Introduction to Jungian Psychotherapy

The Therapeutic Relationship

David Sedgwick

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Introduction to Jungian Psychotherapy

The unique relationship between patient and therapist is the main healing factor in psychotherapy. Following C.G.Jung's pioneering views on the complexity of conscious and unconscious interactions in the therapy process, this book explains the Jungian approach to the therapeutic relationship and the treatment process.

I*ntroduction to Jungian Psychotherapy: The Therapeutic Relationship* shows how taking a Jungian perspective can help deal with the complicated paradoxes of psychotherapy. David Sedgwick outlines a modern Jungian approach to psychotherapy, always with reference to the patient-therapist relationship itself. He considers and criticises key aspects of Jungian and other theoretical perspectives, synthesizing approaches and ideas from across the therapeutic spectrum.

This meditation on Jungian therapy will be invaluable to both Jungian and non-Jungian students and practitioners.

D**avid Sedgwick** is a Jungian analyst and clinical psychologist in Charlottesville, Virginia. He is the author of *The Wounded Healer: Countertransference from a Jungian Perspective* (1994) and *Jung and Searles: A Comparative Study* (1993), and numerous articles and book reviews.

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To my mother, Ann Williams Chapman

And to the memory of my father,
William Parker Sedgwick III

Contents

Preface

This book is about the therapeutic relationship in Jungian psychotherapy. To non-Jungian clinicians, Jungian work is usually known, if known at all, for being about dreams, but Jung also had far-reaching conceptions about the patient and therapist together in the treatment situation. He felt that their personal influence on each other, conscious and unconscious, was the central dynamism in psychotherapy; Jung was the first psychotherapist to emphasize this mutuality. This book's overall purpose is to describe and explore this central dimension, showing some key Jungian principles specifically in connection with the therapeutic relationship.

There are several other reasons for this book. While there are many books on Jungian analysis, there are few on Jungian psychotherapy. Even those books or articles that touch on the Jungian perspective on therapy often wind up being about Jungian analysis. My chief goal is to define a Jungian style of psychotherapy in terms of the therapeutic relationship itself—to suggest also that this is the main thing Jung brought to future therapists—and to do so in a language that is reasonably free of jargon, Jungian or otherwise. Psychotherapists' terms and what they are talking about should have clear referents. Relevant to this and to the reader of this book is Jung's wonderful comment "I can only hope and trust that no one becomes 'Jungian'" (1973a, p. 405). This book does not use much Jungian language, but when it does, it seeks to explain it. Jung invented some terms and attitudes that were unique to analytical psychology (for example, anima and animus), some that are relatively well known (complexes), and some that are understood differently by other schools of psychotherapy (self, individuation).[1] However, many, if not all, roads lead to Rome, and different languages may point to the same or even deeper aspects of a subject, and enhance understanding.

So while one of this book's nominal aims is to reflect on the nature of the affective connection in the therapeutic relationship, another objective is to ponder psychotherapy in general, in ways that build on but are not completely bound by Jung's ideas. This means recognizing the work of generations of Jungian analysts and the work of others, not necessarily Jungian trained, who have things to say that jibe with or extend Jung's original thinking. The book's larger hope is to refine or in some ways redefine Jungian thinking on psychotherapy so that Jungian work is not seen by others as a quasi-religious or symbolic matter, inapplicable to most patients in psychotherapy. Religion and "the symbolic life" are invaluable things, but Jungian therapy has application across the board, and Jungian work should be recognized as making its rightful contributions to the therapeutic community. The Jungian approach deserves a wider audience, and frankly, much of Jung's work is pointless for the average clinician, even sometimes for the Jungian analyst. For the purposes of this book, Jung's investigations into religion, alchemy, and mythology will be viewed as a kind of private research, an exploration of symbolism and psychological depths that was personally meaningful but of less critical importance to psychotherapy. These researches provide a crucial backdrop to Jung's

developing thought, but are not necessary to an understanding of the therapeutic relationship in Jungian psychotherapy.

The imaginary reader of this book (actually there are multiple readers in my mind, including me) is a non-Jungian professional counselor, therapist, or future therapist who wants to know something about Jungian therapy but does not seek a full Jungian immersion program. That is the book I contracted to write. At the same time, this book tries to speak in depth about subtleties in the treatment and relationship that either have not been talked about or are difficult to articulate, so it is not a simple introduction to Jungian therapy at all. Inadvertently there may be something here both for the ostensible beginner and for the more experienced therapist (even for the already practicing Jungian therapist, analyst-in-training, or analyst). The process of trying to take Jungian thought and bring it down home to the non-Jungian clinician or student has turned out to be also a process of bringing it down home to me. I find that the more I try to explain Jungian thought in simple terms—as if to someone with little previous knowledge of it—the more I understand and feel about it. Writing a book is an exercise in processing one's ideas, at times an intense learning process, and I would say that many of the things I have chosen to write about are things I have wanted to think about for myself. My ideas are continually in flux, and this book is in large measure a sorting as I go.

Jack Nicklaus wrote a book called *Golf, My Way,* which I have never read but the title struck me. While I do not have the level of mastery of someone who is "the best" in his profession, I will say that this book is something like "Jungian psychotherapy, my way." Jung insisted that psychological writing was innately confessional—it certainly was for him—and this book is my personal version of one-to-one Jungian psycho- therapy, at least as I currently see it. Since it is Jungian therapy filtered through me, a word on my background is relevant. My involvement in psychology began with Jungian psychology, at a relatively young age, and my theoretical anchor has always been there. However, while I work as a Jungian analyst and find Jung's and his successors' work indispensable, I have also been drawn to other perspectives. During my graduate training in psychology and counseling, and even somewhat later during my seven-year postgraduate analytic training, I found much that resonated with me in client-centered therapy, psychoanalysis, self psychology, and certain humanistic therapies. In particular, much of the work of Harold Searles, Donald Winnicott, Heinz Kohut, George Atwood and Robert Stolorow, Carl Rogers, Eugene Gendlin, and R.D. Laing makes especially good sense to me, or has at one time, and readily complements a Jungian point of view. Many other psychological writers also have affected me along the way. Quite simply, there is a lot worth reading out there, as well as a lot in Jungian psychology (especially recently). I have found little in most other approaches to psychotherapy that is necessarily ruled out by having a Jungian background and orientation. Most of what I have found elsewhere, if it mattered to me, fitted underneath a Jungian umbrella without much strain. While that may be an obvious or circular statement, it suggests either the breadth of Jungian thought or the way I tend to work with it. This eclecticism, and perhaps my experience in non-Jungian settings as a counselor and psychologist, are evident in this book.

I also think there is wisdom in Whitehead's statement "A science that hesitates to forget its founders is doomed."[2] Forgetting the founding fathers can be a necessary deidealization stage, something like leaving home. At the same time, however, such

individuation odysseys may be followed, in psychology at least, by a return home, renewed appreciation, and deepened respect. I reread Jung all the time and continue to be moved by much of what he says, as if reading and knowing it for the first time (*pace* T.S.Eliot). Thus every Jungian has not only his own private Jung and his own private meaning of the term "Jungian" but an evolving relationship to analytical psychology. As it grows, Jungian psychology as a whole is proving able to successfully contain a notable diversity.

Because it cannot cover all of the Jungian method in vivid detail, some of the book is a specific "how to," some covers more general concepts. An entire case history or course of treatment would be the best way to illustrate the Jungian therapeutic relationship, but that is not possible here (or anywhere). Psychotherapy seems doomed to be unable to describe itself in full detail. I provide assorted personal examples here and there but not a full case description. I have chosen personal examples not strictly out of personal vanity or exhibitionism, but because I know them best; furthermore, it would feel strange to me to use and criticize other people's examples extensively. Another personal preference, perhaps quirk, is that I use the masculine pronoun throughout. I have tried it other ways, here and elsewhere, but the wording gets too complex and feels unnatural to me, so I have given up trying to fix it. I also use the term "patient" rather than "client," which some people find nonegalitarian or off-putting. However, I have grown to really like "patient," because it comes from Latin and Greek roots meaning "suffering." A patient is one who suffers. I used to say "client," and recognize its nonpejorative intentions, but it now reminds me of lawyers and business consultants.

Just as this book presents a personalized theory of Jungian psychotherapy, only the individual reader can decide what aspects of this version make personal sense to him in actual contact with patients. A book can help, but it can only get one started or provide some further ways of understanding things already begun. This book is not comprehensive, and while it is to some extent an introductory text for non-Jungian readers, what it requires of the reader is not simple. I tend, I have discovered over the years, to get into trying to explain small aspects of an experience or question, a sort of awareness of the minute. Since this book's center point is the therapeutic relationship, some experience and time spent thinking hard about therapeutic relationships is an advantage. Book knowledge without experience is thin, especially in psychotherapy, where the distance from an apparently well-organized, "We're in control here" model to the chaotic reality can be great. During my graduate work, one mentor offhandedly mentioned to me that it takes about ten years after graduation to get to be a decent therapist. To my dismay, I *again* heard something like this from someone after finishing my Jungian analytic training. (I also recently read where the psychoanalyst Nina Coltart suggested it takes ten years to *recover* from analytic training.) All these people may have been right. While the ten-year rule of thumb seems a little harsh, it does seem true in some ways that you learn to be a good therapist by being a not so good one. This cliché about learning from one's mistakes is especially applicable to therapy because psychotherapy is such an imperfect process. It is a difficult craft to learn, and it is a challenge to maintain one's capacities for it. It is also very demanding personally—burnout is an occupational hazard. As a result of all these obstacles, however, the potential for growth is continuous—therapists grow with and through their patients, and

from each other. That is one of the pleasures of being a therapist. As one grows older and processes more experience both in and out of therapy, one usually gets better at doing psychotherapy (and at recognizing people's usual "routines", too). A wider range of patients, and a greater possibility of understanding them and conveying that to them, becomes possible. The goal of this book is to add to that potential for understanding.

NOTES

1 Note D.W.Winnicott on Jungian terms: "Some of the terms…are not of any value to me because they belong to the jargon of Jungian conversation. …I refer to: transpersonal, transpersonal unconscious, transpersonal analytic ideal, archetypal, the contra-sexual components of the psyche, the animus and anima, animus-anima conjunction" (1960, p. 159). However, vis a vis the anima for instance, Winnicott describes this creatively (and elliptically) as "the part of any man that could say: I have always known I was a woman" (1964, p. 485). Here Winnicott is making a statement that, while not jargonistic, is aphoristic in the extreme and a little less than matter-of-fact to most people.

2 The Whitehead quote is from Bateman and Holmes (1995, p. 17). I could not locate the original source.

Acknowledgments

This book is the upshot of a discussion that took place in London several years ago between Andrew Samuels, Routledge editor Edwina Welham, and me. The idea for a book on Jungian psychotherapy was theirs. Though I went my own way with it, I wish to thank them for their idea and encouragement. Thanks also to editor Kate Hawes and the staff at Brunner-Routledge for their production help and flexibility.

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Although the cases mentioned in this book are mostly revealing about me, my thanks to those patients whose therapeutic relationships with me and whose personal material are noted here.

Writing this book has provided me with the opportunity to speculate about and try to articulate my current thinking on Jungian psychology and psychotherapy, a process I seem to undertake in book form about every seven years (through feast and famine). My special thanks to my wife, and to my children, who have supported me through the thick and thin of it.

Whether in writing or otherwise, thinking about therapy is an ongoing activity for me, part of the “endless learning” Jung once wrote about. Jung’s writings are endlessly stimulating. The personal and professional debt I owe to him, a man I never knew but wish I could thank personally, to his other followers, and to analytical psychology is great.

Why art thou cast down, O my soul?
and why are thou disquieted within me?

Chapter 1
Introduction

> The intelligent psychotherapist has known for years that any complicated treatment is an individual, *dialectical* process, in which the doctor, as a person, participates just as much as the patient…. We could say, without too much exaggeration, that a good half of every treatment that probes at all deeply consists in the doctor's examining himself, for only what he can put right in himself can he hope to put right in the patient.

Jung wrote the words at the top of this chapter in 1951. Few, if any, psychotherapists were talking in these terms then. Even in psychoanalysis, the branch of psychotherapy most concerned with the patient-therapist interaction, considerations about the value of mutual emotional interactions in the therapeutic relationship were just beginning.[1] What's more, Jung had been talking like this for several decades, making him the first psychotherapist to suggest that the therapist's work with his own personal reactions to the patient (countertransference) was the central issue in psychotherapy. Jung's major treatise on the therapeutic relationship talks about the therapist "voluntarily and consciously taking over the psychic sufferings of the patient" (1946, p. 176), which follows from an earlier statement, "For two personalities to meet is like mixing two chemical substances: if there is any combination at all, both are transformed" (1929a, p. 72).

But if few therapists were talking like this about countertransference and mutual therapist-patient transformation, few were paying any real attention back then either to Jung or to Jungian therapy. Jung was well known by name, but his theories had long since slid into the backwaters of mainstream psychotherapy. He was known perhaps to general psychology and psychotherapy as a famous Freudian dissident; in terms of psychoanalysis itself, which was then in its heyday, Jung had been abolished altogether.

This situation has changed. Jung had crucial things to say about psychotherapy, as the above quotes show, and many people are intrigued by his insights. Unfortunately, he is still difficult to locate. Most therapists or therapists-to-be who express an interest in Jungian psychotherapy have had limited prior contact with it. With a few important exceptions in America and the UK, Jungian theory and therapy is not taught in graduate or professional schools that deal with clinical work, nor has it ever been. As the result of a particular professorial interest, courses occasionally appear in undergraduate religion or philosophy departments, but there is usually nothing systematic in graduate-level clinical course work, perhaps a mention here and there of Jung as an early Freudian. As for C.G.Jung himself, he seems recently to have become, somewhat like Freud, an object of specialized biographical and literary interest. Freud seems to show up more often in

English departments or book reviews than he does in psychology departments; Jung rarely shows up anywhere, really. These pioneer psychologists occupy space in the academic-intellectual canon but are studied as historical artifacts or for their personalities, often in overcritical ways.

Although Jung and Jungian psychotherapy remain, like the once wellknown literary hero, "damned elusive,"[2] some persistent clinicians and students still look beyond the academic inquiries and wonder: What *is* Jungian psychotherapy all about? They might hear or find something that strikes them, like a quote from Jung, and want to learn more. Sadly, when the determined few finally do find Jungian avenues, they may get lost in what can seem to be a very private Jungian world, a world with its own terminology and *Weltanschauung* (worldview), embedded in highly selective, postgraduate training institutes. The Jungian world can seem insular—a recent book called it a cult—but most of this mystery is simply the result of its being unknown.

WHAT JUNGIAN THERAPY IS

As this chapter's epigraph indicates, what Jungian psychotherapy is really about is the therapeutic relationship. Many people think it is about dreams, or "archetypes," but it's not, at least not primarily. It's about psychotherapy in the context of a personal emotional interchange. Jung's statements give clear ideas of what Jungian therapy is like, not only for the patient but for the therapist. If you are a therapist, this is what Jung tells you in a nutshell: "Every psychotherapist not only has his own method—he himself is that method…. The great healing factor in psychotherapy is the doctor's personality" (1945, p. 88). Because of this personal factor, being a card-carrying Jungian per se is much less important than the content and therapeutic quality of the clinician's character. In an ironic sense, to be a Jungian is not to be a Jungian.

Still, there are uniquely Jungian aspects to psychotherapy. As noted, C.G.Jung, at his best, was way ahead of his time. His bold statements have come home today: they match current, cutting-edge conceptions of psychotherapy as a two-person interchange in which the therapist is unavoidably involved in an intersubjective process and sometimes changed as well.[3] Jung says precisely that and more. Furthermore, although cognitive therapies (therapies emphasizing regulating thoughts rather than pursuing feelings as such) are effective and popular, much of psychotherapy, especially insight or psychodynamic therapy, has moved from being a psychology of interpretation to being a psychology of relationship and repair.

So, again, what is Jungian therapy about? It is about a specifically therapeutic kind of emotional experience, at unconscious as well as conscious levels, that takes place between a therapist and patient. Their affective connection—the therapeutic relationship—ultimately takes precedence over insight and interpretation, however important and however intertwined they all are. Everyone wants explanations and to understand, but for these to have weight, they must be based on the emotion that comes from a personal relationship. The emotional experience in the therapeutic relationship is what makes therapy feel therapeutic. As Jung observed, the therapist's engagement on a feeling level, whether it be spoken or unspoken, is required.

This two-person involvement usually takes place over a significant period of time, so Jungian psychotherapy typically is not short-term psychotherapy, though its principles can apply to brief treatment. Rather, over time the therapeutic relationship has its ups and downs, unique qualities and tones. Like a marriage, it develops its own history, and a multilayered commitment is involved. In fact, the term "therapeutic marriage" has sometimes been used to describe in-depth psychotherapy, and the analogy is apt in many ways. Every therapy relationship is fundamentally different from all others, no matter how experienced the therapist is, just as every marriage or person is different from others. As Jung says, when two personalities meet, both are transformed. The chemistry between the persons—how they mix—is therefore crucial. To get all this right, some time is usually needed.

It is not the case, however, that psychotherapy can never work in a short time, or that Jungian therapy decries this. The length of Jungian therapy, just like the length of most therapies, varies with the case and psychopathology involved. Jung himself preferred briefer treatments, suggesting that "other therapeutic factors" besides a time-consuming therapeutic involvement can sometimes do the job: the patient's own insight and good will, and the therapist's "authority, suggestion, good advice, understanding, sympathy, encouragement, etc." But he cautiously warned that "more serious cases do not come into this category," and drily footnoted, "'Good advice' is often a doubtful remedy, but generally not dangerous because it has so little effect" (1946, p. 173).

How psychotherapy works—what makes it work—is a mystery wrapped in an enigma. But it works. This was settled subjectively in most people's minds long ago—we know we feel better when we are listened to and feel understood. It was settled objectively and definitively by powerful statistical research three decades ago and continuing research now.[4] Therapy works better, in fact, than many other social or educational methods of change, relatively speaking (Smith, Glass, and Miller, 1980). Although questions about psychotherapy's efficacy have been answered, this does not mean, of course, that it always works. Nothing always works, but the current debate, and the current push, for handier, perhaps cheaper or quicker methods of treatment (including excessive use of pharmacology) does not in itself invalidate psychotherapy's effectiveness. Medications, for instance, if they are appropriate and if they work, only enhance psychotherapy, and vice versa. An either/or dichotomy is not necessary in this instance, and appears to be driven by corporate economics, habits of dichotomous thought, and a general resistance to the inexactitude of psychotherapy. Therapy depends on the personalities of individuals and their personality mix, which are difficult to predict. Also, therapy is hard to do well, and places emotional demands on the therapist, not to mention the patient. Finally, not everything can be put in a box—especially the things that matter most.

SCIENCE AND SUBJECTIVITY

Although psychotherapy has solid research to back it, and although it can be tested by statistical and scientific methods, it is not, in essence, a science. Psychology is inherently subjective: the psyche studies itself, the mind looks at the mind, or someone else's mind (a therapist's) looks at another's (a patient's). In simpler terms: one studies psychology

with one's own psychology. From the early days of psychoanalysis, when Jung reminded readers that "all knowledge is subjectively conditioned" (1914b, p. 182), he continued to note the difficulties in psychological epistemology, and its innate limitations: "There is no Archimedean point from which to judge, since the psyche is indistinguishable from its manifestations. The psyche is the object of psychology, and—fatally enough—also its subject" (1938/40, p. 49). The subjective is the subject.

Furthermore, in the course of comparing his own psychological perspectives with those of others, Jung observed that every psychological theory was inevitably a "subjective confession" (1929b, p. 36). This subjectivity undermines pretenses not only to psychological objectivity but to universality. Jung (1926) also suggested that therapists might need to construct a new theory for each patient. He did not mean this literally, of course, but the spirit of respect for and openness to the individuality of every patient—and for the limits of one's own knowledge and theory—is vital, and a hallmark of the Jungian approach to psychotherapy. The ultimate mystery of personality goes along with the mystery both of how treatment works and how the therapeutic relationship works.

Contributing to the mystery of things is the reality that there are multiple truths about most psychological situations. Not only that, but the truth changes, not just due to subjective differences but to apparent advances in understanding. Thus, for instance, the Oedipus complex looked like the ultimate truth in psychoanalysis for decades (and still does to some), but this was supplanted by a suggestion and new possible truth that Oedipal issues can be a defensive maneuver concealing pre-Oedipal anxieties. As Jung said about Freud, we don't differ on the facts, just their interpretation (1973a, p. 405).

On not knowing beforehand

What do these ruminations on subjectivity, pluralism, and uniqueness imply? In the midst of therapists' zeal to know and patients' need to be known—both of which are important—therapists must, paradoxically, allow room for their "not knowing" (Fordham 1993). This is yet another hallmark of a Jungian attitude. Consider, for instance, Jung's understanding of himself towards the end of his life, a time when one would anticipate a surer wisdom about life and personality:

> The older I have become, the less I have understood or had insight into or known about myself.
>
> I am astonished, disappointed, pleased with myself. I am distressed, depressed, rapturous. I am capable of all these things at once, and cannot add up the sum. I am incapable of determining ultimate worth or worthlessness; I have no judgment about myself and my life. There is nothing I am quite sure about. I have no definite convictions—not about anything, really. I know only that I was born and exist, and it seems to me that I have been carried along. I exist on the foundations of something I do not know….
>
> When Lao-tzu [an ancient Taoist philosopher] says: "All are clear, I alone am clouded," he is expressing what I now feel in advanced old age.
>
> (1963, pp. 358–9)

Jung's late-in-life musings may not hold true for everyone (and probably not for Jung all

the time), but they express some truths about the difficulties of self-knowledge and the inevitable falling short of it. They give rise to humility, properly so, and provide a sober wisdom about life's goals—and psychotherapy's. In relation to this book's subject, Jungian psychotherapy, Jung brought home these modest concepts forcefully:

> No psychotherapist should lack that natural reserve which prevents people from riding roughshod over mysteries that they do not understand and trampling them flat. This reserve will enable him to pull back in good time when he encounters the mystery of the patient's difference from himself, and to avoid the danger—unfortunately only too real—of committing psychic murder in the name of therapy.
>
> (1937a, p. 337)

Jungian psychotherapy holds that patients, and the story and curve of their lives, represent an unknown quantity. In therapy the story is discovered—created perhaps, or at least told—and the therapy itself also becomes part of the story. Too much preconception, too much fore-knowledge, as Jung suggests above, can be misguided or even arrogant. Thus the difficulty for Jungian psychotherapy, as for other viewpoints, is this: therapists need to know and are asked to know a person, yet they cannot know ahead of time and must try to know this unique person uniquely. (And in the end, of course, we are all faced, as Jung implies, with the limits of understanding ourselves or others.) Therefore, paradoxically enough, Jungian psychotherapy cultivates ignorance, because, as Jung also put it, "Nothing is more deleterious than a routine understanding of everything" (1945, p. 87). In fact this stance of informed ignorance is cultivated as a matter of technique by some post-Jungian therapists, who find meaning in the precepts of Wilfrid Bion, a psychoanalyst who suggested therapists begin each session without memory, desire, or understanding: "The psychoanalyst should aim at achieving a state of mind so that at every session he feels he has not seen the patient before. If he feels he has, he is treating the wrong patient" (Bion 1967, p. 244). All this means: forget what you know, or think you know, put aside the goal of curing or helping, do not hold tight to prior understandings, approach each hour and the therapeutic situation freshly and with emotional openness. It is a Zen-like (no mind) approach to psychotherapy, and an ideal. Also, of course, this is easier to do if one is doing a multiple-session per week analysis versus a less frequent psychotherapy, but the spirit of it, which centers a therapist in the spontaneous, here-and-now moment of the therapeutic interchange, still applies.

Individualized theories

In spirit, Jung was right about psychotherapy: the therapist "must begin afresh with each case, for each 'case' is individual and not derivable from any preconceived formula" (1926, p. 93). In effect, every case is a research case and the therapist is creating a new theory with each patient—the theory, or story, of that patient. If not a new theory, then at least a newly developed *understanding*. Furthermore, that understanding is best described as one that the patient and therapist create together. Not simply the therapist's understanding but a mutual understanding emerges out of the two participants' emotional and verbal interplay over a period of time. They are finding and/or creating a language,

some of it almost nonverbal (strange to say, a nonverbal language), that can describe and contain the patient's realities. Through this creative process based in emotion and language, the patient, in his self or inner life, now feels "seen" and accepted. He is visible and exists in another's eyes: "I see you." And with this he comes into his own view and his own self.

These therapeutic understandings and sightings that evolve in therapy must be authentic to the patient—real, not faked or doctrinaire, thus "new." This is why a decent psychotherapy takes some time. Some of the authenticity comes from the fact that they are unique to the patient. As noted above, Truth does not exist in psychology, but in therapy a patient and therapist discover or give birth to subjective truth (or truths, for there are many and they change). Because psychological truth is, in this sense, *flexible*, Jungian psychotherapy maintains a relatively atheoretical attitude. In service of the discovery of a patient's individual truths, Jung, again, was at times almost anti-theoretical:

> Practical medicine is and has always been an art, and the same is true of practical analysis. True art is creation, and creation is beyond all theories. That is why I say to any beginner: Learn your theories as well as you can, but put them aside when you touch the miracle of the living soul. No theories but your own creative individuality alone must decide.
>
> (1973c, p. 84)

Only the reader's own creative individuality can decide whether psychotherapy is truly an art and to what extent this level of creative individuality is possible in work with actual patients. There is a slight, even if admirable and understandable, whiff of the idealization of creativity and individuality here. Jung was not naive about this; he knew that theory sets up what sorts of themes a therapist is going to hear in his patients' material. Still, the Jungian student faces the puzzle of how to create a Jungian psychotherapeutic theory out of Jung's basically atheoretical position. This recalls the above paradox of the therapist knowing but not knowing, especially beforehand. These conundrums have plagued Jungian psychotherapy, like all psychotherapy, for years, but they are also an integral part of its description of psychological realities. One thing Jungian psychology is, and one thing that makes it seem either fascinating or frustrating, is that it is a psychology of paradox. Or if that statement is too much, at least one could say that Jungian analytical psychology *explores* the psychology of paradox. That is, as one attempts to penetrate the depths of psychological life, one comes increasingly to realize the impossible perplexities and contradictions at the core of human personality. That is why Jung could say, "I am astonished, disappointed, pleased with myself. I am distressed, depressed, rapturous. *I am capable of all these things at once, and cannot add up the sum*" (italics mine). Even a wise man like Jung could not quite put it all together. The bottom line is the mystery.

JUNGIAN ENIGMAS

Jung and religion

Life, like psychotherapy and personality, is also a mystery wrapped in an enigma, which is why Jung's researches took him past psychotherapy into the realms of spirituality and religion, or the psychology of religions. Jung, incidentally, was certainly the first depth psychologist, and possibly the only one until recent decades, to show any comprehensive understanding of or to write much that was worthwhile about religious experience.[5] This makes Jung beloved to many men and women of the cloth, and appealing to religiously orientated individuals of all faiths (as well as open-minded agnostics and atheists).

But Jung's spiritual studies present a problem, because this facet of Jungian psychology floats it out of mainstream psychotherapy. Most study of psychology and psychotherapy has a scientific, or at least a rationalistic, secular-humanist orientation. Frequently, psychology is antireligious. While a separation of church and state, so to speak, is probably appropriate in this particular psychological age, some Jungians' perspectives, especially those of Jung himself, seem to surpass the usual limits of psychological-psychotherapeutic discourse, moving into areas that are typically reserved for theologians, philosophers, and the spiritually and mystically inclined. Jung's religious studies were thoroughly nondenominational he wrote excellent essays like "Psychotherapists or the Clergy" and lucid commentaries on ancient texts like the *Tibetan Book of the Dead* and the I *Ching*, meanwhile attending to topics like alchemy, Gnosticism, Buddhism, Hinduism, parapsychology, and even flying saucers. It is no wonder that Jung is found as often in the New Age section of bookstores as in the psychology section. *Psychology and Religion: West and East*, *Psychology and Alchemy*, and *Modern Man in Search of a Soul* are just some of his book titles. Of Jung's massive twenty-volume *Collected Works*, only the first four volumes and then particularly the sixteenth, *The Practice of Psychotherapy*, relate specifically to clinical psychology or psychiatry. The rest, though interspersed with important discussions and theories about the unconscious, do not focus much on the day-to-day practice of therapy. The clinical examples he gives in them mostly amplify and explicate symbolic material—material that is often from patients, it is true, but not necessarily. Some of Jung's largest and most important books explore mythological material in phenomenal detail, while the personal lives of patients are secondary (e.g. *Symbols of Transformation* [1911–12/1952], *Mysterium Coniunctionis* [1955–6]).

