1. Introduction

Psychotherapeutic action refers to the mechanism(s) by which talking can have the potential to cure, like the expression of emotion or seeing something in a new way. References to psychotherapy, the *talking cures*, first appear in artifacts of ancient times. One of the earliest records of medical knowledge, the Egyptian Ebers Papyrus (1550 BCE), describes depression along with the power of magic (a form of suggestion by shamans) to influence human distress. While it is impossible to know how these ideas were actually used, they clearly did exist many, many centuries ago. In fact, throughout recorded history there is evidence of efforts to understand and alleviate human suffering that were based on talking. Thus, speech is a way to connect, to communicate, to feel and to understand. Talking means talking with another person, making the relationship an essential aspect of the cure. One of the reasons psychoanalysis has such potential power to cure is that the frequency of sessions, up to 4-5 a week, and the longer duration of the treatment fosters a deep connection between the patient and the analyst.

Now leap ahead in time over 3,000 years. Sigmund Freud and his students of psychoanalysis stand out because they go beyond specific concepts of psychological suffering, beyond ideas about mental illness, to realize a unity of the human mind and a
continuum of mental functioning from normal to pathological. From the initial years of Freud’s work, it took less than 100 years to see an explosion of different approaches to psychotherapy. Psychology is no longer only a way to understand what goes wrong and why, but also how to understand everyone’s daily and nightly (i.e. dreaming) mental life. Conflict is no longer just about problems, but a normal feature of human nature, in part because civilization requires us to be civilized animals; societies impose restrictions on human behavior. Civilization is not possible if we all act on every wish, urge, conflict and desire. Dogs, for example, are free to fornicate wherever and whenever they wish, whereas we, as civilized humans, cannot act freely on our sexual desires, nor can we act freely on our aggressive impulses; so our minds must be capable of controlling such urges.

But where do our atavistic, animal urges go? It was with Freud’s later discoveries, including the idea of a System Ucs (his label for the unconscious as a system in the mind) that the unconscious was no longer just a underground place in the mind for hiding traumas, but an essential part of normal mental functioning. Think of it, how could you ever master driving an automobile or tying your shoes if you needed to think each step of the procedures through every time, in the same way you did the first time? Fortunately, such procedures develop into skills that become learned, automatic and unconscious. The ego psychologists called this mental function secondary automatization. Nowadays the neuropsychologists call it procedural memory. It appears that a number of psychoanalytic concepts pre-date contemporary neuropsychological concepts by 50 years, yet the mental functions they describe are
essentially the same: but how many psychoanalytic concepts have been lost or replaced by new terminologies without acknowledgment?

My training as a child, adolescent and adult psychoanalyst entailed a very comprehensive, thorough study of psychoanalysis. The inspiration for this book comes from those personal encounters with the substance and significance of Sigmund Freud’s ideas about who we are, how we work, and how we can help people who are lost and suffering emotionally. I am startled by the disparity between the value of Freud’s contributions and the present-day dismissal and disregard of the importance of his ideas. The mental health professions are losing a great legacy and resource for understanding how all psychotherapies work. Are Freud’s contributions really obsolete? Ask yourself, would Freud seem out of date if you knew that one of his earliest theories was essentially the theory of cognitive-behavioral psychotherapy? This is but one instance of Freud’s lost legacy, and this book is an effort to reclaim his many contributions to understanding how those who suffer emotionally can be helped: How talking cures.

The truth is that Freud made numerous contributions to psychology during a period from the late 1800’s into the 1900’s. In these prolific writings he endeavored to understand mental suffering, the human mind, the relationship between the body and the mind, human nature, literature, art, humor, history and civilization itself. Through dreams and other mental phenomena he discovered the ways of the unconscious: the rules of condensation, displacement, symbolism, and timelessness amongst others, that permit us to make meaning of the world of the unconscious. He helped us understand
that psychosis and schizophrenia are not unique states of mind, but disorders wherein the mechanisms that govern the unconscious intrude into conscious thinking; in other words, when we dream we are in effect all functioning on a psychotic level.

