

Dramatology vs. narratology: a new synthesis for psychiatry, psychoanalysis, and interpersonal drama therapy (IDT)

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Summary

The author proposes a new word and concept, dramatology, to emphasize that lived life is primarily a drama, a communication to self and others, in action, intention, emotion, and spoken word. In lived encounters and events persons as agents primarily dramatize their emotions and experiences and secondarily narrativize these into first person or third person stories or narratives. In real life interactions, and those in the special interpersonal situation of psychotherapy, it is the dramatic form that holds center stage and narrating becomes part of the dramatic action.

Interpersonal drama therapy (IDT) focuses on the immediacy of the personal and interpersonal conducts as experienced and expressed in mutually evocative communications, both conscious and unconscious, between patient and therapist. A central technique of IDT, confrontation, is correlated with free association and transference interpretation, with a view to revealing the meaning of the conscious (manifest) and unconscious (latent) content and intent of the patient's and therapists communications in the process of psychotherapy.

drama / story / dramatology / nonverbal and verbal communication / free association / transference

Multa renascuntur, quae iam cecidere; cadentque
Quae nunc sunt in honore vocabula, si volet usus,
Quem penes arbitrium est et ius et norma loquendi
(Horace)

Many terms now out of use will revive; and many now in vogue will sink into oblivion if custom will it so, for usage determines laws, rules and principles of language.

INTRODUCTION

The two literary genres used to portray human personal action and interaction, and to communicate the latter to another person or persons, are the narrative (from Latin *narrare*, to make

known), i.e., telling stories to a listener, and the dramatic (from the Greek root *dran*, to act), i.e., showing staged and enacted plots to spectators. Stories are primarily descriptive, are either autobiographical (first person accounts) or biographical (third person accounts). Science also produces stories, research reports and case reports. The study of narratives, literary or scientific, is called narratology, a term coined by Todorov [1] and it is found in dictionaries.

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Dramatology is a word coined by the author [2, 3, 4, 5] to complete narratology. Dramatology is not yet found in the dictionaries. A Google search only yielded the word “dramatological” in Wiktionary while dramatology is cited in articles by the author. Dramatology means engaging in interpersonal relationships through action and dialogue; facial expression and bodily gesture and posture; mien, manner, mood and music of the voice—all shaping the meaning of communications to oneself and to the other in interpersonal situations. Sociologically, dramatology is concerned with these components of drama: character, conduct, conflict, crisis, conscience, choice, confession, confrontation, conciliation, and compromise, or catastrophe. Psychologically, dramatology is based on the function of *dramatization* [6], the ability to represent conflict and compromise in mental images of nocturnal dreams and diurnal daydreams. The dreamer dramatizes thoughts and feelings in mental images and imaginary scenarios involving actions, emotions, sensations, scenes, and speeches. Whereas narratology utilizes description and may contain conversation, dramatology is all action and conversation, utilizing both non-verbal mimetic expressive action and the spoken word. Dramatology is differentiated from dramaturgy, the art of writing, staging and performing dramas in the theatre. The goal of dramatology is to refocus psychiatry as person-oriented and interpersonal, to emphasize the continuum from the psychopathology of everyday life to the psychopathology of persons who become inpatients and outpatients seeking help from the healers. Dramatology studies persons as acting and interacting from choice vs. constraint, reflection vs. reflex, deliberation vs. drivenness.

Plato distinguished representation of objects and persons by (a) *description* with words and (b) *imitation*, or *mimesis*, as in dramatic mime. As elaborated by Aristotle, in drama imitation becomes impersonation of characters and plots taken from real life and presented in plots and dialogues to portray encounters, events, and emotions on stage [7]. With the modern invention of the printing press, the novel (literally, something new) and the novella, or short story, became the predominant narrative genre, utilizing description and usually read, along with printed dramas, by solitary readers. The descriptions

of actions and scenes in the story use words to evoke in the reader mental images of the actions and scenes of the plot such that the reader becomes a vicarious participant in the narrated plots through the function of imagination [8]. Since drama contains no narrative description and is all action and dialogue, it acts directly on the senses and the emotions of the spectators resulting in an ad hoc emotional bond between actor and audience. The story narrates about interactions that happened in the past, i.e., a piece of history; the drama enacts an interaction happening in the present, directly in the here-and-now, with the various *dramatis personae* gesturing, speaking, and emoting; pleading and suggesting; complaining and confronting; imploring or demanding affection and approval, or consolation and compensation, and more. What is crucial for psychotherapy is the appreciation of the two forms of dramatization: (1) in fantasy and (2) in word and act, a distinction upheld by Anna Freud [9]. Dramatology provides the conceptual basis for *interpersonal drama therapy* (IDT):

While medicine deals with monadic medical *conditions* of the body, psychiatry deals with interpersonal *conduct* in society. In spite of the current return to viewing neuroses and psychoses as brain conditions, what we call psychiatric symptoms are conducts: actions and communications that are interpersonal, from one person to another, or intrapersonal, thoughts and emotions directed to oneself. Ruesch & Bateson [10] extended Sullivan’s ideas to “build a new psychopathology based on the criteria of communication.” My project is similar: to build psychopathology on dramatology. Sullivan differentiated between observation of the medical patient and *participant observation* of the psychiatric patient. Dramatology goes further: therapy is a *participation* in the patient’s real life drama and is itself a dramatic process.

Interpersonal drama therapy is a new synthesis and paradigm based on the dramatic nature of interpersonal relations and can be helpful to professionals who... practice psychodynamic psychiatry. The dramatic perspective facilitates observing the person as a whole gestalt, in all his particularity and uniqueness of the emotional event, paying close attention to the *facts* of bodily appearance, dress, mental makeup, character, temperament, intellect, speech, culture and

social status. Such observation precedes preparation of narratives and premature reaching for closure in diagnosing disorder, resistance, transference or any other formulaic interpretation. It opens the door for comparing the analyst's and analyst's interpretations, a source of learning for both. Dramatology and interpersonal drama therapy approach the two participants not as abstractions or generalities but as unique individuals in their aliveness, in their emotions, in their mutual need to love and to be loved in return.