Jungian languages and changing Jungian concepts

Fortunately, Jung also thought a good deal about basic psychotherapy, and, whatever else he was, he was not doctrinaire. Though confident in the importance of his pursuits and a man whose thoughts could move around in the realm of the potentially grandiose (archetypes, gods and goddesses, the collective unconscious), Jung had a good, self-deprecating sense of humor and a lone-wolf resistance to being a cult leader. He is reported to have said the priceless words, "Thank God I'm Jung, and not a Jungian" (Yandell 1978, p. 57). Once again, to be a Jungian is not to be a Jungian. Jung demanded independence both for himself and his followers, and he seemed to actively dislike groups and group psychology: "A million zeros joined together do not, unfortunately, add up to one" (1957, p. 75). He coined the term "individuation," which means becoming and being one's unique self, that is, the unique combination of general

human traits that comprise one's particular person, and the "individuation process" is another hallmark of Jungian psychology. Furthermore, more than fifty years have elapsed since Jung's last comments on psychotherapy, and the number of Jungian analysts has logarithmically increased since his death in 1961.[6] The inevitable result has been a broadening and refinement—though some more traditional Jungians have considered it a dilution[7]—of original Jungian concepts and emphases. Times and perspectives change, and Jungian psychology and psychotherapy have changed considerably with the times. Jungians roll with the tide and think hard about the same issues that other psychotherapists struggle with, from group therapy to psychopharmacology. Relevant here have been syntheses by Jungians of other depth psychological positions and therapeutic techniques, which further show that Jungian psychology has not been stagnant and that post-Jungian thought is vigorous in its clinical dimension. Once Jungian thought branched out from Zurich and from Jung's enormous gravitational pull, this became unavoidable.

In addition, as Jungian psychology has grown and its concepts diversified, various Jungian factions have developed. Though the numbers are small and the designations informal, three Jungian "schools" have been categorized: classical, developmental, and archetypal (Samuels 1985). The classical school resembles Jungian psychology as practiced by those he directly taught. One hesitates to call it orthodox, as Jung seemed so fundamentally unorthodox, but perhaps that adjective fits. The so-called developmental school focuses on early personality development: infancy issues, object relations, and, in fact, orthodox psychoanalytic technique (couch, high session frequency, analysis of infantile transference). The archetypal group does not appear to exist as a clinical entity per se, nor does its viewpoint inform a training program. It is more an attitude, based on the insights of Jungian analyst James Hillman, with an almost counter- clinical emphasis on archetypal imaginings, especially about psyche and soul, and linkage therefore with those aspects of classical Jungian thought that emphasize imagery.

Although one can talk of schools, it is better to talk of various Jungian *languages*, epitomized by the above classification. The main, new wave of Jungian practice since Jung's death has been from the developmental school, and the language there is psychoanalytic. Jung's no-technique technique opened the door to this, as did the need for nonarchetypal ways to understand the obviously primary pathogenic influences of early family life. Classical Jungians and archetypalists by and large do not make much use of the analytic-developmental perspective, but a well-rounded Jungian these days will be somewhat conversant in all these languages, or at least acquainted with them while perhaps specializing in one. Different preferences and emphases are fundamental, of course, but Jungians are increasingly hard to pigeonhole, in keeping with Jung's precepts about a unique theory for each person. Patients to some extent need an explanation of things; it is just not clear ahead of time which one they will get. Within limits, an in-depth versatility is more the order of the day. Jungian therapists have theoretical blends in mind. In fact, a fourth school of post-Jungian thought—an offshoot of the developmental-clinical category—might be added, one that incorporates some of the latest in analytic thinking while perhaps emphasizing less the work of Klein and Bion. Jungians in this new school seem to be more inclined toward the tones and perspectives of self psychology, its "intersubjectivity" successors, and other "relational" viewpoints.

Outside of the internal Jungian world of analytic institutes and post-graduate trainees, a thoughtful, nonclinical (though psychologically oriented) readership of Jungian-influenced books has developed, a readership interested in best-selling books on "the soul" and its care, the men's movement, and the psychology of women and the restoration of the feminine.[8] This is a literary- and lecture-based Jungianism, oriented toward personal growth but with limited overlap with Jungian psychotherapy as discussed in this book. The inclinations of this sector are similar, actually, to an almost century-long interest in Jung among various spiritually oriented, intellectual or creative individuals. This interest boomed during the twentieth-century era loosely and somewhat inaccurately defined in chronological terms as "the sixties," when alternative cultural—political philosophies pressed hard on western societies.[9] Interest in things Jungian has escalated in this modern psychological era, where self-exploration and psychotherapy are almost more the norm than the exception among educated populations in the industrialized nations—the "triumph of the therapeutic," one could say, even though reactionary voices call it a culture of narcissism or navel-gazing.

Jungian therapy's continuing obscurity

But the interests of a well-healed intelligentsia do not speak much to the issue of psychotherapy or of the training of psychotherapists. In the psychiatric world, Jungian thought has had little influence, except in small pockets. At the turn of the twentieth century Jung was in the psychiatric forefront, first through his work on psychosis ("dementia praecox") and affectivity ("complexes"), his experimental researches at the Burgholzli psychiatric hospital as assistant to Eugen Bleuler (who coined the term "schizophrenia" during this time), and most famously as a loyal, if eventually ambivalent, follower of Sigmund Freud and psychoanalysis. Jung gave Freud entree into psychiatry, and partially for this reason was Freud's designated heir-apparent to the psychoanalytic throne. When Jung drifted away from Freud theoretically and personally, he also drifted into clinical obscurity, at least as compared with psychoanalysis and as far as the developing psychotherapeutic mainstream was concerned. Now even psychoanalysis, once the predominant theoretical if not practical mode in psychotherapy, is no longer mainstream, or is under continuous challenge as to its precepts, effectiveness, and practicality. Jungian analysis, so to speak, preceded psychoanalysis into potential obscurity.

Among individual clinicians, Jung maintained a small following, and was read or cited by non-Jungian therapists who, like Jung, were somewhat unconventional. As a therapist, Jung seemed to possess quasi-shamanic abilities, and was perhaps the kind of charismatic psychotherapist who could best be called a "healer."[10] As far as we can tell from historical reports of patients, Jung was a gifted, even outstanding therapist, who had a healing personality (or access to healing vectors in the unconscious). The quality of his writing and ideas also suggests his therapeutic skills. At any rate, therapists who are less concerned about theoretical allegiances and more concerned about the complex realities of healing have seemed to find something of real value in Jungian thought, if exposed to it.[11]

Despite these pockets of interest, Jung's ideas on psychotherapy were also obscured by

his symbolic approach, an allied impression that his writings are "Zso mysterious as to be undiscussable" (Peters 1962, p. 730), or a sense that he did not write much about psychotherapy per se. A knowledgeable and curious colleague of mine was surprised to hear that Jung said anything about transference (i.e. the unconscious relationship the patient has with the therapist, and vice versa). Another textbook, edited by a leading Jungian analyst, suggests: "Jungian analysis still retains an esoteric aura, bearing the overtones of a cultic experience and 'mystical' approach to psychological life. The Jungian concept of the psyche's reality, to name just one source for this popular view, places Jungian thought for some readers at the borderline of occultism" (Stein 1982, p. xv). And here is a typical journalistic comment about a Jungian patient, taken from the obituary of Paul Mellon, a Jungian patron: "He was curious about mysticism, so he studied with Carl Jung" (*Washington Post*, 3 March 1999).

Jung's relevance and applicability

Basic Jungian clinical thought is, of course, fundamentally defined by Jung's original writings and interests. But any characterization of it as some sort of occult or esoteric psychological practice is unfortunate and inaccurate. Doing therapy sometimes does have its bizarre, some might say "occult," moments, but mostly it is nonmagical, hard work. The depth in Jungian psychotherapy comes less from a magical mystery tour than from deeply felt, emotional things that happen between the patient and himself and the patient and his therapist. Most of Jung's thoughts on therapy are straightforward, profound, and, in fact, nonmystical. The quote at the top of this chapter is a case in point. While providing crucial guidance about the issue of countertransference, no mention is made of archetypal constructs, spirituality, or religious symbols. In fact, the focus is on the psychotherapist and his use of his personality and unconscious as, in effect, therapeutic tools; theoretical constructs and anticipations of any sort, much less mythological, are secondary. Jung's judgment on transference is also clear: it is "the crux, or at any rate the crucial experience" in psychotherapy (1958, p. vii), and, again, he included countertransference in the mix. As for Jung's language and subject matter, they are both boon and bane: to some they are refreshingly different, to others obscure and self-referential. Yet that is the case for most psychological theories and terms; one has to get used to them and know their contexts and reference points to understand them. Without background, for instance, terms like "personal constructs," "transmutative internalization," "borderline personality disorder," "reality therapy," "cognitive-behavioral therapy," "unconditional positive regard," "cathexis" (a pseudomedical word invented, literally, by Freud's translator James Strachey), and so on, are so much, mostly scientistic, psychobabble.

A lot of what Jung said about psychotherapy—alchemy and flying saucers notwithstanding—is quite clear, and it applies, fortunately, to almost any form of psychotherapy that stresses the importance of the patient-therapist relationship The theoretical orientation of the therapist matters little, because the ideas embodied in a Jungian psychotherapeutic perspective can be transposed across most theories. There are some limits: theoretical positions that deny or are uninterested in notions such as an inner life, an unconscious, a person's having or being a "self," or the primacy of feeling states

would probably not do well with Jungian approaches.[12] But almost all nonbehavioristic approaches to counseling and therapy that emphasize the therapist's careful listening, understanding, and, to whatever extent, personal participation in the treatment will find Jungian ideas congenial. Numerous books and articles have shown how Jungian therapeutic concepts coordinate easily with other schools of thought: many non-Jungian writers make explicit use of Jung, others are unaware that their ideas run parallel, and Jungians themselves make broad practical use of others' ideas.[13] From a Jungian vantage point, it does seem like there are a lot of "unknowing Jungians" (Samuels 1985) out there, that is, therapists whose ideas seem to repeat what Jung said a long time ago. Jung's being out of the loop, however, basically puts aside the idea of an unconscious absorption or plagiarism of Jung's ideas. The fact is, Jung was prescient.

As all of the above already indicates, Jungian theory overall has tremendous breadth, and one of the good things about it is that it does not just twiddle around with the clinical but tackles larger life questions. It leaves room for discussion of the richness of personality, which cannot just be described in terms of eros and aggression, powerful though they are. Surely, a truly satisfactory personality theory should be comprehensive, or else it leaves the reader hungry for more: it leaves us hungry as psychologists or psychologists-to-be who are motivated to find meaning through the work we do, and it leaves patients hungry because their lives, too, are concerned with the meaning, or lack thereof, of life. The more time one spends with Jung, the more one appreciates his inclusion of a larger perspective. Even if we disagree with his tenets, or with what some have suggested is, as originally practiced, a psychological quasi-religion, we can thank him for pushing us into wrestling with the deeper issues. In the next chapter, a closer look at selected Jungian principles will suggest how they can be useful in psychotherapy.

NOTES

1 Early references in psychoanalysis to countertransference as a useful, integrated aspect of a therapeutic relationship are usually thought to begin with Heimann (1950), though early work by Searles (1949/79) and Winnicott (1949) precede this.

2 The Scarlet Pimpernel: "They seek him here, they seek him there, the Frenchies seek him everywhere. Is he in heaven, is he in hell? That damned elusive Pimpernel."

3 See *Psychoanalytic Dialogues* 10, no. 3 (May/June 2000) for discussion and articles on analytical psychology and "reactional" perspectives.

4 See Smith, Glass, and Miller (1980). As a result of their meta-analytic statistical studies of all available "controlled" psychotherapy outcome studies (n=475) the authors confidently stated, "The allegation by critics of psychotherapy—that poor quality research methods account for the positive outcomes observed—can now be laid to rest" (p. 126). Noting that "the evidence overwhelmingly supports the efficacy of psychotherapy," they added: "The post hoc rationalizations of academic critics…have nearly been exhausted. They can scarcely advance new criticisms without feeling embarrassed, or without raising suspicions about their motives" (p. 183). A fair amount of scientific research, especially in the softer sciences like psychology, seems to test the obvious and confirm what most people know

intuitively.

5 I am not considering William James as a depth psychologist per se because he was not a clinician but an academician. Jung's contact with and high opinion of James is of interest (see Jung 1973b, p. 452).

6 Approximately two to three thousand at this writing.

7 See, for example, L.Jaffe, "Interview with Edward Edinger" (1999).

8 See Thomas Moore, *Care of the Soul* (1992, 1994) and sequels; Robert Bly, *Iron John* (1990); Jungian analyst Clarissa Pinkola Estes, *Women Who Run with the Wolves* (1992) and sequel; Jungian analyst James Hillman, *The Soul's Code* (1996) and others; most of scholar Joseph Campbell's books and video interviews on myths are essentially Jung-based; slightly less well known though influential are books and workshops on the feminine by Jungian analysts Marion Woodman and Jean Shinoda Bolen.

9 These trends were spurred on, it seemed, by the intense political crises and issues of the era, though it could also be said they themselves spurred the political challenges. While some more conservative thinkers have attempted to define the 1960s as an isolated countercultural mistake, the era was more likely a crystallization of longstanding energies and tensions that cyclically emerge. Radical sociocultural movements seem to show up every generation or two in recent western history, about every thirty to forty years—the 1920s–1930s, the 1960s–1970s, and now perhaps at the new millennium. The search for inner life, psychological or spiritual, may still be brewing, especially in a high-technology age. The tone of the quest is simply different now, quieter than in previous cycles, because western economies are relatively prosperous and political life is in less radical foment (as of this writing). Also, what was previously radical becomes quite acceptable, or at least not unusual: consider the environmental movement, feminism, and, last but not least, psychotherapy.

10 For Jung as shaman, see Groesbeck (1997). This idea of a therapist as a "healer" per se, as opposed to something less dramatic and talented, comes from A.S.Hill, MD.

11 Therapists who come to mind here are H.S.Guntrip, R.D.Laing, D.W. Winnicott, Anthony Storr, George Atwood, Carl Whitaker, Gene Gendlin, James Grotstein, and Arthur Burton.

12 Even Albert Ellis, founder of Rational-Emotive Therapy (RET), saw similarities between his ideas and Jung's. This is quite a stretch, however. He goes on to say that dreams, a Jungian mainstay, are "a waste of time" (Ellis 1979, p. 189).

13 For an early review of studies synthesizing Jung with other schools of therapy, see Sedgwick (1983, pp. 21–41). In recent decades, Jungian analysts have made comprehensive use of psychoanalytic ideas, especially those of Kohut, Klein, Winnicott, Bion, Atwood and Stolorow, Racker, Langs, Searles, Sullivan, Ogden, and Freud himself. Feminism and other psychocultural analyses are also influential in current Jungian thought.

Chapter 2
The Jungian approach: selected theoretical principles

To understand Jungian psychotherapy you have to know something about Jungian theory, especially how Jungians view the unconscious. This task is difficult, however, because the full range of Jungian thought about the nature of the unconscious is a book in itself. Furthermore, it is to a certain extent the spirit of Jung's work, rather than its particulars, that informs Jungian psychotherapy. The general task of this chapter is to provide some of the spirit and some of the particulars about the Jungian view of the unconscious psyche without explicating all of analytical psychology. The specific goal is to explore selected aspects of Jungian psychological theory relevant to the therapeutic relationship. To do so, a careful look at some points of contention in Jungian thought may occasionally become necessary.

PSYCHOTHERAPY vs ANALYSIS

"Psychotherapy" means therapy for the psyche (literal definition), and involves a concerted effort to treat mental disorders (a more psychiatric definition) or to attend to and heal emotional pain and conflicts (a more humanistic definition). In a sense, any kind of helpful treatment is psychotherapeutic—drug therapy would be a form of psychotherapy, as would religion or perhaps some regular tennis lessons. Psychotherapy as usually defined by therapists, however, also includes a specifically psychological understanding of the person in a specifically psychological treatment situation.

By these standards, psychoanalysis, which traditionally involves almost daily meetings, a couch, and a certain interpretive format, is psychotherapy. But psychoanalysis has always sought to distinguish itself from psychotherapy with regard to depth, structure, and method. Jungian analysis, meanwhile, has always been different from classical psychoanalysis in terms of viewpoint and therapy parameters. Jung wrote at one time, for instance, about "a maximum of four consultations a week" for analysis, decreasing as treatment progressed to "one or two hours a week" (1935b, p. 20). So, if—an arguable "if"—analysis is defined in terms of frequency, then Jungian analysis is really an intensive psychotherapy. But then, returning to the basic definition, so is psychoanalysis. While Jungian analysis in the hands of many analysts has recently come closer to psychoanalysis, and psychoanalysis has evolved in ways that look more Jungian, there is still a large difference. The Jungian preference for a here-and-now phenomenology of the unconscious—the unconscious as it is—over an exclusively childhood-based unconscious remains strong. Regardless of whether this non-childhood inclination leads to archetypal perspectives or to considerations of therapist-patient

intersubjectivity, the difference from classical psychoanalysis is intact.

The key thing here is not to split hairs about defining Jungian vs Freudian analysis per se, but to note that Jungian treatment has almost always involved a style and frequency close to what is currently known as psychotherapy. More important than whether sessions are daily, twice a week, or weekly—although this requires careful consideration—is the nature of the therapy, which is what this book is about. Psychotherapy in general was defined above in dictionary terms. Jung preferred a definition at once more literal and more lyrical—"treatment of the soul" (1941, p. 94)—which is telling, and tells one a good deal about the background and spirit of the Jungian approach.[1]

The introductory chapter alluded to three or four schools of Jungian psychology. Another slightly different differentiation can be made, this time between Jungian analysis and Jungian psychotherapy. Basically, two kinds of Jungian analysis exist. The first kind, more classical and more "Jungian," is embodied in the more symbolic path and in understandings like, "We could sum up the goal of Jungian analysis by saying it aims to facilitate conversation between ego and Self" (Ulanov 1995, p. 67). The second type is Jungian analysis that is informed technically and theoretically by psychoanalysis in its old and new forms. Different from each of these, though borrowing from them in spirit and certain techniques, is Jungian psychotherapy. Jungian therapy, as defined here, focuses particularly on the therapeutic relationship. This does not in itself make it different from the various forms of Jungian analysis, but it is less archetypal than classic Jungian analysis, and less analytic-interpretive than developmental Jungian analysis. Psychotherapy may mean only weekly meetings, like classic Jungian analysis in its "synthesis" as opposed to "analysis" mode, but, as shall be seen, it may not pursue archetypes. It may emphasize counter-transference and early family sources and interactions, as psychoanalytic Jungian analysis does, but it incorporates them into areas that psychoanalytically inclined analysts might call nonanalytic "corrective emotional experience" (Alexander and French 1946). Jungian psychotherapy makes use of Jung's direct statements about psychotherapy, meanwhile minimizing some of his preferences for a symbolic approach and some of his uninterest in small-time personal interactions and life.

In general, analysis as such has not been the treatment of choice in the larger therapy world for generations—which is not to speak against it but to confirm a reality. Jungian theory is not glued to old or new forms of Jungian or any other style of analysis, and a Jungian approach to psychotherapy can get in the game and step up to the plate.

JUNG THE MAN

But before getting to Jungian principles, or as a way of approaching them, one must tackle Jung the man. To understand Jungian theory, you have to understand Jung, at least in some way. Why? Because, as noted in Chapter 1, he suggested that his psychological theories, and everyone's, were a personal "confession." In reality, Jungian psychology is no more confessional than others are. Think of any psychotherapy theorist and consider if his or her theory is not an embodiment of his or her personality. Jungian thought is like his psychology; Freud's theories, based on his self-analysis, are just like him (he had

Oedipal conflicts, feelings of sibling rivalry); Carl Rogers, a farm boy and seminarian, was no doubt an unconditionally positive, warm person; Alfred Adler, a socialist, struggled with inferiority-superiority issues and social feeling; and so on. The theories parallel the people. As the introduction also stated, psychotherapy, for better or for worse, is not a science, and most theories of personality are not scientific in an experimentally researchable sense. (Or, the more research-based they become, the more uninteresting they become). What the theories are is one person's private viewpoint, then followers and patients find they resonate with that person's perspective, and then perhaps an ongoing "school" gradually forms.

At the same time, the understanding of personality theorists through their theories has its limits. One of the services that pioneer psychologists inadvertently provide is that their lives become objects for posthumous analysis through written biography. The reading public apparently gets their *person* to play with, not just their theories. However, psychobiography is oftentimes a flawed enterprise. What tends to happen is that biographers, some of whom are psychologists and some not, take their own theories (confessions) and apply them to the subject. At its best, this is thought provoking, but more often it devolves into post hoc, intellectual psychoanalysis, some of it by amateurs. Because there is no therapeutic relationship or intent, the spirit of the endeavor sometimes is wrong—small-minded or nonexistent, voyeuristic or gossipy. It has been said, "The problem with self-analysis is the counter-transference." The same holds true for psychobiography, because the subject has no transference connection to the writer and there is no countertransference in return. Obviously, the intent of psychobiography is not psychotherapy, where a patient comes closest to being known to himself by letting himself be known to someone else, in trust and never revealed to the public. And psychotherapists are not the only people who can understand or be fascinated by someone's life. In terms of the ethic of psychotherapy, however, psychobiography is a kind of confidentiality violation, and technically speaking it is what Freud called "wild analysis".

Jung's personality

With these provisos in mind, I can try to describe Jung as I see him and some sense of how his ideas resembled his personality. Like his theories, Jung himself was extremely varied, even paradoxical. As a prominent follower of his puckishly said, Jung seemed to be "almost impossible to describe…a kind of a union of a Swiss peasant and a scholar, and something more, of a more spiritual nature, [which] describes a man that technically should not exist but did" (Henderson 1989). At least a dozen biographies of Jung exist, and several films reveal his colorful, forceful, and wry personality. Even in old age he was a man of considerable charm. He appeared to move chimerically, in his writings and on screen, from being a practical psychiatrist to being an erudite intellectual and a scholar of arcane, extremely obscure texts (on alchemy or Taoistic meditation, for instance) to being a sort of prophet. Jung was multidimensional, culturally sophisticated, multilingual—he learned Swahili for a trip to Africa—and obviously had a brilliant mind. Some think he was a genius; whatever that means, he was pursued by a genius or daemon in the Greek sense.

Jung was, by his own admission, a thinking and intuitive kind of person, with a near-visionary capacity and proclivity for mystical experience. Though romantic and somewhat combustible in his intimate relations, he was also capable of a coolness in feeling with others that sometimes betrayed him and them. Politically, this Swiss psychiatrist was sometimes controversial in his time and, insofar as this matters, remains so today: he was antitotalitarian in the main, yet could be surprisingly insensitive and naive about the effects of his comments on others.[2] He became a "great man," surrounded by very dedicated followers, yet also felt isolated from the world in many ways. Some have suggested he was transiently psychotic as a child or in middle age; others have suggested that his own struggles for mental balance were a creative and healing act that fueled his theories.[3] He recommended that some patients should develop the capacity to have conversations with themselves—a proposal that on the face of it sounds strange, but on further reflection is quite ordinary. He studied literally out-of-sight subjects like alchemy and astrology (as did Isaac Newton) and was interested in mantic methods (the *I Ching,* tarot). Besides being creative, diverse, and brilliant, Jung was a famous man when fame was based on lasting achievements, ideas, or a truly interesting personality, rather than television or technologically driven celebrity. (He died in 1961.) Psychobiographically speaking: given his fame, following, and the strength of his ideas, he seemed to strike a fairly healthy narcissistic balance between believing in the value of his ideas (and enjoying expressing them) and being able to see their limitations.

Jung's contributions

Jung's diversity was embodied in the range of his theorizing, and especially in his personal and scholarly interest, already noted, in myth, symbol, and religious experience. It is primarily for these, and his work with dreams, that he is remembered. These nonclinical (except for the therapeutic use of dreams) dimensions tend to drown out his clinical contributions, or at least dilute them, both in public and professional minds. Yet, as a practical, and practicing, clinician, Jung added significantly to the field of psychotherapy and general psychology. Jung was the first therapist to:

- analyze in sophisticated, psychological terms a case of what is now called schizophrenia (1907), thus helping bring the sufferings of that huge diagnostic area, and also dissociative orders, into the realm of psychotherapy;
- suggest that future therapists must undergo therapy themselves;
- view pathology as a failed attempt at human growth;
- insist on the usefulness and informative value of countertransference;
- see the full extent to which a mutual involvement in the psychotherapeutic relationship is the key dimension in psychological healing.[4]

In addition, Jung was more or less "present at the creation" of psychoanalysis, first president of the International Psychoanalytic Association, and, until they broke up, Freud's heir apparent and designated "crown prince" (or, as Freud also put it, "Joshua" to Freud's "Moses"). In the wider realm of psychology, Jung's early researches on the word-association test, including studies of psychogalvanic skin response and the pneumograph that foreshadowed lie detector and other tests, were seminal at the time; his

ideas were fundamental to the development and conceptualizing of projective tests, especially the Rorschach and TAT (Thematic Apperception Test);[5] Jung's delineation of psychological types—introvert or extravert, combined with intuitive, thinking, feeling, and sensation preferences—has been widely adopted as a way of thinking about people, not only in the psychological world but in business and other organizations; and his 1930 paper "The Stages of Life" has been a springboard for a great deal of current psychological and popular thinking about "midlife."[6]

JUNGIAN THERAPY AND THE NUMINOUS-ARCHETYPAL

Regardless of Jung's pioneering work, anyone approaching Jung's ideas about psychotherapy still must come to grips with the fact that part of the way Jung put the depth in depth psychology was through his study of archetypal or "numinous," symbolic experience. The main examples of his work imply, and he also stated at least once, that for the patient "the approach to the numinous is the real therapy" (1973a, p. 377) and that to assist with this, the therapist "must abandon all preconceived notions and, for better or worse, go with him in search of the religious and philosophical ideas that best correspond to the patient's emotional states" (1943, p. 80). Numinous experience means transcendent experience: human experience that is imbued with a feeling of something holy, divine, or mystical. Spiritual experience, however, is not usually a psychotherapeutic topic (except with reference to delusions or psychoses). Whether it should be or not depends on one's worldview and philosophy, but it is clear that Jung gave religion and spirituality the highest value. He sometimes described the goals of psychotherapy specifically in religious terms. "The goal is transformation," he once said, "…the only criterion of which is the disappearance of egohood" (1939b, p. 554), which is a Buddhist concept; or, when describing the experience of the Self (see below), an analytic goal that is also a God-concept, "Yet not I live, but Christ liveth in me" (1928, p. 221), which is Christian doctrine from St Paul.

The therapeutic limits of "numinosity"

Some people who have read Jung or are interested in personal growth are drawn to his religious perspective. They expect, understandably, that their Jungian therapy will resemble Jung's analysis of himself, his patients, or his early followers, whose therapeutic paths were highly colored by Jung's immediate presence, symbolic interests, and evolving theories. However, commenting on his later years as a therapist, Jung noted that most of his patients in that era were culturally sophisticated individuals with previous therapy experience. They were well adapted to society and thus concerned (and able to be concerned) about problems of self-realization. "About a third of my cases," Jung said, "are not suffering from any clinically definable neurosis, but from the senselessness and aimlessness of their lives. I should not object if this were called the general neurosis of our age. Fully two thirds of my patients are in the second half of life" (1931a, p. 41). Without diminishing this insight about twentieth-century alienation and about the nature of personal suffering—since emotional pain is not necessarily correlated with

psychopathology as such—many of the patients Jung wrote about extensively appear to be what are now called "the walking well." Some of them were people "often of outstanding ability, to whom normalization means nothing…Thus, my contribution to psychotherapy confines itself to those cases where rational treatment does not yield satisfactory results" (ibid.). Jung's approaches were encouraging to those seeking and creating deeper, sometimes uniquely spiritual meaning in their lives, and their Jungian paths sometimes involved direct transpersonal experience through introspection and imagination.

Certainly, anyone who has transcendent or conversion experiences can be healed by them (or, as Jung also noted, overwhelmed by them), but the fact also is that these experiences are rare and Jungian psychotherapy cannot guarantee them. From a religious perspective, such experiences would probably be considered acts of grace (or illusions), outside of psycho therapeutic intention. Despite Jung's comments on numinosity, Jungian psychotherapy does better not to imply that religious "close encounters" are the cure or the goal. Rather, if such experiences or spiritual questions arise, the Jungian therapist will respond empathically and help the patient explore what they mean to him, as a good therapist does with anything that is presented. For the majority of therapy patients, the sense of a unique *psychological* understanding of their problems, not necessarily a religious or philosophical quest, is sufficient. This helps put aside any unreal expectations of either party, while maintaining the attitude of openness to whatever the psyche—the psychology—of a person presents. It also removes the therapist somewhat from a guru-like position, a position that is not necessarily suspect (as a patient may need to project this) but can be suspect if unconsciously promoted by the therapist or his theories. In addition, it moves Jungian psychotherapy out of being restricted to a limited range of patients. For Jung, the solution is in the *spirit*, but Jungian therapy needs to be able to relate to mundane psychopathology and the more deeply disturbed patients often seen today, who cannot be effectively approached with a primarily archetypal-symbolic method. A therapist can think of such patients this way perhaps, but with some exceptions cannot work with them without a focus on the personal issues and deficits involved.

