

# Challenges for Psychotherapy and Psychoanalysis

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This paper addresses some challenges that psychoanalysis and psychodynamic therapies face in this era of reductionist evidence-based practice and administration of health-care. The topics chosen are illustrative, and include the following: the need to clarify the aims and goals of the practices; the need to validate theory further, with greater inter-school and inter-disciplinary dialogue and greater use of the University as a forum for this; the need to participate appropriately and actively in the quest for validation of practice. Psychotherapy with medically ill patients is used as an example of a common and increasingly important domain still relatively unexplored in these ways.

The David Ingamells Memorial Lecture commemorates David's contributions to the practice of psychotherapy, and to the public debate about its place in health care delivery. The title of the paper, 'Challenges for Psychotherapy and Psychoanalysis', reflects the concerns that he had about the fate of those disciplines and practices in the post-modern era. This article, based on the 2005 Lecture, takes up some of the current issues that David would have likely pursued with vigour, and with that genuine curiosity and open-mindedness that characterises both a good scholar and a good psychotherapist. The French Lacanian psychoanalyst, Eric Laurent, epitomises those concerns when he speaks of the way in which the State uses science and its procedures to determine what its responsibility is in health, in order to legitimize its disengagement, and no longer concern itself with happiness and welfare (Laurent, 1995).

## Psychotherapy and Psychoanalysis

Why 'Psychotherapy *and* Psychoanalysis'? Herein lies the first challenge: for theoreticians and practitioners to achieve clarity about the relationship between these doctrines and practices in a way that is useful to scholars and users alike. Here the term 'scholar' refers to all who may wish to study the field and perhaps train in it. I employ the term 'user' to avoid closure on the debate as to whether those who seek psychotherapy or psychoanalysis are patients, that is, sufferers, as well as being clients. For most schools of psychotherapy this is unproblematic. They offer therapy, as the name indicates, and they defend this strongly in their dialogue with health care

funders. The definition of psychotherapy given by Strupp would lie well with these schools:

An interpersonal process designed to bring about modifications of feelings, cognitions, attitudes and behaviour which have proved troublesome to the person seeking help from a trained professional.  
(Strupp, 1978)

For the experiential and psychoanalytic schools however, there is a dilemma. Many of their practitioners assign patient status to their users, thereby attracting third party payment. Yet those schools claim, as Freud did, a much wider, non-clinical goal:

The goal of Psycho-Analysis is the achievement of self-awareness; the goal of Psychotherapy is to feel happy or better. It is possible to feel better or happy without any increase in self-awareness; an increase in self-awareness might lead to feeling extremely disturbed or to feeling very lonely.  
(Symington, 2004)

Jacques Lacan, the French psychoanalyst whose writings have inspired a rapidly increasing number of schools worldwide, is very perspicacious about the aims of psychoanalysis. In *The Nucleus of Repression*, Lacan (1988) describes the process of psychoanalysis as one in which the imaginary history is completed and the anxiety-provoking desires of the subject are named and reintegrated. They must then be related to the 'totality of the symbolic system (that which bounds inter-human relations) in which the subject is called ... to take up his place' (Lacan, 1988, p. 198). This may not be confined to the structure represented by the Oedipus complex, for as cultures beyond Western civilization increasingly bear upon us, it may have to involve other structures belonging to the same level—the register of the law—that with which the super-ego deals. Lacan (1988, p. 199) asks the important question with respect to the end of an analysis, 'Where should this adjournment come to a stop? Do we have to extend analytic intervention to the point of becoming one of those fundamental dialogues on justice and courage, in the great dialectical tradition?'. He makes the observation that this is a dimension on which analysts often do not reflect. Notable exceptions to this are reviewed by Dreher (2000) in her rich paper on this issue.

With respect to the difference between psychotherapy and psychoanalysis, Lacan is enlightening also. He uses the concept of treatment, but this is in terms of the analyst directing the patient to apply the analytic rule. In *The direction of the treatment and principles of its power*, Lacan (1977, p. 275) spells out that this means leaving the subject to try 'full' speech, refraining from satisfying any of the patient's demands (including that for cure), and placing no object in the way of the subject's avowal of his desire. In *Television*, Lacan (1990, p. 8) says that psychotherapy, in colluding with the demand for cure, may still produce meaning that is good sense. It may do good, he says, but 'it's a good that's a return to what's worse'—because, he says, there is a residue that remains as an enigma which continues to mark itself as neurosis or psychosis.

