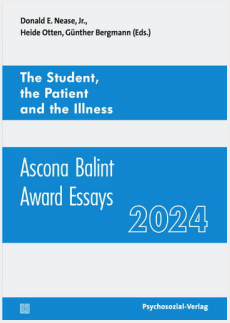
Julian Neugebauer

Ausweingärtner



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Ausweingärtner[1]

Julian Neugebauer

It is 2:30 p.m. on Friday afternoon. Despite a low turnover on the psychiatric ward, the morning had been exhausting due to spontaneous discharges and a staffing level decimated by COVID infections. I was just looking forward to the upcoming weekend when I received the news that there had been another new admission. Equipped with a laptop for documentation, I accompany the senior physician to the admission interview in our ward room. On the way there, we are briefly informed by the attentive nursing staff that the patient is a medical colleague. When we enter the room, we are greeted in a friendly and direct manner by an obviously hyperactive woman in her fifties, who, when I introduce myself as a PJ student, promptly replies: "Now listen carefully, you could write your doctoral thesis about me!"

1 Exposition

The First Impression

When I met Ms. K. for the first time on that Friday, I had no idea that she would be right in part and that she would trigger so many impulses in me.

At the beginning of the intake interview, everything seemed routine. Ms. K. had been suffering from Parkinson's disease for years and her medication could

1 "Ausweingärtner" is a German neologism derived from the treatment relationship described here. It refers to a gardener in a very special garden, namely the "Ausweingarten". An "Ausweingarten" is a metaphorical word creation that plays with the homophony of

explain her hypermotoric. She had also undergone a bilateral mastectomy two weeks ago. She described that a few days ago she was violently attacked by her neighbor, who hit her on the wound on her chest in the stairwell. In addition, something that could be detected by magnetic radiation had been implanted during the mastectomy. Her great fear of being followed by the neighbor was evident in every sentence and she repeated several times that she did not think she would survive the night.

Her eagerness to talk coupled with her technical eloquence made the conversation really special. She was always friendly, but showed no insight into her illness and, due to her background knowledge, often found a way to challenge our arguments with an inconceivable, minimal residual probability of the opposite. As we were firmly convinced that we could help her well with this symptomatology, but there was no basis for forcing her into treatment, we aimed to convince her to stay voluntarily. After almost two and a half hours, during which the senior physician conducted the conversation with the patience of a saint, we finally succeeded in persuading Ms. K. to stay in hospital voluntarily.

Somewhat exhausted, I collected my things after the interview and was about to leave for the weekend when Ms. K. asked me to sit on a bench next to her because she wanted to show me something. I set up internet access on her tablet and she tried to download an app for detecting magnetic radiation. The download process stopped several times, so she decided to tell me why. She knew that her fellow patients had jammers in their cigarette packs that would connect to the part in her chest and cause her terrible pain.

After this, I was finally sure that she was in good hands on the ward. I left the clinic with the good feeling of knowing that Ms. K. was now being treated and with the firm expectation that in her case, for once, the symptoms could be alleviated relatively "quickly and sustainably".

When I returned to work on Monday morning, I found out that Ms. K. had discharged herself a few hours later against medical advice. This depressed me a little, as not only did all the effort seem to have been in vain, but I was also firmly convinced that we could have helped Ms. K. quickly with good medication. But if there was one thing I had already learned, it was that you usually see each other more than once in a lifetime in a psychiatry ...

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crying and wine in German. On the one hand, the term creates the image of a beautiful vineyard and, on the other, of a place where you can cry out your sorrows. The term "Ausweingärtner" therefore refers to the ward doctor and me as a practitioner, as we supported Ms. K. in her work in her "Ausweingarten".