The psychological perspective and solution

From the opposite direction, almost all Jungian psychotherapists also resist the temptation, especially strong in this age of impressive neuro-psychological research, to discount unconventional psychological experience as an epiphenomenon of biochemistry, as "nothing but" (to borrow Jung's phrase about reductionism, which he borrowed from William James) dopaminergic or serotonergic movements across sodium-gated channels, etc. Though not anti-psychiatry—Jung postulated a biochemical toxin aspect of psychosis that was not too far off—Jung resisted in his bones the suggestion that personality, emotions, and imagination were functions solely of either brain physiology or infantile experience. This nonreductive, phenomenological approach to the psychological is another healthy cornerstone of the Jungian standpoint. Jungian psychotherapy values the psyche as it is and where it is, and fundamentally assumes that a person, even in illness, is trying to evolve. Brain chemistry hypotheses and other forms of psychological

determinism tend to take this away, closing off exploration of psychological meaning. While not denying the physiological correlates of much human misery, the Jungian therapeutic approach falls sharply on that side of the psyche-soma question that places psyche first. For example, certain forms of depression may be the result of serotonin deficits or at least can be treated that way, or one can envisage depression as occurring when one is unhappy about something but does not yet know why (or does not want to know why).

Jung's multidimensional personality and his emphasis on the nonpersonal transcendent led him to contradictory viewpoints about the nature of the therapeutic relationship that must be addressed by anyone involved or interested in Jungian psychotherapy. If Jung seemed to paint himself into a corner by declaring the approach to the numinous to be the central healing ingredient, he also painted himself out of it by naming transference—again, the unconscious relationship between patient and therapist—as the crucial ingredient in psychotherapy. What he did was merge the two: transference is the "crux" (the essential point requiring resolution or resolving an outcome),[7] but Jung also suggests it is a transcendent process. That is, Jung tended to describe the patient-therapist involvement in the numinous terms mentioned above, or at least employed potentially numinous, archetypal imagery, such as that of alchemy, to illustrate transference and counter-transference phenomena. He used mythical symbols to describe the "emotional chemistry" between the therapeutic participants, rather than an explanatory system that rested, for instance, on early childhood developments.

Jung postulated that the unconscious was inherently, or potentially, transcendent. While it is doubtful that he thought psychotherapy per se was transcendent, he did definitely and repeatedly state that numinous or archetypal unconscious material existed and could be projected onto and into the therapist, and that the psychological healing process had an archetypal basis in the unconscious mind. The nature of the unconscious—the "unknown"—is thus a fundamental question in Jungian therapy. What is the unconscious, and how does it affect the therapeutic relationship?

THE UNCONSCIOUS IN JUNGIAN THEORY

Jungian psychology rests fully on the idea that part of the mind or psyche operates outside of awareness yet exists and has effects. The unconscious psyche is real. The idea of *the*, or *an*, unconscious precedes Jung, Freud, and modern psychology, but was creatively developed by them: though they did not invent it, they explored it clinically and began to talk about it. The Jungian approach, different from the Freudian, places high hopes on the unconscious, and view it as a kind of psychological powerhouse. This perspective comes from Jung's own experience and orientation with modifications, additions, and sometimes reorientations coming from the analytic and professional experience of Jungian analysts who came after him. As noted earlier, there are different kinds of Jungians and no single Jungian view. Yet despite individual differences, almost all Jungians came to Jung through some basic resonance with Jung's ideas about the unconscious, or at least some of them. (All therapists, naturally, gravitate towards theories that match or help explain their own experience.)

To postulate an unconscious mind is no more than to say that people have feelings, thoughts, sensations, memories, knowledge, and so on, they are not currently aware of. Unconscious simply and literally means "unknown." And Jung offers the telling caveat that all statements about it are tentative, because "the unconscious is just unconscious… [a description of] it is always *as if* (1935a, pp. 7, 9). He subsequently added the Heisenberg principle to this formulation: "Any attempt to determine the nature of the unconscious state runs up against the same difficulties as atomic physics: the very act of observation alters the object observed. Consequently, there is at present no way of objectively determining the real nature of the unconscious" (1955–56, p. 81). The shape of things in the unconscious cannot be directly known, but is filtered and probably altered through consciousness. So the unconscious is by definition an indirect, second-order phenomenon, and usually attributions about it are second-hand, coming from someone else's viewpoint.

The unconscious and the ego

Although we cannot know their precise unconscious form, hundreds of thousands of things we usually know, from words alone to broader information, are unknown at any given moment. This is a necessity, of course, or else our minds would be flooded. (Certain forms of mental illness seem to be characterized by this flooding, in fact.) To this river of known facts we bring a selective, conscious awareness, so that, amazingly, much of what we know is potentially available to us. We can ring up the data more or less at will. A great deal of this not currently conscious area of the unconscious mind consists of memories, memories of myriad things that have occurred (events), been sensed, or been learned or thought about in some way. And in the same way that much of the mind is based on memory, so is a large part of one's sense of identity, one's "ego" ("I," in Latin). Jung puts it this way: "The ego is a complex datum which is constituted first of all by a general awareness of your body, and of your existence, and secondly by your memory data; you have a certain idea of having been, a long series of memories" (1935a, p. 11).[8] Without a memory, you cease to exist to yourself (as in amnesia, senile dementia, Alzheimer's), though you exist to others because they see you and have memories of you.

The unconscious implies the conscious, and vice versa. Although Jung had a fair amount to say about consciousness, his is mainly a psychology of the unconscious, not an ego-oriented psychology. It is not primarily concerned with defects in the ego or even in consciousness. It stresses the vital importance of consciousness and acknowledges the need for it, but it does not rest there. Rather, consciousness's place in Jungian psychology is as a functional means for integrating the unconscious, and its place is decidedly secondary. Jung indicates clearly how in Jungian psychotherapy the ego is crucial, but within limits: "We find that thoughts, feelings and affects are alive in us which we would never have believed possible… [and] can hardly fail to be impressed by all the ego does not know or never has known" (1951c, p. 19). The ego, according to Jungian thought, rests on a vast unconscious, like a boat on the ocean.

The penetration of consciousness by unconscious contents creates an adjustment in the nature of one's ego, or self-awareness, as does the failure to successfully integrate them

(in which case the boat leaks). In this scheme, unconscious contents challenge the conscious self, which in return either lets them permeate in some manageable way or else erects defenses to combat them. The unconscious in this sense constantly modifies the ego, which can respond appropriately or not; in a well-functioning individual the ego is continuously and successfully processing the emerging unknown, in whatever shape it chooses to present itself. The job of the therapist, in part, is to assist with this synthesis, and this has traditionally come about through understanding and interpretation—the therapist informs the patient what his unconscious experience is all about. As it turns out, however, a consciousness-based model, where the patient and therapist discuss, ego to ego, what is going on, sometimes operates better on paper than in therapeutic reality.

Another way to envision this is to talk about "the self." What most people mean by self is defined by what Jung called the ego or consciousness. It is a conscious sense of oneself, of who one is, which is based on the above-mentioned sense of having a physical body and continuous memory. To refine this a bit: the self is really a *sense* of self, not just knowing or recalling memories and a body but an awareness of having experienced these things in time. One has felt or gone through various things, had various experiences. These experiences of what one participated in form the quasi-concrete basis of what is remembered.

The persona

It is possible to be simultaneously conscious and unconscious, to the detriment of both states. This has to do with being "real" or present—present with one's subjective sense of self, one's feeling self. Jung does speak of certain people who go on as if they were never going to die, or as if terrible things (illness, tragedy) could never happen to them (1976, p. 94). They are, in a sense, asleep (or only half awake). Jung, though, did not speak of a "real" or "true" self opposed to a "false self," a distinction which is relevant to this discussion. But he did speak of a *persona*, which means how one presents one's self to the external world. The persona is a necessary adaptation to society's regulations and its more subtle expectations, and also an expression of one's self. Jung felt that it tended to be inauthentic, not necessarily in tune with one's inner, real self.[9] In this sense, the persona can be compliant with perceived demands of the world, to the detriment of one's true being. The trick, obviously, is to fashion a persona, to present oneself to the world, in a manner that is congruent with one's inner dimension—a true "self-expression."

Jung was perhaps a little harsh on the persona. Rather than being a hindrance, persona as expression, true or false, is a vital avenue towards discovery of another's personality—and one's own. All the choices one makes as to dress, style, manner, interest, or role are reflective of personality, even if they are, for example, reactionary or defiant (e.g. purple hair). Particularly in a world increasingly viewed as inter subjective—a world where identity is more dependent on relations to others than preciously considered to be, where impressions we give and get of others are fundamental—the persona and its vicissitudes are telling. What can be objectionable about persona is less its compliant, compromising aspects than its self-aggrandizing aspects. With persona, often, one tries to create an idealized impression of oneself—the "me" I would like others to believe I am. When presented in extreme forms, such a shadowless impression is simply a fake self, indeed, a

"false self." Jung also objected to persona, it seems, because it could present an unreal view of the unconscious, and he was always interested in accurate manifestations of the unconscious. Day to day, however, what persona demands is that one should more or less present one's best, or perhaps least disturbing, self to the world. This helps the wheels turn smoothly. The persona, usually, masks pathology, unconventionality, or unhappiness, and is in that sense a sop to societal expectations. Problems can arise, as Jung indicates, when one becomes identified, particularly in a narcissistic way, with one's social self-presentation at the expense of one's self-understanding, integrity, and the trust of others in relationship.

Affects, the unconscious, and fantasy life

The unconscious mind, at any rate, consists of memories coming from the stream of life happening to us, but each of these experienced memories or units of thought is, usually, accompanied by feelings of some sort. Some thoughts, of course, seem utterly neutral—just the facts—but many have a slight mood to them. A memory, or cluster of memories, about an important event or crucial person, for instance, comes with a distinctive feeling or set of feelings. In fact, there is a subjective hierarchy of memories and thoughts in the unconscious mind: they are ranked by their importance and intensity. For instance, my thoughts about someone I vaguely knew a long time ago are less important than my thoughts about my daughter; my thoughts about what to have for lunch are less important to me than my thoughts about this car accident I just had.

So in the unconscious mind are not just events, words, and ideas but reactions and feelings. A psychological or life event happens and we respond to it. Consciousness—the ego, the sense of "me," what I know—relates to the stream of life events, in fact is inextricably involved in them. But consciousness, depending on its sophistication and development, can only focus, like a searchlight, on discrete or limited aspects of current experience, as Jung notes. As with memories, it cannot focus on all of them, at least not simultaneously. Psychological experience in fact is dense, and this richness cannot be monitored all at once. At any given time, one is mostly unconscious of things. The conscious mind, for all it knows, cannot register all the outer events passing by, much less the internal ones.

Internal events are for the most part our reactions to outer events and people. These internal reactions are usually affectual, or emotional in some degree, though they may simply be ruminations or thoughts. However, there is also a stream of interior activity capable of consciousness that may be only loosely connected to current events, or disconnected from them: fantasies and imaginative activities; longings, desires, and daydreams; night dreams (which seem to be a special kind of thinking and feeling while asleep); and other intuitions. All this material is relatively available to consciousness and, with the exception of the latter two, potentially under conscious control, as noted before, but it is layered and some of it may never have been conscious or even existed before (again, especially true of dreams). This is where the real idea of the "unconscious" comes in, the idea of a deeper layer of the mind—part of ourselves—that is operative but about which we know nothing.

Thus far, the Jungian unconscious consists of (1) a vast reservoir of memory-based

general knowledge and learning, (2) more or less available and hierarchically arranged memories of life events and relationships that are or have been lived through, (3) the subjective reactions to those events and people, and (4) evolving fantasies, both under control and not. Both the memories themselves and particularly the feeling states associated with them exist in varying degrees of conscious awareness, depending on their value, intensity, or the passage of time. With reference to psychotherapy, painful or "negative" feeling states tend to exist with lesser degrees of awareness—we tend to prefer that they be unconscious, unknown, or forgotten. However, Jung felt that these thought-feeling combinations grew in intensity or at least kept their intensity when they remained unconscious, and also formed into psychological clusters he called "complexes."

COMPLEXES AND ARCHETYPES

Jung's most important early contribution to psychology and psychotherapy was his theory about these clustered feeling-states known as complexes. Jungian psychology in fact was originally known as "complex psychology," before becoming "analytical psychology" after Jung parted from Freud. Jung began approaching psychology via the complexes in the early 1900s, and he modified complex theory over the course of his theorizing, eventually arriving at his broader theory of archetypes. However, Jung's initial theories about unconscious complexes of emotion, thought, and behavior remain the underpinning for much of his later thinking, which is confusing to attempt to understand without complex theory.

Jung suggested that complexes were the structural bases of personality; the concept of complexes itself, meanwhile, formed the basis of his original personality theory. His theory describes personality as an ego (a complex of self-consciousness, as noted above, providing a central sense of self) surrounded by part-selves, often unconscious and autonomous (the complexes). As also mentioned above, complexes are emotionally based personality structures, tied to certain images, and they circulate, as it were, around the conscious personality, popping up when a situation or an image touches them. They then, to varying extents, temporarily supplant the personality, depending on their strength or the strength or cohesiveness of the ego.

The expression "complex" (or "having a complex" about something) is part of the vernacular (at least of twentieth-century vernacular) and essentially means being emotionally sensitive about a particular topic. For this reason Jung specifically defined complexes as *feeling-toned* complexes. Thus people have "mother complexes" or "father complexes," which points to specific affects and anxieties around these persons and one's relationships with them. Complexes also form around issues, such as guilt, money, self-esteem (e.g. inferiority complex), events (trauma). Clearly, most of these issue-oriented complexes involve people, and vice versa (that is, one's money issues may link with feelings about one's father or mother, and vice versa). Jung originally connected complexes to pathology: complexes were wounded parts of the personality that were in orbit around the conscious personality, or ego, and sometimes eclipsed it. What brought people into treatment was pain, dissociation, or other symptomology caused by an

unconscious complex, which needed diagnosis and interpretive understanding. This is still what brings people into treatment: something is bothering them enough to come in. Complexes are a way to talk about that. As the web of emotions and thoughts connected with a complex becomes conscious and—this is important—accepted by the patient and therapist, the complex loses its strength and autonomy. Indeed, as a complex become integrated, in a sense it ceases to be a "complex." In behavioristic terms, it loses its stimulus value; in human terms, the issue and all that went with it does not hurt so much or is manageable emotionally.

Complexes can be strong. As Jung amusingly remarked: "Everyone knows nowadays that people 'have complexes.' What is not so well known…that complexes can *have us*" (1934a, p. 96). Because they seem to have a life, energy, and, a quasi-consciousness of their own, Jung further theorized that complexes give shape not just to past difficulties but to future possibilities. The activity of complexes is therefore not simply related to painful "personal matters" from the past but to the new and "not yet" conscious, sometimes in relationship to those very matters that caused them (Jung 1911, p. 599; 1916, p. 270; 1948b, p. 12 n. 19). Thus, complexes are dynamic: new things are taking shape in the unconscious, and Jung felt that the unconscious looked more forward than back, and that it had creative, healing potential. In terms of psychotherapy, therefore, he eventually began to look less at complexes per se and their causes than at "what the unconscious is doing with the complexes," as he put it (1935a, p. 84).

The collective unconscious

This shift was based on and mirrored by the fundamental theoretical shift that occurred when Jungian psychology became analytical psychology rather than complex psychology: at this point, when Jung referred to the unconscious he generally meant the *collective unconscious* rather than the *personal unconscious.* He began to postulate that the unconscious had two levels, personal and collective, but although he still attended to the personal level, Jung began focussing more broadly on inherited psychic structures, the archetypes, that were there at birth. These were "organs" of the mind, so to speak (like physical organs, only psychological). Since they were considered to be inborn, they were "archetypal" and prototypical rather than learned or derived from personal experiences in life, as complexes seemed to be. Because they were innate, archetypes were considered to be akin to instincts, and therefore evolutionarily based. Jung described them as "systems of readiness for action, and at the same time images and emotions" (1927, p. 31)—these interior structures have a behavioral (action), a fantasy (image), and an affective (emotion) component, and so they give rise to innate, natural ways of doing, imagining, and feeling things. The archetypes are linked with typical human and psychological situations, around which they organize experience and filter one's thoughts and fantasies along archetypal lines. A situation feels archetypal when it is saturated with affect; fantasies are archetypal when they contain nonpersonal, sometimes historical imagery. At the same time, in Jungian theory the archetypes, though ages old, in effect become the driving forces behind the creation of the new contents arising from the unconscious.

Thus the personal unconscious in most Jungian thinking is related to personal history, as its name implies, while the collective unconscious in effect pertains to world history in

an inner sense, that is, to the evolutionary history of the mind in the human species. This means for many Jungians there is a whole layer of possibility in the unconscious mind, possibility that extends backward in time to unremembered human prehistory and that points forward to human potential.

Archetypal theory is important for Jungian thought because it provides a background explanation for Jungians' therapeutic vision of the unconscious. The creative, generative aspect of the unconscious, the part consisting not just of memories and painful complexes, is informed by archetypes, and archetypal possibilities. So whereas for Freud, for instance, the unconscious is striving for discharge, for Jung the unconscious is striving for health and growth. The implications for psychotherapy, particularly for the therapeutic relationship, are important.

ARCHETYPAL ASPECTS OF THERAPEUTIC RELATIONSHIP

When a therapist and a patient meet, it is a special situation. Indeed, from the traditional Jungian perspective, psychotherapy is itself an archetypal situation. The atmosphere of psychotherapy has a distinctive feeling about it—many Jungians talk in terms of the creation of a *temenos,* a sacred place or sanctuary. Psychotherapy is not church, but it does have to do with suffering, healing, and with a serious contemplation of the deepest things in a person. Furthermore, people come into therapy because they have to, usually as a kind of last resort. The situation of coming, usually in crisis, for help, guidance, or solace is a universal one, and its emotions and patterns could be called archetypal. While the specific dimensions of individual psychotherapy are, of course, not mapped out ahead of time, Jungians generally sense that the healing process in therapy is in many ways outside of one's conscious control and, because of that and its depth, instinctive or archetypal. A participant's feelings, dreams, and conscious thoughts may mirror this. The ritualistic aspect of psychotherapy also lends itself to this sense of a process with a dynamic of its own.

Another relevant, though difficult to understand aspect of Jungian archetypal thought is that the archetypes themselves are both transcendent and, almost literally, transpersonal: they seem at times to go beyond standard space-time and personal boundaries. An archetype apparently can coordinate the interactions of two people, though it is hard to say whether this is due to (1) a single, overarching archetype coordinating both people's conscious and unconscious, (2) similar archetypes constellated in each person separately, (3) complementary archetypes, or (4) archetypes themselves having a bipolar, relational aspect encompassing both participants. Regardless, when two people meet in psychotherapy, one could say that powerful, independent energies are about. Part of the mutual assessment by patient and therapist of whether psychotherapy will work out may be an unconscious or intuitive evaluation of whether these forces are about. Going to the doctor, or being lost and looking to be found, are no doubt archetypal themes, but the real question is whether putative archetypal energies will kick in.

Because of its fourth-dimensional aspect, an archetypal perspective can have a tendency, on the down side, towards abstraction. The danger is getting preoccupied in a heady (though uplifting, to be sure) process of pondering, imagining, or searching for

archetypes in the collective unconscious. Here the archetypal approach becomes a categorization of images that distracts from the therapy process and can cause it to become ungrounded. In fact, Jungian psychotherapy does well enough by simply recognizing that the process of therapy is probably archetypal in a general sense. Discussion of which archetypes are involved is not particularly fruitful for the patient though a therapist may need to conceptualize in that way.

The best and most useful archetypal consideration vis a vis psychotherapy process has to do with the archetype of the "wounded healer" (see Chapter 3). Jungian thought sometimes derives archetypes from mythological stories and imagery, noting how the themes and dimensions of such longstanding tales crystallize around basic motifs, considered to be archetypal. The stories of the wounded healer are a case in point. In terms of psychotherapy, not just the themes but, much more importantly, the specific energies associated with this archetype help explicate the mysterious workings of the patient-therapist healing process, especially its counter-transference dimensions.

The Self

Another dimension of Jungian archetypal perspective useful for psychotherapy is the concept of the Self. The Self is a central Jungian concept and first among equals in the hierarchy of archetypes, as demonstrated by its capitalization. This capitalization, in fact, is like the capitalization of the word God in Christian theology—the comparison is appropriate because the Self is really a God-concept, though it does not carry the same Christian connotations. The Self is the center of everything, according to Jung. Though it is transcendent and therefore cannot be directly described, it encompasses both the sum total of one's conscious and unconscious processes—hence, the Self represents one's "wholeness"—and the energizing and organizing center of the personality. Because the Self underlies and expresses the overall organization of the personality, it is, as Jung says, a "supraordinate" concept, often imaged in fantasy as a "supraordinate personality." Usually, though, it is associated with the unconscious in the sense that it is a sort of special agent or core within the collective unconscious, whereas the ego or consciousness is more limited (or the ego is associated with consciousness). This is a little confusing conceptually, because the Self by definition also includes the personal unconscious and consciousness. The ego rests on the Self, or is seen as a smaller part of the larger Self that lets the Self in, as it were.

It should be noted that, for many Jungians, the Self so described is experientially real. They have or have had some sense of an overriding guiding principle described by this terminology. Although the Self is not simply a theoretical, even mathematical idea, Jung nevertheless admits it can never be fully conscious and is thus to some extent "a postulate" (1921b, p. 460). For psychotherapy, the concept means that the process is sensed as having an ordering foundation, mediated by the Self. This does not mean psychotherapy is always orderly, or always successful. But there is a sense, similar to that described above, that an archetypal operation is somehow in operation; the Self is thought to be engaged in the situation, encompassing both participants. For many Jungian therapists, then, the Self stands over the healing process, while the wounded-healer archetype more specifically describes it. All this relates strongly to the previously

mentioned *spirit* of Jungian theory that infuses the Jungian psychotherapeutic relationship.

The creative unconscious

Most people, of course, do not come for psychotherapy seeking spiritual direction, the Self, or wounded-healer archetypes. This would require ascribing to a psychological belief system. Sometimes Jungians or prospective Jungians consider the collective unconscious to be a storehouse of spiritual possibilities that have been rejected or suppressed in the modern scientific, rational age. From this perspective, the archetypes and collective unconscious come close to being spiritual concepts, standing in almost for God as a source of wisdom (often transmitted by dreams) and as something to which an individual has a relationship similar to that of a religious fountainhead. Classical Jungian analysts, as described earlier in this chapter, often describe Jungian analysis as an ego-Self operation in this way (Ulanov 1995). But people coming to Jungian *therapy* hoping to tap into this metaphysical cornucopia may come away disappointed, because psychotherapy may not necessarily go in that direction. A conscious desire for a spiritual leap may be secondary to, or on some occasions even a defense against, the personal unconscious (i.e. personal issues that cause pain to the individual). These issues are often lifelong in nature, exacerbated by current events perhaps. Their depth and longevity lend to the idea that the issues are archetypal, or in a beyond-time dimension, but their core is in fact in one's personal life.

Jungian psychotherapy, however, is able to retain the idea of the potentially therapeutic nature of the unconscious without having to rely on spiritual explanations. It can do so by leaving the spiritual dimension to spiritual experts, and de-emphasizing that historical aspect of Jungian analysis that tends towards a kind of secularized religion. Splitting off the religious and giving it back to religion allows post-Jungian psychotherapy to focus on the unconscious as a repository of potential psychological development, not just mystical experience. The purposive aspect of the unconscious may be retained for those patients who do not require religion or are put off by it.[10]

This brings us back to Jung's complex theory, though not precisely in its original form. Jung initially described complexes as "sore spots" in the unconscious, caused by trauma of varying degrees (1931b, p. 528). (The dissociative effects of sexual and child abuse, incidentally, which receive considerable clinical attention today, are readily understandable as splitoff complexes within a Jungian complex-theory framework.) To this idea of damage or wounding from the past, Jung added the idea that the unconscious could contain certain personal characteristics or feelings that were not repressed but simply unknown and developing. These unconscious factors might arise in compensation to trauma or other negative events, or indicate developments beyond the trauma. Again, the unconscious, for most Jungians, is a creative place, sometimes hatching something new, generating new complexes and new opportunities of feeling and action. This is where the archetypes come in. For the practical purposes of most psychotherapy (and most patients, who are not consciously concerned with archetypes per se), it would therefore be better to call the collective unconscious the *creative unconscious.* While the notion of a collective unconscious does catch the sense of the universality and power of

the unconscious, it tends to get bogged down in the theological considerations described above, "group mind" theories, or a focus on symbols and imagery. The part of Jung's descriptions that gives account of its powerful dynamic without further symbolic amplification of archetypes per se is more useful. In his amplification of the archetypal perspective, Jung was trying to get at the building blocks of this creativity of the unconscious mind; furthermore, he was trying to explain the psychological sources of imagination. The archetypal viewpoint is a good theory about how and why the unconscious can be so creative, but the unconscious is creative regardless of this explanation.

PATHOLOGY AND PURPOSE

Jungian ideas about the nature of psychopathology fit well with this. Indeed, the Jungian approach to psychopathology is representative of the bi-level oscillations of Jungian theory as propounded by Jung. Jung in general moves between a kind of cosmic, collective view of psychology and a more personalized view. For example, in contrast to his view that "the unfailing causes of neurotic and even psychotic disorders" (Jung 1951b, p. 157) are neglected archetypes, Jung also proposed a different, more utilitarian hypothesis: pathology has an unconscious purpose, i.e., some sort of direction and as yet unrecognized meaning. Neither the symptoms nor the person who has them are pointless, according to Jung, because "there is no illness that is not at the same time an unsuccessful attempt at cure" (1939a, p. 46). The perspective of this statement is not particularly archetypal or even causal. It is accepting and optimistic, and it makes plain Jung's fundamental orientation towards the *future*, which is further specified in the following statement about the childhood origins of psychological disturbances: "It is impossible to tell at first glance whether we are dealing with a regrettably persistent fragment of infantile life or with a vitally important creative beginning" (1934c, p. 162). Jung speaks here not just to the sources of problems but to an alternative view of how they should be treated—again, this viewpoint and the spirit behind it inform Jungian psychotherapy. "Hidden in the neurosis," says Jung, "is a bit of still undeveloped personality, a precious fragment of the psyche lacking which a man is condemned to resignation, bitterness, and everything else that is hostile to life. A psychology of neurosis that sees only the negative elements empties out the baby with the bath water" (ibid., p. 167). In a nutshell, concludes Jung, "A man is ill, but the illness is nature's attempt to heal him, and what the neurotic flings away as absolutely worthless contains the true gold we should never have found elsewhere" (ibid., p. 170). This core attitude runs way back in Jung. As early as 1914, just after (and emblematic of) his break with Freudian viewpoints, Jung dramatically sermonized, "The neurotic is ill not because he has lost his old faith but because he has not yet found a new form for his finest aspirations" (1914a, p. 289). Jungian psychotherapy believes in the value of illness, or at least that there is value in it.

Such an attitude is vulnerable to being criticized as either soft-hearted rationalization or clinical naivete. Yet Jung and the Jungian approach are, as one analyst has stated (and as Jungian patients have experienced), "tough-minded" (Stein 1982, p. xv). Jungian psychotherapy is not a walk in the park or a spiritual journey. The view that there may be

something more in pathology—something better trying to happen—is not necessarily ingenuous but, quite simply, hopeful. Though he did not paint as dark a picture of the unconscious as Freud did, and his theories were characterized by teleology and hope of transformation, Jung was also clear about the dark or "shadow" side of personality, the hopelessness of certain cases and psychopathologies, and the limits of psychotherapeutic aid. Regarding therapeutic ambitions, he noted that usually "you can't wrest people away from their fate" (1935a, p. 131). He added, in another place:

> The principal aim of psychotherapy is not to transport the patient to an impossible state of happiness, but to help him acquire steadfastness and philosophic patience in face of suffering. Life demands for its completion and fulfillment a balance between joy and sorrow. But because suffering is positively disagreeable, people naturally prefer not to ponder how much fear and sorrow fall to the lot of man. So they speak soothingly about progress and the greatest possible happiness, forgetting that happiness is itself poisoned if the measure of suffering has not been fulfilled.
>
> (1943, p. 81)

Clearly, Jung does not send us valentines, rather, a sober wisdom: lest we forget, to be alive is also to suffer, and people must bear it (and learn the attitude of acceptance that allows them to bear it). This is a balanced analysis of therapeutic goals and of life.

While it keeps these cautions in mind, the Jungian model is not at bottom a conflict model; instead, the model endorses a creative striving through a dynamic tension of conscious and unconscious. While fully recognizing ambivalence and personal conflict, it emphasizes much more so the tendencies in the personality toward unification and growth. This attitude in Jungian psychotherapy, along with an openness to spiritual life, links it directly with humanistic approaches to psychotherapy and shows, rightly, why in its essence Jungian psychotherapy might be better affiliated with existential-humanistic psychologies than with psychoanalysis and psychiatry.