If we can clarify our thoughts about the aims of psychoanalysis, we may have a more solid basis for arguing for its support. If improvement in the well-being of the immediate family and social network, and of society as a whole is considered a desirable thing, then the extent to which practices like psychoanalysis lead to such improvement arguably should justify that support.

# Extending and validating theory

The second challenge is that of extending and validating theory.

Psychoanalysis shares with some other schools the claim that it is a theory of mind as well as of practice, one based primarily on clinical observation (Dreher, 2000). Development of theory requires ongoing dialogue between clinicians of various schools, and between them and philosophers and experimental psychologists, since theory of mind is their province as well. The extent to which this dialogue has broken down is epitomised by the theory wars between different schools of psychoanalysis, so well described by Kirsner (2000), and between psychoanalysts and cognitive behavioural therapists. Failure to acknowledge the importance of social and cultural determinants of behaviour deprives psychoanalytic theory of the important advances in our knowledge about the complexity of such phenomena. The challenge is great. All schools face the problem that there is remarkably little relationship between outcome as measured in psychotherapy trials and the underlying theory of the type of psychotherapy used (Fonagy, 2004). It contributes little to the variance in outcome (Roth and Fonagy, 2005, p. 51). It is time for more cross-school and interdisciplinary dialogue that might in turn improve the clinical validation of theoretical models.

The standoff between schools stands in contrast to what psychotherapists do in practice; they are often eclectic. We find for example that in the USA National Institute of Mental Health trial comparing cognitive behavioural therapy (CBT) and Interpersonal Therapy (IPT), CBT therapists utilised IPT techniques as well, and vice versa, and that their use of such other techniques contributed to successful outcome (Ablon and Jones, 2002). Other studies have shown that when CBT therapists use psychodynamic techniques, it is a factor in the production of change (Castonguay et al., 1996). There is a problem here. Unless eclectic practice is grounded in theory, such practice may do more harm than good, since there is nothing on which to base its scrutiny in supervision or in process research. As a response to this problem we see the emergence of some therapies designed to be eclectic, such as Ryle's Cognitive Analytic Therapy (Ryle and Golyenkina, 2000).

Developments in cognitive theory provide an opportunity for dialogue between schools. Cognitive psychologists are able to draw on the extensive findings of experimental psychology to a much greater extent than have other schools in developing theoretical models (Brown, 2004). They propose a structural theory of the mind, as does psychoanalysis, not a psychogenetic one. Structural models imply that symptoms are determined by the way that the mental apparatus develops; they are not simply reactions. The cognitive psychology literature gives evidence of the increasing acknowledgement of non-conscious processes in the determination of behaviour.

Brown (2004) provides a review of how cognitivists have reconceptualised the theory of hysterical conversion and other so-called somatoform disorders, and indeed of neuroses in general. He finds that Janet's dissociation model and Freud's conversion model are heuristically valuable in adding a perspective to the understanding of symptoms, noting that both models are supported by empirical evidence that has accumulated since they were formulated. But he criticises these older models for paying insufficient attention to the wider biopsychosocial context, and thereby failing to provide a framework that elucidates the risk factors associated with the expression of neurotic symptoms.