In dramatic interactions patient and doctor are drawn into conscious and unconscious enactments which take both members of the therapeutic team by surprise and then offer considerable heuristic and healing value. Such enactments also transcend transference and countertransference, which are determinations are to be made *after* the fact of the enactment, *nachträglich* [afterwards], as Freud said. Such enactments are inevitable. They pose no danger if both participants keep faith with the procedure, process, and principles of ethics and mutual responsibility. In the drama of the therapeutic encounter patient and doctor work as a team in search of love, justice, and truth [5].

Love truth and justice may be viewed as both ends and means. These principles are, on the one hand, the foundations of wisdom as a goal in life and, on the other hand, they also define the ethics of the means we employ to promote the healing of suffering and the personal growth of the patient.

A philosophical grounding of dramatology may be found in Merleau-Ponty's 1964 programme [11], the primacy of perception:

By these words, the "primacy of perception," we mean that the experience of perception is our presence at the moment when things, truths, values are constituted for us; that perception is a nascent *logos*; that it summons to us the task of knowledge and action. ... On the basis of perception, ... [this] attempts to define a method for getting closer to present and living reality and which must be applied to the relation of man to man in language, in knowledge, in society and religion, as it was applied to man's relation to perceptible reality. We call this level of experience "primordial" ... [for] it reveals to us the

permanent data of the problem which culture attempts to resolve [11].

As a method dramatology is also grounded in the primacy of perception. It starts with closely observing the perceived, manifest, or overt, actions, gestures, and speeches, the consciously expressed thoughts of the person, or individual, and subsequently focuses on the secret, or unconsciously suppressed, motives of the manifest behavior. Similarly, psychoanalytically-oriented therapy seeks to uncover the person's latent, i.e., repressed, thoughts, fantasies, emotions, and transferences. It cannot be emphasized enough that the person of dramatology, even more than the *dramatis persona* on stage, is not a generic but a particular individual, i.e., a whole gestalt not further divisible, a singular embodied person.

DIAGNOSTIC DEFINITIONS OF DISEASE: SCIENCE VS. HEALING ART

The problem of the generic vs. the individual person goes back to an ancient philosophical problem and the medieval disputations between so-called realists, who believed that universals, abstract nouns such as beauty, or categories, such as class, genus, and species (e.g., man, animal), refer to real entities that exist outside the mind, and nominalists, who regarded universals as mere names without any corresponding reality. The doctor and Rockefeller University scientist Alexis Carrel suggested a solution:

in nature ... there are only individuals. The individual... is a concrete event. He is the one who acts, loves, fights, and dies. On the contrary, the human being is a Platonic Idea living in our minds and our books. He consists of the abstractions studied by physiologists, psychologists, and sociologists. His characteristics are expressed by Universals. We need both the general and the particular, the human being and the individual, [both are] indispensable for the construction of science, because our mind readily moves only among abstractions [12].

Carrel applied the above distinctions to the problem of classification and nomenclature in medicine:

A disease is not an entity. We observe individuals suffering from pneumonia, syphilis diabetes, typhoid fever, etc. ... However, it would have been impossible to build up a science of medicine merely by compiling a great number of individual observations. The facts had to be classified and simplified with the aid of abstractions. In this way disease was born. And medical treatises could be written. A kind of science was built up, roughly descriptive, rudimentary, imperfect, but convenient, indefinitely perfectible and easy to teach. Unfortunately, we have been content with this result. We did not understand that treatises describing pathological entities contain only a part of the knowledge indispensable to those who attend to the sick. Medical knowledge should go beyond the science of diseases. The physician must clearly distinguish the sick human being described in his books from the concrete patient whom he has to treat, who must not only be studied, but, above all, relieved, encouraged, and cured. His role is to discover the characteristics of the sick man's individuality ... [and] the psychological personality of the individual. In fact, medicine which confines itself to the study of diseases, amputates a part of its own body [12]. Science, Carrel emphasized, is not an end itself but serves medicine as a healing art.

J. G. Scadding [13], a self-declared methodological nominalist, traced medical nomenclature to Sydenham's 1696 notion the "all Disease should be reduced to certain, and definite Species, with the same diligence we see it is done by Botanick writers in their Herbals", to conclude that in medicine there is no room for essentialism, for "attempts to elaborate a unified concept of disease are doomed to failure, and lead only to confusion". A fortiori, such dilemmas are even more critical for psychiatry: since "conditions cannot be related to specific physical disorders or causal agents, it is especially important to avoid the danger of reifying abstract concepts, whether they be called diseases, disorders, syndromes, or anything else as causes; and in such contexts it is arguable that these concepts are a hindrance to clear communication". Furthermore, "behavior that deviates from politically accepted norms, with no suggestion that it originates in an abnormality causing biological disadvantage, is obviously not of medical concern"