A great part of Jung's view of the unconscious, and a part of it with therapy application, has to do with a self-correcting, homeostatic relationship between conscious life and the unconscious reaction to it (and vice versa). His concern was with the relationship between the ego and the unconscious, with communication across an imagined boundary there. Consciousness looks outward (to the world) and inward (to the unconscious). The unconscious, with its creative propensities and a certain wisdom born of the ages, can respond with something that increases adaptation to life—a useful idea, a reaction either repressed or not yet realized that is appropriate or at least relevant to a psychological situation, or an image of the situation that helps one manage it emotionally. In therapy, as has been noted, the unconscious of each participant is activated: therapist and patient each have unconscious as well as conscious reactions to each other and to the situations under discussion. So, between *both* their consciousnesses and their unconsciousnesses, a sum total of four people are working on the problem, in a manner of speaking. This can be said because, for most Jungians, the unconscious itself is like a second consciousness that is commenting on, reacting to, and observing the state of affairs. This commentator is treated with respect, whether its comments take the form of

dreams from patient or therapist, or countertransference reactions from within the therapist.

DREAMS

What kind of comments does one get from the internal resource called the unconscious? In terms of dreams, Jung was enthusiastic:

> The view that dreams are merely the imaginary fulfillment of repressed wishes is hopelessly out of date. There are, it is true, dreams which manifestly represent wishes or fears, but what about all the other things? Dreams may contain ineluctable truths, philosophical pronouncements, illusions, wild fantasies, memories, plans, anticipations, irrational experiences, even telepathic visions, and heavens knows what besides.
>
> (1934b, p. 147)

For Jung, dreams were wild and wonderful, and working with dreams is probably the best-known aspect of Jungian psychotherapy. Jungian dream theory is a book in itself—indeed, already is taken up in many Jungian books—and cannot be fully discussed here.[11] It is enough to say that most of what Jung thought about the unconscious is embodied in how he thought about dreams, which are to Jung "specifically the utterance of the unconscious" (ibid.). Dreams give voice to the unconscious in colorful imagery; the trick is understanding them in order to bring in the alternative or additional viewpoint of the unconscious. Jung felt this was best done by trying to comprehend them in their own language, so a metaphorically orientated state of mind is necessary. The Jungian study of myth, fairy tales, and religion flows from this, as these provide a kind of symbolic library and mind-set akin to dreams.

Dreams in psychotherapy

Aside from noting dreams' near ecstatic possibilities, Jung also had a systematic angle on the application of dreams to personal life and to psychotherapy. He suggested that dreams showed not just how the unconscious was responding to things but what was the actual state of things in the unconscious, or inner life, of the patient. Dreams are a kind of psychological X-ray, indicating where the person *is* internally, and they also suggest where he, or a psychological situation he is involved in, might go (internally or externally). Therefore the Jungian approach, generally speaking, attempts to get with the dream world and the wisdom attributed to it, rather than to uncover hidden meanings as such. Jung did not feel dreams were deceptive or intentionally disguised by the unconscious mind, but just spoke, as it were, in a primitive language that requires some subtle translation on the unconscious's own terms.

This attitude towards dreams already puts the Jungian approach off most people's charts, even many psychotherapists'. It requires considerable faith to take dreams that seriously. But if these Jungian assumptions around the unconscious and dreams are accepted, then their importance for therapy is obvious. Of special interest here is their

running commentary on the therapeutic relationship. The unconscious will certainly express itself about that, among other things, because psychotherapy is important to the person in it, who may start dreaming about his therapy or therapist. Psychotherapy is also important to the therapist, who may find himself dreaming about a patient. For example, a patient new to treatment dreams that he is in a dentist's chair with sharks all around him—perhaps he is more anxious about psychotherapy than he lets on. Another patient dreams that he and his therapist are taking a look under the hood of his car—pretty routine, relaxed examination of his inner workings by the boys. A therapist dreams that he is in bed with his patient—things are getting very intimate (too much so?) or maybe he has unrecognized erotic feelings. A patient dreams that there are other patients in the therapy room—is there jealousy here, past or present, or is the mother/therapist distracted? A patient dreams that a forlorn plant has begun to sprout leaves—signs of growth? A patient of Jung's dreamed that Jung died but the saddened patient felt determined to go on—it was time to end his therapy (Adler 1989). All these sorts of understandings can suggest not only where an individual is but where the participants are vis a vis one another and where things are in the therapy. And, again, Jungians are typically as interested in "what the unconscious is doing with the complexes" as they are in the complexes themselves.

Types of dreams

Jung delineated several dream categories, most of which would apply to psychotherapy as well as to other psychological situations. In general, Jung felt that the unconscious acts in a *compensatory* fashion toward the conscious mind. Thus a dream can fill in gaps in a person's attitude, or sometimes, by speaking forcefully, try to rearrange the dreamer's current point of view. A good example of a compensatory dream, and one that also demonstrates a dream about the therapeutic relationship, is one Jung (1928, 1937a) often told on himself. A treatment of a particular patient had stalled, and Jung had developed a condescending, sometimes impatient attitude towards her. He then dreamed that she was up at the top of a high castle tower and he had to strain his neck to look up at her. His principal association to the dream was to the Virgin Mary. Though in retrospect this dream might have had several alternative meanings, Jung understood it as suggesting that he had too low an opinion of this patient and needed to elevate it. He had underestimated her, and the dream commented on this in an almost literal way. Jung's work on this dream also demonstrates the necessity of having a conscious position before one can integrate an unconscious commentary.

While this is an example of a compensation or *complementary* dream, a close cognate of that is what might be called the *supplementary* dream. These dreams bring another angle to the psychological discussion, though not necessarily one that is the polar opposite (like Jung's compensatory dream). I once dreamed that a rageful character from a movie I had seen was emerging from a grave, but he looked, to my surprise, like Jesus Christ. This dream juxtaposition of sacred and profane suggested, perhaps, a revaluation of, or even a redemptive aspect to, my buried anger or little-known hot temper. In a sense, every dream is either supplementary or complementary (though not necessarily complimentary) in that it offers something else that completes the picture or suggests

one's other possible motivations or impulses. What is presented may not seem positive or upbeat to the dreamer, at least in the short term. A dream can be critical or blunt, and if taken seriously, it alters the dreamer's self-image or adds another self-image, which can be painful. Jung's dream above, as interpreted, did not put him in a good light. A patient's dream about a therapist (see, for example, Chapter 4) may question the nature of the therapist's work or character. A similar function is demonstrated by another, less common type of dream called the *reduction* or "negative compensation" dream, in which the dreamer is pictured cavorting with important people or the gods and is thus being lampooned for having too high a view of himself. However, Jung's view was that such "personal exaltation" dreams can cut either way: they may deflate the narcissist or shore up the self-esteem of the lowly (1961, p. 224).

The previous examples are of relatively simple, single-idea dreams (at least as understood). Thus they are easy to use as examples. Most dreams are longer, and harder to understand, however. The above examples, too, are not heavily archetypal in image or content; or if they are (the dream of the Christ-like resurrection or playing with the gods), they are referenced to personal therapeutic issues. This is appropriate for a Jungian psychotherapy and for the point of view espoused in this book that does not elevate the archetypal symbol per se as much as the personal life. It is clear from the above dream examples that a dream's meaning cannot be understood without first having some idea of the dreamer's real-life position—his current awareness or feelings about himself, a person, or an emotional matter (for instance, psychotherapy). The dream provides the counter- or additional position in response to the standpoint currently in awareness.

However, Jungians in general also believe that dreams can sometimes take the lead. This connects with ideas about the highly creative nature of the unconscious, of course. A not uncommon type of dream, then, is the *prospective* dream. These are dreams that appear to anticipate the future and are not reactive, except in a broad sense. In such dreams the unconscious seems to instigate something new for the dreamer's life or a way out of a dilemma, sometimes on a rather grand scale. Jung thinks that they scout ahead: "The prospective function [of dreams]…is an anticipation in the unconscious of future conscious achievements, something like a preliminary exercise or sketch, or a plan roughed out in advance. Its symbolic content sometimes outlines the solution of a conflict" (1948a, p. 255). Here the dream works to actually create answers, not just bring a compensatory viewpoint. These are problem-solving dreams, appearing like little elves to help one get the job done. While Jung did not feel that dreams in this prospective/anticipatory category were specifically prophetic, he did feel that some dreams seemed to contain specific warnings or even uncanny information about inner or outer reality or other people. Such *premonitory* dreams are not common, usually, but they are striking. Some people find that they dream of future events, sometimes around the deaths of loved ones (or themselves) or the birth of children. Jung does not rule out the possibility of telepathic dreams, either, and the idea of unconscious but unexplainable communications between people fits with merger and fusion issues within the transference/ countertransference dimensions in treatment.

Though less cosmic in dimension, all these types of anticipatory dreaming can show up in psychotherapy. A patient of mine, for example, dreamed she was growing dizzy or weak and falling into a black hole, which foreshadowed a major depressive episode. Most

Jungians also pay close attention to dreams at the beginning of treatment—the "first dream"—that may suggest a prognosis, diagnosis, treatment potentials, or other useful hypotheses. These can come from therapist or patient.

R*ecurring* dreams, and what Jung termed *reaction* dreams, are particularly important in psychotherapy. Repetition pretty surely indicates the need to attend to the issues symbolized in the dream, as well as their being frozen in psychological time. Such dreams are often trauma-related, and their details, if obtainable, may be important, for they may indicate minute shifts or slightly different ways of approaching the issues at hand. In reaction dreams related to post-traumatic stress disorders, however, the basic thought is that the traumatic situation is trying to wear or work itself out emotionally but is stuck because the psychic, emotional, and defense systems have been blown. It is a processing failure due to overwhelming shock—trauma. In less severe circumstances, recurring dreams may shift once attention is given. A patient dreamed repeatedly for decades of a long-lost, but psychologically crucial, former girlfriend whom he was with but could not speak to. Following the recurrence of a second major depression—the first having followed the rocky end of this relationship twenty years earlier (and the relationship itself having been the emotional answer to still earlier pain and identity issues)—the patient began to address in treatment the meaning of the relationship and its loss. As he did so, the stuck dream began to move: in dreams, his girlfriend and he began to talk.

Many of the dream categories exemplified here actually fold in on each other, so instead of speaking of types of dreams it is perhaps more accurate to speak of "aspects" of individual dreams. A dream may demonstrate several, if not all, of the above elements (compensatory, anticipatory, etc). Also, dreams are usually mentioned in therapy textbooks in isolation from the patient's full story and from other dreams. There is only so much writing room available, and the catchier dreams that seem to coordinate with a particular psychological situation are naturally chosen because they stand out. However, dreams accompany the treatment for the whole journey, forming an ongoing series of images, themes, and commentaries on the treatment process and the individuals involved. The image, let's say, of "therapist and patient" will not only present itself initially at some point but will usually re-present itself periodically. This recurrence may take weeks, months, or whatever (sometimes never), but its return will suggest some kind of evolution. Thus the patient may picture himself in dreams undergoing that fearful dental examination, then, next, looking under the hood of the car, then in bed with, then wrestling with the therapist. Or they may meet in the office, then one time in the old childhood home, or in bed but the patient's wife is there, or in bed but the therapist's wife is there. Sometimes the images are direct, such as when the patient says, "I'm with you as I return to my childhood home," or "You are working on my car and I am watching." Other times, the dream situation is more abstract but seems like it might refer to the therapy situation: "I have cancer and go to the doctor's office and…or "An older black man shows me how to…" While it is unclear if these latter, indirect references are necessarily related to the intricacies of the therapeutic interaction per se—that is a matter of how the therapist is inclined to interpret them—it does seems more definite that they are images of the treatment situation as a whole and as experienced by the patient. Once a person is in therapy, his or her healing process becomes a primary reference point for

dream life. A dream series follows the treatment in a kind of parallel universe; the in-session therapeutic interaction and the ongoing unconscious commentary snake together like a double helix to form the core of the psychotherapy process.

Archetypal dreaming

The issue of archetypal imagery in dreams, alluded to above as a Jungian mainstay, is a complex one. Orthodox Jungianism has a tendency to "privilege" the more collective imagery, but this usually takes place when there is a very symbolically oriented, classical "Jungian analysis" taking place, sometimes with a strong dream orientation, "active imagination" (a focused imaginal technique), or creative adjuncts (painting, sculpting, or sandtray work). The imagery that takes shape in such a set-up tends toward, and is subtly encouraged toward, the archetypal. In terms of dreams, however, the archetypal may be more a matter of feeling than imagery as such. That is, some dreams feel "big"—exceptional, deep, or even magical. But such dreams need not necessarily carry archetypal symbols, or if they do, the symbols ultimately may refer back to personal issues (e.g. the Christ dream above). This is not to deny the ineffable quality of many dreams, and the fact that they may refer to transpersonal dimensions of life. However, the fact of archetypal imagery does not necessarily imply a transcendent dimension to the issue. An extremely powerful dream, indeed an archetypal one, may be clothed in personal images. And extremely powerful experiences, inherently archetypal, (for example, one's relationship to one's mother, one's children, death, even mystical experience) may not invoke archetypal imagery. Some Jungian therapists have suggested that the more collective the imagery in a dream symbol, the less personally integrated it is or the farther away it is from consciousness: as the meanings behind the imagery get closer, the images themselves become more humanized. This seems like a reasonable, useful hypothesis. But we do not know whether archetypal imagery supercedes personal imagery *within* the unconscious, or that the collective unconscious actually lies below the personal unconscious. If anything, personal and impersonal contents probably lie around together, all mixed up or, more likely, undifferentiated. The same holds true for the archetypes and complexes, which are imaginary structures within the mind. (All statements about things in the unconscious are speculative and theoretical, as Jung noted.) Dreams appear to have symbolic meaning primarily, but sometimes the symbolic will cross over in an intuitive way into everyday or treatment realities. This *tras*personal aspect of dreaming, and of the unconscious, perhaps has its most vital meaning not in terms of transcending reality as such but vis a vis the cross-personal, unconscious communications and relationship between therapist and patient.

The relative importance of dreams

Overall, the place of dreams in post-Jungian psychotherapy is a fluid one. It is fair to say that a primary concentration on and use of dreams is considerably less frequent, on average, than it once was in Jungian therapy, and indeed in other therapies. Dreams may be, as Freud famously stated at the beginning of the twentieth century, the "royal road" to an understanding of the unconscious mind, but perhaps are not the royal road in

psychotherapy, which on the whole has shifted out of a strictly interpretive or "let's analyze your dreams" mode and more into relational models (that is, the therapeutic relationship). Patients, too, occasionally can get into an "I'll ask the dream to tell me how I feel" frame of reference without working hard enough on their own inchoate feeling states. This can result in an inability to remember dreams, as if the unconscious has shut down (Jung 1973b, p. 514). A dream cannot tell a patient, what he feels, nor can a therapist. Any suggestions must be checked out against a patient's own internal reality and subjective sense of rightness, which is the final arbiter. And while dreams remain wondrous and often very penetrating, a fair amount of therapy time can go into meditating on them. A full working out of a dream and its referents would take up a major portion, if not all, of a once-per-week therapy, for example, so a more limited use has evolved simply for practical reasons, not just because dreams are less highly valued than before. A patient usually has to be really struck by a dream or has to do some outside work on it beforehand.

Whether previously thought about or not, dream-study works best when a dream comes up in the flow of the therapy session. It thereby fits into the fabric of the dialogue and the therapeutic interchange, rather than being prerehearsed. It is not a requirement of Jungian psychotherapy that the therapist ask for dreams or point the patient in that direction. Patients who are inclined toward their dreams carry the dream images around in their minds, and a therapist can do likewise when a patient recalls a dream in therapy. Even if they do not work on it or try to interpret it, it will have been given an important hearing, and the therapist will have it in mind as a unique bit of metaphorical information from the psyche—a view from the unconscious that also goes into the complex mix of his thinking and imaginings about the patient.

PSYCHOLOGICAL CONTAGION

The unconscious assists psychotherapy through dreams, through a therapist's use of his unconscious, and through the bridge between people that the unconscious creates. Whether one focuses on the personal, compensatory, or archetypal aspects of the complexes—indeed, discussion of the therapeutic relationship might require all these dimensions in a theoretical sense—a crucial aspect of the Jungian-style unconscious is that its contents are contagious. Feelings and complexes can pass between and affect the individuals involved. This is another sense in which the unconscious supports psychotherapy. Not only can my complexes rev up your complexes but, like germs, they penetrate the psyche in a kind of psyche-to-psyche, unconscious-to-unconscious transfer. In extreme cases, this can take the form of *folie a deux* ("two-person madness"), which is an actual psychodiagnostic term for a psychosis or delusions shared by two, usually intimately connected people. It is also evident in mob psychology, which is similar to *folie a deux* but requires more people playing off each other emotionally. Less extreme and quite common are instances when an individual says somebody "gets under my skin" or "bugs me"—note the metaphors, which could apply to germs, insects, or insect bites. Complexes are like viruses or lice; some people's complexes are pretty serious, some are really irritating, and some are simply annoying. However, the mechanism of

psychological transmission is problematic, because, as far as we know, there is not a physical transfer between people of the contents of the feelings and ideas wrapped up in complexes. We are influenced by others in a sort of psychological osmosis at the self/other boundary, and we are affected through presence and repetition even if we have other intentions (advertising jingles are an example of this). Short of some magical substance or of something like mental pheromones, the usual explanation of why someone bothers us is that our complexes are somehow reverberating with their complexes. An unconscious similarity causes one person to be affected by the other. In scientific terms, this phenomenon is a matter of separate people having parallel reactions; in personal terms, the phenomenology of it is more like the metaphors. So "he's a pain in the neck," "I've got you under my skin," "unchain my heart," "you don't own me," better portray this sense of things. Though people are physically separate, the psychophysical question remains intriguing, as indicated by Jung's statements that complexes not only act like "foreign bodies" (1934a, p. 96) in the psyche but have "a sort of body, a certain amount of [their] own physiology" (1935a, p. 72). Jung's earliest and most classically scientific studies noted the physiological correlates (psychogalvanic skin response, changes in respiration rates) of unconscious complexes. And Jung later linked emotions and complexes with the sympathetic nervous system and with instinctual-archetypal dimensions of the psyche; so when people get "down" to these levels, the herd or collective, rather than the individual, may be the more central unit.

Therapeutic contagion

Of particular relevance to psychotherapy, therefore, is the influence that a patient's complexes can have on a therapist (and vice versa). This is, literally, *transference*. In psychotherapy, the therapist puts himself, or his unconscious, in the way of the patient's projected complexes and may become, in effect, their target. The operative term for this today, derived from the work of the psychoanalyst Melanie Klein (1946), is "projective identification," in which the patient is thought to project his impulses and unconscious relationships into the therapist's unconscious. In his most thorough treatise on transference, Jung makes special note of the fact that therapists can be infected by their patients psychologically, even suggesting that this is therapists' fate:

> Presumably, he had good reasons for choosing the profession of psychiatrist and for being particularly interested in the treatment of the psychoneuroses; and he cannot very well do that without gaining some insight into his own unconscious processes…. The doctor knows—or at least he should know—that he did not choose this career by chance; and the psychotherapist in particular should clearly understand that psychic infections, however superfluous they seem to him, are in fact the predestined concomitants of his work, and thus full, in accord with the instinctive disposition of his own life. This realization also gives him the right attitude to his patient. The patient then means something to him personally, and this provides the most favorable basis for treatment.
>
> (1946, pp. 176–7)

For therapists, doing psychotherapy is their destiny, Jung seems to be saying.

Psychotherapy is therefore an act of emotional involvement, self-understanding, and healing for the Jungian therapist as well as for the Jungian patient. In the course of responding to the contagious complexes of the patient, the therapist's reactions and processes form the backbone of the work. Not only does the patient discover his feelings, the therapist discovers his. For therapists, part of the reason for doing therapy is that they get to discover who they are as a result of it: who they are in general and who they are in relation to the particular patient who affects them.

As noted earlier vis a vis dreams, the nature of the unconscious, as envisioned by Jung and many Jungians, is not only creative and conceivably transcendent but cross-personal (literally transpersonal). This is an elaborate way of saying that people have an emotional effect on each other or that emotions are contagious. The unconscious of one affects the unconscious of the other. What this means is that two people who are literally separate seem to have an unconscious connection and are "in relationship" to each other. The unconscious is like a pipeline between them, below the ground, and whatever the unconscious is, or contains, can flow between them.

This psychological conception has major implications for the therapeutic relationship, of course. For Jungian psychotherapy, it shifts the leverage from vertical to horizontal: the main concern is less a patient's vertical, ego-to-unconscious relationship with himself alone, or the therapist's somewhat superior position to the patient. The focus is now on a horizontal, unconscious-to-unconscious relationship between therapist and patient, a relationship equal in nature as regards their unconscious emotional investment in therapy. To be sure, there remain the professional responsibility, expertise, and role of the therapist. The therapist does not become a patient. But he is in a more vulnerable position vis a vis the patient and vis a vis his own unconscious as affected by the patient. Jung was adamant, almost to the point of role reversal, about the therapist and patient meeting on these equal psychological terms, and he was highly critical of a therapist's escaping this by hiding behind a professional persona:

> One is naturally loath to admit that one could be affected in the most personal way by just any patient. But the more unconsciously this happens the more the doctor will be tempted to adopt an "apotropaic" attitude, and the *persona medici* he hides behind is, or rather seems to be, an admirable instrument for this purpose. Inseparable from the *persona* is the doctor's routine and his trick of knowing everything beforehand, which is one of the favourite props of the well-versed practitioner and of all infallible authority. Yet this lack of insight is an ill counsellor.
>
> (1946, p. 176)

Apotropaic means "designed to avert evil," and in this context no doubt refers to a defensive distancing or posturing through appearances and expertise (or quasi-expertise)—knowing it all. The intention of the distancing is to move away from the patient's unconscious, from the "evil," namely, the bad stuff, that lurks there. This creates a rupture in the "pipeline" between the two participants, and amounts to a rejection, which is a potential retraumatization or even psychological disaster for some patients.

What patients seem to seek, above all else, is to get in touch with *a real presence* in the

therapist. The one-to-one engagement or chemistry cited earlier in this book will not take if the therapist is not present and especially if he or she is not "real." What does this mean? It relates to the previous discussion of false selves and true selves. A therapist who is relating to a patient through a persona, even if it is a benign or authoritative one, essentially engages the patient with a false self. Thus the involvement becomes inauthentic and superficial. The pipeline connection described before does not exist; the participants do not connect via the unconscious and are uninvolved, literally. So nothing really happens because at a deep level the situation is schizoid. Some patients, because they need a connection and to have an effect on the therapist, will know if the relationship is false, or a "false self" one. Others will not know the difference, since this is what they are used to. Still others will defensively prefer this kind of distancing. And some will recognize it but go along with it out of compliance, that being a dimension of their other important, earlier relationships. Once again, Jung's statement about "psychic infections" being a therapist's fate is apt: "The patient then means something to him personally, and this provides the most favorable basis for treatment." In a basic way, the patient has to matter to the therapist, and this means fundamentally that the patient has to be able to have an effect on the therapist, which in turn means that the therapist's "real self must be engaged—or else no real impact is possible. Whether or not Jung's suggestion that psychotherapists are born and not made is accurate—an arguable point—a complex interpersonal involvement with a patient is common enough, tricky enough, and, ultimately, important enough that Jung makes it the cornerstone of the cure.

NOTES

1 For more on a definition of psychotherapy, particularly in the context of the therapeutic relationship itself, see Chapter 3.

2 According to Hannah (1976, p. 269), Jung was on Hitler's "blacklist" and slated for capture if the Nazis invaded Switzerland. But Jung, like his country, seemed to hew a somewhat "neutral" line vis a vis Germany, which in the ease of retrospect does not seem very admirable. The perception even some well-meaning observers have is that he was anti-Semitic or collaborated, inadvertently perhaps, with the Nazis: "Jung, whose psychoanalytic creativity didn't deter him from a murky involvement with Nazi-controlled psychiatry" (Coles 1999, p. 101). Jung vehemently denied this, and was clearly not a Nazi or pro-Nazi, but certain of his comments about "Jewish psychology," particularly in the context of the times, can only be viewed, as even one of his most loyal followers put it, as "a grave human error…that one has to deplore" (Jaffe 1971, pp. 85, 96). Jungians have taken a brave look at this in recent years (see Maidenbaum and Martin 1991). Jung was given to making bold statements about nationalities, races, and cultures, statements that have some sort of provocative truth but can also seem stereotypic and inflammatory. At least Jung seemed to be an equal opportunity commentator—no country or culture (and neither sex) was safe from a certain kind of generalizing.

3 See Winnicott (1964), Ellenberger (1970), Fordham (1975), Atwood and Stolorow (1977), Brome (1978), Satinover (1985, 1986), Maidenbaum and Martin (1991),

Storr (1991, 1996), Feldman (1992), and Skea (1995). Jung's memoir (not really an autobiography) *Memories, Dreams, Reflections* (1963), reveals his inner experience, loneliness, and specifically his turmoils as a child quite vividly.

4 Ferenczi's "mutual analysis," though it went askew in practice with him and the patient literally switching positions on occasion, appeared to be moving along these lines. However the difference between mutual affective involvement and role reversal is a crucial one. A good review of some of Jung's groundbreaking contributions to psychotherapy can be found in Paul Roazen's *Freud and His Followers* (1976).

5 Henry Murray, creator of the TAT, fully acknowledged Jung's ideas and influence. Jung's influence on his fellow Swiss, Hermann Rorschach, is less clear and, according to Jung, was not acknowledged by the test's author: "I was anathema because I had said it first, and that is unforgivable. I should never have done it" (McGuire and Hull 1977, p. 329). Rorschach's intratensive and extratensive concepts are very close to Jung's introversion and extraversion, it would seem. Bruno Klopfer, a leading Rorschach interpreter, was a Jungian analyst.

6 See, for example, Levinson's *The Seasons of a Man's Life* (1978), which explicitly acknowledges Jungian thinking and was the first and probably best of the midlife-crisis researches.

7 This definition of "crux" is from *Merriam-Webster's Collegiate Dictionary*, 10th ed, p. 281. Note also its original Latin meaning as "cross" or "torture."

8 It is unclear if the comma in this sentence, easy to overlook, between "having been" and "a long series of memories" is intentional, but it makes the quote read thus: "you have an idea of having *been,* [you have an idea of being] a long series of memories." It may be an editorial addition or a typographical error, in either case confusing.

9 This could be, in part, because Jung's inner self, what he called his "number two" personality, was fairly unconventional.

10 My opinion is that spiritual matters, especially spiritual guidance, belong in the hands of spiritual mentors or systems. Despite their expertise and training in matters of the psyche per se, most psychotherapists, even classically trained Jungians, are out of their bailiwick in matters of spiritual development.

11 Jung's approaches to dreams are spread throughout his *Collected Works*, with the best sources being specific papers like "The Practical Use of Dream Analysis" (1934b), "General Aspects of Dream Psychology" (1948a), and "On the Nature of Dreams" (1945/48). These papers and others have been gathered into a book called *Dreams* (1974). Jung's 1928–30 seminar on dream analysis, formerly available only to trainees, has been published (1984) and is most interesting in itself and for his interactions with the participants. One of the last things Jung wrote before his death, "Symbols and the Interpretation of Dreams" (1961), is also an excellent introduction for the reader. It originally appeared in a popular and well-illustrated book on Jungian psychology called *Man and His Symbols* (1964).

Chapter 3
The therapeutic relationship I: basics and overview

> In the treatment there is an encounter between two irrational factors, that is to say, between two persons who are not fixed and determinate quantities but who bring with them, besides their more or less clearly defined fields of consciousness, an indefinitely extended sphere of non-consciousness. Hence the personalities of doctor and patient are often infinitely more important than what the doctor says and thinks…. For two personalities to meet is like mixing two chemical substances: if there is any combination at all, both are transformed. In any effective psychological treatment the doctor is bound to influence the patient; but this influence can only take place of the patient has a reciprocal influence on the doctor….
>
> …[T]he doctor is "as much in the analysis" as the patient. He is equally a part of the psychic process of treatment and therefore equally exposed to the transforming influences.

Although the quotation above from Jung makes reference to analysis, its contents apply equally well to Jungian psychotherapy. Its six sentences epitomize Jungian therapy's thinking about the therapeutic relationship. First and perhaps foremost, the Jungian perspective stresses the personal over the technical: above all, the specific personalities of the participants are the main thing. Furthermore, analytical psychology emphasizes the preponderance of the unconscious factors in psychotherapy over the already known or conscious side: there is more unknown than known in people, and this particularly applies to the therapist and patient in psychotherapy, where the unknown or the evolving will be studied, even encouraged. In addition, in Jungian psychotherapy the participants meet on relatively equal terms: each of them, not just the patient, brings "irrational factors" to the treatment situation. This discourages therapists from putting themselves on a pedestal, because in this paradigm rationality (or even, perhaps, normalcy) does not reside exclusively with therapists, irrationality with patients. Akin to all this is the Jungian assumption of a fluidity of personality: in therapy it is possible, perhaps inevitable, for personalities to fuse unconsciously to some degree. Finally, in psychotherapy these two indefinite elements form a new compound: two personalities merge at an unconscious level and something new, a third thing, is created. This new creation is, at bottom, the healing of the patient. In short, psychotherapy is the affective mixing of two personalities at several levels, resulting in something better, especially for the patient but also, as a by-

product, for the therapist—hence, a mutual transformation.