Brown (2004) proposes a new structural model based on cognitive psychological principles that is consistent with Janet's dissociation theory and Freud's conversion theory and which attempts to address the shortcomings, 'placing them within the remit of everyday psychology, allowing for a more normalizing interpretation of this phenomenon.' (Brown, 2004, p. 808). It is evident that there has been a reframing of psychoanalytic ideas:

... symptoms are caused by stored information in the cognitive system that disrupts the interaction between conscious and preconscious aspects of information processing. In line with conversion theory, the model suggests that this process is often driven by a defensive reaction that operates to reduce the individual's exposure to traumatic affect.  
(Brown 2004, p. 808)

Brown makes it clear that his use of the term 'preconscious' implies something like repression:

The development of symptoms also provides a way of expressing negative affect without acknowledging its psychosocial source ...  
(Brown, 2004, p. 806)

In addition to the primary gain of reducing negative affect, symptoms may also confer additional advantages to the individual, or secondary gains ...  
(Brown, 2004, p.806)

Importantly, he implies a structured, dynamic mental apparatus formed at an early stage:

... unexplained symptoms constitute an alteration in the body image generated by information in the cognitive system, rather than disturbances in the neural hardware itself.  
(Brown, 2004, p. 802)

The model accounts for this by assuming that traumatic events such as physical, sexual, and emotional abuse often lead to the use of body-focused attention as a means of avoiding the affect and cognitive activity associated with experiences of this sort.  
(Brown, 2004, p. 806)

However, the mechanism is couched in cognitive terms:

... one way of reducing this potentially overwhelming affect is to divert ... resources from self-regulatory processing and onto the body. Such a strategy could be used both during an episode of victimization and/or afterward, when a motivation to avoid trauma-related material and its associated affect remains; this is particularly likely in cases in which revictimization is perceived as inevitable (e.g., in a consistently abusive family environment).  
(Brown, 2004, p. 806)

Perhaps the best example of reframing comes when he speaks of representations:

Rogue representations can therefore be acquired from many different sources, including direct exposure to physical states in the self, indirect exposure to physical states in others, the sociocultural transmission of information about health and illness, and direct verbal suggestion.  
(Brown, 2004, p. 802)

Arguably, traumatic experiences such as physical or sexual abuse provide one of the richest sources of material for the development of rogue representations, often encompassing organic damage, intense emotional arousal, and the defensive use of physical reactions within the same experience.

(Brown, 2004, p. 803)

Clearly there is room for dialogue between theorists.

## Neuroanalysis

Reframing also comes from those who seek to emphasise the biological basis of mental structure and function. This quotation from Solms, a neuropsychologist and psychoanalyst of the British School, conveys the flavour of it:

... it is not easy for an older generation of psychoanalysts ... to accept that their junior colleagues and students now can and must subject conventional wisdom to an entirely new level of biological scrutiny ... an encouraging number of elders are at least committed to keeping an open mind.

(Solms, 2004, p. 88)

There are major methodological problems in attempting such bridging, and it is these considerations that should make us wary of the use of the words 'can' and 'must' in Solms' article. I would prefer to say that the exciting developments in both fields make more urgent the need to sort out the question of whether or not they can be linked.

An example of such developments is our capacity to create visual representations of neuronal network activity. These multi-coloured images can be seductive, tempting us to believe that we are viewing neurons that are in the process of creating experiences such as depression—or happiness. It takes self-discipline to remind ourselves that these are only representations, artificial constructs, and that the experience concerned, depression, is also an artificial construct (Berríos, 1999). Slippage in the use of terms is the enemy of truth, and there is plenty of slippage in our fields. There is a larger problem known to philosophers as the mereological fallacy (Bennett and Hacker, 2004, pp. 29). In this case the fallacy is that of attributing to the brain functions which are rightly attributable to the whole human being.

The most important problem is that of the validity of reductionism. Reductionism holds that one kind of entity, for example a thought, is no more than a structure of other kinds of entities, such as neurons and molecules (Bennett and Hacker, 2004, pp. 355 ff). It also holds that a complex system can be explained by the behaviour of its parts. It assumes that all entities are material ones, or can be represented materially, and that each can be identified in ways that permit entities to be equated. The nub of the issue here is whether mental processes can be well enough represented materially.

Implementing reductionist analysis requires a science for each level and also a set of bridging principles. Are the laws of mental life and of behaviour, of the psychological system, sufficiently

well established to warrant ‘biological scrutiny’? Are the entities sufficiently well identified to warrant an attempt to equate them with entities in another level? The Cambridge psychiatrist, historian and philosopher German Berrios says that our whole psychological language is in need of refinement, particularly with respect to the identification of phenomena, whether these be current, discarded or undiscovered (Berrios, 1999). The limitations of classificatory systems in psychiatry are a reminder of this (Jablensky, 1999), as is the ongoing debate about the validity of the concept of illness (Kendell and Jablensky, 2003). Experimental psychology has an important role here, but the derivation of laws requires the methods of philosophy.