The Reunion

It happened as expected and a week later Ms. K. was transferred back to us from another psychiatric ward by PsychKG[2]. We found out that she had actually been beaten by her neighbor and had broken two ribs. However, the imaging of her head carried out in a somatic emergency room after this incident was unremarkable. In addition, her breast had become inflamed in the meantime, so that accompanying gynecological treatment had to be sought. All these somatic ailments, which could now be objectified, apparently reinforced Ms. K.'s impression that she had no psychological component. At the same time, this made it difficult for us to convince Ms. K. of the need for drug therapy for her psychological symptoms. She only took some of the prescribed medication and refused to take an antipsychotic. The PsychKG in particular was an enormous burden for Ms. K., as she felt "locked in" and was not used to having to relinquish control in her life. The whole team had numerous conversations with her, reassured her and waited for a change.

Cloud 7

After another week, it became apparent that Ms. K. was becoming increasingly more orderly in thinking. Although she was still refusing to take antipsychotics, she had gained the trust of the ward doctor with neurological experience, who optimized her Parkinson's medication and explained to her in detail the reasons for each individual dosage.

During a visit, she recited a poem she had written herself *(7 strong clouds)* and told us that we had animals in the walls. Ms. K. suggested "objectifying" this with a simple experiment so that she could show that she wasn't crazy and we could finally lift the PsychKG. Contrary to my expectations, the experienced senior physician agreed to this "experiment". So we went into Mrs. K's room and watched as she began to remove the plaster from the wall with a fork. When nothing could be seen at the first spot, Ms. K. changed the spot again and began to pick at another side of the wall with the fork. Nothing was visible here either. Ms. K. then got her SLR camera and tried to photograph the lamps in the room so that the animals hiding there could be seen. But none of the photos produced

2 PsychKG is the common abbreviation for the Mental Illness Acts, i. e. German state laws that regulate the detention of mentally ill people in a specialist psychiatric hospital in the event of acute danger to themselves or others.

the desired result. Somewhat disappointed, she realized that we had apparently been right.

Since the "experiment", Ms. K. seemed to have gained even more trust in us. Two days later, we were even able to lift the PsychKG prematurely, as she was able to give us credible assurances that she would remain in treatment voluntarily. She even started taking the antipsychotic medication "on a trial basis" soon afterwards.

One morning when I had just arrived on the ward, she was waiting for me at the entrance and pressed her poem *7 Strong Clouds* into my hand. It was a gift for me, she said. Because I would have known which cloud was her "Ausweingarten". I had already been touched by the beautiful poem during the visit, but the fact that she even gave it to me was a special honor and joy!

7 Starke Wolken

Wenn eine eiskalte Hand dein Herz in Schutt + Asche legt,
und niemand mit dir fühlt, was es so fehl-erregt,
dann lehrt es dich durch's einsam überleben,
daß in all den schönen Zwischenräumen
zwischen Himmel, Erde, Bäumen
in reichlich Platz aus Lust am Leben,
7 starke Wolken kleben.

Die 1. ist zum Ordnen.
Die 2. zum Korrigieren.
Die 3. die kann tragen,
die 4. kann man alles fragen,
die 5. hat 'nen Ausweingarten,
die 6. läßt fließen
+ dann kommt Wolke 7
zum Lieben

(Für meine geduldigen Ärzte mit Team, die mit mir sämtliche Wolken durchmachten, damit meine 7 bleibt)

7 strong clouds

If no one feels with you what makes it so wrong,
then it teaches you to survive through loneliness,

that in all the beautiful spaces
between sky, earth, trees
in abundant space for the pleasure of living,
7 strong clouds cling.

The 1st is for organizing.
The 2nd is for correcting.
The 3rd can carry,
the 4th can be asked anything,
the 5th has a Ausweingarten,
the 6th lets flow
+ then comes cloud 7
to love

(For my patient doctors and team who went through all the clouds with me so that my 7 stays)

2 Reflection

Treatment Relationship with Ms. K. – Poetry Makes Medicine

The poem triggered in me an intensive reflection on the treatment relationship with Ms. K., which was not primarily rational, but rather characterized by emotional understanding through the poetry. For this reason, I would like to use the structure of the poem as a guide when writing down my reflections.

