

Dramatology: A New Paradigm for Psychiatry, Psychoanalysis and Interpersonal Drama Therapy (IDT)

by Zvi Lothane, M.D.

Birth of the Person

People of all ages live with other people and express themselves in conduct and communication. From the beginning, the developing person is an *agent*, one who acts, alternating as active and passive, giver and receiver, and increasingly aware of right and wrong. Action entails interaction, i.e., interpersonal action and communication, with or without words, to assure individual and social survival. The bond between mother and child as persons progresses from bodily *contact* and *communion* via touch and the other four senses to *communication* with words. In this process the infant learns about language and love, the foundation of all future interpersonal relationships, including the therapeutic one. Sullivan made “interpersonal” a household word and, like Sullivan, I use interpersonal as a reality and as a methodological concept, not a name for a psychoanalytic school. *Interpersonal relationships* is not a pleonasm, for we can have relationships with inanimate objects as well. As a *therapist* Freud was dyadic, or interpersonal (Lothane, Freud and the interpersonal, *International Forum of Psychoanalysis*, 1997; 6:175—184, 1997). As a *theorist* Freud was monadic and organismic, e.g., in his libido and death instinct theories.

The person as agent creates a history, or story, his story or her story, about a life. That history contains events and incidents of dramatic action (from the Greek root *dran*, to act). Webster’s defines drama as “a series of events invested with dramatic unity,” e.g. the drama of war, or a family drama, as “situation or series of real events involving interesting or intense conflict of forces suggesting the characteristics of a play.” Thus real life dramas become fictional dramas, enacted by actors, i.e. those acting on a stage, with gesture and word, with costume and scenery; or screenplays for films and sitcoms, all of the above representing a story in action and dialogue. Shakespeare’s “all the world’s a stage, and all the men and women merely players” does not abolish the difference between real-life dramas and fictional dramas, but merely underscores their shared focus. In life we act ourselves or perform various professional roles; on stage actors impersonate the lives of others, which can also happen to people in real life.

For life dramas I proposed the term *dramatology* (*Dramatology in life, disorder, and psychoanalytic therapy: A further contribution to interpersonal psychoanalysis. International Forum Psychoanalysis*, 2009; 18:135-148) distinguishing it from *dramaturgy*, the art writing and performing written dramas. Dramatology also proposes a paradigm shift from *narratology*, the composing or telling of narratives. In 1982 Donald Spence extolled narrative truth over historical truth and claimed that the narratives created by the analyst cure the patient. I submit that dramatic truth is both inner experience and outer action and completes historical truth. Life dramas are primary and the stories made of them are secondary, whether the latter are first-person accounts or third-person biographies, or case histo-

ries. Narratives utilize description and may contain dialogue or may not; dramas are not descriptive and are all dialogue. The events and scenes depicted in narratives are visualized through imagination (Lothane, *Imagination as a reciprocal process and its role in the psychoanalytic situation. International Forum Psychoanalysis*, 16:152-163, 2007) and relived vicariously by the reader. Real life dramas and staged dramas are witnessed, usually with greater emotional resonance, and with catharsis or abreaction.

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 (*Communication The social matrix or psychiatry*, 1951) 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.

Discovery of Dramatology

Returning to Vienna after a brief absence Breuer “found the patient [Anna O.] much worse. She had gone entirely without food the whole time, was full of anxiety and her hallucinatory *absences* [French] were filled with terrifying figures, death’s heads and skeletons. ... As she relived these things, she partially *dramatized* [*tragierte*] them through talking, so that people around her understood their content” (1909, p. 20 my translation). Strachey translated the crucial word as “she acted these things through” (*Standard Edition*, 2:27, correcting the mistaken 2:26 in the original article). *Tragieren* is obsolete for composing and performing drama on stage, acting a role. Anna O.’s *trauma* of transient abandonment was enacted as a *drama* of terror, both consciously and unconsciously. Ten years later Freud’s Dora “acted out [*agierte*]... her memories and phantasies instead of reproducing them” (SE 7:119), strictly her *transference*, with little awareness of his own *counter-transference*. Today there is growing literature about reciprocal *enactments*, i.e., dramatizations, by patients and analysts.

Dramatization comes in three forms: 1. *dramatization as embodiment*, as above; 2. *dramatization in thought*: images and scenes lived in dreams, daydreams, and fantasy scenarios (dramatization was Freud’s name of the pictorial nature of dreams), accessible via free association and spontaneous recall of the past; and 3. *dramatization in act*: in real life scenes and situations of love and hate, faithfulness and betrayal, ambition and apathy, triumph and defeat, despair and hope, genuineness and make-believe, living and dying, and calling for here-and-

now clarification and confrontation.