This emphasis on the therapist's personality and mutual influence through the blending of personalities is a radical view of psychotherapy, a view that is unexpected, anxiety-provoking, and, in a sense, risky for all parties involved. Most therapies do not go quite this far (and certainly did not go this far in 1929, when Jung articulated these principles against a backdrop of psychoanalytic techniques that recommended keeping the therapist's personality out of the treatment). In place of the usual doctor-patient paradigm, with the patient here and the doctor over there dispensing diagnosis and good counsel, this model emphasizes a deeper, more personal interchange. Jung himself was adamant about the importance of an intimate therapeutic involvement between therapist and patient, and subsequent Jungian therapists have followed suit (though with individual variations around self-disclosure, neutrality, and other technical issues). Jung insisted on the therapist's authentic presence, much as Carl Rogers's client-centered therapy would later call for "genuineness or congruence" (Rogers, 1961, p. 49). Any stance that artificially placed the doctor at a distance was, Jung felt, a "smokescreen," that is, a defense against involvement and against the patient's pathology. (Indeed, some of Jung's harshest words about Freud, with whom he started as a colleague and ended as a polemical enemy, are around this issue.)[1] Quite simply, Jung thought it was neither possible nor helpful for a therapist to be emotionally distant from his patients. He believed it and meant it when he said a therapist is as much in the process as the patient. For Jungian therapy, emotional engagement is in the nature of unconscious processes and hence in the basic nature of psychotherapy.

This chapter describes in further detail what this emotional process is actually about, what its implications are, why it might work, and how one manages it as a therapist. The myriad metaphors and different ways Jungian psychotherapy approaches the therapeutic relationship will become evident, and as this chapter moves through them, something of each may rub off, and a thread between them may begin to take shape.

EMOTIONAL CHEMISTRY (PSYCHOLOGICAL ALCHEMY)

The basic metaphor in the epigraph from Jung at the start of this chapter is from chemistry—two elements ("two chemical substances") uniting to form a compound. But Jung needed something less scientific and more symbolic to really get at the therapeutic process, and he found it in *alchemy*, which became his root metaphor for psychotherapy. Jung suggested that the work of psychotherapy is symbolically like alchemy's prescientific attempt to make gold out of "base metals." The early alchemists sought more than gold: they were also after "the discovery of a universal cure for disease, and… of a means of indefinitely prolonging life"[2]—the *elixir vitae*. In Jungian translation, the true base metals are the unconscious and conscious personality components in both patient and therapist, which combine to form the psychological gold. Even the alchemists, who referred to themselves as "philosophers," knew that their search was not just for real gold but for the inner gold.

Jung's major treatise on the therapeutic relationship, "The Psychology of the Transference" (1946), is alchemically oriented, and relies on a series of unknown pictures

from a 1550 alchemical text called the *Rosarium Philosophorum*. In these illustrations (actually woodblock cuts or "woodcuts"), a sort of chemical or baptismal fountain is first depicted. Then a male and a female figure, called the King and Queen, or *Sol* and *Luna* (Sun and Moon), meet, strip, and wind up in the bath. They submerge, merge sexually *(coniunctio),* and their bodies become a single, compound body as the font turns into a kind of casket. Out of this impregnation and death, a small figure—the soul—emerges and ascends to the heavens. After a healing dew descends, this soul returns into the corpse-like couple. The final image is of a rejuvenated, hermaphroditic king/queen figure. The transformation is complete.

These images symbolize not only the gold-making materials, as the alchemists thought, but also, according to Jung, the intermingling unconscious processes of the alchemist and his assistant, projected into those materials. Thus the alchemical laboratory with its attached "mystic philosophies" was not as much about early chemistry as about the projections and unconscious interactions of the participants. (And the alchemists were less the early prototypes for chemists than forerunners of psychotherapists and physicians.) It is the alchemist and his assistant who really throw themselves into the pot. These processes correspond more or less to psychotherapy and really to the psychological chemistry and "reciprocal reaction" between therapist and patient (Jung 1935b, p. 4). In the end, as a result of this mixing of the personalities, the patient is reconnected to himself, which is the ultimate goal of psychotherapy. This is imaged in the alchemical texts as a rebirth or reformation of the personality, symbolized as the bisexual *filius philosophorum* (philosopher's son)—a unified self.

The problem for bringing Jungian psychotherapy to a wider audience is that this alchemical imagery is truly obscure. (The woodcuts are primitive, and they really are from 1550. It is unusual, dusty stuff, like wading into the medieval art section in a museum.) Few people are acquainted with this these types of texts, or even with alchemy. Nor can it be expected that therapists or students should be. Yet, all efforts to describe the healing effects of a psychological treatment process are necessarily metaphorical and based on certain assumptions. All are attempts to describe underlying, perhaps unknowable realities. Psychotherapy, like other disciplines, attempts to construct explanatory models, which in turn describe or provide access to the material. Any model, provided it explains the realities, can be useful. Nevertheless, while fascinating and mysterious to some, Jung's alchemical model is confusing to those therapists who are not used to it or not inclined towards its cryptic imagery. As noted in the introduction and elsewhere, studies of abstruse symbolism, however creative, account in part for analytical psychology's clinical anonymity. In terms of gaining a wider understanding from others, Jung shot himself in the foot: he followed up his thought-provoking discoveries about the therapeutic relationship with a rather rarified symbolism rather than a deepening clinical elucidation. His uniquely nonmedical, nonscientific imagery, however refreshing, risks getting stuck in the metaphor and falling into a trap Jung warned about—drifting away from experience into a purely aesthetic stance.

WHAT IS A "RELATIONSHIP"?

Risking, perhaps, the very obscurity noted above: since the topic of this book is the therapeutic relationship, it is appropriate to think about relationships in general. The question is: how can a *relationship* heal? And what is a relationship, anyway, therapeutic or otherwise? People use the word "relationship" as if they know exactly what they are talking about, but it is an indefinite term. A relationship does not occupy physical space; it occupies something like mathematical space. It is an abstraction, a mental construct—or is it? Although the idea of relationship is confusing, the word takes on more meaning when specified. In fact it only takes on meaning when specified, because to exist at all is to be in relationship to something else. A relationship implies the presence of at least two things and a connection between them. We can always speak at minimum of a relationship to physical surroundings; for example, space, air, ground, or even a vacuum.

Human psychological relationships are both simpler and more complicated than this, and usually more interesting.[3] They are what we typically mean when we use the word "relationship": we mean relationships involving another human, as opposed to relationships, important as they are, to ideas or inanimate objects (although the term "objects" has been applied, perhaps regrettably, to certain dimensions of human relationship; hence, "object relations" theory). What a relationship actually means is that there is some sort of *affective* involvement with something, a feeling of connection to it, to whatever degree (or to no degree). The degree of emotional relationship, in fact, is indicative of how much life is in something. If there is no emotional connection, there is no relationship—or at least no psychological relationship that matters much.

Relationships, then, are discernable in terms of who or what we are related to, and in terms of degrees of intensity (levels of emotional attachment). The latter dimension, intensity, often has something to do with the amount of time spent with someone or something. This has particular importance for human relationships in general, and psychotherapy in particular, since both require time. The intensity of relations between people can also be differentiated by *type*. Thus I may have a friendship (a relationship between friends) with you, or a work relationship (hopefully a "working" one) with my colleagues; a love or sexual relationship with my partner; a family-style relationship with my child or my family relation (relative). Clearly, relationships entail different roles; or rather, certain roles predominate in certain relationships (though roles within a single relationship may shift). Sometimes multiple types of relationships exist—several simultaneous roles—which can be enriching and/or complicating. Multiple roles are more common than not (or rapid shifts, at least, between roles are common).

Jungians also speak of conscious or unconscious relationships, such that different levels or intensities of relationship may be going on without our knowing fully about them. Relationships are eternally fluctuating in these regards. And relationships are added or given up, sometimes forever or sometimes for a while. All in all, relationships present a totally dynamic, fluid picture. It is no wonder then that many people, unless they are either inveterate change-seekers or fearful, seek stable and steady, ongoing relationships. In psychotherapy, steady relationship is sought, consciously or not and resisted or not, and is often the core subject of psychotherapy. And it is no wonder, too, that some people opt out altogether from relationships, which is generally thought to be a pathological move, or need some occasional respite—a vacation from relationships, except for a few pleasurable ones.

PSYCHOTHERAPY AND THE THERAPEUTIC RELATIONSHIP

The specific type of relationship a therapist and patient have is a *therapeutic relationship*, which can first be studied generally, then by its components. For a patient, "therapeutic" connotes two things, who the relationship is with (a therapist) and what it is supposed to be. This type of relationship, then, is defined by its purpose (psychotherapy, leading to understanding and healing of psychological difficulties) and its correlated parameters (namely, it takes place with a therapist and almost entirely within an established psychotherapeutic framework or situation).

More than just being therapeutic, the relationship is specifically psychotherapeutic. A definition of psychotherapy is not only important in itself, but the word's derivation conveys, literally, something of the spirit of the Jungian sense of it. The word is formed from "psyche" and "therapy," which are derived in turn from the Greek words *psyche* and *therapeuein*. Psyche in Greek meant "soul" or "breath, principle of life, life." Interestingly, the word "psyche" is closely related to the verb "breathe," and to the Sanskrit *babhasti* ("he blows"). The Greek behind the English word "therapy" is a verb that translates as "to attend, treat," and the noun on which this is based *(theraps)* translates as "attendant."[4]

Playing with these derivations, the root translations for psychotherapy are "life treatment," "soul therapy," or "attending to life"; and the etymological sources for psychotherapist result in something like "soul attendant," "one who attends to or treats the life principle," or, more poetically, "the one who helps you breathe." Besides providing an etymological anchor for modern psychotherapy, these ideas and images bear a thought-provoking relationship to religious conceptions ("breath" in Latin is *spiritus*, or spirit; the well-known Biblical sentence "the wind bloweth where it listeth"), to meditation practices, and to creativity ("inspiration," to breathe in).

Although it is a special kind of relationship grounded in the background just described, the therapeutic relationship nevertheless partakes of most of the relationship dimensions noted earlier. First, it is a working relationship—therapists have taken pains to delineate this aspect of it, in particular its being a mutual working relationship as opposed to one where the client is passively operated on. It is, furthermore, a professional relationship, where the patient-to-be seeks expert help and usually pays for the service. At the same time it is an intimate relationship, emotionally if not sexually speaking, as intimate a relationship as exists in the sense that a patient truly lets himself be known or reveals his deepest secrets. Finally, at an unconscious level, it can be a version of a family relationship, wherein the therapist or therapeutic encounter is either infused with qualities pertaining to parents (or other relatives) or is the object of feelings originally directed towards family members or longed for from them. This means that at an unconscious level the therapeutic relationship may be psychologically incestuous, or at least may be involved with those sorts of energies and dynamics. Between that and all these multiple levels, it can certainly be called an extremely complex relationship.

Yet psychotherapy is weirdly one-sided, a relationship in which the patient does most of the talking and emotional sharing. This is a curious twist for such an intimate involvement, but a fundamental paradox of psychotherapy. The therapist relates primarily

through listening rather than speaking, although he or she does communicate in subtle and sometimes quite powerful ways. In fact, just listening carefully to someone is a powerful position to be in, especially if the other person is open and vulnerable, putting themselves in your hands. Active listening is in fact a highly communicative stance, a type of relationship role that might be called "receptive communication" or "active reception." What's more, while the communicator is emphasized when discussing communication, it is also true that someone has to be communicated to for communication to take place at all. There has to be an audience. Psychotherapy shows that having an audience and the responsiveness of that audience are the sine qua non of communication, that communication rests on a communication *dyad*. Most good therapists are, simply, good listeners or born listeners—no less than that, though a good deal more too. Psychotherapy is a highly amplified listening process, among other things.

The psychotherapeutic relationship is thus something like a friendship, only one friend mostly listens. (And, for the most part, therapy does not have too much friendly lightheartedness to it.) It is one-sided, yet the one who does most of the talking is usually the less dominant one, due to the patient's vulnerability and to the expertise and positional power of the therapist. However, the listening stance of the therapist and the tendency to communicate less actively do not necessarily imply that the therapist is not emotionally engaged. He is, but the engagement is mainly for the patient's benefit. A therapist puts his emotional responsiveness and person (his psyche, conscious and unconscious) temporarily there for the patient to engage with and make use of. (In reality, this can be more than temporary or passing, as the therapist in some measure carries the patient around with him.) So the therapist is involved, but he is just not indicating this to the patient, at least not in the usual sense of responding freely, as a friend might. Rather, the therapist is continuously reflecting on what is going on in the patient, on what he is thinking and feeling about the patient, and on what this might mean to or about the patient. A therapist listens very closely to a patient, and he listens simultaneously to himself.

A therapeutic relationship is an unusual mixture of overlapping, complex, and contradictory dimensions. In its paradoxical way, it is unlike any other kind of relationship, especially because it attends to the many types of relationships that, as noted above, may be simultaneously in play at an unconscious level. These multiple dimensions are what a therapist is available both to participate in but also to try to understand and heal with a patient. Although the exact components of all this may not be conveyed (in fact may not be fully understood by the therapist nor conveyable to the patient), this is what the therapist is working on, too. (Patient and therapist are both "working" in psychotherapy, though their respective jobs may be different.) The therapist feels and ponders the relationships or patterns that are going on, usually ones that are modeled on family experiences or other blueprints from the past. From the psychotherapeutic perspective, a patient has those kinds of relationships with a therapist at a so-called unconscious level. This is what is usually called *transference*.

At the same time, however, a therapist participates with a patient in the evolution of a previously unknown relationship—in a special, therapeutic form (hopefully). This is where *countertransference*, in the sense of what Jung calls a "genuine participation" with the patient, comes more into play. (While countertransference certainly is a reaction to

the patient's transference as such, the transference of past relationships to the current situation may be an unconscious attempt at a new relationship as well.) The psycho therapeutic relationship, then, is twofold, incorporating the transference relationships of the past and a new, unfolding relationship in the present. The two intersect nicely: the current, therapeutic relationship evolves from collaborative working on or working through of the past relationships, yet this repair of the past is also founded upon the connection in the present.

Overall, a therapeutic relationship is a relationship where transference and counter-transference come into play—are expected to come into play—and where these processes receive serious conscious attention and are permitted to evolve. Thus psychotherapy has not only a particular, serious purpose but also a unique strategy for meeting its ends. The therapeutic relationship becomes a kind of laboratory (recall alchemy) or stage (reenactment) where the patient's relationship issues—that is, his life—will be presented, engaged with, and played out. Viewed this way, the therapeutic relationship is a crucible, "a place or situation in which concentrated forces interact to cause or influence change or development." Similarly, Jung called the transference—by his definition the unconscious "mixing up" of the two therapeutic participants—the crux of treatment. The hope and challenge is that the therapeutic relationship will provide, through various means, a reworking or healing of these problematic relationships and patterns that the patient brings into the crucible of therapy.

TRANSFERENCE

Transference typically means the transfer of unconscious feelings from one relationship, usually a past one, to the therapeutic relationship in the present. By this definition, transference would have to be multiple—*transferences* would be more accurate. Some, including Jung, have noted that transference, broadly defined, exists in all relationships; that is, prior relationships do not get played out only in a therapeutic situation. This is obviously true, but it applies a clinical word that works well in the consulting room to a general situation where a clinical angle is not necessarily called for. Jung notes at one point that transference is just a certain application—to therapy—of the universal phenomenon of projection, a process that can ascribe unconscious significance to any relationship (1946, p. 172 nn. 14, 15; see also Jung 1935a, p. 136). However, transference takes on particular meaning, and has its most applicable meaning, where it was originally applied—in psychotherapy. In therapy, the understanding and hence modification of these projections is part of the heart of the work. The term "transference" started with psychotherapy and belongs there.

The psychoanalytic view

Like so many psychological terms, transference has several possible meanings, and is used by clinicians in different ways. As defined by its inventor, Freud, it refers specifically to the displacement onto the therapist of childhood wishes and instinctual drives (plus the associated anxieties and defenses) that were originally and primarily

directed at parental figures. In this model, relationships are drive-oriented. The infantile feelings are conflicted and therefore repressed by and into the patient's unconscious, where they still seek outlets, which might be found in dreams, compulsions, obsessions, psychosomatic symptoms, perversions, or other acts. The central aspects of these drives and correlated defenses become focused on the therapist in transference. As Freud put it, "The decisive part of the work is achieved by creating in the patient's relation to the doctor…new editions of the old conflicts" (1916–17, p. 455). This "transference neurosis," once achieved, is the focal point of psychoanalytic treatment. Due to this transplant from original sources to the here and now, a patient's issues are brought into and really relived in the therapeutic relationship. This is invaluable, as it moves psychotherapy from being simply explanatory to being an experiential learning process.

Clinical thinking about transference has evolved considerably over the years, but much of it is still flavored by the above outline. Psychoanalysis itself has articulated much further the nature of the needs that might be active and has emphasized not just the drives themselves but the two- or three-person relationships in which they take place. For most theorists the target of the drive now has an equally significant place in the paradigm. This is because (1) a person has an important, ongoing relationship with the object of his drive (a so-called object relationship), (2) that relationship is not simply a quasi-sexual, tension-release, discharge one, and (3) for some clinicians, the nature of the object's response to the subject is important. An interactive subject-object paradigm thus supplants a oneway, subject-only picture. In addition, some theorists have expanded the nature of what is sought from the object beyond infantile instinct states. In other words, ideas about the fundamental nature of human strivings have changed.

The effects of the present and of the therapist on transference

However much the definitions and knowledge have advanced, the central feature of this literally historical view of transference remains that the *past* still exists in the present—a patient's unconscious past, specifically, is determining his feelings in the transference relationship. When most therapists talk about transference, they are talking about childhood feelings or patterns being active in the current therapeutic relationship (and/or in other interpersonal relations, in which case there is a triangular situation of past, transference, and present relationships). Sometimes, the therapist is thought of as having nothing or little to do with this: the patient unconsciously makes a transference, regardless of the objective realities of the therapist's personality. However, sophisticated observers of therapistpatient interaction suggest that the therapist's style and personality do, in fact, influence what the patient transfers.[5] It would be hard to imagine otherwise, and this is why issues of therapist-patient match or chemistry are always relevant. Jung certainly felt the need to push past drive-driven theory and one-sidedness, as indicated by his criticism of Freud's "blank screen" theory of the analyst and by his (Jung's) raising the issues of "projection hooks." These are the actual aspects of the therapist's style and personality upon which the patient "hangs" his fantasies and feelings: "Experience shows that the carrier of the projection is not just *any* object but is always the one that proves adequate to the nature of the content projected" (Jung 1946, p. 291). Furthermore, as noted earlier, Jung felt that dreams, for example, could indicate the truth, or at least an

objective possibility, about another person's personality, including a therapist's. What the patient sees or imagines about the therapist may have considerable validity to it. This reality-in-projections aspect further personalizes the therapeutic relationship, such that the particular mix of personalities becomes more relevant than technique. The relationship is more individualized, as Jung suggests in this chapter's epigraph.

While the past may always be present, all one can really know at the outset of a therapeutic relationship (or any other relationship, for that matter), is that the *present* is present in the present. Transference is easier to see when a patient demonstrates a specific feeling about a therapist, rather than a less pointed pattern of relationship with him. But even if a patient, for example, falls in love with his therapist, it is a presumption to assert that this desire is founded on something else in the past. Certainly, current feelings may be influenced by past ones, but it may be the patterns in past relationships, not just the desire itself, that are significant in some way. A therapist does not know ahead of time. So, initially anyway, the past is a second-order consideration.

The Jungian view of transference

Jung's view of transference clearly fits with this and was less fixed than the traditional view. This trend continues with many Jungians today. Aside from seeing transference as a subset of the larger phenomenon of projection, the classical Jungian view is colored, naturally, by Jungian assumptions about the unconscious as archetypal and purposive. The Jungian perspective thus faces in two, seemingly opposite directions. First, it does not hold, usually, that the distant past in the form of childhood is the only story in transference. Jung's perspective was that conflicts in present-day life were as significant as, or more significant than, unconscious infantile libido and aggression issues.[6] Furthermore, his reference point was not so much on specific, past conflicts or drives as such; instead, he focused on the "whole man" on a larger scale:

> The object of therapy is not the neurosis but the man who has the neurosis…. Nor does it [neurosis] come from an obscure corner of the unconscious, as many psychotherapists still believe: it comes from the totality of a man's life and from all the experiences that have accumulated over the years and decades, and, finally, not merely from his life as an individual but from his psychic experience within the family or even his social group…. Neurosis—let there be no doubt about this—may be any number of things, but never a "nothing but." It is the agony of a human soul in all its vast complexity—so vast, indeed, that any and every theory of neurosis is little better than a worthless sketch.
>
> (1934c, pp. 159, 168)

Similarly, when viewing transference Jung did not want to close down the discussion too rapidly, nor did he want to narrow it. He hesitated to reduce it to a "an obscure corner" of the past and childhood personality with a single drive or its associated object relationship. Thus, Jungian psychotherapy is wary of single-cause, past-time hypotheses.

A lot rests here on how much consequence one ascribes to childhood. Is it an "obscure corner" or not? At this point an opposite, seemingly contradictory direction of the orthodox Jungian view obtains. The personality, and hence the transference, is not so

much determined by the personal past as by the nonpersonal or archetypal past. This, in fact, is where Jung differed from Freud: whereas Freud said early sexual yearnings were transferred and then had to be analyzed and eventually given up, Jung said people transferred their spiritual yearnings, which had to be given back to the person. Jung looked beyond the infant to the preinfantile collective unconscious to explain aspects of the transference. Thus Classical Jungian thought goes past individual childhood and ponders the childhood of the human race. Jung felt people frequently projected not just parental images (complexes) but archetypal images. To understand this further, note that this was not either-or: *either* personal-parental *or* archetypal-collective. Rather, since Jung thought that the collective unconscious was the chief determinant of things, archetypal energies fueled the parental imagoes of childhood. Therefore what gave childhood, and the parents in childhood, such potency were the archetypes that were postulated to be behind them. The world of early infancy, Jung believed, was saturated with, or insufficiently differentiated from, these images, and traditional Jungian theory holds that regressing psychological energy in the unconscious goes past the personal parents, as it were, and into the deepest layers of the personality. A therapeutic regression seeks there a new starting point for growth, which is in keeping with the Jungian hypothesis of a helpful unconscious.

Jung tended to view childhood, like many things, symbolically. He was less taken with the reality of childhood psychology than with the *idea* of the child: that which is immature but also full of potential, that which is new and alive, not dead. In his words:

> Infantilism, however, is something extremely ambiguous. First, it can be either genuine or purely symptomatic; and second, it can either be residuary or embryonic. There is an enormous difference between something that has *remained* infantile and something that is in the process of growth. Both can take infantile or embryonic form, and more often than not it is impossible to tell at first glance whether we are dealing with a regrettably persistent fragment of infantile life or a vitally important creative beginning.
>
> (Jung 1934c, pp. 161–2)

Jungians typically look less for the infantile wish than for that embryonic possibility, though the ambiguity Jung notes and the intertwining of the possibilities are inevitable—patients' problems and patterns are both infantile *and* forward-looking. Some of Jung's more important archival research in religious and mythical symbolism effectively explored the image of the "divine child," which corresponds to this concept of child-as-potential, the value of the childish. Jung's very high evaluation of play, for both adults and children, is also indicative of the value of the apparently infantile.[7] What one sees with Jung ("Young," in English) is an explanation going full circle: it goes beyond the childhood past to the archetypal past of mankind and then winds up, from there, with a future possibility.

The tension between the literal, infantile past and the symbolic (the so-called inner child with potential for growth) will always be a constant in therapy. Is it childhood or adulthood? Is it childhood in adulthood? Does a child mind really exist, still, in an adult mind? In the therapeutic relationship, whether the images of youth are interpreted

personally or archetypally is less important than the actual potency they individually possess and whether a patient and therapist take the retrospective or prospective angle on them. That is, the power of the projections—the emotional strength of the patient's experience of the therapist—is of more importance than a theoretical discussion of whether they come from the collective or personal unconscious. The question is: who is the therapist to the patient, what shape does he take subjectively? In a transference context, a personal image may hold more psychic weight than an impersonal one, as Chapter 2 indicated. An image is an image is an image: it is an academic question whether an image relates, for example, to the personal mother or the Great Mother, because experientially they may be approximately one in the same and conceptually they interact. Most modern Jungian thinking on transference in the consulting room does not deal too much with personal vs. collective in a polarized, one-or-the-other way. This is because to do so invokes a speculative discussion that is neither necessary nor appropriate for psychotherapy patients, and because in the final analysis such questions are unanswerable. The conflict between personal and archetypal perspectives is resolved to some extent by the theoretical conception that the personal rests on the archetypal, or that the personal experience or image clothes a skeletal archetypal structure or potential. In Jungian terms, the personal complex has an archetypal core.

Some Jungians, as has been mentioned, concentrate their theoretical attention and therapeutic focus on issues of early infancy in ways that are very similar to, and strongly influenced by, psychoanalytic thought. Jung's uninterest in developmental thought has been supplemented, even repaired by later Jungians who are open to psychoanalytic ideas. Other Jungians, following the spirit of Jung's focus on the present and his broader conception of transference, suggest that pathology derived from infantile issues is nevertheless worked out in the therapeutic relationship according to principles and energies articulated, sometimes in archetypal terms, by Jung. While the developmentalists pioneered Jungian attention on the patient-therapist interaction (countertransference/transference), their emphasis on infantile impulses and object relationships is more neo-psychoanalytic than traditionally Jungian. A more generalized Jungian viewpoint might emphasize the importance of conflicts constellated in the current transference/countertransference field as more important than the interpretation per se of their infantile roots. Problems happened in the past, but they are healed in the present through the therapeutic relationship. Although the therapeutic transferential field is always a mix-up of the "here and now" with the "there and then" (Kernberg 1984, p. 9), the precise coordinates of the historical understanding or reconstruction are not as important as the actual healing that takes place in the here and now. From a Jungian therapeutic perspective, the issue is not what happened, it is how to *repair* what happened.

This latter perspective is transference in a different key than usually thought of, not an infantile desire transposed to the therapist but a broader conjunction of their personalities in the service of transformation. Again, there is the idea of whole persons engaged in the process, mutually. In this, Jungian terms and approach are very different from traditionally psychoanalytic ones, just as many Jungian theoretical assumptions are different.

Even far along in treatment, it can be difficult to say with any scientific assurance that

what emerges in the therapeutic relationship is "old" material, old urges, or old object-relationships. We cannot know if patterns from the past are literally relived, however self-evident this seems or repetitive the patterns seem to be. It *appears* they are, we might think or even dream they are, but we rely on theoretical assumptions here. Patterns of behavior and feeling do not emerge in precise detail in the transference, and an unconscious mind, in which patterns, complexes, emotions are hypothesized to exist, is not directly provable or observable. Even if such patterns truly do exist there, we cannot say how and why just this portion of a complex emotional pattern would stand forth at this particular moment with the therapist. We must assume that what emerges is the most important dimension, or that it is especially constellated by the patient and therapist involved. But we do not know in what form emotional patterns persist in the unconscious, nor do we know if an original interaction, which would in itself be a long series of extremely complicated interactions, is returning in accurate form. All these things have been subjectively elaborated by the patient—and this could not be otherwise because everything is subjectively elaborated. Psychological patterns evolve. This incidentally, is in part why trauma theory, and the search for traumas, are appealing they provide concrete, clear-cut events to hang one's understandings on. Incest, war, accidents, physical abuse, illnesses, natural disasters—all these are tangible "events" that happened, in the "past", at such and such a time. Less radical happenings, or diffuse broader-based traumas like divorce, lack specificity. Furthermore, the personal response to trauma—how it is personally encoded—is a highly individual variable, and may even fluctuate at different times within one individual.

What troubles a patient may, or may not, be in distant-past experience. Usually, failure to deal with current problems brings to light older weaknesses in the personality, that is, prior wounds or fault lines in one's personal experience. But current life problems may not touch off old vulnerabilities. From a Jungian perspective, it is unwise to make assumptions in this regard. The traditional Jungian assumption is that a current event may be related to archetypal issues—gods hidden in the form of symptoms (or, put another way, frustrated archetypal demands fueling current events, not just on the personal but on the collective scale). But this too may be wrong. We simply do not know until we get there what will fit with a patient's outlook. As Jung says, "The less the psychotherapist knows in advance, the better the chances for the treatment" (1945, p. 87).