1st Cloud – Organizing

Like Ms. K., many patients are not sorted at the beginning of their stay in psychiatry. As a term used in psychopathological assessment, I had therefore been quite familiar with this term. However, its positioning as the first cloud of the poem made it clear to me that this is not a mere symptom description, but an important and elementary step in the recovery process. Of course, I remember some situations in which things got out of hand and I needed time and peace to collect myself. However, I can in no way measure how intense the feeling of inner chaos must be when you not only lose control and confidence in your perception,

but are also forced into a completely unknown environment by a decision of the state authorities. This verse by Ms. K. made her intense fear and mistrust really tangible for me for the first time. In such a situation, sorting things out could only happen within herself and could not be forced from outside. She needed time and the treatment team needed patience. For me, this patience is the central element from which all the clouds, the metaphor for her steps in the recovery process, are woven. Contrary to my impressive experience of an always tight clinical time corset in most internships during my studies, it was a really profound experience for me to have to give Ms. K. the necessary time to start a recovery process and to be able to do this increasingly better.

2nd Cloud – Correcting

In contrast to somatic disciplines such as surgery or internal medicine, where the cause of the illness is treated "from the outside" by the practitioner through targeted intervention, I believe that mental illnesses require a great deal of active processing by the patient. The patient is not primarily – as I have often encountered in clinical traineeships – a passive object in which a broken bone is set or an electrolyte imbalance is rebalanced with medication, but as the main actor must muster the strength to independently integrate the impulses set by the environment into the world view. In order for this correction to be successful, I believe that not only an orderly state of consciousness is required, but in particular the presentation of offers tailored to the individual. Of course, medication can be one such group of offers, but its strengths seem to me to lie primarily in symptom management.

In the case of Ms. K., the right offer was the experiment described in the exposition. How often was I present or active myself when we tried to influence Ms. K. in long arguments? But it was only the patient offer of the senior physician, which gave Ms. K. the freedom to convince herself of the hallucination, that brought about a change in her world view. I personally think that Ms. K.'s need to be convinced through self-awareness was due to her fear, which was fed by the feeling of loss of control. This insight was of immense importance for the further treatment, as we now knew better which offers we could suggest to Ms. K. In a similar manner, I was allowed to accompany her to an appointment with the head physician of the breast center where the mastectomy was performed. As the head physician took a lot of time to answer Mrs. K's questions in detail, I felt that I had a lot of time too. I could literally see with every

minute how the inner tension that had been building up in Ms. K. for days was easing.

Impressed by the sustainability of these treatments, my understanding of the role of a medical student or doctor changed. What I thought of as holistic medicine was subject to a point of view error. For me, it previously meant looking at as many areas of a person as possible and developing the most optimal pathogenetic-oriented intervention from this, but always from a perspective where I was the actor, the "problem solver". The treatment relationship with Ms. K. broadened my perspective and showed me that it is more productive – especially in the case of mental illness – to be a companion who offers connectable support – often also as a "Ausweingärtner".

3rd Cloud – Carrying

For a correction to be sustainable, it seems important to me that a fragile change in the world view of the person undergoing treatment is supported by the environment. He or she must experience that the correction is sustainable and reliable. When Ms. K. once saw animals in her room lamps, we tried to capture them with her SLR camera. No matter from which perspective we photographed, the pictures always showed ordinary lampshades. This not only led to Ms. K. being able to distance herself more and more from such perceptions, but in my view also strengthened the treatment relationship enormously by "experimenting" together. Ms. K. built up more and more trust in the ward doctor and me. This trust was incredibly valuable, as it gave us the opportunity, for example, to convincingly supplement the personal support offered with medication. While I had previously believed in the Habermasian coercion of the better argument when giving medication, Ms. K. taught me to appreciate the non-coercive advice of a confidant.