Throughout his professional years Freud also created a succession of theories of psychopathology linked to methods of treatment. With the creation of psychoanalysis—in its heyday a radical and innovative treatment—mental health providers, mostly psychiatrists at first, learned and applied the new procedures to their patients suffering with various forms of mental illness, in some cases even including the more severe psychoses. Early on, psychoanalysis became so accepted and popular that the official psychiatric, diagnostic classification system was eventually based on its theories.

For the first three quarters of the 20th century psychoanalysts continued to expand on psychoanalytic theories and treatments. During these years, psychoanalysts were among the leaders of medical schools, designing the programs for training psychiatrists. Psychiatric hospitals based their in-patient treatments on psychoanalytic principles. Academia embraced psychoanalysis in departments of art, the classics, economics, English, history, philosophy, political science, psychology, sociology, theatre, and theology. Many private practitioners provided psychoanalytic treatments. In short, Freud’s new science remapped the human mind. His ideas were so groundbreaking that he has been compared to pioneers like Copernicus, who remapped the universe, and Darwin, who remapped the origin of our species.

So why, at the beginning of the 21st century, has psychoanalysis lost so much of its prominence? What happened? How can it be possible that such momentous
contributions to science are now commonly viewed as obsolete? Why the decline in the acceptance and popularity of psychoanalytic points of view. In fact, there is no simple explanation, but a number of different reasons. It didn’t happen overnight but over time, beginning with the early enthusiasm for psychoanalysis as a treatment resulting in it being recommended to patients who were not suitable, with disappointing results. This kind of initial, unwarranted optimism is a common occurrence in many disciplines when there is a breakthrough, whether it is in the social or the natural sciences. For example, radical psychosurgery was done in the early days of psychiatry, often with disastrous consequences. Still, with no good alternatives and tragic human suffering, these surgeries were performed. Furthermore, it takes time and experience to discover the limitations of what initially appear to be promising treatments, in part due to the prevalence of temporary placebo effects, and in part due to the complexities of longitudinal outcome studies. In the case of psychoanalysis, this initial optimism was magnified because the procedure was not treacherously invasive, and there were no good alternatives for people who were suffering. It was better to try psychoanalysis than continue treatments known to be ineffective.

In addition to the fact that psychoanalysis was over prescribed, an unscientific reverence for Freud and his writings contributed to a reluctance to modify how analysis was being conceptualized and conducted. For decades, a religious-like deference to the writings of Freud’s and his direct disciples had a strangle hold on innovation. Psychoanalytic training continued to emphasize older techniques that failed to keep pace with new developments in the theory, a problem epitomized by the caricature of
the analyst who rarely speaks at all. Efforts to innovate were encumbered by an unspoken requirement that new contributions could not challenge Freud’s basic ideas, but had to be built upon them. Most publications in psychoanalytic journals, for example, included preliminary references that traced the author’s contribution back to Freud. The result: a psychoanalytic science of mind and theories of psychopathology that were very slow to integrate discoveries in related fields like child development, and an inflexible, intensive treatment that lacked efficacy for too many patients.

Around the middle of the 20th century, the advent of psychiatric medications ushered in a new paradigm for medicine, further marginalizing psychoanalysis. Neurobiological views of psychopathology quickly came to be seen as more scientific. From the beginning, drugs promised a much more effective, efficient, inexpensive, and available treatment for human suffering, to say nothing of the fact that bad brain chemistry is easier for patients to swallow than the challenging work of facing one’s conflicts. It’s easier to just take a pill. Unfortunately, this initial enthusiasm for medications has also proven overly optimistic, just as with psychoanalysis, and while medications certainly have a place in treating mental illness, ongoing research is making it increasingly apparent that they do not live up to the initial hopes of near magical healing powers. For the most part, these medications do not cure diseases, but treat symptoms related to syndromes of psychopathology.

Last, but not least, the actuarial economics of health insurance and the introduction of managed care (viz. managed “cost”) have slowly but surely made psychoanalytic treatment procedures either unworkably micromanaged or not
reimbursed at all. This change in the health insurance landscape has favored short-term, symptom oriented treatments like cognitive-behavioral therapy; “manualized” procedures that can be simplified in step-by-step manuals, requiring much less training, far fewer sessions, and performed by providers at a lower pay scale. If this were not enough, these new short-term treatments were offered not merely as inexpensive substitutes but as superior to the intensive, individualized, self-exploration of psychoanalysis and the psychoanalytic psychotherapies. The result: psychoanalysis became an increasingly marginalized, misunderstood, insular profession dominated by complex conceptual theories and a lack of empirical support. I would wager that most psychoanalysts, when asked what they do, have become familiar with responses like: “people still do that” or “you still use a couch!”