Early days in therapy are often a trial period to see if the patient's and therapist's assumptions, implicit or not, will fit to some reasonable, workable degree (see Chapter 4). Can these two people get into a therapeutic relationship or not? Can they truly work together? Therefore, of more practical importance than the archetypal-personal or past-present differentiation for discussion of the therapeutic transference are Jungian views on the infectiousness of the psyche and on countertransference.

COUNTERTRANSFERENCE—THE THERAPIST'S SIDE OF THE PROCESS

> A good half of every treatment that probes at all deeply consists in the doctor's examining himself, for only what he can put right in himself

can he hope to put right in the patient.

Jung proposed that the therapist is as much in the therapy as the patient. Regardless of whether one imagines the therapeutic relationship to be based on infantile, personal, or archetypal processes, Jung is right about the powerful dynamic of this commingling of personalities. A central Jungian metaphor for the therapeutic relationship that is closer to home, and to medicine, than the previously mentioned ones of alchemy or childhood is *psychotherapy as psychic infection.* Jung suggests that the therapist is contaminated by the patient, psychologically infected. Some popular psychology books today use the term "toxic" to describe certain people or relationships with them (as in "toxic parents," for example); some professionals speak of "detoxifying" or "metabolizing" (chemistry again) the projections of patients. The idea of psychological infection is consistent with this. Jung does not mean this pejoratively—his attitude towards patients is uniformly supportive—but he means to raise the idea, as he explains it, of the patient's "maladjustment" mixing with the therapist's psychological health. In Jungian psychotherapy, the therapist really does take on the patient; in Jung's words, "He quite literally 'takes over' the sufferings of his patient and shares them with him." Jung adds, crucially, "For this reason he runs a risk—and must run it in the nature of things" (1946, pp. 171–2). The risk is that the patient may make him sick.

It is one thing to hypothesize that the therapist's and patient's personalities intermesh deeply and that the therapist gets infected by the patient, and another to realize the full implications of this point of view. Jung's statement above about a "good half" of psychotherapy being the therapist's working on himself is a significant one. A *good half:* that means at least half, more than half, probably a majority. Most of it. This is the cornerstone of the Jungian approach to the therapeutic relationship. To this important statement Jung adds another crucial addendum about the work of the therapist: "It is no loss, either, if he feels that the patient is hitting him, even scoring off him: it is his own hurt that gives the measure of his power to heal" (1951a, p. 116).

Personal therapy and self-analysis

The Jungian prescription for an engaged therapist therefore involves something more than just a sympathetic ear and therapeutic knowledge and understanding. It involves some degree of struggle for the therapist and necessitates critical self-examination both before and during psychotherapy. The ability to do this is fostered by the therapist's own psychotherapy and the healing that results from it, and by an ongoing selfexploration that represents the interiorization of that prior therapy process (as well as by other aspects of life experience and other avenues of selfreflection, of course). The therapist's own therapy does not just enable the therapist to work, it very much colors the specific ways that particular therapist works with patients. Therapists tend to practice therapy according to the therapy they've had, which makes obvious sense because, in general, one can only really know what one has been through oneself. Other aspects of psychotherapeutic training run the risk of being abstract or intellectual. Book-learning alone, though important, is limited. (As has been said, "There is no substitute for experience—none at

all.") From his own work, the therapist learns how to do therapy on the basic level: how to structure it, how to handle certain technical issues, how it progresses. Simultaneously, his therapy also provides the emotional and reality basis for belief in the approach. These are two roots of the tree. So the therapist's therapy is essentially a kind of apprenticeship, which in turn is augmented by his subsequent, ongoing experience with patients. (Again, there is no substitute for experience: a therapist has experience with himself *and* with others.) A therapist gets stretched out and created over time, and whatever his therapeutic standpoint, in the Jungian view he has to try out on himself what he has learned. Even after his personal therapy is completed, he must "go on learning endlessly." Thus, because such a large part of psychotherapy takes place, in effect, in the therapist's own mind, "the doctor must change himself if he is to be capable of changing his patient" (1929a, p. 73) and keep on changing in order to do the work. To understand and to do psychotherapy, you have to have been in it and you have to live it. Jung's simplest yet most cogent remark along these lines is: be the person through whom you wish to influence others. This, then, is a call to authenticity in this most integrity-dependent of professions.

For this reason, and to deal with the issue of psychic infection, Jung prescribed therapy for all future psychotherapists, and was the first therapist to do so. This was originally called "training analysis," as psychoanalysis was the only game in town at the time. As it was practiced then, analysis was sometimes and in some ways much shorter and closer to psychotherapy than to what later became orthodox psychoanalysis. Originally, therapy of the therapist was intended to prevent the therapist from subtly, or not so subtly, bothering the patient with his own problems, which is what has been traditionally called counter-transference, in its negative form. If a therapist has not cleaned up his act, he may misunderstand or defensively reroute patient issues and emotions that touch his own. In Jungian therapy this self-purification has a further dimension: the therapist's therapy (and ongoing self-examination) also allow the therapist to take on the patient's infection, that is, take on his complexes and problems and "literally share them with him." A therapist gets to know the reality bases for a patient's future projections. So his therapy prepares the therapist for therapy in many senses. It is something like a medical internship where the doctor gets to be the patient. It has been suggested—whether rightly or wrongly, but probably wrongly—that doctors' career-choice motivations are counterphobic (i.e. that doctors deal with disease and death to counteract their own fears of it). In the psychotherapy of the future psychotherapist, this defensive motivation, if it exists, is eliminated (if the therapy is done properly).

There is, interestingly enough, no solid research evidence that therapy for therapists makes better clinicians, other than the evidence, which is solid, that therapy in general works on patients. (Insofar as a therapist is a patient in his own therapy, the benefits should apply to him too.) Nevertheless, for someone operating within a model where "the greatest healing factor in psychotherapy is the doctor's personality" (Jung 1945, p. 88), the benefits seem self-evident. This is bolstered by the impression that many therapists are led to psychotherapy due to their own personal suffering and conflicts. They have been there in their own way, and, as Jung averred, only the wounded healer really heals.

In the Jungian model the therapist has to keep on doing therapy—his own therapy—to some extent with his patients. The therapist "puts things right" in himself ahead of time

and continues to do so up ahead. But Jung prescribes something more than this when he refers so specifically to the therapist's "own hurt" being connected to his "power to heal." With this statement, the Jungian metaphor begins to shift from physical infection -as in a healthy victim getting infected by the sickening disease—to something to do with equality and human emotional vulnerability. Perhaps infection and vulnerability are the same thing, or two sides of a single coin: if one is infected, one is obviously not immune to the disease. But subtly the metaphor has moved out of medicine and become fully psychological when one speaks, as Jung does, of emotional hurt. Psychology is about human subjectivity: we have left the medical-disease image (infection) for a strictly human one (psychological pain); gone from what Heinz Kohut aptly called the "experience-distant" to the "experience-near" (1984, p. 187). Indeed, we have almost left the metaphorical altogether, as emotional pain is sui generis. Literal infection is, after all, not what happens in psychotherapy. It is a useful way to think about it, but as far as we know there are no microbes involved, no pheromones or suchlike, no actual chemistry in fact.

Jung talks about the therapist's *hurt*. Words matter, and psychotherapy of course is mostly about words (or, at least, based on words). So it is telling that Jung ultimately points away from the patient-as-infectious to the therapist's own hurt being "the *measure* of his power to heal" (italics mine). The power to heal has something—indeed, everything—to do not just with the therapist's personality but with the patient's hurting the therapist in some way, getting to him, "scoring off him." This is a another striking and enigmatic idea, which, because it is at the heart of Jungian psychotherapy, requires close attention. First Jung said the patient can only advance as far as the therapist has gone himself, psychologically; and now he says the therapist must examine the hurt touched off by the patient. The therapist's capacity to manage this situation will tell the tale—the measure—of the psychotherapy.

The shamanic metaphor

Jung only provides a general outline for this, having set up an outline by noting the occupational hazards of mutual transformation, infection, and endurance involved in the therapeutic relationship. As might be expected, he amplifies all this in its archetypal dimension. The Jungian therapeutic metaphor leaves medicine entirely at this point, because medicine involves a more detached relationship between doctor and patient. Medical doctors and staff all know how important communication and bedside manner are with patients, and do not underestimate the helpful effects of optimism, hope, and support. At the least, a good personal connection allows for better information and more clues about the illness at hand. But most medical communication stops at information-gathering and diagnosis, and the nature of the treatment procedures is swift and not in itself very personal. As opposed to medicine, in which the personality of the doctor is not the procedure, in Jungian psychotherapy the therapist's personality is the procedure. Jungian psychotherapy sometimes uses a medical metaphor, but basically does not approach things medically.

So, abandoning the medical model, the Jungian conceptualization of the therapeutic relationship next embraces shamanism, the primitive healing practice where a shaman or

medicine man's spirit travels to a spirit world to locate and communicate with an ill person's lost soul or demons. The shamanic metaphor jibes well with classically Jungian inclinations toward the ancient, the archetypal, the anthropological, and the religious-spiritual. (Certain more torturous shamanic initiation processes also seem to correspond symbolically and experientially with therapeutic training rites, including personal therapy.) Aspects of the religious rite of exorcism are relevant to psychotherapy processes, too (Guntrip 1952). In the words of Guntrip's mentor and psychoanalyst W.R.D.Fairbairn, "The psychotherapist is the true successor to the exorcist…he is concerned, not only with the 'forgiveness of sins', but with 'casting out the devils014'" (1943, p. 70). In psychological terms, the therapist, like the shaman and exorcist, moves into the patient's unconscious and wrestles with the same problems on an emotional level. The therapist, one hopes, is better equipped by training and experience to deal with such things than the patient is, but, as Jung warns, "Whether it is so in a deeper sense is open to question" (1946, p. 177). So the jury is out on whether the psychological situation—the disturbed spirits or inner demons—will overwhelm the therapist as it has the patient. In Jungian psychotherapy, the implicit therapeutic contract between a patient and therapist is for a mutual involvement and a shared challenge.

Some care needs to be taken with the shamanic metaphor, as to some extent the shamanic quest can resemble a sort of action adventure/fantasy. On the downside, this imagery is perhaps overly heroic, or can be, with the therapist slaying dragons as patients wait patiently by. Therapists are not St George, and patients not helpless damsels.[8] Naturally, the degree of the pressure on the therapist depends on the nature of the patient's consciousness and his unconscious, and on his level of pathology. The therapist's mental health is not always or totally at risk; that depends also on the particular state of his mental health (i.e. *his* pathology, chronic or transient, and his current struggles in life). The therapist's own therapy should have helped with this, playing an important role in his own cure, if necessary, and stability. Also, a therapist eventually learns how much, or how much of a certain type of difficult patient, he can stand. Aside from indicating an appropriate humility in the face of difficult work, recognition of limitations is a vital skill.

Yet Jung amusingly notes, vis a vis this idea of the psychological influence of the patient, that therapists sometimes "are apt to become a little queer" (1935a, p. 154). This fits a popular and somewhat hostile stereotype of therapists—that they are half crazy or driven to be—as well as the reported condition of some shamans and some psychotherapists. However, with a few notable exceptions, most therapists have both oars in the water. Patients no doubt want a therapist who is normal, but they also need someone who knows the territory. So, having spent a fair amount of time in the unconscious, therapists sometimes become rather unconventional. To a certain degree, psychotherapy, especially Jungian psychotherapy, resists the conventional, focusing on an individual's need *not* to adapt to standards that do not fit his nature. Jung's call for personal individuation reflects this, as does his description of his therapy: "If the therapeutic results are satisfactory, we can probably let it go at that. If not, then for better or worse the therapist must be guided by the patient's own irrationalities" (1931a, p. 41). This is psychotherapy as counter- or anti-rational. Psychotherapy is periodically criticized in some political quarters for allegedly producing overly adjusted people, but in reality

this is rare. On the other hand, some sort of adjustment can be a very appropriate goal for people whose chronic difficulties with relationships and society render their lives and others' massively unhappy. Some people need to adjust, some do not, most need to find a balanced point where their individual natures can express themselves within at least some of society's conventions.

In psychotherapy the final issue is usually not whether the patient will completely overwhelm the therapist but whether the therapist can remain consistently open to the patient when the heat is on and the therapist is uncomfortable. These two can be tied, to be sure, but, in psychotherapy with most patients, a therapist's overall mental health is not at stake. Therapists need not engage in psychological brinksmanship with every patient. Varying levels of personal anxiety, induced by the patient or the patient's situation, are the issue the therapist has to manage. Again, the personal therapy of the therapist helps him with any excessive, prior vulnerabilities and provides him with the tools and character development, hopefully, to wrestle with those disturbances that arise subsequently.

The wounded-healer metaphor

At this point the Jungian metaphor for the therapeutic relationship shifts tack yet again, away from modern medicine and shamanism, the former representing a more detached, semi-objective world and the latter an active foray by the therapist into a spirit world. In psychotherapy the foray is, rather, into an emotional world, a world of powerful feelings the patient transfers over to the therapist. The therapist, in effect, is agreeing to get close to emotional disturbance in a certain personal way.

A patient in psychotherapy is potent, psychologically speaking. His unconscious is loaded, and the therapist must be open—his *unconscious* must be open—to that. From a Jungian perspective, because of the power and collective nature of the unconscious in general, the therapist will inevitably be affected. As Jung points out, back in the medical metaphor,

> Emotions are contagious, because they are deeply rooted in the sympathetic system; (hence the word "sympathicus")…. In psychotherapy, even if the doctor is entirely detached from the emotional contents of the patient, the very fact that the patient has emotions has an effect upon him. And it is a great mistake if the doctor thinks he can lift himself out of it. He cannot do more than become conscious of the fact that he is affected.
>
> (1935a, pp. 138–9)

The final Jungian metaphor for imaging psychotherapy does not come from alchemy, medicine, or shamanism, all of which are worthy models but broad rather than specific in scope. Rather, the central myth or story of the Jungian therapeutic relationship is the Greek myth of the "wounded healer." The wounded healer is not just a story, in fact, but a hypothesized archetype that underlies and gives shape to Jungian psychotherapy. It is based on the ancient Greek worship of Asklepios, "founder of medicine" and god of physicians, as the main god of healing.[9] (Just as alchemy in some senses prefigures chemistry, the wounded-healer myth predates modern medicine.) In the story, which has

some variations, Asklepios, the abandoned son of Apollo, is raised by the centaur Chiron, who teaches him the arts of healing. Chiron, half man and half animal, has an incurable wound, and so, eventually, does Asklepios himself: he becomes so skilled at healing that he can raise the dead and is then slain by a thunderbolt from Zeus for his god-usurping hubris. Asklepios is subsequently resurrected as a god, the "divine physician," and placed in the stars among the immortals. (His instructor and mentor, the wounded healer Chiron, is represented astronomically by the northern hemisphere constellation Sagittarius.) This story, the worship of Asklepios in a widespread panhellenic healing cult (over four hundred sanctuaries), and its archetypal implications have been closely studied in Jungian circles by Kerenyi (1959), Meier (1967), Guggenbuhl-Craig (1971), and Groesbeck (1975), the latter two especially taking a clinical approach.

The wounded-healer archetype is also linked with the image and story of Christ, the wounded healer par excellence. Jesus' healing ministry consisted among other things of casting out the evil spirits or demons of mental derangement in God's name.[10] In fact, with the rise of Christianity, the fifth century BC figure of the healing god Asklepios evolved into a kind of "Christian deity or saint," for some on a level with Christ; there are nearly verbatim parallels between stories of healing miracles at pre-Christian Asklepian sanctuaries and Christian healing shrines in the Middle Ages (Meier, 1967, pp. 24–5). The archetypal image of the wounded healer thus became clothed in new, Christian forms.

Jungian thought, at least consciously, is more interested in the Greek than the Christian sources of wounded-healer imagery. However, the Christian paradigm is so ensconced in all aspects of western thought and the western way of life that it is worth noting, and a fair number of Jungian analysts come out of a ministerial or pastoral tradition. (Jung himself, though ambivalent about Christianity, literally came out of a pastoral tradition: his father, maternal grandfather, and eight of his uncles were pastors.) As Jung said: "Religions are psychotherapeutic systems. What are we doing, we psychotherapists? We are trying to heal the suffering of the human soul, and religions deal with the same problem. Therefore our Lord himself is a healer; he is a doctor; he heals the sick and he deals with the troubles of the soul; and that is exactly what we call psychotherapy" (1935a, p. 162). The Christian idea or ideal, especially in the helping professions of the West, is often not too far away. Even the atheistic Freud (1912, p. 121) invokes it a bit in his papers on technique, citing the "old surgeon" who said, "Je le pansai, Dieu le guerit" (I dressed it, God cured it). Themes of suffering, redemption, rebirth, healing, relief, and so on, are obviously relevant for patients, and themes of the healer's sympathy, sacrifices, and, at times, own woundedness and forsakenness are relevant for therapists.

While not necessarily seeking religious answers, people today do seem to be seeking a more compassionate face from the healing arts, especially from medicine. Advances in technology, which are frequently life-saving or life-enhancing but sometimes impersonal and difficult to understand, have not necessarily been matched by growth in the human dimension of healing, even in psychiatry. Economic forces and externally oriented sociocultural trends dominate the spirit of healing. It sometimes seems that the hope lies in technology rather than care (though they need not, of course, be mutually exclusive).[11] But people yearn too for the personal-empathic side of healing, which connects with the

idea of the wounded or vulnerable healer and shows up in the continued importance and popularity of psychotherapy. To be heard, to feel understood, to feel accepted—there is no substitute for these.

COUNTERTRANSFERENCE AND COUNTER-TRANSFERENCE NEUROSIS

The idea of the therapist's own hurt requires more than religious parallels, flattering as they might be to therapists. When Jung, in one of his final significant works on psychotherapy, "Fundamental Questions of Psychotherapy" (1951a), addresses the issue of the patient's influence on the therapist and the nature of the treatment, he invokes the above-mentioned image of the healer who has an open wound or is constantly rewounded: "the wounded physician." In psychotherapy the therapist's woundedness in a certain sense is the driving force (along with the patient's woundedness); hence Jung's words about the therapist's own pain and about half the work being his work on himself.

All this throws on its head the standard, almost axiomatic view—and earlier psychoanalytic ideal—that the therapist should be impenetrable. The wounded-healer image and idea is the ur-myth of the Jungian therapeutic relationship. While Jung wavered at times in his long history of thinking on countertransference/transference, at one point saying somewhat offhandedly that transference was not necessary and that dreams had therapeutic issues sufficiently covered, his final evaluation was that it was the main thing. Jung, in fact, came full circle over the years, from seeing transference as the sine qua non of psychoanalysis, to (when he left Freud's orbit having some doubts about its centrality) to this final assessment. What enabled this final, favorable judgment to happen was that he had come to his own definition of transference and its place in the therapeutic relationship. Jung's understanding of transference demanded counter-transference as an equally important, perhaps even more important, dimension of psychotherapy. Without counter-transference, there can be no real therapeutic relationship and no Jungian psychotherapy. What there is instead might be narrowly called "counseling."[12]

Whereas Freud brought psychotherapy the transference neurosis, the new edition of the old conflict encapsulated in the relationship with the therapist, Jung really brought it the countertransference neurosis, the therapist's participation in this event.[13] Both these terms, and their description in terms of "neurosis," are specifically psychoanalytic and slightly restrictive as often used. As noted, Jung redefined and broadened the conception of transference into his own terms, including countertransference as an equal partner. In a Jungian sense it might be more accurate to speak of transference and countertransference without the "neurosis" added—the *countertransference situation* might be better. Along these lines, one highly respected Jungian analyst introduced the terms "analytic dialectic" and "interactional dialectic" to indicate this mutual participatory situation, but these phrases never caught on, perhaps due to their philosophical sound (Fordham, 1979, p. 645). Nevertheless, countertransference neurosis works well enough, and speaks to the infectious aspect of the situation as well as the therapist's imperfections. The countertransference neurosis—the therapist's "distress" and his straightening out in

himself something that corresponds to or is tied up with the patient's emotional problems—arises in quite specific ways with each patient. As that patient "gets to" the therapist in some way, the patient in fact generates a unique countertransference reaction in the therapist, based on the patient's peculiarities, the therapist's, and the particular mix of these that arises.

The "counter" in countertransference tells the traditional tale of its being essentially a response to the patient's transference. This conceptualization of countertransference as reactionary (in the nonpolitical sense) is legitimate, and correlates with the idea of the patient's transference being the starting point for the affective interaction and with the idea of projective identification (the patient's "putting" his unconscious "into" the therapist's unconscious and unconsciously responding to or trying to control the therapist accordingly). However, it also speaks to early ideas about transference being an obstacle to the work and of the therapist himself being projection-free. A projection-free therapist does not exist, and transference viewed as an obstacle is wrong, according to the Jungian perspective. Transference, variously conceptualized, has come to be seen as the central factor in all psychodynamic therapies, not an obstruction, and what Jung calls the "projection-making factor"—namely, the unconscious—is inexhaustible, a kind of infinite inner generator. In Jungian therapy, the unconscious in the therapist, the countertransference, is equally active.

Historically (except for Jung), much of the countertransference discussion was about how to get rid of it; the current discussion in psychotherapy is how to get into it and get something out of it. Both transference and countertransference originally were thought of by Freud and others (including Jung) as *distortions*, as things interfering with the observation of objective reality. Which is partially true—but "reality," particularly emotional reality, is inevitably a function of the subjectivity brought to bear on it, as has been discussed earlier. So we speak instead of "perception." While it has not disappeared, objective reality per se has become a more nebulous concept than it once was and a less important bone of contention. Distortion is less the point, since reality at bottom is unknowable, and the meaning of one's particular perceptions of reality is more the point. The original notions of transference and countertransference assumed that objective reality exists and therefore the patient's lenses needed cleaning, or that the therapist's needed to be kept clean. Of more interest now is what the patient's feelings and fantasies tell the patient about himself, not whether the perceptions are ultimately true or not. From the point of view of Jungian psychotherapy, they are true for that patient, but in therapy a patient is asked to examine that. (This aspect of Jungian thinking, among others, provides an opening for linkages with Heinz Kohut's self psychology.)

Neurotic countertransference

The therapist's perceptions of the patient are as important as the patient's perceptions of him. Therapists study the kinds of emotional positions that patients put them in order to find out about the patient. Therefore therapists need, paradoxically, both to go back to the old notions of countertransference and to go beyond those notions in the course of developing a fairly reliable countertransference capacity. Again, the therapist's personality and feelings, aside from his theories, interpretations, and understandings,

become the chief tools in the work. This entails cleaning up his act in the traditional sense of not letting his projections and feelings distort his understanding and empathy with the patient. Thus the first part of training in the use of counter-transference is the aforementioned training analysis, or psychotherapy for the therapist. The second part is a continuous self-analysis and monitoring, which is necessitated by life and by the ongoing treatment of patients. Both these factors help prevent the classically defined *neurotic countertransference*, where the therapist's ideas and affects, kicked off by the patient, are irrelevant to the patient. Instead of being illuminating, in this instance the therapist's reactions merely distort, in the worst sense, and prevent communication. This kind of counter-transference belongs to the therapist, and is not a function of the patient except in the loosest sense: the patient's presence and issues set off a line of unconnected and overwhelming emotion and action in the therapist (i.e. his own complexes, in classical Jungian terminology, are counter-transferred back to the patient). A neurotic counter-transference, in other words, is when the therapist has an unconscious transference to the patient. The therapist, and hence his patient, are its victims, and the therapist is unable to maintain empathy or psychological nuance because what he sees is not there, but in himself. A therapist who has had effective personal therapy and is not characterologically disturbed would probably not manifest this very much. But many therapists have not received help, and among those who have, this kind of counter-transference usually shows up where a therapist has fallen in love with his patient or otherwise enacted his feelings outside the therapy situation.

While neurotic-countertransference distortion is obvious in some cases, most of the time it exists more subtly: a therapist loses touch with a patient around a certain emotional issue that is too sensitive for the therapist, or he deflects or guides the patient in certain emotional directions as a result of his own issues there. For example, a therapist with unresolved hostility towards his father may in effect say, "Yeah, give him hell," to a brow-beaten patient; or a therapist still sensitive or guilty about his own father's death may steer a patient's course away from feelings to medical or funeral particulars. Aside from deflection or encouragement, chief indicators for the therapist are either shutting down or not being able to shut up. (Incidentally, if he has nothing to say, as a rule the best thing a therapist can do most of the time in therapy, whether counter-transference is an issue or not, is to be quiet: the patient will continue, fill in the gaps, and work it out. Also, as Abraham Lincoln reportedly said, "I'd rather keep quiet and be thought a fool than speak out and remove all doubt of it.") In neurotic counter-transference, the therapist, if he is at all conscious, may feel himself losing his usual therapeutic stance and being out of himself, but nevertheless has trouble stopping these things. His own anxieties are usually the issue. This connects with the occupational hazards of psychotherapy that Jung speaks of, though here there is a hazard for the patient. If it occurs in a sustained and fixed way, the therapy is compromised: unhelpful to the patient and unbearable for the therapist. For it to occur transiently, however, is right near the core of the psychotherapy, linking it with "taking on the psychic sufferings of the patient." Thus a key factor is whether the therapist can manage his emotions and contain himself. Knocked off his center, a therapist will tend to act out in some way to regain balance. Instead of this, the better position is to wrestle with it privately. In this way, the neurotic counter-transference can turn into useful counter-transference; that is, the "influence of the

patient" can then become "a highly important organ of information" (Jung 1929a, p. 71).

Therapeutic countertransference

Personal therapy and continuous self-analysis do not imply perfection or perfectionism. They only imply some personal healing, an ability with self-understanding, and a readiness to take up the task. Countertransference can be used positively by a therapist who understands that his reactions are in some measure generated by the patient's unconscious and who can contain and work through his feelings. For example, I have a patient who depresses me considerably, and I struggle with the issue of whether he depresses me, or I am embodying a projection of his depressed mother, or I am just depressed on my own. Another typical example: a therapist may feel a strong urge to criticize a particular patient, but if he restrains this he may realize that he is about to act out the patient's own self-criticism (in other words, his "inner critic") or the critical attitudes of an internalized or actual parent figure.

Recognizing and measuring such feelings in himself, the therapist may use them as a basis for hypothesizing about, understanding, or interpreting a patient's subjective experience and emotional history. The therapist's working with and through his own emotion thereby carries potential meaning about the patient. This countertransference processing is therefore an *informational countertransference*, which can be seen as part of a communication dynamic in the patient-therapist relationship. The therapist is getting to know the patient directly through experience: the therapist is not thinking about but is embroiled in the patient's unconscious. "Informational" is probably insufficient to describe this. A patient does not just tell a therapist something, some bit of knowledge about himself, but invokes its reality in the therapist. It is more than an information transfer; Jung speaks cogently of "psychological induction" (1946, p. 199). The dynamic's actual presence, spontaneous presentation, and the unconscious components as experienced by the therapist are what are revelatory. Jung's metaphor of the transfer of the "demon of sickness," while it has a Biblical or medieval ring, is a more accurate description of this process, phenomenologically. In scientific-Jungian terms, a complex has been transferred. Furthermore, a complex is a complex of feelings, and in transference/countertransference more than discrete bits of information or experience are encountered. The separate threads are part of a larger fabric, so in general a whole person and whole relationship is experienced by the therapist—a full-fledged *countertransference neurosis* or countertransference situation, as noted above, that corresponds to the patient's transference neurosis. This is a more sophisticated way of saying that the therapist "literally takes over the sufferings of the patient and shares them with him." He has, as noted, a very particular countertransference to this particular patient, and they have a therapeutic relationship with the unique qualities the patient's healing requires.

Phrases like neurotic countertransference, informational countertransference, and countertransference neurosis do not come from Jung. But they are more precise terms for the realities Jung was pointing to. Later Jungians have made much use of them, breaking down, for instance, what I am labeling informational countertransference into categories like "syntonic," "concordant/complementary," "reflective/embodied," "neurotic/useful,"

and "projective/objective/antithetical/archetypal," all of which discriminate the precise nature of what is happening in the therapist.[14]

Therapeutic transference/ countertransference

These recent Jungian reflections represent countertransference as seen by therapists. Countertransference can also be viewed from a patient's perspective, as well as from a third point outside and above the vantage points of the two participants in the process. Countertransference is not simply the patient constellating the therapist's unconscious. It is also the therapist bringing his own unconscious into the scene regardless of the patient. This is what Jung talks about in "Psychology of the Transference" (1946) when referring to two people and two unconsciouses involved in the therapy. The therapist arrives with his own self; he is not a blank page that the patient then draws upon. The therapist can be a person, too, who constellates the patient's unconscious just as the patient does his. Accordingly, the patient's transference is not simply the instigator of everything; it interacts with the therapist's. From the patient's point of view, the therapist affects him, all the more so because the patient is typically in a vulnerable state. (It could be said that the patient has a counter-transference to the therapist's transference.) Therefore it is the interpersonal and unconscious bond between the two that matters; this leads to metaphors like chemistry, alchemy, or "a good match." Jung makes the good point that the therapist's personality should not act harmfully on the patient, but he makes the further point that its effect is inevitable. Thus the therapist's personality ultimately becomes "the harmful or curative factor" in psychotherapy (1929a, p. 74).