The types of studies that Solms and others describe as neuroanalysis were pioneered by the great Russian neurologist, A.R. Luria, who was actually a psychoanalyst. Like many analysts of the active Moscow school in the 1930s, he had to camouflage his interest in psychoanalysis after Trotsky fell from grace (Kaplan-Solms and Solms, 2000). In their book *Clinical Studies in Neuro-Psychoanalysis*, Kaplan-Solms and Solms (2000) describe psychoanalytic work with patients with various brain lesions, and correlate their lesion with the extent to which psychoanalytic constructs can be observed.

Kaplan-Solms and Solms (2000) concluded that some otherwise quite incapacitated stroke patients were nevertheless able to mourn and work in a psychodynamic way. Others were not. The results show us what neurological structures need to be intact for a person to work in that way, but that does not necessarily validate the constructs. Nevertheless, Solms and colleagues feel sufficiently satisfied to conclude that the Ego and the Id can now be given precise anatomical locations. It reflects an extensive literature by authors such as Damasio (2003) documenting the extraordinary advances in knowledge of and conceptualisation of higher neural functions such as emotion and consciousness, drawing on animal experiments and observations on humans. However, for the psychoanalytically informed reader of these authors’ works, there is a constant niggling thought: a number of the terms are used in ways that do not tally with their use in psychoanalytic theory. The use of the term ‘unconscious’ is the most obvious example, where its ultimately unknowable characteristic emphasised by Lacan is absent.

Even foremost psychoanalytic writers can display over-certainty about the mind-body relationship:

Psychotherapy can be available to provide a “work-around”, a set of techniques, that the mind can use to overcome a biological deficit.  
(Fonagy, 2004)

Fonagy is keen on neural correlates of complex subjective states as non-biased, non-subjective measures of outcome. Freud had a more cautious view:

We know two things concerning what we call our psyche or mental life: firstly, its bodily organ and scene of action, the brain ... and secondly, our acts of consciousness ... Everything that lies between these two terminal points is entirely unknown to us and, so far as we are aware, there is no direct relation between them. If it existed, it would at the most afford an exact localisation of the processes of consciousness and could give us no help toward understanding them.  
(Freud, 1940, pp. 13–14)

# Accountability

Accountability is a dominant current challenge, but it is not new. The challenge is not just a product of the evidence-based medicine movement of the past 20 years; accountability has long been expected of professionals. Psychoanalysts have attended to this requirement assiduously ever since the discipline began, using the quality control processes of peer review and supervision that have become a hallmark. There can be no other health care discipline that has been as disciplined in this respect. This was qualitative research of individual cases, a research method now much refined and becoming increasingly important in the study of human behaviour and experience in general. Furthermore, psychoanalysts' scrutiny is a naturalistic study, not an experimental one, an important distinction to which I will return later. That scrutiny always included objective evidence, in the form of process notes and transcripts of audio and visual recordings. Vast archives of this material exist; what other discipline has been so exposed?

But that is not enough. It is a vital but not sufficient part of the complex process aimed at determining which therapy, delivered in which way by whom to whom, is most likely to produce specific beneficial outcomes and least likely to produce harmful ones. Answering the latter question in particular requires other methodologies, since follow-up of patients who leave therapy would be necessary. In general it can be said that an adequate model to answer the questions posed would be the following quality control cycle, based on Roth and Fonagy (2005, p. 55):

- Development of technique by clinical and theoretical creativity
- Formal research of outcome and process in clinical trials
- Field testing in natural service systems
- Creation of clinical practice guidelines informed by both research and clinical practice
- Clinical audit of implementation
- Addressing skills deficits
- Repeating the cycle

All components are essential, but in the past too much value was placed on clinical experience alone, and now too much on the Randomized Controlled Trial (RCT). RCT's represent an application of the scientific method, and by definition can study only those matters that are not subjective. An attempt can be made to represent subjective phenomena objectively, but this is contentious. The scientific method requires rational reasoning, which challenges its ability to deal with subjectivity and its inherent irrationality.