[13]. From the time psychiatry was founded as a medical profession with the publication of Philippe Pinel's [14] *Traité medico-philosophique sur l'aliénation mentale, ou la manie* in 1801, it was clear that it is a hybrid discipline with roots in biology, psychology, and sociology. Physician Pinel (1745-1826), who learned psychiatry from the lay director of the Bicêtre hospital, was not only concerned with nosology and classification but also with "the variety and profundity of knowledge requisite on the part of the physician, in order to secure success in the treatment of insanity" [14], remarks prefacing "Section II. The Moral Treatment of Insanity," i.e., psychotherapy. Whereas Pinel's 288 pages long treatise lists six "species of mental derangement," or diagnoses, the current DSM-IV [15] runs 886 pages, of which pages 829-841 list all the diagnoses. The editors offer some caveats: "although this manual provides a classification of mental disorders, it must be admitted that no definition adequately specifies precise boundaries for the concept of mental disorder. The concept, like many concepts in medicine and science, lacks a consistent operational definition that covers all situations", due to the "limitations of the categorical approach". Moreover, and more significantly, they declare: "to formulate a treatment plan, the clinician will require considerable additional information about the person being evaluated beyond that required to make a DSM-IV diagnosis" [15]. Applying the razor of Occam, the most celebrated nominalist and author of the dictum, entities must not be multiplied beyond necessity, brings to mind Joseph Guislain's and Ernst Albrecht von Zeller's "unitary psychosis," a single basic disorder from which the various pathological forms evolve, clearly, a pre-Kraepelinian concept. Replacing previous diagnostic-statistical manuals, based on Adolf Meyer's (1866-1950) psychobiology [16], in which disorders were observed longitudinally and classified as reactions, the DSM-IV [15] was a return to Kraepelin's descriptive psychiatry. Continuing the ideas of Sydenham and Linné, Emil Kraepelin (1856-1926) published the first edition of his influential *Textbook of Psychiatry* in 1883 and in the 6th (1899) drew the distinction between manic-depressive psychosis and dementia praecox, renamed schizophrenia by Eugen Bleuler (1867-1939). Kraepelin's clinical method was to collect

hundreds of case histories recorded on cards, the legendary *Zählkarten*, which were abstracted and generalized as cross-sectional psychopathological paradigms in the *Textbook* and utilized to produce diagnoses and prognoses. The *Textbook* abounds in eloquent descriptions but contains few life histories and less dynamic formulations or accounts of psychotherapy. Having repudiated the early 19th century dynamic psychiatry, Kraepelin created a behaviorist, static, organically-oriented science primarily for the benefit of institutional and forensic psychiatry. It was Sigmund Freud (1856-1939), taught psychiatry by Theodor Meynert in Vienna, who, together with his mentor the internist Josef Breuer, paved the way for the revival of dynamic psychiatry in the epochal 1895 *Studies on Hysteria*, co-authored with Breuer [17]. As noted by medical historian Pedro Laín Entralgo, “the contribution of psychoanalysis to medicine ... [was] to assign to its proper place, in the over-all biography of the patient, the event of the illness. ... In the field of neurosis, Freud has succeeded in demonstrating that pathography is, and should be, basically, biography”. “Thanks to Freud, Western pathology has begun to be anthropological. Both clinically and pathologically, the patient has come to be considered as a person” [18]. This innovation was completed with the elaboration of Freud’s dream psychology in *The Interpretation of Dreams* [6], published in 1899 but dated 1900 on the title page, where Freud formalized the fundamental psychoanalytic method for the investigation of the inner psychological life of the individual, the technique of *free association* (*freie Einfälle*), which enabled the patient to express thoughts, sensations, and emotions effortlessly and spontaneously, free from the fear of being criticized. However, while free in the above sense from self-criticism and internal resistances, such associations are not free in the sense of arbitrary or random but are determined, i.e., ruled by the psychic determinism of cause and effect of past or present events [8, 19, 20, 21]. Neither conscious reflection nor symbolic decoding but free association is the key that unlocks the hidden, repressed, thus unconscious, meaning not only of dreams but also of symptomatic acts, hallucinations [22], delusions [23], and dramatic enactments [24, 25, 26, 27]. Another pillar of Freud’s psychoanalytic technique was the discovery of transference [17], as dramatiza-

tion in fantasy or in act, or both. From the outset, two identities crystallized in Freud, the therapist and the theoretician. In his office Freud treated persons with neuroses and very rarely psychotic patients. However, Freud’s treatment method was adopted in treating psychotic patients at the Burghölzli Hospital by Bleuler, C.G. Jung (1875-1961), and Jung’s patient and student, Sabina Spielrein (1885-1942), a tradition that is still very much alive today [28]. Freud’s major work on psychosis was his 1911 analysis of a book written by the most famous inpatient in the history of psychiatry, Paul Schreber (1842-1911). Lacking a good social and personal history, Freud erred in explaining Schreber’s entire illness and alleged paranoid delusions as caused by a passive homosexual desire for his psychiatrist Paul Flechsig. Freud explained Schreber’s desire as transference from similar desires towards his father, but had no evidence for either of these assumptions and Bleuler and Jung were the first to reject this interpretation. Actually Schreber suffered from a severe mood disorder and his fantasies of turning into a woman were related to dramas involving career, love, and marriage, and his wife’s repeated miscarriages and stillbirths, an identification with his wife due to a transference from his mother [29, 30]. In 1907 Freud had provided a more truthful analysis of the dreams and dramas of love of a fictional character, Norbert Hanold, as depicted in Wilhelm Jensen’s (1837-1911) novel *Gradiva* [23, 31]. Freud characterized Hanold’s dreams and delusions, both fantasied and enacted, as “*In-szenierung*,” as staged, i.e., dramatized. Hanold was inhibited in loving a woman of flesh and blood named Zoe Berggang and “transferred” his love to a marble relief of an imaginary young woman he called Gradiva who died when the Vesuvius eruption buried Pompeii in 79 AD. Addressing Zoe as Gradiva, Hanold dramatized his love emotions in various acts and speeches, “a triumph of ingenuity and wit to be able to express the delusion and the truth in the same turn of words” [23]. Freud analyzed Hanold’s “symptoms of a delusion—phantasies and actions alike—[as] the products of a compromise between the two mental currents ... a struggle, ... a conflict...between suppressed eroticism and the forces that were keeping it in repression”, “which has been demonstrated by me in the case