4th Cloud – Asking

If you have a lot of (specialist) knowledge like Ms. K., there are all the more points of contact for uncertainties, so I could empathize with her great urge to ask questions. I remember too well the phase during my studies when, after reading almost every clinical picture, I thought that the symptoms actually applied to me too. After a while, however, the habituation effects were so strong that I switched to

the opposite and ignored my own body signals in a feeling of inviolability until I finally had to go to the clinic as a patient with a serious illness myself. I had a déjà vu with Ms. K. and saw myself again in the same clinic, where my dangerous half-knowledge constantly fueled my fear and I inwardly doubted every treatment approach because there was still a study there that did it differently or the pharmacology slide said that you just shouldn't take a certain combination of drugs. For this reason, I was able to empathize with Ms. K. particularly well. It was easy for me to answer her numerous questions with patience and to the best of my knowledge, as I was well aware of the great reassurance potential that answers and empathy can bring.

In the course of reflection, I then asked myself whether I show the same level of commitment to others, even though I sometimes find it more difficult to emotionally relate to them. Unfortunately, the answer is quite clear, as I invested significantly more time than usual in the relationship work with Ms. K. Just because other patients don't demand as much time and perhaps can't formulate as many questions doesn't mean that their illness is any less complex, let alone less painful. I would therefore like to take away from Cloud 4 that there are many sufferers who are unable to express their inner fears and tensions in any questions or words and that this should not be a reason to assume that they are absent.

5th Cloud – "Ausweingarten"

Ms. K. was particularly proud of this cloud. For me, the neologism of the "Ausweingarten" stands for a place where you feel safe and protected and where you can sort out your thoughts. For me, this atmosphere of trust and security is the prerequisite for being able to cry at all. Linking this place with the idea of a garden really appeals to me. I am a person who feels a great sense of connection and peace in nature. For example, when I go mountain climbing, I feel very humble before the vastness of nature and feel part of a larger whole. This often leads to my own problems and needs fading into the background in these moments, sometimes even seeming very small and unimportant. Combining this feeling of nature with a place to cry and creating such a space in the clinic seems to me to be a very noble goal.

I also find the metaphor very successful because the elixir of a magnificent garden is not expensive gold, but water. Perhaps even the very water that is released when we cry. This interpretation applies well to Ms. K., because in my opinion, she drew the strength from crying to be able to stand up again.

6th Cloud – Flow

For me, flow has something dynamic about it and goes in a certain direction. For this reason, the 6th cloud can be understood as the actual (minimum) goal in the recovery process. For me, this is where the rigidity and constriction during an illness is dissolved.

In relation to Ms. K., this cloud also has an intensely physical component. She suffered not only from hyper-, but also from hypomotor phases as part of her Parkinson's disease. I find it hard to imagine the feeling of being trapped in one's own body. It is perhaps most comparable to the sleep paralysis I experienced some time ago. I can still feel the fear from back then, but my immobility was in a dream world in my head. In Ms. K.'s case, this helplessness existed within interpersonal interaction. It is understandable to me that she was incompliant with such a wealth of experience and preferred not to take too much medication in order to get into the hypermotoric phase. The sensitive approach of the ward doctor, who determined the medication together with Ms. K. almost every day and in this way guided her step by step into the optimal setting, seemed all the more exemplary to me.

Cloud 7 – Love

For me, loving means being able to do something for someone else. However, when you are ill, you have to concentrate on yourself and focus all your energy on recovery. Helping a person to regain so much strength that they can not only give something back to themselves, but also to someone else, i. e. to be able to love, is the most beautiful goal of treatment for me.

In psychiatry in particular, the environment is closely linked to the patient's situation, so the treatment work often has a far-reaching effect on an entire social structure. The treatment relationship with Ms. K. made this very clear to me. Her husband suffered greatly from seeing his wife in this state. At the beginning of her treatment, Ms. K. was very suspicious of him and often accused him of not supporting her properly. When her condition gradually improved, a few days after she had presented her poem to us on the ward round, she came back from a walk around town with her husband wearing a beautiful new necklace around her neck. The necklace was adorned with a large, blue, drop-shaped gemstone set in silver, which drew the eye to her breastbone. She told me that it was a gift from her husband, who normally didn't buy her such expensive things on the spur of

the moment. For her, this necklace is now a symbolic "declaration of war" against all the things that have happened to her since her mastectomy. Now she wants to tackle them. Whenever I met her in the corridor in the days that followed, she would simply tap the necklace with her index finger and I noticed how a broad smile always spread beneath my mask.