If an RCT of psychotherapy involves processes such as recruitment of subjects with diagnostic and severity homogeneity, randomisation to the treatment or control arms (placebo or waiting list), use of multiple serial measurements of patient characteristics, outcome variables that are diagnosis—and severity-related, external monitoring of therapy and time-limited therapy, then this is most unlike what psychodynamic psychotherapy or psychoanalysis is (Westen et al., 2004; Roth and Fonagy, 2005). Those who enter psychotherapy have sought help, and sought it for symptoms or problems—not for DSM (Diagnostic and Statistical Manual of the American Psychiatric Association) diagnostic categories. Their particular needs have been assessed, and they will have been given a range of options appropriate to their needs and characteristics. They are more likely than not to have both psychiatric and physical comorbidities, unlike the subjects in RCT's. Furthermore, each will have unique needs that are not necessarily measurable as outcomes using standard instruments. Their expectations will probably differ from those entering

RCT's; this has implications for the transference.

Nevertheless RCT's provide valid and reliable answers to the narrow questions that they pose, and as such provide a sound and acceptable basis for field trials. They are often seen as privileging CBT, but a more useful way of looking at them is to regard them as having used CBT on behalf of all psychotherapies in the process of establishing answers to the questions that are common to them all. Health care funders have mistakenly believed that RCT's provide the answer to the question, 'Which therapies should we use in our service, or reimburse in our plan?'. They are not designed to do that.

Psychotherapy techniques may be shown to be effective in clinical trials, but they are not efficient; they do not work so well in clinical practice (Westen et al., 2004). Patients who receive their psychotherapy in RCT trials have unacceptably high relapse rates (Hollon et al., 2002). This is likely to be related to the brevity of therapy (a maximum of 16 sessions), since the emerging naturalistic studies show a dose-response relationship such that long-term therapy is required (Sandell et al., 2002), at least to the point of complete remission (Hollon et al., 2002). This is not surprising, for it is what is required when antidepressant medication is used.

While there are some high quality studies of modified psychoanalytic therapy using RCT's, such as Bateman and Fonagy's study on Personality Disorder (Bateman and Fonagy, 2003), for most applications of psychoanalysis there are legitimate reasons why an RCT would be inappropriate (Dreher 2000; Roth and Fonagy, 2005). These include the nature of the therapy and its broader, less measurable goals. Well argued reasons for this should be accepted, and more weight put on other methods of scrutiny. There is an increasing acceptance of the value of psychoanalytic therapy in complex presentations and as a second line treatment when simpler measures have failed. This is based on its sound developmental structural theory and validation to some extent by longitudinal developmental outcome studies (Leichsenring and Leibling, 2003).

## **Psychotherapy in the 'Medically' Ill**

One field of psychotherapy presents unique challenges to psychotherapists of all persuasions; psychotherapy of the 'medically' ill. The title contains a redundancy, hence 'medically' is enclosed in quotation marks. Illness is unitary; it is the conceptualisation and treatment of it that is split.

The first challenge is that the psychological phenomena experienced by the 'medically' ill are to a large extent qualitatively different from those whose disorder is largely confined to the psychological system. Demoralisation is prominent. Demoralisation or profound despair, described long ago by Jerome Frank, is distinct from depression in that, for instance, it lacks anhedonia (Clarke et al., 2003). It is also distinguishable from grief. These differences in presentation have implications for management.

The second challenge is that in the medically ill, psychological phenomena may prove troublesome both directly and indirectly. When they induce 'abnormal illness behaviour', problems can develop in relationships with those on whom the patient has to depend: carers, family and health care professionals. This in turn can lead to reactions such as 'abnormal doctor behaviour'. In these systems issues, those involved are typically unaware of the determinants, and tend to act rather than think. This means that the patient may be seeking help in dealing with



what they see as problems in other people rather than in themselves. 'Medically' ill patients do produce problems; non-psychiatrist doctors often express a sense of helplessness when faced with demoralisation and depression in their patients. They attribute this despair to a sense of inadequate educational preparation for their task and inadequate support. Work with Balint groups suggests that it is likely that they are also responding to feelings stirred up by processes of which they are not consciously aware, and which no amount of education will allay. Measuring the cost of psychological problems in the 'medically' ill must take into account the indirect cost on those others affected.