of patients observed and medically treated in real life". The conflict had a happy ending: "the procedure which the author makes Zoe adopt for curing her childhood friend's delusion shows a far-reaching similarity—no, a complete agreement—with a therapeutic method which was introduced into medical practice in 1895 by Dr. Josef Breuer and myself ... to which Dr. Breuer first gave the name of 'cathartic' and which I prefer to describe as 'analytic'" [23]. What turned Breuer's cathartic method into an analytic one was the introduction of transference, to which Freud refers in these terms: "the process of cure described by the author of *Gradiva* reaches its climax in the further fact that in analytic psychotherapy too the reawakened passion whether it is love or hate, invariably chooses as its object the figure of the doctor. It is here that the difference begins, which made the case of *Gradiva* an ideal one which medical technique cannot attain. *Gradiva* was able to return the love which was making its way from the unconscious into consciousness but the doctor cannot." [23]. Clearly, Zoe-*Gradiva* acted as a sexual object, a lover and an intuitive psychodrama therapist whereas a real therapist may not get sexually involved with a patient, and transference provides the necessary barrier against such temptation. Non sexual love, love writ large as *agape*, as care and concern for the other, is another matter. Thus, while the emotions of love and hate are as real and as dramatic in therapy as such emotions are in real life, the artificial situation of therapy, with its professional roles and ethical rules, precludes both participants from acting at the behest of their emotions. What Freud experienced in the 1890's with his first hysterical patients hit him again with greater force treating Dora in 1900 [32]. Further elaborations of transference were given the 1912-1915 papers on technique [33]. Dramatology brings psychiatry and psychoanalysis back to its source: the real-life, personal, and social context of individual existential dramas that forever elude all formulas and schemas. Dramatology as a method aims first to perceive, to observe, to establish facts, to avoid premature closure by grasping at diagnoses and dynamics or hunting for patterns and schemas. Diagnosis subsumes, dramatology individuates; to use an oxymoron, it is a historically-grounded science of the particular. Like warfare, medicine, psychi-

atry, psychoanalysis and psychotherapy utilize basic sciences but in practice they are all arts when dealing with human actions in interpersonal situations.

DRAMATOLOGY IN EVERYDAY LIFE AS COMMUNICATION TO SELF AND OTHERS

Real life is inherently dramatic because it involves people interacting with each other in interpersonal relationships. We begin our development and maturation as persons in the dyadic situation of child and mother, the child's first teacher of love and language. Persons also engage in relationships with *things*, or external objects, with plants and animals, and with *thoughts*, in which images of external and internal objects dwell. It is thus desirable to speak of interpersonal relationships when we mean persons and object relationships when we mean objects external to us or the internal objects of cogitation, emotion, and fantasy. Quite special objects are theological entities such as God, angels, the Devil, the saints, with which we can entertain various relationships. Thus, we act on things that may or may not act back but we interact with people in reciprocal and mutual, or interpersonal, relations.

Plato defined thinking as the soul talking to itself. Freud [34] viewed "the power of thinking" as trial action, "as experimental action, a motor palpating", "thinking is an experimental action carried out with small amounts of energy" [35]. Given that thinking is a kind of action, or drama, we now move from action in dramas of everyday life to dramas of disordered, or pathological, acts.

DISORDER AS DRAMA

Freud was also concerned with acts as such: symptoms--and of course we are dealing with psychical (or psychogenic) symptoms and psychical illness--are *acts* detrimental, or at least useless, to the subject's life as a whole . . . 'being ill' is in its essence a practical concept...you might well say that we are all ill--that is, neurotic -- since the preconditions for the formation of

symptoms can also be observed in normal people" [36].

The acts in this passage imply speech acts, i.e., communications, as he stated: "Nothing takes place in psycho-analytic treatment but an interchange of words between the patient and the analyst" [36]. After having journeyed from hypnosis and suggestion to the memory model of psychopathology [17], thence to the libido model [30, 37], and finally to the ego model [38], Freud reaffirmed his original interpersonal approach to life and disorder: "in the individual mental life someone else is invariably involved, as a model, as an object, as a helper, as an opponent; and so from the very first individual psychology ... is at the same time social psychology as well" [39], where by 'object,' a contraction from his original term, love-object, he clearly meant person. The final stage represents a fundamental paradigm shift: Freud's memory and libido models of disorder were monadic, or intrapersonal, the social context of the disorder is dyadic or interpersonal. Monadic as a theoretician, Freud was from the outset dyadic, or interpersonal, as a practitioner of psychotherapy and psychoanalysis [40].

Traditionally, psychiatrists and psychoanalysts have focused on the monad, or a one-person psychology, at the expense of the dyad, or a two-person psychology: on the intrapersonal vs. the interpersonal, on the solitary vs. the social, the dreamer vs. the agent, the narrator over the dramatizer. Interpersonal relations are a counterpoint of conscious and unconscious actions and interactions, of external conflicts of interests and internal conflicts of motives. The dyadic *is* dramatic. Dramatic interactions are public, they are seen, shown, and observed by oneself and others, justified as reasons or rationalizations, whereas the truer motives of actions and interactions remain private, unavowed, unseen but potentially avowable and understandable, i.e., analyzable. The most important finding of the interpersonal approach is that the complete meaning of a so-called symptom, or action, is revealed only after its interpersonal message from sender to receiver and meaning has been fully brought to light [40]. The interpersonal meaning includes not only the content, but also the *intent* of the communication, i.e., what do the two communicators *want* from each other. The monadic

model belongs in medicine, but psychiatry must be dyadic, or interpersonal: it takes one person to develop pneumonia, it takes two or more persons to create paranoia.

Traditionally psychoanalysts have predominantly worked with the *ideational* content of the person's internal world of thought and fantasy in formulating theories of disorder. Consistent with this approach, they tended to see the patient as a narrator [41] rather than as an actor and interactor. The consequence was to look for meaning in the thinking and fantasizing of the monad, which resulted in a pervasive intellectualism and a de-emphasis of feelings and emotions, the central phenomenon in everyday conversations, in drama (tragedy and comedy), in telling jokes, [42] as well as in emotional communication of the nonverbal esthetic domains: music, dance, and the visual arts.