To be seen as someone who has made a small contribution to her being able to love again by dedicating her poem flatters me and makes me very happy!

The Team – All for One

In my clinic, I was lucky enough to work in an interdisciplinary and multi-professional treatment team that managed to work together as equals.

This credit goes above all to the senior physician and the nursing management, who created an atmosphere in which everyone was able to contribute their skills and was appreciated for it. In Mrs. Ks. poem, this treatment environment is well reflected in the image of the "Ausweingarten", because if you see the patients as plants in this garden, it takes more than just a gardener to make the flowers grow again. Social services could provide sunshine, medicine could fertilize the soil, psychology could provide a supporting skeleton, nursing could water, etc.

Nevertheless, I know that this kind of collaboration requires a great deal of effort to structure and organize. Being part of the many meetings – with their different compositions – and experiencing the enormous communication skills required for such a round of talks made a lasting impression on me. I have a vivid memory of how the senior physician once put her point of view aside and decided against her own position in favor of the majority opinion, even though she was the one who was solely responsible.

I could literally feel how I had arrived in the team after a while, when I was able to make my first contributions and contribute my student perspective. Thanks to my good treatment relationship with Ms. K., I was not only listened to, but was also able to use this to help the others in the treatment team better understand Ms. K's actions.

The relationship with my ward doctor was also particularly formative for me. We shared responsibility for Mrs. K's case and I enjoyed the luxury of being able to invest a lot of time in a complex case like Mrs. K's in psychiatry. We had long discussions, pored over the literature to better narrow down a possible etiology and developed treatment ideas, as we had learned from Mrs. K's "experiment" that an experiential approach could be very effective for her. Thanks to the constant ex-

change and direct feedback on my ideas, Mrs. K's treatment was very exciting and productive for me. It was not uncommon for questions to arise from our conversation that touched on my own ethical ideas. Suddenly it wasn't just about Ms. K., but about a general understanding of how you want to fulfill your role as a doctor. The critical openness and willingness of the ward doctor to discuss this not only on an abstract level, but also to incorporate his feelings and experiences from his clinical work, gave me a lot of food for thought. Once when we were discussing the thresholds of a possible forced medication of Ms. K., I was impressed by his tireless optimism that Ms. K. would take her medication voluntarily. Based on this conviction, he initially stopped the Parkinson's medication for over a week, in daily consultation with Mrs. K, until she had gained enough trust in him to voluntarily try taking another antipsychotic. I was very impressed by his willingness to choose the ethical path over the more comfortable one – despite the great effort and rather low chances of success – and to draw so much patience from this.

3 Action

While I had been thinking about Ms. K.'s poem for a few days, I discovered a reminder of the Balint-Prize in my mailbox. The first sentence that Ms. K. had said to me immediately came to mind. As many threads of thought were still buzzing around in my head and I was still very moved by the poem, I plucked up my courage and described to Ms. K. my idea of writing down our treatment relationship pseudonymously and submitting it. I was surprised that she not only immediately gave her consent, but was also immensely happy about it. We then talked at length about my interpretation of her poem and the lessons I had learned from it. Two major goals emerged for me: to become more patient in treatment relationships and to pay more attention to people who are less able to articulate their fears and needs.

Patience

Ms. K. confirmed to me several times how important the patience shown by the treatment team had been for her. In a situation in which she was largely deprived of her freedom, at least allowing her the autonomy to make her own decisions about her medication was a very important support. I would also like to try to provide this support in the future and support such experiences of self-efficacy.