If indeed the "the great healing factor in psychotherapy is the doctor's personality," the doctor's personality requires close inspection (1945, p. 88). A wounded-healer orientation helps here. In a psychological sense the therapeutic healer has an open wound (Groesbeck 1975). He is already wounded in life, or by life, and according to this book's therapeutic paradigm, he frequently gets in some way rewounded by the patient. This is a difficult (and unpleasant) phenomenon. Being injured in life does not make the therapist unique, but making a point of living in that zone by returning there with patients is somewhat so. He is supposed to be better off than his patient, and by and large this is true. Yet there must be in the therapist some sort of propensity to feel scarred, hurt, sad, mad, or even "sick." For some reason, he feels some sort of gravitational pull toward the healing process; the mystery of healing (and the healing mystery) grabs him, as does, perhaps, the need to be further healed. Maybe his own psychotherapy was insufficient; or on the other hand, maybe doing this work with others reflects some gratitude for his own successful treatment, or, as some think, reparation for the aggression or inherent ambivalence towards others that seems to be part of normal development and living. In any event, ongoing life problems and pains present new needs for the therapeutic in some form. Life, as Jung mentioned, does not cease to sting, it just becomes more manageable (as well as richer, one hopes). As he also noted, choosing to practice psychotherapy may reveal a "fateful predisposition," meaning a connection with a hypothetical blueprint of one's life drawn up by the Self, a vocation.

Doing therapeutic work through a therapeutic relationship involves living through and picking apart the patient's transferred illness. By understanding himself, by working on

"his own hurt" that is generated by the patient, the healing is effected in the patient. Whether it be his initial wounds or simply the patient's rewounding of him, the therapist's hurt and the patient's are fused, so to speak, in the unconscious or in a therapeutic space created between them where the emotional problems crystallize. This is a position that can be attacked by logic: how could they truly be one, isn't this a *folie à deux*, isn't the therapist overidentified here? Probably, but in temporary forms. As a college classmate of mine once said: "Identity is fluid and stable, as long as one keeps reintegrating" (Golbin 1973). In the unconscious—in that unknown area where their personalities collide and mix—there seems to be a unified field. Because it is unconscious, this is difficult to describe: this chapter showed how Jung used the alchemical *coniunctio*, an image of male and female locked in intercourse and then merged into one person from which a new, third person emerges, to suggest it. This set of images in itself is as good as any, better than most in fact, except for its obscurity. If one gets past the medieval penumbra, one finds the images intriguing.

CORRECTIVE EMOTIONAL EXPERIENCE

This point where patient and therapist have locked in to each other could be called an *engaged countertransference*. This means that the unconscious connection has been established, that therapist and patient are "involved." The emphasis here is on countertransference because the therapeutic assumption is that the patient's transference will automatically be engaged, even if resisted, and the question is whether the therapist's will be too. The healing force of the therapeutic relationship has not been engaged unless the therapist's countertransference has engaged it.

All these phrases and metaphors—engagement, involvement, intercourse—utilize the imagery of intimacy. The therapeutic relationship which they describe is intimate in the extreme, although uniquely so (in the paradoxical personal-professional sense noted), with many of the sensitivities, vulnerabilities, and dangers that go with intimacy. And as people grow close, their standard patterns of closeness emerge—transference and countertransference. Because they have emerged in this engaged relationship, they can be repaired. The relationship, engaged, becomes the medium for change.

Articulating the nature of this change is a continuous challenge. When classical psychoanalysis was in its heyday, it was critical not only of countertransference but of what psychoanalyst Franz Alexander called a "corrective emotional experience" in therapy (Alexander and French 1946, p. 22). This was because Alexander's theory and technique, in an effort to shorten and improve psychotherapy, seemed to abandon therapist neutrality and veer into a transference- and interpretation-diluting role-playing by the analyst. Orthodox practitioners thought that, at best, any emotional correction was provided secondarily by the analyst's steady, interpretive stance. Furthermore, Alexander's ideas sometimes called for a deliberately contradependent stance by the analyst (countertransference in the extreme: literally "countering" the patient's transference needs or expectations, not interpreting but deflecting them or acting oppositely so as not to fit them). This all seemed slightly stilted and overstrategic, and ran up against the psychoanalytic emphasis on interpretation as the ultimate agent of change.

Considerable thought was given as to what in interpretations caused them to be change-producing, or "mutative" (Strachey 1934).

As a result, any notion of corrective emotional experience in psychotherapy has been up against it in psychoanalytic psychotherapy, at least among those of the more traditional, interpretation camp. Jungian psychotherapy has never been in the interpretive camp (though it has been in what could be called the symbolic camp). As we have seen, Jung (1917) was critical of reductive analysis—of reducing things to earlier, especially infantile sources; instead, he thought psychotherapy should be "synthetic"—putting things together in a new form with a future orientation. This was how he understood the nature of the unconscious. The possibilities rather than the reasons for things intrigued him.

Jungian psychotherapy emphasizes not just a corrective emotional experience but, to borrow and create more terms from several just mentioned, a mutative affective experience, one in which the therapist emotionally participates. (Hence, as Jung said, both therapist and patient are transformed in some way, even if not necessarily in the same way or to the same degree.) The engaged countertransference represents a slightly different dimension and perspective on corrective emotional experience, one in which the synthesis is reached not interpretively but through a healing participation in the therapeutic relationship.

The point of therapeutic leverage in a *therapeutic transference* is therefore primarily on affect rather than interpretation. Interpretation, furthermore, really means understanding, but the experience and process of understanding are not necessarily conveyed verbally or intellectually, that is, interpretively. They emerge from an affective mutuality, and the interpretation should be mutually worded. Therapist and patient combine their understandings into an emotional vocabulary the patient understands. Freud was on to this in general early on, when he noted that interpretation should come when the patient is right there on it, just about to get it. Nevertheless, there is a significant history in psychoanalytic therapy of interpretations coming from places (namely, the therapist's mind) that are alien to the patient. That is why Jung points out that resistance is not necessarily wrong, that patients are unique, that resistance to psychotherapy may indicate the understandings "rest on false assumptions" (1951a, p. 115). An interpreter is someone who translates one language into another one—your foreign language, let's say, into my language. A participant is someone who shares in the translation process. The central point is that the mutual understanding arises out of mutual affectivity, rather than a separate, therapist-derived understanding.

A therapist has to decide if he is going to be an interpreter or someone who is involved in the process, or both (but with the particular balance that suits him). This decision may take place in a general sense—to some extent this is a basic personality issue—or at a specific moment in psychotherapy. Sometimes it depends on the patient, too, of course. In any event, the decision for emotional engagement, an engaged counter-transference, does not mean that a therapist cannot also be smart or insightful, but it may mean that he may not be acting in a "bright" way in the intellectual sense. The smartest thing a therapist can do is hear and speak in the patient's own language. What a therapist may add verbally or interpretively, if he indeed has a different language, must be translated into the patient's tongue. Otherwise, interpretive understandings are for the therapist, not

the patient. This is a basic communication issue.

Practically speaking, this means that classical Jungian interpretations may be out, either because the patient may not know what the therapist is talking about, or may in a spirit of compliance collude with them and try to learn them, or, on the other hand, may too easily fit them into a preexisting Jungian educational project. Jungian psychotherapy does not involve an indoctrination or training in Jungian thought, but an engagement with the patient's psychology. Of course, Jungian theory and assumptions will form a crucial part of the therapist's viewpoints in individually assimilated form. But the focus is not on a Jungian viewpoint per se but on the patient's developing viewpoint, which may be anything but Jungian (or if it is Jungian, may need to be released somewhat from that). Jung himself noted that certain patients needed or fitted different theories. Within the Jungian flock of therapists there is considerable variety, and with the emphasis on the therapist's personality and, accordingly, the match between patient and therapist, the variety is all the more extended and individualized. It becomes difficult then to characterize a Jungian therapist in any systematic or predictable way.

NOTES

1 Whether Jung was setting up Freud as a straw man here is another question. Many of his discussions use Freud as a foil for his own perspectives. On the other hand, the difference between Freud and Jung in temperament and technique is a valid one. If Freud, in his writings if not his actual treatment, sometimes erred on the side of "neutrality," Jung, in his writings and sometimes in his treatments, seemed to sometimes burst forth on the side of "spontaneity." For further discussion, see Sedgwick (1995, 1997a).

2 *Webster's Collegiate Dictionary*, 10th edn, s.v. "alchemy."

3 Note, however, the psychoanalyst Harold Searles's important study *The Nonhuman Environment* (1960), which calls attention to the crucial importance of psychological relationship with inanimate objects. See also, D.W.Winnicott's (1971) theories of transitional objects, which are about the humanizing of "subjective objects" (people) as they become separate from infantile omnipotence.

4 All derivations are according to *Webster's Collegiate Dictionary*, 10th edn, s.v. "psyche" and "therapy."

5 See the work particularly of psychoanalyst Harold Searles (1965, 1979), who raises the issue of the therapist's contribution to the therapeutic situation, and of Robert Langs (1976, 1978), who asserts that the patient's unconscious is monitoring the therapist and supervising the therapy.

6 Many post-Jungians, incidentally, disagree with this, and place high emphasis on extremely "early" infantile drives and object relations. These Jungians are much closer to psychoanalysis in their perspectives, closer specifically to the theories of Melanie Klein, which ascribe significant psychogenic factors to developmental issues as early as the first months of life. The approaches of Wilfred Bion and Donald Winnicott, among others, are also important here. See especially the work of Jungian analyst Michael Fordham, which is very influential on post-Jungian

thought.

7 Jung's valuing of play finds striking resonance in the work of child therapists and particularly psychoanalyst D.W.Winnicott. See the latter's *Playing and Reality (1971)*.

8 On therapeutic dragon-slaying, see Searles (1967). A patient's responsibility to get well is ultimately his own, as is his refusal to do so.

9 For the stories of Asklepios, Chiron, Apollo, etc., see Robert Graves, *The Greek Myths* (1986). The serpent-ringed staff of Asklepios, "the only true symbol of medicine," has become bastardized into the modern medical symbol of the winged caduceus, which is actually linked with the messenger god Hermes (see *Encyclopedia Britannica*, s.v. "Asklepios").

10 For Jesus as healer of the mentally ill and epileptic, see especially the Book of Matthew in the synoptic gospels. For a more general perspective on Christian ministry, see also Henri Nouwen's *The Wounded Healer* (1979).

11 The healing image of Asklepios is thought to have two dimensions, mythologically speaking: the bright or Apollonian side, which relates to technology and Asklepios' father, the god of light Apollo; and the darker, wounded side connected with his tutor and adopted father, Chiron (Groesbeck 1975, p. 125).

12 This is a semantic difference based on a particular definition of psychotherapy and a literal definition of counseling (giving counsel). Therapeutic counseling, whether it be psychological, pastoral, alcoholism, or whatever, is psychotherapy in the wider sense.

13 Jung may have brought psychotherapy the counter-transference neurosis in all senses: he was one of the many early analysts who got caught up in erotic countertransference with at least one of his patients, perhaps inspiring Freud's early warnings about "mastering" countertransference. See Carotenuto (1982).

14 See Sedgwick (1994) for a review of the Jungian countertransference terminology and literature extant at the time. Some of these terms are themselves non-Jungian in origin. The phrase "countertransference neurosis" comes from the psychoanalysts Racker (1953) and Tower (1956). Michael Fordham, a British Jungian analyst influenced by psychoanalysis, was the first post-Jungian to begin to map out an original Jungian lexicon for countertransference. In the 1950s—an era that also marked major psychoanalytic shifts concerning the uses of countertransference—Fordham (1957) delineated both "countertransference illusion" and "syntonic countertransference." The former refers to countertransference as traditionally understood (i.e. neurotic). Syntonic countertransference, however, relates to reactions that mirror the patient's unconscious and thereby enable empathy, understanding, and interpretation. Jungian analyst Kenneth Lambert (1972, 1974) subsequently used Kleinian analyst Heinrich Racker's terms "concordant" and "complementary" to further differentiate syntonic countertransferences into those that reflect patients' ego states and those that reflect internal objects, respectively. Another British Jungian, Andrew Samuels (1989), invoked different words and images to describe these types of countertransferences, emphasizing bodily felt states with his terms "reflective" and "embodied." At a more general level Warren Steinberg (1990), also influenced by Racker, noted for Jungians the difference

between “neurotic” and “useful” countertransferences, and also mentioned archetypal countertransference components. Using a more Jungian vocabulary, German Jungian analyst Hans Dieckmann described projective, objective, “antithetical,” and archetypal countertransferences on a continuum from classically neurotic to classically Jungian. Almost all these viewpoints benefit from the influence of psychoanalytic writers, which is a significant step for Jungian psychotherapy because it unlocks the Jungian perspective and proceeds beyond sectarian interests. For some, psychoanalysis is a new dimension altogether that seems to overwhelm a Jungian standpoint; for others, psychoanalysis is a way station on the path to new views still consistent with Jungian thought and spirit.

Chapter 4
The therapeutic relationship II: processes and issues

Psychotherapy needs to be grounded and talk about psychotherapy needs to be grounded as well. Chapter 3 laid out some basic Jungian conceptions about the therapeutic relationship; this chapter continues in that mode but also moves from the general overview to some particular realities of the therapeutic relationship. If the therapeutic relationship is the key to psychotherapy, what are its components, how does it get set up, how does it shift at different stages, how is it affected by the various things that come up in and out of therapy? This chapter will look at such processes within the therapeutic relationship and follow the therapist-patient dyad as it evolves from preliminaries to aftermath, with emphasis primarily on the earlier aspects because they can be prescribed ahead of time to a certain degree. The description here will oscillate somewhat between the viewpoints of the two participants but concentrate more on the therapist than patient, in keeping with this book's focus.

Because Jungian psychotherapy is founded on the personal dimension, from the point of view of the therapist this dimension primarily consists of two components previously mentioned—empathy and "wounded healing". Together, these form the internal work of the therapist in therapy—what can be called, in very expanded terms, countertransference (meaning all the fantasies, feelings, thoughts of the therapist about the patient and the therapeutic relationship). All this could also be called the "therapist's mind" (i.e. his personality and all he contributes from his side of the equation). This definition of countertransference is broad, but it is adequate code for the therapist's side, just as transference works for the patient's side.

The focus in this chapter will specifically be on how the therapist uses his countertransference, wherever it is along the reactive spectrum from empathy to the actually "wounded" parts of himself, during the therapeutic process activated by the therapeutic relationship. Using the word "use" makes counter-transference sound like a tool one picks up, but "making use" of countertransference is an inaccurate way of speaking. Actually, like most things in psychotherapy, countertransference is not voluntary and not something one picks up at random or at will. In this sense, it is not used; rather, countertransference represents a continuous approach and a process. It is a fundamental dimension of doing psychotherapy, based on a recognition of something that is always there, even if sometimes only marginally conscious. For Jungian psychotherapy, because the therapist's personality is always relevant, countertransference is always present. Psychotherapy is like a good-sized river formed by smaller two rivers flowing together, and countertransference is a continuous current in that river. It is not so much used as discovered and realized. The therapist's struggles with empathy are part of this.

EMPATHY

There is no substitute for empathy in the therapeutic relationship, and in the end nothing is more important. It is the basis of all psychological healing, or at least the basis for the sense of understanding upon which healing rests. As noted in Chapter 3, to feel listened to, understood, and thereby to feel accepted and even loved are the critical experiences in therapy. Jung suggested that transference was the key element in therapy; for the patient this boils down to the sense of acceptance of himself that he ultimately develops in relationship with another. Although he was pointing in a slightly different, more sexualized direction, even the dour Freud mentioned in early days (in a letter to Jung, incidentally) that in a sense "the cure is effected by love" (McGuire 1974, p. 13).[1] The use of the word "love" sometimes throws therapists and others for a loop, but it is the acceptance-understanding aspect that is emphasized here. Broadly put, psychotherapy is an act of love, though not romantic love. It is *agape* rather than *eros* (though erotic energies in psychotherapy and a refined psychological eros should not be ignored). Deep empathy really conveys this or at least is similar to it. At the core of empathy is a type of love for another person, which takes the shape of a serious concern for him. Therapy requires caring, or caring enough to want to know about a patient *and* to bear with him when he is annoying. Some patients, sadly, have lived long lives of being difficult people, and the more disturbed they are, the more toxic they are, however unintentionally. So it is not just the love, it is the being with them when you don't love them; hence the agape, Christian-love idea is relevant, whether one subscribes to a religious faith or not.

A patient responds to a therapist's genuine, embodied curiosity. People begin to imagine themselves through being imagined by others. Because we imagine ourselves first through other people's eyes, being thus reflected back to oneself or cared about is, of course, something most people and patients can never get enough of. Limits on it create frustration, but if the therapist can in turn empathize with this, then more understanding again ensues, because the patient feels acceptable across the board, in his love, frustration, and even hate. This translates into a self-acceptance and ongoing self-care; that is, liking oneself in all one's facets (in other words, self-esteem).

Right from the start, a therapist's task is to assume an empathic position. For some therapists this comes naturally, and with some patients it is more natural because they arouse sympathy. Some do not. Regardless, the therapist's struggle with empathy is a model for the patient's struggle with self-esteem, and the therapist's determined if inevitably incomplete acceptance of the patient is a model for the patient's self-acceptance. The patient, in effect, introjects the therapist's empathy and acceptance, takes in this goodness of understanding, and feels nourished psychologically. The patient does not just do this consciously; over time he identifies subtly, perhaps unconsciously, with the therapist's understanding. In other words, the patient learns through the therapeutic experience to be self-caring. Psychotherapy gets complicated, of course, when the patient is unable to take this in—stressful for the therapist because his empathy is now "unworthy," or unsuccessful; stressful for the patient because he is still stuck.

Empathy as "parenting"

Inevitably, empathy and other aspects of therapy call up parenting as a therapeutic metaphor (good parenting, that is) and effective psychotherapy can undoubtedly be viewed as a repair of emotional damage and developmental failures that often are the result of poor parenting. However, the parenting idea, whether it be metaphorical or even, as in some cases, concrete "reparenting," does not work in the end. The idea comes up because (1) a patient's psychological damage is usually rooted in the past, (2) therapists themselves often feel parentlike, (3) patients, feeling lost and hurt in childlike ways, seek a parentlike succor, and (4) they often reenact parent-child relations in psychotherapy. Patients frequently move into dependency positions emotionally and want to be taken care of, and therapists more or less feel like doing so (the latter is sometimes a response to the former).

But just as much as patients want a parent they probably never had, therapists just as much cannot be their parent (and, frequently, would not want to be). It is, in any event, impossible to be so. The time factor alone precludes it: an intensive psychotherapy of, for instance, 350 total hours, which would be extremely lengthy and rare, would translate into only about two weeks total time spent together—hardly a parental situation. Certainly, the time spent in therapy is special and intentionally psychotherapeutic, but adequate parenting takes place over a huge period of time and is a tremendously dedicated effort, as well as a function of maternal or paternal love, good sense, and instinct. While therapy partakes of these qualities and can do some repair work in these areas, the deal, as they say, has already gone down. Whatever problems were there cannot be directly changed or wiped away. The wounds from these and other processes can only be managed and to some extent healed, in order to be lived beyond. But this repair does not come from finding a new parent, though patients might fantasize this (or wish, in the same way, that the therapist could be a continuously available lover). A therapist would be, at best, a fairly good but partial substitute for a parent, if all went well. Therapy is not compressed parenting but a very specialized modality which in fact could not be maintained by the therapist without its being limited to an hour at a time and to the limits of the therapeutic setting. If it were like any kind of parenting, it would perhaps be like grandparenting, where traditionally there is limited time together, less frequency of meeting, and more distance, all of which allow for a certain patience and perspicacity.

A therapist may have fantasies of being a parent, or being a better parent, than the patient's, but this is related to transference and countertransference. The therapist is feeling there the patient's need (or his own). Also, working empathically, therapists readily side with patients' complaints or dissatisfactions with their parents. And the field of psychotherapy as a whole seemed to have blamed parents and families for their children's pathologies—often with some justification. Not-good-enough mothering and abusive fathers are usually the culprits, but horrifying abuses and neglects of all kinds crop up. These are not good things, but therapists sometimes reinforce a patient's sense of victimization with a "bad parent" or "who failed you?" search.

This can lead to an implication, fueled by patient expectations and the therapist's empathic position and indignance, that the therapist could do it better. It could be so, but this is a moot point, and possibly an arrogant one. It is definitely gratifying to a therapist

to feel that he might be more understanding, patient, intelligent, and mature than his patient's apparently second-rate parents. Also, part of the thrill of being a therapist can be to be the wise or helpful one, the "one who understands." On the other hand, while a therapist may resonate with a patient's perspective, sometimes he may be surprised to find himself identifying with the reportedly bad parent's perspective towards the patient. Furthermore, the patient approaching psychotherapy may sue the therapist, in effect, for the failures of his life and improper parenting—sue for damages as it were. In a negative transference, this failure becomes the therapistparent's, and the heat can be intense. An understanding therapist may collude unintentionally with a patient's need or desire for a good parent—and does indeed provide some good-parent-like qualities—but in the end it is a promise a therapist cannot keep.

However, what psychotherapy does provide overall can be concep-tualized as a repair to the area of what Jung called *the parental imago*, meaning the internalized or inner parent, at least insofar as that area is related to psychological well-being. A parent also appears to be the first carrier, so to speak, of one's self-image (or the Self, in traditional Jungian terms). If—and this would be close to a Jungian psychotherapeutic assumption—an inherent propensity toward self-development exists, and if the experience of being parented is affected by this, which seems obvious, then therapy would seem to replace negative introjects or experiences with a more positive internalization.

It is sometimes suggested that, when this positive internalization works, the therapist becomes a "new object" or "good object" for the patient, or that repeated good or nourishing experiences in therapy crystallize into something like a new inner parent for the patient. Perhaps this is so, but it might be more accurate to call it an inner therapist. The new thing is actually a new *capacity*, which one's parents, among others, either facilitated or did not, to whatever degree. This is the "self-care" capacity noted a few paragraphs ago.[2] To reverse the emphasis of these paradigms a bit: there is a self-care or, in this context, self-therapy potential in people, which could be termed the inner therapist. Life experiences with parents and the resulting modifications of innate parental images particularly go into cultivating this ability and forming this image. To some extent, effective psychotherapy may displace the negative parental complexes from the inner self-care area, or modify their influence. Although these imagined structures are all *façons de parler*, reifications of psychological and emotional abilities, they are compelling because people tend to refer to themselves like that, as having "parts" or by saying "part of me feels…" These partial self-images may also surface in dreams, and they may be the real subject when a patient makes an attribution to or about the therapist, or has this or that fantasy about a therapist.

The nature of empathy

While it is not real parenting, psychotherapy does seem to rest on the empathic dimension present in effective parenting or mentoring. Yet one hesitates to make psychotherapy simply a matter of understanding and empathy. Shouldn't there be more—more expertise, more interpretive magic, more psychological knowledge, less soft-minded clientcenteredness? Perhaps, but in the final analysis there may not be. This is no cause for dismay because, first of all, empathy is not simple; second, it is quite demanding;

third, it is very subtle; fourth, it is not just a response to the consciously presented statements of the patient; fifth, it is active, not just reliant on what the therapist already knows or has experienced; sixth, there is considerable theoretical background to empathy (as to any understanding); and seventh, it may not be nice (empathy with some shadowy aspect of patient experience or desire). In short, empathy is a lot of work. It stretches a therapist out, and becomes part of the "endless learning" Jung talked about for the therapist. Empathy is not just "empathy"; it is an endless emotional learning. Each case, if individually approached, requires new empathic efforts as the therapist gradually comes to know the patient (in a process that somehow enables the patient to know himself).

Sometimes its absence, or temporary disappearance, makes empathy and its effects more evident. For example, after a fairly extended effort and a sense of relative failure with a patient, I finally began in a session to "see" what it might be like to be him, experientially. This came when I could get with his fears about becoming like someone he either feared or had it in him to be, namely, his father. It finally clicked with me, and I felt it, though I did not say anything. Later in the session, this tightly bound, flat patient began to cry. I don't think the silent empathy caused this, as such, or even opened the door to it precisely, but it somehow went with it. It was part and parcel of a being with and a crying that occurred almost simultaneously. The pieces came together. When a therapist can, finally and genuinely, see something, the patient can move.

Empathy is fully imagined experience; that is, it is felt as well as thought. This makes it in some ways like the Jungian technique of active imagination, which requires a complete, if temporary, emotional engagement with the imaginal process (Jung 1928). Or one could say it is similar to fully engrossing play, like a child at serious play or an adult at a serious hobby. In other words, one can put oneself in someone else's shoes casually or one can really do it. It takes considerable effort. A "trial identification" with the patient is a good way to describe this concentrated activity (Fleiss 1941). If you consciously identify with somebody, you are imagining yourself to be like your fantasy or experience of him or her, usually to bolster yourself; in empathy, you also try to be or identify with that person, but not usually to bolster yourself, which is what can make it hard. Carl Rogers and client-centered therapy used to talk about "accurate" empathy, and empathic target-shooting requires a fairly complete imaginary participation in the other person's feeling states. Otherwise the empathy will be thin and, to the patient, inauthentic (Rogers 1961). A therapist cannot just go through the motions of empathy; or if he does, the therapy will eventually founder.

The precise nature of empathy is complex. It certainly has something to do with understanding through immersion in another's experience, in so far as this is possible. The concept's roots are pretty close to those of sympathy, only empathy connotes something more genuinely felt and more active, whereas sympathy has developed a funeral-home aura ("our deepest sympathies"). Both words rest on *pathos*, which denotes feelings in general but more particularly "suffering" or something evoking pity or compassion (though it sometimes implies derision, as in "you are pathetic"). Following their prefixes, sympathy is suffering with and empathy is suffering in or within. In empathy, one truly goes over… there, into the other person. Heinz Kohut, the self psychologist, speaks of "vicarious introspection" (1984, p. 175), and the dictionary

speaks both of "vicarious experience" and being sensitive, aware, and understanding of another. However, the dictionary also notes the projection of an "imaginative state" into another—a therapist has an internal fantasy of what a patient is feeling. The first of these empathic operations is receptive, the second is active. The therapist is taking in and imagining out, introjecting and projecting. This dynamic is interesting, and the dictionary definitions are deceiving, because the standard psychological use of empathy tends toward the receptive rather than the projective aspect. However, one sometimes must project to introject, that is, imagine what it must be like in order to take it in. Empathy is a conscious projective identification.

But empathy is really not vicarious, voyeuristic experience, though it is vicariously sourced. In empathy, the patient's story affects the therapist. That is to say, the patient, not just his story, affects him. The therapist becomes "in pathos" with the patient, into the patient's feeling, experience, and especially his suffering (again, Jung's statement: "The doctor …quite literally 'takes over' the sufferings of his patient and shares them with him"). Getting into a patient's pathos is like sympathy (pity and compassion for the suffering), but not just that. It is relatively easy to have pity or compassion for someone. Empathy, in fact, may not involve compassion at all (except in the general sense that it is a compassionate move to put oneself in another's place). It means getting with whatever the patient is feeling, or might be feeling, a process that becomes difficult for the therapist when he cannot immediately resonate with the patient's story and especially acute when he would rather not resonate with it. Therefore the primary empathic questions are about the therapist's inability or reluctance to do so, which is a therapist resistance or so-called neurotic countertransference. Neurotic counter-transference is essentially a failure of empathy.

The empathic challenge

Can the therapist get in empathic touch with the patient and can he stay in touch when the going gets heavy? That is the question. When a patient tells a therapist something, what goes through the therapist's mind? Thoughts, anxieties, assessments, moral judgments, feelings of like or dislike for the patient, images, tentative interpretations, one's own memories, connections to other things the patient has said or to the patient's history, things strangely unconnected, or nothing (sometimes). A therapist is simultaneously empathizing, theorizing, "countertransfering" (noting his personal feelings and associations, sorting them, seeing if they fit, doing a continuous bias-check to see if this internal history from which he draws is relevant to the patient's). So, when a patient talks about his inferiority complex and his hostile, argumentative yet insecure father, I may personally resonate with certain aspects of that, recalling some experiences of mine that lead to a possible understanding of such feelings, meanwhile also noting the ways in which my experience with my father was different. I may think about the patient's narcissistic issues, his family, his personal transference to me as someone to fight, resent, top or twin with, feel mirrored by. This all comes in a complex, fast-moving mesh. Things race through a therapist's mind all the time, and a therapist can, and should, be able to think anything; however, in the empathic mode he focuses on what it is like to be someone else. He tries to think or feel—experience things—as if he were that person, as

if he had that person's mind and experience. A therapist wants to get inside your head. In a way, the therapist has to be a different person, at least temporarily, a disengagement of his identity that could be frightening to him, or quite a relief.