We receive with feelings everything that happens to us, experiencing pleasure or pain, deprivation or gratification, hunger or satiety, and more. Feelings are emotions undergone, whereas emotions, as directed motions, are feelings enacted: we feel, are aware of, jealousy and envy of the other, we emote in reacting to the other by engaging in jealous and envious acts and attitudes. Similarly, we feel angry but emote towards the in acts of anger. In experiencing feelings and emotions we also dramatize an appeal to another person for support and survival: we ask the other to give us food, help, and money, approval, pity, consolation, or love. The ubiquitous plots of dramas span the spectrum from disappointment to despair over love betrayed, love lost, love threatened, unrequited, or wounded, or love regained, along a continuum from manageable traumas to uncontrolled tempests.

FROM NARRATOLOGY TO DRAMATOLOGY

Freud, the creator of a new science, wrote: "It still strikes me myself as strange that the case histories I write should read like short stories [Novellen] and that, as one might say, they lack the serious stamp of science. I must console myself with the reflection that the nature of the subject is evidently responsible for this rather than any preference of my own" [17]. Freud's stories contain both descriptions of forgotten or remem-

bered traumatic events and lively dialogues. The stories and dialogues serve to depict traumatic—thus dramatic—social and interpersonal events, situations, and scenes. What was defined medically as a disorder called hysteria turns out to be *historia*, history, his story or her story, memories of lived traumas that are variously relived in therapy in dramatic form. Thus, there are two story tellers here: the patient and the doctor, the patient dramatizing his story, the doctor narrativizing the patient's drama. Here is vignette of the only man described in the *Studies on Hysteria*: an employee who had become hysteric as a result of being ill-treated by his superior, suffered from attacks in which he collapsed and fell into a frenzy of rage, but without uttering a word or giving any sign of a hallucination. It was possible to provoke an attack under hypnosis, and the patient then revealed the he was living through the scene in which his employer had abused him in the street and hit him with a stick. A few days later the patient came back and complained of having had another attack of the same kind. On this occasion it turned out under hypnosis that had been re-living the scene to which the actual onset of the illness was related: the scene in the law-court when he failed to obtain satisfaction for his maltreatment [17]

The above episodes show how a life drama, either told to a listener or dramatically enacted and witnessed, becomes a form of disorder, then a mode of therapy, resulting in healing.

The legendary Anna O., the first patient of psychoanalysis and co-discoverer of psychoanalytic psychotherapy, called this therapy in English "'the talking cure' and referred to it jokingly as 'chimney-sweeping'", which Breuer called abreaction or catharsis. Breuer demonstrated this in his analysis of the following event. Anna O. suffered from thirst but found it impossible to drink ... like someone suffering from hydrophobia ... one day she went on ... to describe, with every sign of disgust, how ... her English lady companion's little dog—horrid creature!—had drunk out of her glass there. The patient said nothing, as she had wanted to be polite. After giving further energetic expression to her anger she had held back, she asked for something to drink.... These findings...made it possible to arrive at a therapeutic technical procedure left nothing to

be desired in its logical consistency and systematic application ... this *process of analysis* [17].

Note that Breuer was the first to call this therapeutic procedure 'analysis', which Freud renamed 'psychoanalysis' in 1896. However, his 1895 chapter is entitled "The psychotherapy of hysteria" [17] and thereafter Freud used both terms to refer to his method of therapy. However, it was Breuer who underscored the dramatic aspect of the disorder and the dramatic process of healing. Thus he observed that Anna O., "*da sie diese Dinge durchlebend, sie teilweise sprechend tragierte*" [43] as she relived these experiences, she *dramatized* them partially in speech, but also in gesture and with expression of emotions. The crucial word '*tragieren*' was lost in Strachey's translation: "she acted these things through as though she was experiencing them and in part put them into words" [17], unfairly adding the qualifying words "as though" and thus hiding from view Breuer's verb *tragieren*, which in those days meant to dramatize, compose and perform drama on stage, to act a role, to represent dramatically. *Tragieren* contains the word *agieren*, to act and enact, that would be used by Freud as a technical term, acting out: Dora "took her revenge on me as she wanted to take her revenge on [Herr K.], and deserted me as she believed herself to have been deceived and deserted by him. She *acted out* [*agierte*] an essential part of her recollections and phantasies instead of reproducing them in the treatment" [32]. Dora's 'acting out,' or drama, became Freud's trauma: in his sour grapes mood he scorned Dora for having deserted him. It is not only that "the greater the resistance, the more extensively will acting out (repetition) replace remembering" [44], because Dora more tellingly dramatized her disappointment in Freud in the here-and-now for having sided against her with her parents and her seducer, Herr K. Moreover, while the repetitions were acts of unconscious remembering, in the form of dramatic interpersonal enactments, as discussed in recent years [24, 25, 26, 27]. Such enactments call for two kinds of analysis: first, detailed observation of the surface, of the actual dramatic confrontation, as to who, when, where, why did what and to whom; second, a depth exploration of the unconscious meaning of the enactments with the technique of free association.

DRAMATIZATION IN FANTASY

Anna O. resorted to a theater simile to paint an important habit of her character: “this girl who was bubbling over with intellectual vitality, led an extremely monotonous existence in her puritanically-minded family. She embellished her life in a manner which probably influenced her decisively in the direction of her illness, by indulging in systematic day-dreaming, which she described as ‘her private theatre’ ... this habitual day-dreaming while she was well passed over into her illness without a break” [17]. Day-dreaming, remembering and hallucinating contain visual imagery as an important and ubiquitous component of dramatizing in fantasy, across a spectrum from the faintest to the most vivid, from the normal to the pathological [22].