The perception by 'medically' ill patients that the problem lies in others is relevant to the part of the definition of psychotherapy that refers to 'seeking help from someone expected to be able to give it', which is central to the concept of transference. The problem here is that the 'medically' ill patient often needs to be educated about the relationship between their feelings, cognitions, attitudes and behaviour on the one hand and their physical symptoms on the other, and about how these may be impacting on their relationships with carers and health care professionals. Rather than presenting with a psychological need, these patients have to be convinced that such a need exists.

The third challenge is that the greater need for the therapist to communicate with other doctors and health care professionals when dealing with the 'medically' ill patient has implications for confidentiality and therefore for the transference.

This raises a fourth challenge: how much medical knowledge does the psychotherapist require in order to function effectively with 'medically' ill patients? This is an obvious problem when we consider the differences between medically qualified psychotherapists and others, but even for doctors it is an issue.

I have not yet defined the term 'medically' ill. Its use implies that there is some other sort of illness from which it must be distinguished. That 'other' is of course 'mental' or 'psychological' illness. The persistence of the concept of the mind/body split is one of the tragedies of Western medicine, particularly because it is accompanied by a negative value judgement about the mental side of the apparent division.

We see this played out at a political level; implementation of the Australian National Mental Health Policy through the Care Plans has compromised the multidisciplinary management of complex illnesses such as renal failure, cancer and diabetes, and of problems such as pain and somatisation, and certainly compromised the availability of psychotherapy. The Third National Mental Health Plan (Australian Health Ministers, 2003), after considerable lobbying, recognised the problem, and its key directions include increased recognition of the impact of physical health on mental health and vice versa, training of mental health workers in the interrelatedness of physical and mental illness, improved capacity of the mental health sector and the general health sector to deal with this complex interrelationship and development of comprehensive continuums of care. However, the failure of the implementation of these and other directions of the Plan has led to the current Senate Enquiry on Mental Health. One promising development is that in 2003, the Victorian State Parliament passed an Act to provide for the management of those with complex health, psychological and social needs, in response to a perception that existing agencies find integrated management problematical. Constant vigilance will be required to see that these initiatives become more than lip service to the needs of those with medical and psychological comorbidity, since they, for various reasons, do not constitute a powerful lobby,

despite their numbers, and since re-integration of psychiatry into the community has largely bypassed acute health care.

The new perspective emerging is that physical/psychiatric comorbidity and somatisation are the commonest forms of psychiatric presentation in the community and that their presence predicts greater morbidity and mortality. Moreover, depression even at sub-threshold levels is a major risk factor for the development of 'medical' illness such as coronary heart disease, stroke or diabetes (Smith, 2003). These data provide a new imperative to treat psychological symptoms, particularly once 'medical' illness has become established. But, and here is the challenge, does it help? If so, does it help reduce morbidity and mortality as well as relieve psychological symptoms? Does it reduce the risk of development of physical illness?

There is very good evidence that psychosocial interventions in the 'medically' ill not only relieve psychological symptoms but in some cases improve compliance with medical treatment and reduce morbidity. Although the evidence is mainly for psychoeducational interventions, specific psychotherapy applications are also effective. These include CBT but also brief psychodynamic-interpersonal therapy (PIPT). PIPT in patients with irritable bowel syndrome not only produces significantly greater improvement in psychological distress but also in physical aspects of health related quality of life, and in health care costs (Creed et al., 2003). To put all of this in context, we should note that there is little evidence for the efficacy of antidepressant medication in the 'medically' ill, mainly because there is such a paucity of studies on their use in this population.