So why bother trying to revitalize Freud’s contributions? What does he offer that merits such efforts? If his ideas are still important, how do we integrate them into all the contemporary mental health fields? Well, this book is intended to be one response to all these questions; a step toward making sure we do not lose the potential for Freud’s contributions to inform all contemporary efforts to promote mental health. My plan is to show how his discoveries of psychotherapeutic actions are relevant to all contemporary forms of talking therapy, and not only relevant but instructive. Freud gave us the means to isolate and identify the various therapeutic components that contribute to psychotherapeutic change, no matter what the approach to treatment. At the same time, Freud’s appreciation of the importance of the therapist-patient relationship in the therapeutic process, one of the reasons for the frequent sessions and
the longer duration of most psychoanalytic treatments, helps us understand some of the unavoidable limitations of short-term psychotherapies without being critical of them. Such understanding facilitates the establishment of realistic goals for short-term psychotherapies, goals that do not depend on therapeutic actions that require the immersion in an intensive therapeutic relationship.

Demonstrating Freud’s contributions to understanding all psychotherapeutic treatments requires a fresh approach to his work. For the most part, psychoanalysis has tended to develop progressively rather than cumulatively, with new ideas replacing older ones, and old ideas persisting without integration. As Kuhn (2012) pointed out, science tends to progress with those invested in familiar ideas shunning new ones. Consequently, we do not have a composite theory of therapeutic actions that incorporates all of Freud’s discoveries. In fact, he himself did not update and incorporate his previous thinking with each new idea. For example, his writings on the technique of psychoanalytic treatment were completed before some of his most important discoveries about the mind, and he never updated them according to his later ideas. One consequence was the perpetuation of the silent analyst, trained to stay out of the way, based on an earlier theory that the patient’s unconscious mind would only reveal itself when frustrated. It was not until 43 years after Freud’s death that the problem of the technique of analytic treatment failing to keep pace with Freud’s later concepts of the mind and psychopathology was addressed directly (Gray, 1982). Unfortunately, Freud’s tendency to move onto new ideas, leaving the old ones aside or behind has continued. As a result, Freud’s discovery of multiple therapeutic actions is
concealed by a proliferation of subsequent theories that to various degrees are not new, or are not integrated into his discoveries.

I will show how, by paying careful attention to the evolution of Freud’s thinking, it is possible to derive basic modalities of psychotherapeutic action that are generic and revealing of the means by which all “talking cures” have a therapeutic impact. They are ingredients for deconstructing and comparing all psychotherapies, as well as differentiating different approaches to psychoanalysis. They provide a basis for determining and recommending approaches to treatment that are more likely to be effective with a given patient. They even can guide an approach to the treatment of couples. Lastly, these basic modes of therapeutic action have implications for training mental health professionals and for psychotherapy research. Given that these generic modes of therapeutic action are derived from Freud’s ideas, psychoanalysis is more relevant today than it has ever been.

Thus, the plan is to build a composite system of therapeutic actions; one that includes all of Freud’s work, even his very early discoveries that precede the introduction of psychoanalytic concepts. To accomplish this requires setting aside the idea that his newer ideas should replace older ones, or that his newer ideas are superior to older ones, and instead taking his body of work as a whole. With this approach, it is possible to discern six distinctive generic modalities of therapeutic action, each one equally important in its own right. These six basic modes of therapeutic action are elementary to all forms of psychotherapy and psychoanalysis, making it possible to identify and compare the essential ingredients of all talking cures, including
psychotherapies that are supportive, behavioral, cognitive-behavioral, cathartic, etc.

From the shadows, a facet of Freud’s genius emerges, and his body of work can take its rightful place at the center of all forms of psychotherapy, with psychoanalytic treatments being only one outcome of psychoanalytic science.