Having learned the technique of analysis from his mentor Breuer, Freud described how he “made up [his] mind to embark on an analysis” of an unnamed patient’s “attacks of dizziness”: Freud would ask her “what does that mean?” [17], while teaching her “to rely on the things that come into your head under the pressure of my hand”. Four years later gave up all physical pressure and only asked the patients to free associate, a procedure he formalized later [6]. “We [Breuer and Freud] had compared the symptomatology of hysteria with a pictographic script [*Bilderschrift*] ... In that alphabet being sick means disgust. So I said: ‘If you were sick three days later, I believe that means that you looked into the room and felt disgusted’ [17]. ‘Pictographic’ meant thinking in pictures, or visual images which was also meant dramatically reliving and expressing emotions. With another patient it became a question of finding out the cause of the pain ... When I asked her... whether anything occurred to her or whether she saw anything, she decided in favour of seeing and began to describe her visual pictures. ... She went on with her vision: a sun with golden rays. And this she was also able to interpret ... What I had to deal with were allegories and at once I asked her the meaning of the last picture. She answered without hesitation: ‘The sun is perfection, the ideal, and the grating represents my weaknesses and faults which stand between me and the ideal’. ... A minute later I was initiated into her mental struggles and her self-reproaches and was hear-

ing of a small episode which gave rise to a self-reproach [17].

Under Freud’s guidance the patient became an interpreter, too. This was a revolutionary insight: just as the key to the dream are in the dreamer’s associations, so the patient’s interpretations are at times more valid than those of the psychiatrist or the psychoanalyst, supplying confirmatory evidence to those of the analyst. Guided by this principle I took Schreber’s self-interpretations as more valid than those of his psychiatrists and those of Freud [45].

Dreams and day dreams represent ideas and emotions in mental pictures, or images, a process Freud called “representability” (*Darstellbarkeit*), from *darstellen*, which in German means to describe graphically and to put on stage:

Dreams ... think predominantly in visual images, but not exclusively. They make use of auditory images as well... and other senses... The transformation of ideas into hallucinations is not the only respect in which dreams differ from waking life. Dreams construct a *situation* out of these images, represent something as an event happening in the present,... they *dramatize* an idea ... in dreams ... we appear not to *think* but to *experience* ... we attach complete belief to the hallucinations. Not until we wake up does the critical comment arise that ... we have merely been thinking in a particular way” [6].

Freud [6] further defined “condensation, together with the transformation of thoughts into situations (‘dramatization’), [as] the most important and peculiar characteristic of the dream work”. Such transformation also takes place in “dream symbolism [that] extends far beyond dreams but exercises a similar dominating influence on representation in fairy-tales, myths and legends, in jokes and in folk-lore. ... Dream symbolism in all probability [is] a characteristic of the unconscious thinking which provides the dream work with the material for condensation, displacement, and *dramatization*” [6], and, by extension, material for daydreams and the conscious and unconscious meanings of actions.

Freud’s awareness of the role of mental images in life and disorder led him to emphasize the mutually evocative function of images emerging in the process of free association in therapy in both patient and analyst, further elaborated by Isakower under the term analyzing instru-

ment [19, 46], and operationalized as reciprocal free association by Lothane [47, 20, 21].

DRAMATIZATION IN ACT

Freud's method points to the inherent affinity between therapeutic analysis and literary analysis, which he prized highly: "Before the problem of the creative artist analysis must, alas, lay down its arms" [48], expressing his admiration for Dostoevsky. In literature analysis means "the investigation of any production of the intellect, as a poem, tale, argument, philosophical system, so as to exhibit its component elements in simple form" [49], analysis is "the elucidation, clarification, and explication of expressions and statements through a determination of their meaning or logical use" [50]. Freud saw "creative writers [as] valuable allies and their evidence is to be prized highly ... in their knowledge of the mind they are in advance of us everyday people" [23].

Freud discovered even greater affinities between dreams, desires, and conflicts in ancient and modern literary dramas. It was in Sophocles' *Oedipus Rex* and Shakespeare's *Hamlet* that Freud uncovered the Oedipus complex, "a universal event of early childhood... Each member of the audience was once, in germ and in phantasy, just such an Oedipus" [51]. In an essay written in 1905-1906 and published in 1942 Freud [52] wrote:

Since Aristotle the purpose of drama is to arouse 'terror and pity', and so 'to purge the emotions, ... opening up sources of pleasure or enjoyment in our emotional life, just as *joking* or fun opening up similar sources... The prime factor is unquestionably the process of getting rid of one's own emotions by 'blowing off steam' ... the consequent enjoyment corresponds ... to an accompanying *sexual* excitation... the playwright and the actor enable [the spectator] to identify himself with a hero, [to gain] an enjoyment ... based on an illusion, [because] suffering on stage ... is only a game, which can threaten no damage to his personal security. [Compared to] lyric poetry [and] epic poetry, ... drama seeks to explore emotional possibilities more deeply and to give an enjoyable shape even to ... suffering and misfortune ... as happens in tragedies. [In drama] mental suffering [occurs] in connection with some ... event out of which the illness

shall arise. ... Some plays, such as the *Ajax* and the *Philoctetes*, introduce the mental illness as already established. ... It is easy to give an exhaustive account of the preconditions governing an event of the kind that is here in question. *It must be an event involving conflict and it must include an effort of will together with resistance*" [52].

It cannot be emphasized enough: the factor of a *repressed*, i.e. unconscious, conflict, one of the pillars of Freud's psychoanalytic method, is the indisputably novel addition to the classical definitions of drama since Aristotle. Freud delineated five kinds of drama: (1) religious, "a struggle against divinity"; (2) social, "a struggle against society"; (3) tragedy of character, "a struggle of individual men"; (4) psychological drama, where "the struggle that causes the suffering is fought out in the hero's mind itself—a struggle between different impulses", "where we have tragedies of love, the suppression of love by social culture, by human conventions, or the struggle between 'love and duty', ... the starting point of almost endless varieties of situations of conflict: just as endless, in fact, as the erotic day-dreams of men" [52], i.e., conflicts of conscience; (5) psychopathic, "between a conscious impulse and a repressed one", the "repressed impulse [of regicide, i.e., parricide] is one of those which are similarly repressed in all of us ... is shaken up by the situation in the play". The dramatist's business to induce the same illness in *us*; and this can best be achieved if we are made to follow the development of the illness along with the sufferer" [52]. Here Freud shifts from dramaturgy to a dramatological conception of psychoanalysis and conjoining it with the psychotherapeutic method.