In 1894 Freud held that distressing or incompatible ideas and emotions are defensively “*sums of excitation transformed into something somatic, for which I would like to propose the name of conversion*” (SE 3:49, Freud’s italics), couched in quasi-physiological terms. For George Engel (*Mental Development in Health and Disease*, 1962) conversion was a metaphor: when forbidden wishes, ideas, or fantasies are blocked, “they are kept out of consciousness [and] translated (“converted”), not into words, but into some bodily activity, or sensation, which suitably represents it in a symbolic form. It is a token gesture, so to speak, which substitutes for the real thing. ... A useful analogy for understanding of the conversion reaction is the game of charades. In this game one is asked to translate a verbal (cognitive) message into bodily terms, as pantomime, gesture, or other movements” to be guessed by onlookers (p. 369).

Freud lives on in DSM-IV: Conversion Disorders and in Somatization and Somatoform Disorders: “Conversion symptoms [of Conversion Disorders and Somatoform Disorders] are referred to as “pseudoneurological” ... it does require that psychological factors be associated with their onset and exacerbation” (pp. 452-453). Such charades are also classed as histrionic personality disorder, from the Greek word *histrion* = actor, suggesting conduct striking or inappropriate, affecting an emotionalism deemed excessive or insincere, as “theatrical” and “melodramatic.” Dramatology is more charitable. From the perspective of dramatology, a hysterical paralysis is neither a genuine nor a pseudo-paralysis, it is no paralysis at all - it is embodied metaphor, it is behaviour of a person enacting or impersonating or dramatizing the imagined behaviour of a paralytic, a patient who frequents medical and psychiatric emergency rooms, inpatient and outpatient services, and private offices.

Case Vignette

Gwen was the eldest child of her prim and proper mother, who died of multiple sclerosis; and a loud, vulgar and adulterous father. Gwen’s brother was born when she was 2; and a congenitally deformed, mentally retarded sister when Gwen was 8. Mother “fattened her up” gave her enemas until age 15. Gwen remained emotionally tied to her parents until they died. Father was obsessively curious about Gwen’s sexuality and beat her brother with a belt, sometimes dragging him across the room. Brother called her a fat whale, tore the head off her favourite doll, tortured insects, drowned her kitten, and was eventually diagnosed with schizophrenia. He apparently died of starvation. Brother and sister, who apparently slipped from Gwen’s hands onto the floor, caused her life-long guilt. In our first session I said to Gwen, “you had a childhood holocaust.

Gwen grew up chronically fearful, submissive, clinging dependently to relatives, friends, employers, and doctors. She continually tried to wrest love from them by seeming compliance, ingratiation, and compulsive altruism (e.g., giving gifts, alms, and food to the homeless) alternating with bursts of rage or passive-aggressive behavior. Gwen never married and had multiple affairs with sickly, old, married men, whom she fantasized rescuing from their infirmities and impotence. Earlier Gwen engaged in fleeting lesbian encounters, which led to not permanent relationships. She often felt as if she were in “in a black hole, making myself act crazy so as not to show up my crazy family.”

Since she was eight, Gwen nurtured an imaginary companion, a “foetus, enclosed in half an almond-shaped shell in my stomach, a healthy child to compensate my mother for my sister.” This imaginary scenario produced another fantasy: being split into a “good Gwen” and a “bad Gwen” and “living trapped in a plastic bubble.” This splitting of the self was insurance against “making mistakes or being angry. It was the dad Gwen’s fault. If you knew the real , you would love me. This way no one could hurt me or abandon me.” In the course of free, association Gwen dramatized “birthing sessions,” complete with screaming, “the wet foetus leaving my body and soul forever.” These fantasies were her “big secret” and inhibited her ability to focus on what on what people were saying to her in the moment. She had to “burst the bubble” to reconnect with the world.

She would arrive to her sessions with scripted speeches filled with dramatic depictions of current calamities and crises, accompanied by descriptions of aches and pains in various parts of the body, which resulted in phone calls for extra sessions, which were never granted. She complained of dizziness when she felt angry with me.

At a start of a recent session, Gwen showed me a 1975 US Government telegram about her brother’s death. She then pointed to the flowers on my table, and the following (reconstructed) dialogue ensued:

Gwen: Where did you get those lovely daisies?

Dr. Lothane: These are not daisies, these are chrysanthemums.

G: No, they are not!

L: you are insulting my veracity! (my voice deliberately raised).

G: You sound like my mother, she would take it personally.

L: Why do you insist that these are daisies?

G: The best defense is a good offense. Of course, I knew these were chrysanthemums.

This mundane interchange illustrates interpersonal drama therapy. Gwen defended herself against the pain of anger at her brother and parents and also anger with herself, for having wasted so much of her life, unable verbally to challenge her parents, her brother, or her previous therapist. She also harbored anger at me for not having cured her yet. As in many previous incidents, Gwen’s behavior was infuriatingly perverse, deliberately denying the truth of her perception by calling my flowers daisies. She needed to be confronted with her talking without thinking of the consequences, a habit that repeatedly got her in trouble with people.

