental Logic: The method follows the individual developmental pathway rather than diagnostic categories. It does not proceed by means of a manualised treatment plan, but through an empirical-regulatory cycle that derives what is needed from the child or adult themselves — always oriented toward the next step of their hero's journey.

- The Hero's Journey as Universal Framework: The SZM understands every developmental process — with or without intellectual disability — as a hero's journey: a self-organising movement toward greater differentiation, in which each challenge — including traumatic injuries — exceeds the heroine, and in which trauma marks not a derailment but a new dragon to be faced. Therapy does not correct a deficit; it accompanies the next step of a journey that has already begun from within.