PSYCHOTHERAPY AS DRAMA, THE CENTRALITY OF CONFRONTATION

Breuer named his therapeutic method cathartic, from the Aristotelian drama theory of catharsis, literally, purgation. It was not only a matter of recalling a trauma but

whether there has been an energetic reaction that provokes an affect (emphasis in the original) ... the whole class of voluntary and involuntary reflexes—from tears to acts of revenge ... The injured person's reaction to the trauma only exercises a completely '*cathartic*' [emphasis in the

original] effect if it is an *adequate* reaction—as, for instance, revenge. But language serves as a substitute for action; by its help, an affect can be ‘*abreacted*’ almost as effectively. In other cases speaking is itself the adequate reflex, when, for instance, it is a complaint [*Klage*] or giving utterance to a tormenting secret (confession!) [17].

Breuer is silent about his own emotions reactions to the patient. However, in therapy the two players, while interacting according to mutually binding roles and rules, also confront each other as individuals with their own needs and emotions, both consciously and unconsciously, every step of the way, and at times in strikingly momentous enactments, as real people, unique in their physical lineaments of face and body, thinking, acting and speaking style, working and loving, character traits and idiosyncrasies, philosophies and prejudices, in sum, singular as real interactors in the here-and-now, sharing emotions and expectations, learning from each other about love.

In the very first encounter they perceive each other both consciously and unconsciously and sense how they are alike or different, how compatible, whether they like or dislike each other, and how much they would like to collaborate with each other. The patient assesses the authority, abilities, and knowledge of the therapist, the therapist whether he will be able help the patient. If they decide to work together, they might still consider a preliminary trial period before they make the final commitment to each other.

As staged drama is not primarily a narrated story, although story telling is woven into the dramatic dialogue, so both patient and therapist are not primarily narrators but dramatic interactors. The story is told by the patient piecemeal, as it emerges in the stream of consciousness, while it is also being enacted as a real and as transference relationship, and after months or years that story may asymptotically reach the ideal of “a search of a picture of the patient’s forgotten years that shall be alike trustworthy and in all essentials respects complete” [53]. Freud’s job description includes that of the patient offering “lost memories, his dreams, ... ‘free association’, ... actions...some fairly important, some trivial, both inside and outside the analytic situation, ... the relation of transference, calculated to favour the return of these emotional connec-

tions...the two portions of the work of analysis, between [the analyst’s constructions] and that of the patient. ... Both of them have an undisputed right to reconstruct... both of them are subject to many of the same difficulties and sources of error” [53]. This job description shows the difference between the epistemology of interpretations as constructions, which can fairly be characterized as a method of exploration and *contemplation*, and that of dramatization in act and pertaining to *confrontation* in both the real and transference drama. Although Freud did not use the word confrontation, he described it in military metaphors: “this latest creation of the disease must be *combated* like the earlier ones. This happens, however, to be by far the hardest part of the whole task. It is easy to learn how to interpret dreams, to extract from the patient’s associations his unconscious thoughts and memories, and to *practice similar explanatory arts*: for these the patient will always provide the text” (emphasis added); a whole series of psychological experiences are revived not as belonging to the past but as applying to the physician at the present moment” [32]; “all the patient’s tendencies, including hostile ones, are aroused” [32]. Freud also discussed these issues in 1912: “This struggle between the doctor and the patient, between intellect and instinctual life, between understanding and seeking to act and act out, is played out almost exclusively in the phenomena of transference. It is on that field that the victory must be won—the victory whose expression is the permanent cure of the neurosis. ... For when all is said and done, it is impossible to destroy anyone *in absentia* or *in effigie*” [33], for “the patient brings out of the armory of the past the weapons with which he defends himself against the progress of the treatment—weapons which we must wrest from him one by one” [44].

Struggle is commonly called confrontation. Confrontation in the therapy is something more: it is a fundamental technique of psychotherapy [54] and the term itself is not found in Freud. Traditionally, psychotherapy is defined as comprising the operations of clarification, confrontation, and interpretation. However, these functions are not sharply demarcated but flow into each other. Fenichel [55] noted that “clarification” is achieved when “we succeed in using confrontation... of his reasonable ego with the fact of his

resistance and the history of its origin"; "resistance analysis was evolved from interpretation analysis"; "an interpretation in the true analytic sense ... is a real confrontation of the experiencing ego with something which it had previously warded off". It was left to Wilhelm Reich [56, 57, 58] to include confrontation in his technique of *analysis of character resistance*:

we ask ourself [sic!] *why* the patient deceives, talks in a confused manner, why he is affect-blocked, etc.; we try to arouse the patient's interest in his character traits which presents the cardinal resistance... it is left up to him whether or not he will utilize his knowledge for an alteration of his character. In principle, the procedure is not different from the analysis of a symptom. What is added in character-analysis is merely that we isolate the character trait and confront the patient with it repeatedly until he begins to look at it objectively and to experience it like a painful symptom; thus, the character trait begins to be experienced as a foreign body which the patient wants to get rid of" [58].

To confront is to compare, to produce ocular evidence, to demonstrate, to show, to point out behavior the patient was unconscious of. Character analysis was cited by Anna Freud [9].