The challenge is to create a much larger culture of psychotherapy in the 'medically' ill, from which more research will be possible. Such research must be qualitative as well as quantitative. Our recent research on psychotherapy in women with metastatic breast cancer illustrates this (Kissane et al., 2003). We used an empirically derived supportive/expressive group therapy designed to enhance social support and encourage expression of disease-related emotion, since there is evidence that impairment in these domains may be a risk factor for the development of cancer (Spiegel, 2002). Women were randomised to 20 sessions of weekly group therapy plus 3 relaxation classes or to a control arm receiving 3 relaxation classes only. There was only a non-significant trend for those receiving psychotherapy to have reduced anxiety and improved family function. The therapy did not extend survival (Kissane et al., 2004a), as has been reported in some similar studies (Spiegel, 2002). However, the women receiving the psychotherapy reported greater satisfaction with their therapy, appreciating the support and citing better coping, self-growth and increased knowledge about cancer and its treatment. In our publication we made the observation that the mature group process seems to transform existential ambivalence into creative living, evidenced by humour, celebration, assertiveness, altruism, new creative pursuits and eventually courageous acceptance of dying (Kissane et al., 2004b). The challenge is to ensure that future psychotherapy research captures these existential aspects.

## **Psychoanalysis and the University**

In 1919, the socialist Revolutionary Governing Council nationalised Hungarian Universities. Students had petitioned to have Sandor Ferenczi give lectures on psychoanalysis (Stanton, 1990, p. 29). The Revolutionary Governing Council appointed Ferenczi as the foundation Professor of Psychoanalysis in the University of Budapest, the first and almost the only person to have held such a position in the world, strange as that may seem. Freud, writing at the time of Ferenczi's installation, said:

The inclusion of psycho-analysis in the University curriculum would no doubt be regarded with satisfaction by every psycho-analyst. At the same time it is clear that the psycho-analyst can dispense with the University without any loss to himself.

(Freud, 1918, p. 171)

Speaking of the psychoanalytic society, he says:

The fact that an organization of this type exists is actually due to the exclusion of psycho-analysis from Universities. (Freud, 1918, p. 171)

Freud criticised medical psychology as providing an insecure basis for preparing medical students for the 'problems of human life', and ensuring that 'quacks' have a greater effect on patients than does a doctor. He proposed psycho-analytic teaching and clinical supervision as being more appropriate. Importantly, he acknowledged that the medical student will never learn 'psycho-analysis proper', but that it will be sufficient if he learns something about it and from it. In this article Freud also argued for a general course in psycho-analysis for students of other disciplines such as art, philosophy and religion, on the grounds that the application of psycho-analytic theory is not confined to the field of psychological disorders (Freud, 1918).

As the major new theoretical paradigm of the 20th century, psychoanalysis should have continued to have a major place in the University, but not so. Psychoanalytic principles certainly informed teaching in psychiatry, and to a lesser extent in other professional disciplines, for much of the 20th century but the systematic study of psychoanalysis in the University was extremely limited. Where it did occur, it was usually in the Humanities and as such divorced from its clinical context. In Australia, several Departments of Psychiatry and Psychological Medicine have supported such enquiry, but this was serendipitously dependent on the interests of their Chairs. For instance, at Monash University in Melbourne, several Masters degrees in psychoanalytic studies have been introduced, and a number of PhD students have pursued psychoanalytic topics. Lacanian Schools of psychoanalysis have had close ties with some Universities, particularly in the Humanities. This is most obviously so in France, but is true for many other countries including Australia. In Victoria such ties have resulted in the development of Masters degree programs in psychoanalytic studies in two Universities.

The challenge here is that of understanding why there has been such tension between Psychoanalysis and the University, and what prevents psychoanalysts and their institutions from using such a context to help meet the challenges described in this paper.

## Conclusion

Psychoanalysts and psychodynamic psychotherapists should continue to do that which they do exceedingly well; make clinical observations in their extraordinary privileged laboratory, subject these to their highly developed quality assurance processes, and proclaim the legitimacy, indeed necessity, of such observations as part of the overall strategy for determining what works for whom. Scrutiny needs to be extended by dialogue with other schools and disciplines; the University has been an under-utilised forum for that.

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