In two months' time, I'll be moving on to my surgery tertial. The high time pressure there seems to me to be an ideal testing ground for practising patience under systemic pressure. Of course, I realize that I will encounter different time corridors there than in psychiatry, but I believe that a patient attitude can be felt quickly in the high-frequency, somatic hospital routine, even on a small scale. Whether it's in the information session, where I try to ask questions to make sure that the procedure has really been understood, or in the emergency room, where I don't want to interrupt the first answer after 10 seconds, but want to leave time to tell the story. Particularly when it comes to prescribing medication, I see great potential for increasing compliance through patient education. I have the feeling that due to the unanimous professional evidence – e.g. for some long-term medications – there is often little empathy on the part of doctors for those being treated, or at least this is not expressed due to the performance-oriented time pressure. This is why, in my opinion, patients are given (too) little time to accept the need for medication and thus convince themselves of its relevance. I would like to counter this form of persuasive education with patient persuasion and learn to endure the fact that medically indicated therapy proposals can also be rejected (for the time being). For me, this also implies being open to unusual treatment methods in further training in order to have more individually tailored treatment suggestions in my repertoire and to be able to offer them as an alternative.

Quiet Waters

When writing down the reflection, I realized that I am very involved in treatment relationships in which a lot is demanded of me. However, those who do not express their fears and are perhaps not even aware of their needs are neglected. In future, I would like to be more proactive in my approach to these patients and take them into consideration. In concrete terms, this means that I want to take the time to put myself in the other person's shoes in every treatment relationship and find out what emotions are currently guiding their actions.

This was very easy for me with Ms. K., but when I subsequently tried to do the same with more reserved people, I noticed how difficult it could be to grasp the individual emotional state. Although I had diligently given items in the psychopathological assessment that described the affect in a structured way, I could not say why someone was depressed or what the hopelessness arose from. For this reason, a huge range of connecting factors remained closed to me in these treatment relationships.

4 Progression

Disturbances Have Priority

Ruth Cohn's postulate "Disturbances have priority!" from Theme-Centered Interaction (TCI) seems to me to be very important for responsible medical action. It can be easily adapted to treatments, as the disorders are often not at the content level but at the relationship level. In everyday clinical practice, the focus is usually on the professional dimension and the relationship level is minimized through distanced behaviour in the understanding of professionalization. Especially with people like Ms. K., this seems fatal to me, as the relationship level is a necessary condition for a substantive discussion. In my opinion, it would be desirable to adopt more perspectives in both medical and student activities in order to include the relationship level more strongly.

For me, empathizing with another perspective begins with the common use of statements in doctors' letters such as "The patient introduced himself …", "The patient reports …" "The patient was … under treatment" or "We recommend the patient …". These phrases seem disrespectful to me. From my point of view, they do not express the necessary appreciation for another person who has a name and a story. I think such formulations contribute to reification, which is also emphasized on the ward when a distinction is made between "room 266 window or door". In the end, this reification culminates in the allocation according to certain disease categories, when only "the gall bladder", "the liver" or "the appendix" are mentioned.

I would like every practitioner to regularly try to empathize with the patient's perspective before making a decision and to critically reflect on their own position in this regard. Simple questions such as "How do you feel when you meet Mrs. Müller?", "How does it feel to be on dialysis for years like Mr. Müller?", "How do you feel when you think about Mrs. Müller's future?" can be used to get a sense of the emotional situation. This complements the purely functional dimension, as you are involved in the treatment relationship as a person who is capable of feeling. Just as it is routine to inquire about certain areas in the medical history, such questions should be an integral part of a treatment routine.

Persuasion Medicine

Reflecting on the clouds from Mrs. K's poem made me realize that the doctor's role includes both the active problem solver and the supportive companion. Here

I see a connection to argumentation theory, where the distinction between persuasion and convincing has existed since antiquity. While persuasion is done with manipulative intent, persuasion aims to persuade an individual to adopt an attitude to action by means of testimony. The similarity lies in the perspective. Just as the listener is the decisive subject in argumentation, who convinces himself of something and is not convinced, it is the treated person in (psychological) medicine who is not talked into recovery, but heals himself through support that can be connected.[3]

For me, this means that medical practice needs to be aware of this dual role of problem solver and companion, even in specialties that are not oriented towards conversational medicine. Because as soon as a somatic illness is coupled with a stressful, psychological component, such as in the case of tumors or chronic illnesses, both roles are needed for the recovery process. For training and further education, I would therefore like to see more training on when the focus should be on active (problem) solving and when we should see ourselves more as companions who provide individuals with resources that promote their health and well-being.