Greenson [59] defined "the term 'analyzing' [as] a shorthand expression which refers to... insight-furthering techniques...usually including four distinct procedures: *confrontation, clarification, interpretation, and working-through*". However, since "confrontation leads to the next step, *clarification*", and since "the third step is *interpretation*, which "means to make conscious the unconscious meaning, source, history, mode, or cause of a given psychic event," it follows that "the procedures of clarification and interpretation are intimately interwoven". Having quoted Wilhelm Reich in the connection with resistance analysis both as due to the patient's character habits and traits and to transference, Greenson states: "in order for an interpretation or a confrontation to be effective we must be sure that the patient can perceive, can understand, can apprehend the interpretation or confrontation... that a reasonable ego is available to the patient. We analyze the resistances first, because the resistances will interfere with the formation of a reasonable ego". The latter is essential, because "we analyze transference resistance only when

a reasonable ego, a working alliance is present. ... Usually, *silence* on the part of the analyst is enough to bring the transference resistance into sharp relief. If this does not succeed, the often *confrontation* will make the patient aware of the transference resistance". Greenson's ideas were endorsed by Gabbard [60, 61].

From Freud [17, 33] on, analysts regarded transference interpretations as central to psychotherapy, e.g., in Otto Kernberg's transference-focused psychotherapy (TFP) [62]. Interpersonal drama therapy (IDT) offers an alternative approach to transference. Actions and interactions do not enter the scene with the label 'transference' on them, anymore than psychiatric diagnoses are; they are first enacted and observed as dramatic verbal and nonverbal communications, a subject for the primacy of perception. This is the due order: first deal with the conscious and the observable facts of the interaction and then explore fantasy, imagination, transference, and unconscious dynamics with the help of free association. The initial impressions are also based on intuition, common sense, and clinical tact. Since the patient is primarily turning to the therapist with an appeal for help, understanding, and support, it should be met with actions that are responsive to that appeal: care and concern, empathy and sympathy, reflecting the complementary and reciprocal needs and roles of both interactors. In the dramatic here-and-now, transference should not to be applied a priori as an explanation of the patient's actions. Whether the patient's actions are determined by past transferences can only be ascertained at the conclusion of a careful mutual exploration, since both the patient's resistance and transference may provoke the therapist's counter-resistance and counter-transference.

Freud's intent to humanize the organic psychiatry of his times was coupled with the ambition to universalize his insights as stereotypes and patterns, thus repeating similar dilemmas of descriptive psychiatry, e.g., in the aforementioned wrong formulas and stereotyped use of transference to create Schreber the myth, instead of addressing the concrete complexity of Schreber the man, limitations now corrected by dramatology [45]. Moreover, dramatology approaches disorder not only in terms of its causes but also in terms of its goals: it addresses the pa-

tient's healthy, rational and resilient personality, directed towards self-regulation and re-integration, while seeing the therapist, as Freud did [17], as a mentor, a liberator, a teacher, for therapy was for Freud an after-education, or a re-education.

Moreover, since dramatology is linked to deontology, i.e., the ethics of duty, moral obligation and moral commitment, interpersonal drama therapy focuses on ethical conflict that inevitably accompanies crises in interpersonal relationships [63, 64].

THE ROLE OF DYNAMIC PSYCHIATRY

At the beginning of the 20th century Freud's psychoanalytic dynamics gave birth to dynamic psychiatry in one place only, the Burghölzli hospital, thanks to its director Bleuler and deputy C.G. Jung. Jung reported to Freud's that he successfully treated his famous patient, Sabina Spielrein [64], with Freud's method, and Freud wrote back: "essentially, one might say, healing [*Heilung*] is effected by love ... and transference" [65]. In contrast to the static-organic German psychiatry, Jung's mentor Eugen Bleuler combined Kraepelin descriptions with Freud's dynamics in his formulations of paranoia [66] and schizophrenia [67]. Thanks to Bleuler's other Swiss follower, Adolf Meyer, and Burghölzli trained American psychiatrist A. A. Brill, dynamic psychiatry became firmly established in the United States [28]. The dynamic approaches of the outpatient treatment of people with neuroses inspired generations of physicians and others to merge inpatient treatment of psychoses with dynamic psychotherapy, as exemplified by the tradition of Chestnut Lodge in the USA, or the Tworcki Psychiatric Hospital in Poland. This approach traveled back to Europe after World War II, inspiring therapists like Gaetano Benedetti, and Martti Siirala and the founding of the International Society for the Psychological Treatments of the Schizophrenias and Other Psychoses, with branches in Europe and the USA [28].

The repeated calls for merging psychiatry and neurology as neuropsychiatry [68, 69] have undermined the traditional meaning of the role of the psychiatrist, literally, a doctor of the psyche, a healer of the soul. The former psychosocial ap-

proach to history taking and clinical description has devolved into eliciting target symptoms and matching those with medications, with a concomitant neglect of understanding the suffering person, the family background, and the social and cultural environment. In many cases the result has been stagnation and therapeutic nihilism, with harm to the patients.

On the geriatric unit at Mount Sinai Hospital in New York City the author has conducted weekly senior attending clinical rounds. After the presentation of the patient's present and past history by the resident, the patient is invited to participate in front of the treatment team in an interview. The interview method is based on combining the free-associative process, and the technique taught by his teacher George L. Engel, M.D. [70, 71], who formulated the biopsychosocial model [71], with the dramatological approach, the latter focusing on the drama of the present conflict and crisis. Engel [70] cited Meyer [16] who advocated a holistic approach: taking a good history, attending to biological and facts and "affective assets," "habits," "psychogenic" and "dynamic determining factors," to arrive at a comprehensive diagnosis and an assessment of the entire "psychobiologic adaptation" of the patient. This interviewing technique repeatedly revealed relevant data and connections missed by the traditional check list and diagnostic tree method of history taking and interviewing. Further data would come to light in the team discussion that followed: observations and associations by nurses, social workers, psychodrama therapists, medical students, resident and attending psychiatrists. The dynamic perspective was also integrated with biological and milieu treatments. The rounds not only shed light on the patients' dynamics, which were then further explored by the therapists, but were also an important teaching tool and built cohesion and esprit de corps among the team members. The approach and videos of patient interviews were presented at Ground Rounds of the Department of Psychiatry and a paper about this work is in preparation.

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