In this episode Gwen displayed her habitual stubborn contrariness and rebelliousness, and her demanding dependency. The enactment then led to how past character traits interfered with her performance on the job. Over time Gwen was able to give up dependence on all her medications, dispense with her defensive maneuvers, accept herself as she is, be more in touch with herself “in the moment,” and be more direct and forthright in communicating with people. In my work with patients like Gwen, I combine confrontation with “reality coaching,” which works on both a cognitive and emotional level. I teach patients social skills and psychological self-regulation.

In her own assessment of our work, Gwen wrote: “Dr Lothane uses humor and confrontation to let you reveal yourself.

He sees through lies and self-deception. He always listens with the “third ear.” He allows me to be aggressive and angry, to wish him dead out loud. He can talk in psychotic language and understands before I do what makes me tick” (modified from Lothane 2010, *Dramatology: A New Paradigm for Psychiatry and Psychotherapy*. *Psychiatric Times*, June issue, pp. 22-23).

In response to calling daisies chrysanthemums I was guided by my intuition of the right tactic, tact, and timing in favor of confrontation. Following my intervention she gave her associations: she was consciously and unconsciously imitating her mother who had a ritual of speaking in opposites, e.g., you are wearing a cotton blouse that was wool. Confrontation may sound combative or harsh, but, as Freud remarked, if you want to make an omelet you must break the egg. Confrontation creates a stronger sense of conviction for the patient (Lothane, 2010, *Sandor Ferenczi, the dramatologist of love, Psychoanalytic Perspectives*, 7(1):165-182). As the focus shifted from symptom neuroses to personality disorder and innovations in psychoanalytic characterology, thanks to Reich, Alexander, Kohut and Kernberg, confrontation becomes an essential complement to free association (Gabbard, G. 2009, *Psychoanalysis and psychodynamic psychotherapy*. In: Oldham, Skodol & Bender, eds., *Essentials of personality disorders*, American Psychiatric Press). Confrontation is a way of pointing something out, of saying to the patient: look at what just happened and tell more. As such, confrontation leads to clarification: new memories emerge and a past episode or a long-standing character trait is illuminated. It is essential for making the patient aware of how she deceives herself and how she repeatedly wants to deceive the therapist, for defensive and emotional reasons such as covert triumph over

the analyst or keeping a secret from him.

Conclusion

Interpersonal drama therapy is a new synthesis and paradigm based on the dramatic nature of interpersonal relations and can be helpful to professionals who do not limit themselves to practicing psychoanalysis - who can these days? - but who also practice psychodynamic psychiatry. The dramatic perspective facilitates observing the person as a whole gestalt, in all his particularity and the 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 interpretations. It opens the door for comparing the analysand'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 counter-transference, which are determinations are to be made *after* the fact of the enactment, *nachträglich*, 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.

Paradigms in Psychoanalysis

by Marco Bacciagaluppi

When we see patients we always apply scientific theories. Some are conscious and explicit, as when we believe we are Kleinians, Jungians or whatever. Others are implicit. In this paper I try to make explicit the scientific theories which I find useful in my work with patients. Others could add other theories. I call these theories paradigms, following Thomas Kuhn, who introduced this term in his 1962 essay, *The Structure of Scientific Revolutions*. (The University of Chicago Press, Chicago & London, 1962) Our practical aim is to integrate the paradigms after having made them explicit. In what follows I make these integrations explicit.

I list seven paradigms: neurobiology, attachment theory, the trauma paradigm, the relational model, the family system, Fromm's psychoanalytic social psychology, biological and cultural evolution. They belong to different systemic levels. To use the distinction introduced by Max Weber and applied by Karl Jaspers to psychopathology (*General Psychopathology*, The University of Chicago Press, Chicago, Ill., 1963), the appropriate method to apply to the first paradigm is “Erklären” (explanation), whereas “Verstehen” (understanding) is the appropriate method for the other paradigms, though the two are often intertwined.

1. Neurobiology

The material in this section is based on Solomon and Siegel. (Solomon, M.F. and Siegel. D.J., *Healing Trauma*, Norton, New York and London 2003)

In the first year of life the brain is still immature. Myelination must be completed. Connections have to be established, both horizontally, between the two hemispheres, and vertically, between the cortex and subcortical areas which regulate emotion (the amygdala), memory (the hippocampus) and hormonal secretion (the hypothalamus). The right hemisphere, which is dominant during the first three years of life, is the seat of nonverbal communication; the left hemisphere is the seat of language and logic. This asymmetrical development is the reason why, in a double bind, the nonverbal message prevails. A crucial center of integration is the right orbitofrontal cortex, which, in particular, regulates the ANS (autonomic nervous system). It is also a higher center for the regulation of emotions. Finally, it enables a coherent autobiographical narrative. In front of a predator (integration of paradigms 1, 2, 3 and 7), the sympathetic branch of the ANS is activated. If there is no escape, surrender, freez-