Structures

Based on the realization of the great potential that can be found in involving oneself with one's feelings in a treatment relationship and the awareness of having to meet the requirements of both a problem solver and an accompanying insight helper, I believe that new spaces for this emotional reflection are needed in everyday clinical practice. Of course, some of these spaces already exist (Balint groups etc.), but the decisive criterion for me would be integration into the daily work routine. Just as a physical and psychopathological examination of the patient is part of the standard toolkit, a kind of mini-emotional status of the practitioner seems to me to be an enrichment in order to professionalize a more empathic attitude in the treatment relationship.

I am very surprised that there are a number of AWMF guidelines, but not a single one that deals with the culture of communication in medicine across disciplines. As deeply differentiated as the professional content level is in evidence-

3 In Socratic maieutics, this becomes particularly clear linguistically, as this technique literally means midwifery. The rhetorical insight helper and the midwife both have a supporting function in something that originally comes from itself.

based medicine, the relationship level in medical contexts seems to be superficially illuminated. For me, efforts are therefore needed to establish evaluable communication structures in order to create resonance spaces for empathy and joint reflection and ultimately make communication in treatment relationships more successful in this way.

The entire reflection on and with Ms. K. convinced me that it is personally beneficial for me to integrate a mini-emotional state into my routines. The experience of how my own emotions brought into the treatment relationship can enrich it has permanently changed my whole attitude with which I now enter into further treatment relationships.

My challenge now is to translate these insights into appropriate attitudes and actions on a daily basis.

Epilogue

I read this report together with Ms. K. on the day it was handed in. It may not have become a doctoral thesis, but it worked on my understanding of "being a doctor". Wrestling with certain formulations in the writing process brought me to a level of reflection that I would not have reached through purely cognitive analysis. However, being able to reflect not only on my own or as part of the treatment team, but also to engage in a metacommunicative exchange with Ms. K. about the patient's perspective, was a formative experience that had a lasting effect and for which I am very grateful to her! We found a common projection surface in the "Ausweingarten". Here, Ms. K. was able to forget her worldly worries, gather strength and feel free. Similar to the biblical Garden of Eden, the "Ausweingarten" is a paradisiacal, utopian place of refuge for Ms. K. By allowing me to go with her to this place, I was able to support her in a different way than in the usual role relationship of a treatment relationship. This form has lasted far beyond the initial meeting and has formed the basis of our contact ever since. Using the power of metaphors, both Ms. K. and I were able to express our respective feelings, make them understandable to the other person and thus become effective. As an example, I would like to mention the fantastic idea of the "Seelenkompost"[4]. After Ms. K. had shown this text to her family and friends, we received initial feedback and tried to process it together. As expected, the "Ausweingarten" triggered the most response, so we reflected on the impulses. Suddenly Ms. K. said that for her,

4 Another neologism that can be translated as soul compost.

it was not the cross-references to the Garden of Eden, Adam and Eve or a painted paradise that were in the foreground, but the small riches of the garden, such as a "Seelenkompost". This is a source of new growth for those who have enough patience to nurture and care for the garden. Here, what had once blossomed and then withered could become something new. The whole wealth of different life events, which are presented in the numerous plants in the garden, could blossom anew with a little (gardening) work and time on the "Seelenkompost". In addition, sometimes a good digging is needed to keep the compost fertile.

This metaphor describes our treatment relationship so impressively and wonderfully, and has since then influenced me to use the power of figurative language. Thanks to Ms. K., I often think of the 7 clouds of the poem in difficult moments with patients, especially of the "Ausweingarten" and the "Seelenkompost". They remind me that sometimes a patient gardener is needed to help with the "Seelenkompost". But also how arduous and persistent it is to try to be one every day.

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