What are the possibilities and limits of this temporary imaginal inhabiting of another person? Considerable, both ways. Psychotherapy is basically a massive effort at empathic understanding. However, the scope of this is limited by how well the therapist can imagine things, that is, by his personality, personal experiences, theoretical perspectives, creativity, and feeling range. All this constitutes his *empathic range*. From a patient's point of view, the key thing is to feel that the therapist "gets it," most of the time. Failing that, he must sense that the therapist is trying, that he is consistently working "with" him. If he feels this, the patient then trusts the therapist, and creating this trust is the main initial task of psychotherapy. Indeed, this is the crucial task of psychotherapy, because once it is established, the patient can then pursue what he needs to, knowing he is not alone with it.

Another aspect of therapeutic empathy is the therapist imagining what the patient is going through *unconsciously*. This is psychological experience that is there but not yet well known to the patient. Many patients are unaware of, or unable to manage or make sense of, the semiunknown parts of their experience, and so the therapist through empathy helps these things eventually become known. The therapist imagines possibilities of feeling based on theories, his own experience, and what he has come to know of the patient. His thinking is something like: given what I sense of the person's nature, what I recall of his past history, what might be possible theoretically, what my own reactions might be in such a situation, and what this patient just said—what might this patient be feeling? Although the therapist's imaginings can perhaps be broken down into these separate thoughts, these musings usually come less methodically. Fantasies about a patient's feelings are akin to interpretations, although they are not necessarily revealed, as interpretations usually are.

FROM EMPATHY TO COUNTERTRANSFERENCE

There are times when the therapist *really* feels empathy for or with the patient, either feels what the patient feels deeply or what patient doesn't yet know he is feeling. At these latter times the therapist may wonder: is this in fact what the patient is feeling, or is it me? Him or me? At other times a therapist has to work hard at getting to empathy, and at still other times he may question his empathy altogether. All these are examples of where empathy veers into countertransference, which means that the therapist really has to wrestle with himself alongside the patient. Thus there are two kinds of empathy, *uncomplicated* and *complicated*. When it is complicated empathy, the therapist must actively ponder what is going on inside himself, and this moves him into the realm of countertransference, which follows empathy out into an act of closer selfexploration.

An example

A patient tells me her tortured feelings about seeing a dead cat beside the road as she

drove by. As I imagine this, I am not filled with the ghastly horror of this that she is. I am not happy about it but it doesn't bother me. So here I have to work, trying to imagine the feeling state of a person, the sensibilities and delicacy, of a person who would be *that* upset by a dead cat. But I then find myself thinking, "Oh come on." Next, I feel a little guilt and wonder if I am a hard case; I wonder about my own propensities for denial, but the dead cat still does not affect me that much. Perhaps it would if it were my cat, but I don't have a cat and am not particularly a cat person. So I have to imagine being a cat person, or someone who is tremendously attached to their pets. To really empathize, I have to set myself- my typical reactions and personality—aside and try to be a cat person. To work with empathy, at times one has to work against oneself.

But unfortunately my thought-feelings do not readily budge—this was not *her* pet after all, I think—and I continue to feel a mild impatience at what seems to me to be an overindulgence, perhaps a misplaced sentimentality. I feel something like, "This is immature, this is hysterical"; but then, having not ignored my internal impatience with her, I begin to think, "It's okay, who am I to judge?" Then I think of this patient's reported family history, recalling that she told me her father was cruel to animals. This patient feels for all the animals in the world, and despairs because she cannot—life cannot—care for all of them. The image of her father is the embodiment of this heartless world as a whole (or, the "mean world "is generalized from her experience with her father).

I therefore start to ask myself: is my impatient way of thinking and feeling simply my callousness, or is it a callousness in him (the father in her, projected into me by her), or is it her own (very unowned and projected onto him *and* me)? Me, him, or her—I cannot tell which. Or is it all of these: my character, her projection of her father's character (which also links up with an aggressive internal critic in this depressed patient), and her own unconsciously sadistic character? Or is it none of these, just my response to hers and there's no problematic counter-transference issue per se? It could even be an "objective counter-transference," in which my natural reaction to a distasteful—in this case a childish, in the negative sense—aspect of the patient is appropriate (Winnicott 1949). Or, in opposition to that, isn't this an interesting melange of transference and countertransference, a mix-up needed by the patient, about which nothing has to be clarified yet, just experienced? In empathy/countertransference, a therapist sometimes must simply contain and wait.

The difficulty, if difficulty it is, is my getting with the patient's point of view vis a vis the cat. Actually, her general insistence on the overall hopelessness of everything is what makes me feel impatient, and this is the real countertransference issue with this patient. I am transiently depressed at times by her perpetual depression, and I resist it (and its implications about life and also about an unsuccessful treatment). Her internal persecutor constellates my internal persecutor, and in response I want to lash out. Occasionally I remind her (and myself) of the positive steps she has indeed made in her life. But she appears always to forget, or to fall back into this treatment-resistant depression. I sometimes wonder if she is sadistically (even if unconsciously) torturing *me* by not getting better. I'm like one of the poor little animals. They can't do anything, I can't do anything, and neither can she. We all feel the same way—helpless—caught up in this disheartening paradigm of victims and victimizers.

Countertransference challenges

Situations like the above are a muddle, made more complex by the apparent fact that *all* of a therapist's ruminations may seem true at various times. Such ruminations, which occur in split seconds, may seem extensive to the outside observer. They are extensive, but the mind covers a lot of ground and, like anybody else's, a therapist's ongoing thoughts in a session move much faster than they read. (Thoughts are always thought faster than they are spoken, written, or even read.) These are part of the in-session flow of his mind, his psyche.

Thus a failure of empathy, a question or reluctance about empathy, or so-called complicated empathy may be indicators that a deeper countertransference issue is being engaged in the therapeutic relationship. The countertransference struggle then becomes not the end but the beginning of the therapeutic process. Now, as in the example above, the therapist and the patient are in it together. As was quoted in Chapter 2, "The patient now means something to him [the therapist] personally, and this provides the most favorable basis for treatment" (Jung 1946, p. 177). In other words, for a patient to "matter" to a therapist, the therapist must have a countertransference.

Most countertransference writings exhibit the above type of scenario and then a resolution. In the above instance, for example, the therapist would realize that the patient has been projecting her aggression, her own guilt, or her bad internal father into him and that the therapist has resisted, enacted, or identified with it in his impatience. Then, having realized and metabolized this, a therapist might interpret it back to the patient in some healing way. In my understanding of the Jungian perspective, which is slightly different, the interpretive dimension is less emphasized. The above type of situation plays unconsciously on the therapist's current wounds (his despair and torturedness in this situation) and perhaps some old wounds (existential despairs). Jung mentions that it is his own hurt that gives the therapist power to heal. So here it is: therapist and patient both have a problem—feeling persecuted and worthless—and it is currently unresolved. They will live through it together, though the therapist most likely has to work it out first because, according to the Jungian perspective, a patient can only get as far as his therapist has.

This can be rough on a therapist, when he knows that he does not know and is unsure of the outcome. The distance between empathy and countertransference is not great. They are on a continuum that varies with the depth of the patient's effect on the therapist. If empathy is vicarious experience, then countertransference occurs when the experience becomes not so vicarious. A therapist finds that a sticky countertransference has just happened. This is marked by the therapist's unease with the situation, his unease with the patient. The countertransference has hooked him, and he is in it.

It is here that the therapist is dealing with a wounded-healing situation, which is a situation where his own wounds get healed or reactivated in conjunction with the patient's. This has traditionally been thought of as undesirable, and, as noted, the therapist's own therapy was the preventative measure. A wounded-healing perspective, however, assumes the reactivation or creation of anxiety and conflict in the therapist and the therapist's working through of the issues generated in his contacts with the patient. Jung (1963, p. 143) puts it well when he states that the therapist and patient must

"become a problem to each other." The degree of such problem-creation varies with the particular chemistry of patient and therapist, the level of the patient's pathology, and what the therapist brings to the table from present and past. A therapist, in other words, makes use of his own psychopathology. Not every patient requires this sort of complicity, but any longer-term therapy at some time or other will become difficult for the therapist.[3] The healing situation seems to demand this from the psychotherapy. The following example highlights this idea.[4]

Example

A patient dreamed two dreams in the same night. In the first dream he has a "hard book" under his mattress. This "object" is his "pain," which is "wrapped up by day" but comes out at night. In the second dream the patient brings this dream to me, his therapist, but I am uninterested. Confused by this, he goes into my office building where he meets my partner (a dream creation), whom he likes. The patient then meets with me and again gets "nothing," but bumps into the other therapist on the way out. He finds this therapist to be "ethnic," friendly, but also "deeply troubled." My colleague tells my patient a story about how he and I rented the offices together but he by chance got the smaller room. The patient doubts this was by chance. Their conversation stops and the patient is left "alone" as the dream ends.

This second dream shows the patient seeking a more open, "troubled" therapist, and seems on the objective plane to show some not-too-veiled criticism of my lack of, or repression of, emotional vulnerability. It also indicates what the patient wants from a therapist, and perhaps suggests what the therapeutic relationship needs. Respecting the dream's perspective, I felt anxious and embarrassed about this vision of me. So the dream did in fact wound me, insinuating that I closed out the deeply troubled. (Though not "ethnic," as that term is traditionally used, I did not usually consider myself disengaged or invulnerable.) Still, it suggested that more space needed to be given to that which is looser, even psychologically disturbed. In other words, the patient sought more contact with the wounded healer.

In terms of the therapeutic relationship—if the dream is taken as having outer as well as internal reference—it was now up to me, as therapist, to provide more space for this messier and more messed-up healer, which could be done in part by my personally wrestling with the implications of the dream. But the second dream also linked with the first dream: making a connection with an imperfect therapist might enable this patient to get into his own repressed pain. This patient was somewhat superficial and intellectual—as his first dream possibly indicated, his pain only walked by night, hidden in a book under the bed. These dreams called attention to the considerable, bound-up feeling that he objectified and had hidden away, perhaps through intellectual defenses or bookish abstractions. For this particular patient to get at his pain, he needed a therapist to be involved with him in a deeper, similarly troubled way.

This example suggests two things: how a wounded patient needs a vulnerable therapist, and how a dream can provide considerable food for reflection on the status of the actual therapeutic relationship. As has been suggested, the therapeutic relationship has an inward as well as an outward component. One could say the external relationship is

internalized by the patient, though perhaps this would be too schematic. Internalization is a much more complex process than a blank-slate patient taking in an available external therapist (the same holds true for childhood internalization). In fact, it is almost a mystical process, in the sense that internalization is a subjective absorption by nonphysical means of both the real and imagined presence of another person over a long period of time. How this happens is a mystery. In any event, this patient was trying to get to the wounded part of the wounded healer, both externally (in me) and internally (in himself). The dream, as understood, seemed to suggest it was necessary for the external version to exist in some form in order that the internal side could constellate.

The two previous examples both show a progression in the therapeutic relationship as experienced from the therapist's side. There is movement from empathy (uncomplicated) to counter-transference (where empathy becomes complicated) to wounded healing (where the therapist lives through a countertransference situation in a process of mutual transformation with the patient). To articulate this, Jungians invoke the archetypal idea of the wounded healer (see Chapter 3), meaning, for the therapist, the bipolar fluctuation between the healing or doctoring part of his experience and the vulnerable, "patient" side of his experience (Guggenbuhl-Craig 1971; Groesbeck 1975). These two poles exist in dynamic tension in both the therapist and the patient. In empathy, generally what is happening is that the therapist is trying to get to his own "inner patient." He is moving to the memory or experience of his wounded parts as a basis for empathy.

Of course, there is not really a patient inside a therapist, nor is there a concrete, "inner therapist" inside a patient. These are ways of describing something that *seems* to occur within the participants. The therapist, in effect, is plumbing the patient's woundedness either through his own prior wounds (an identification via empathy) or any dealt him by the patient now (countertransference, which often echoes early or other experiences). Usually, empathy is light, because the issues are not unfamiliar and have been dealt with already; countertransference is heavier, potentially hurtful. Meanwhile, the patient is trying to get to the idea (or rather, the feeling and experience) of an inner therapist; that is, of the healing potentials within him, mediated by an actual therapist.

BEGINNING A THERAPEUTIC RELATIONSHIP

For the above processes in empathy and counter-transference to take hold, a therapeutic relationship must be established, obviously, so we turn now to the patient as he considers psychotherapy. The preceding discussion of inner-outer, internalized-externalized patients and therapists is a reminder that the therapeutic relationship starts with the separate parties to the treatment and with their preconceived fantasies of each other. At the outset, in terms of a therapeutic relationship, only the *possibility* of a relationship exists. Where and when a therapy process begins is difficult, if not impossible, to determine. For the patient, it starts somewhere near the time when the mere idea of seeing a therapist takes hold.

Except for someone already experienced in psychotherapy, therapy is typically not the first thing considered. Only after enough time has gone by and enough unremediated disturbance endured is this last resort considered. (Or else the person is so pained or so

tractable that he will accept a well-meaning recommendation.) At this point therapy and a therapist begin to be imagined. The soon-to-be patient often has considerable anxiety and a wealth of fantasies about therapy and about this therapist he is to meet. The patient is going to reveal himself, and he wonders how he will be received and if the whole thing will work. He imagines all this in accord with his mood, his present and past experiences with parents or other figures in support or authority, his previous therapy, and with the reports, if any, of a referring party, whether a friend or professional. Other patients are nonreferred, and get their therapist's name out of a phone book, which is more of a gamble. (I found my first therapist, a Jungian analyst, in the yellow pages.) Patients also may choose their therapist according to gender, as some people are more comfortable with women than men, or vice versa. Quite a few people directly seeking Jungian modalities anticipate someone like Jung himself, or expect, naturally, a therapy that at least incorporates his principles and psychological material as they perceive them. Some have read Jung's or Jungians' books and arrive with impressions or expectations from them. Some try to fit a mold of being a "Jungian" patient, which is an understandable mistake that the therapist might point out.

Patients' initial contacts and expectations

Whatever their presuppositions, future patients all have some idea of what a Jungian therapist might be like, and they bring this to the first contact with the therapist, whether this is by phone or, less commonly, letter or electronic mail. What is more, the first actual contact with a therapist is usually with an answering machine (or a secretary), which is a striking fact, given the subtleties of the therapeutic relationship that is forming. (That is why an informed, sensitive receptionist is a boon to psychotherapy, particularly in an agency setting.) Therapists need to be mindful with these initial contacts that contribute so much to the tone and trust-building of the treatment. Even the forms a patient might fill out, if any, and the feel of the waiting room are meaningful, as they, along with the therapist's actual early-session comments, are the first substantive communications about therapy.

It is necessary, then, to deliteralize the initial stages of the therapeutic relationship, and realize that it takes place very much in a fantasy atmosphere. As Jung once remarked: "A transference is not by any means always the work of the doctor. Often it is in full swing before he has even opened his mouth" (1946, p. 171). This would be especially true with a well-known person like Jung, but would also be the case for an unknown therapist or one with only a local reputation. Even in small ways, expectant fantasies of the therapist are constantly being generated, as when, for example, a therapist comes highly recommended or is characterized by a referring party one way or another ("good," helpful, experienced, new, "Jungian," older, or whatever). The person who recommends a therapist is some part of the equation, too.

Such characterizations and expectations are natural, unavoidable, and related to hope, so there is nothing wrong with them. In fact, most patients entering therapy either have, or are trying to figure out if they dare have, some hopes for it. A patient who cannot mobilize or find some of this in initial meetings is in difficulty, and without it the therapeutic relationship begins in an unpromising state (for both parties involved).

Whether the sources of the patient's hopeless feelings be depression or defense, negative expectations call for careful assessment, and probably should be addressed quickly. Low expectations may also be fueled by prior treatment difficulties, or negative family attitudes and life experiences. At the same time, even a dubious patient's attitude is belied by his willingness to come in for psychotherapy. They may disdain it, but they are here. Mixed motivation is standard, and an attitude of overly high expectation may ultimately have to be tempered by a response of realistic hopefulness. One potential, very upbeat patient, for example, told me on the phone that colleagues both in the Northwest and New England had spoken highly of me. This was a source of therapeutic optimism to the patient; as for me, though I did not know these references personally, I was flattered by the idea of literally coast-to-coast fame. In spite of myself, however, I responded with a neutral, "Well, we'll see how it goes when we meet." Perhaps I was foolishly raining on the parade, or recoiling from overstimulation, the burdens of high expectation, or idealization, but to me my response felt about right, because I really did not know. I could not know.

Because a patient's myriad mental activities and unconscious expectations pour into the therapeutic relationship before he meets the therapist in person, a therapist has the difficult task of trying to see through and sense what the patient might be feeling even at this very first contact. While the therapist often cannot understand things this fast, this soon, it helps to have an empathic mind-set in place and some theoretical possibilities in place, since an attitude of seriousness and potential understanding is what the patient is probably seeking. The therapy is already happening during the first call.

The therapist's expectations

At the outset, psychologically speaking, the therapist is waiting for a patient, albeit the unknown patient, and ready for the therapeutic relationship to begin. The therapeutic outlook described in Chapter 3 provides the basis for this. To work via the therapeutic relationship, one has to expect it and, of course, have some faith in it. This connects, too, with the realistic hopefulness just mentioned. While this faith may start out intellectually for the therapist—based on what he has read, been taught, and thought about the therapeutic relationship being the backbone of psychotherapy—it becomes more concrete with experience, including his own experiences as a patient. Psychotherapy for therapists is necessary because through it they know a theory inside out and know it fits them. His personal work shows a therapist at a tangible level how healing within a relationship can take place and provides conviction: he knows this treatment can work, it helped him. While this more or less successful process has also expanded his specific range of feeling—that is to say, his empathic range and potential—it is the personal therapeutic experience overall that forms the emotional bedrock for his future work.

For example, in my experience it was not exactly what therapists said to me that helped but what was conveyed to me over time (more accurately, what formed in me while I was "in their care"). My cares were in their care, which is what I needed to feel, and the bottom line is that a patient needs to feel psychologically contained or held. They listened, seemed to understand, and what I was trying to say seemed to matter and was not rejected; therefore I mattered. The painful and shameful were acceptable to them

and, gradually, to me. What's more, I felt there was always somebody there, whose exclusive attention I had. Whether this was true or not, I could feel and create it in my mind, in effect finding or creating the internal therapist I needed. Ultimately I began to like myself better and came to myself. (I emphasize the "liking" part because it follows a dream where a former therapist, listening to my overpsychologized explanation of how I was doing, said simply, "You mean you like yourself")

A patient may feel understood more than he understands per se. My example suggests not only how the therapeutic relationship is absorbed but that what a therapist knows about therapy, and what he is inclined to focus on, are modeled on his own therapy. His way of doing therapy is also modeled on his own therapist. For instance, I notice at times that some therapists sound to me like their former therapists; I also notice, more reluctantly, that I sometimes half assume an attitude or make a gesture like one of my ex-therapists. This is communicating out of an identification with one's therapist, and is not unlike looking in the mirror one day and realizing one physically looks, let's say, like one's mother or father. The childhood form of this is imitation—like the pleasure of walking around in your father's or mother's big shoes. Its more conscious, and sometimes more difficult, adult form is realizing how much one acts, thinks, or feels like one's teacher, which can be disconcerting. In therapy the identification with one's therapist(s) is usually a stylistic matter—a way of saying something—but can be embodied in a general attitude or approach to a therapeutic problem at hand. Identification is a way people learn unconsciously, and, it should be noted, also a way a patient learns from a therapist. Specific teachings from supervisors also flash across a therapist's mind sometimes, ready reserves to be called up. Thus, this special relationship that the therapist as patient or trainee received, or found, in therapy is now passed on in almost unconscious ways to his patient, much like a family gesture. Some of this may explain why some therapists have pictures of Freud, Jung, or other mentors on their office walls (a practice, however, that seems questionable vis a vis the transference-countertransference situation). Nevertheless, as with a family influence, it is the subtle, overall influence that lingers and means more than imitative physical gestures.

BEGINNING THE TREATMENT

At the start of psychotherapy, then, a therapist is expecting the therapeutic relationship to happen, is prepared for it to happen, and is reasonably confident about it if it does happen. He does not, however, know *if* it will happen with a particular patient. That is what they both are going to find out. The therapist has an advantage, so to speak, over the patient here, because he knows about psychotherapy's nature and what it may entail. Prepared especially by his own therapy, he comes prepared in every sense. The patient, on the other hand, does not know exactly what to expect, so it can come as a surprise to find that he is required to participate in an emotional process. He probably does not have it framed quite that way in his mind, and psychotherapy is a big step for anybody. Implicitly, as noted above, the patient probably wants someone like a good parent; implicitly, according to this Jungian model, he is signing up for an emotionally intimate, albeit specifically therapeutic, relationship. This is really not like any parent, and it is no

wonder that this engagement may be resisted by the patient, either because its nature is unexpected, because the patient resists intimacy in general, or because his specific conflicts around relationship may be brought into play.

Educating the patient

Should a therapist therefore educate patients about this, to help them along and encourage active participation? Sometimes it does not hurt to do so in minimal ways. Certain patients themselves ask during an initial meeting, "How do you work?" (or about the Jungian theory of psychotherapy or if there's a book they should read). They want to know what to expect. I find this kind of question difficult to answer directly, in part because it cannot be answered, only demonstrated. Sometimes I will say just that. But if asked, I respond. My usual response, aside from emphasizing the showing rather than telling, is to say something like, "Our goal is to understand together, as best we can, the things that are bothering you." This simple statement is subject to considerable improvisation, and I occasionally add, if some further theoretical explanation seems warranted, that I think that the therapeutic relationship is the main thing in psychotherapy. These fairly minimal, even vague responses can be further specified when therapy begins or if the patient struggles over where to begin in early sessions. If a patient is stuck, if necessary I note that we already have an idea of the important issues that have brought him in. Sometimes, to let him know that I have been listening and what I have gathered so far, I enumerate these, which can also help organize the situation for a disorganized or nervous patient. At the same time I also let the patient know that *he* needs to set the pace and talk as honestly as possible about whatever is on his mind—feelings, thoughts, fantasies, including those that might even come up about me—anything. This slightly narrows the field to the central issues he has mentioned and gives a hint that he might develop some sort of feelings about the therapist, all of which he should try to speak openly about. If the patient seems fearful (and his history supports this), I sometimes gently reiterate that our goal is simply to understand what is going on, not to criticize. This is an encouragement. Alternatively, because I have in mind that beginning this new therapy is probably a key reference point for an anxious patient, I may bring that up directly, intertwining an observation or interpretation with what I have gathered about his personal or therapeutic history (e.g. "Given your previous experience [in therapy, with your father, with abuse, etc.], talking with me must be difficult for you…). This makes reference to the therapeutic context and to the interpersonal context, the therapeutic relationship with me. It is, in fact, a transference interpretation. Tone is more important than specifics in the way all such instructions and encouragements are conveyed. The therapist's implicit message is: I'm here to help you, this is how we can go about it, this is what I'll be doing and what you need to do, and, finally, you can trust me.

Resistance

Patients have various reactions to this, and trust is not immediate, especially given the backgrounds of many patients. It is also one thing to hear instructions and another to take

them in, which takes time. The original guidelines may not be heard the first time, or may be ignored or misunderstood. But having set up how he does therapy, a therapist can then recall these instructions as necessary. It is not possible to offer more than a general rule on this. Some patients plunge right into the therapy, some may continue to have trouble starting in early sessions. The latter situation can be handled in assorted ways: waiting receptively and saying nothing; encouragement ("Let's see what comes to mind"); encouragement with a cue and clue ("We have a pretty good idea from last time about your problems, let's see what comes to mind about them"): inquiring confrontation ("You mentioned your concerns last time—I wonder what makes it hard to talk about them"); empathic interpretation-confrontation ("You listed many important issues the other day, you must be pretty anxious about them, that you can't remember them"); pointing out a defense ("You mentioned all these problems, but somehow in your anxiety about them you seem to have placed them out of your mind"); therapeutic astonishment ("It's hard to believe that all those issues you mentioned have disappeared already"); ironic-comic astonishment ("You mean *all* those problems you mentioned have gone away already?"); direct confrontation ("You mentioned___as very important concerns last time, and yet this time you're acting as if they are not there and there is nothing to talk about. What do you make of this, and how can therapy be helpful to you if you won't talk about the things that are important to you?"); or, finally, the transference understandings outlined earlier ("Given your previous experience…") These fantasy interventions are entirely tailored to the individual patient, and many of them run together in practice. (For me, the first three and the last are common, while the others have been rare.)

A therapist's response to a patient's initial hesitations about, or resistances to, psychotherapy is a major communication about how therapy works and how the therapist works: the seriousness of the task and his therapeutic personality, which are crucial information to an inquiring, possibly edgy patient, are being communicated. Some therapists have a set response to resistance based on their theoretical orientation and temperament. From a countertransference point of view, it is telling to note how a therapist may be inclined to one intervention or another with a particular patient. Also, some responses may also be geared to a diagnostic assessment and, certainly, to the stage of treatment and a perception of the patient's current state of mind. Recently, for example, I find myself being more confrontational with heavily defended or more character-disordered patients, depending on my perception of their ego state. Other patients may demonstrate their problems so rapidly in treatment that they almost beg for confrontation. For example, a patient with a procrastination issue came in very late for his first session and I responded, "You are here to work on your issues around being late and now you are twenty minutes late. What is going on here?" Whatever the intervention, in Jungian therapy, as in others, the therapist is setting up the therapeutic structure, even if the intervention appears to be rather open-ended ("whatever comes to mind").

Whether encouraged gently, actively, or confrontationally, the patient does need to realize that he, too, needs to be an active participant. Jungian therapy, again like all others, is no easy task for a patient. Some patients come to therapy expecting a parent, prescription, an answer, or, because it's Jungian, to do some growth and dream work. These expectations are understandable but usually not realizable, at least not in the anticipated form. What they get instead is a process—the therapeutic process, which is

based on what is expected to be a therapeutic relationship. There is no way around this. Again, the therapist assumes a therapeutic relationship—that this is what the patient has inadvertently or unconsciously elected to get involved in—even though the patient may make no such conscious assumption. That is to say, the therapist is prepared for it, while the patient needs it. As noted earlier, most patients don't really know what they want or what they'll be getting into in psychotherapy; they just want to feel better or changed (though this is subject to resistance, as fundamental change is difficult and is often more than was bargained for or can as yet be handled). So a patient may be surprised and may backpedal from the whole thing, as if to say, "I just wanted a tune-up, not an overhaul." This is the proverbial "flight into health." In Jungian psychology (though Jung applied this specifically to a patient's retreat before the collective unconscious), this is known as a "regressive restoration of the persona" (Jung 1928, p. 163), meaning a denial-based retreat to a superficial state of pretreatment well-being. But the problem with falling back is that it is usually too late, the persona cannot be restored. Even if an earlier, status quo ante mask of well-being could be reconstructed, it would likely be hollow and therefore at considerable cost. The cat is out of the bag and saving face does not really deal with the core problems. In psychotherapy, apparently, you can't go home again, only forward in some way.

THE PATIENT'S HISTORY

One of the initial assessments by a therapist is whether or not he and the patient can engage usefully in a therapeutic relationship. (He also simultaneously needs to gauge if he, the therapist, can or wants to do so with this particular patient.) How does he make this judgment? As alluded to above, the judgment hinges on aspects of empathy, which also involve elements of countertransference and intuition. The judgment in a relationship-based therapy is feeling-based, though this is supplemented by cognitive assessments; in other words, some of the criteria are personal and countertransferential, and some are professional (though in a treatment based on the personal, the two are conflated). A therapist initially is trying to figure out if he likes the patient and what it would be like for them to work together: can I help him? Do I want to work with him?

For the therapist to make judgments about the feasibility of therapy, the patient must do more than simply present his issues. The therapist needs more, and needs to ask for more, than a "presenting problem." In fact, if the presentation is a mere report, it is pointless (though certainly diagnostic). The content of the concerns is critical, of course, but, like all personal communications, it is not what you say but how you say it. A tremendous amount of information is communicated quite quickly by the patient's initial style of presentation, whether it be flat or vivid. The Jungian therapist, like others, is sensitive to language, because how the patient speaks of himself—or struggles to—tells a good deal about the patient's sensibilities, intelligence, emotional range, and psychological-mindedness. Most of the information is in the telling.

Getting a history

To facilitate this telling there is the storytelling: a therapist needs to get the patient's history (his story).[5] Most therapists develop some sort of standard protocol for this, though others choose not to take a formal history at all, preferring to let it come out gradually. However, in psychotherapy, which differs from analysis in terms of available time, it may take too long to let time take care of it. Actively taking a history is good professional practice, and Jungian analysis has traditionally involved an "anamnesis," a preliminary case history. Jung suggests trying to "piece together the historical facts of the case as flawlessly as possible" (1945, p. 85). Somewhere in post-Jungian practice a tradition also emerged, at least for some analysts, of requesting written autobiographies from patients. The idea of an autobiography is sound—therapeutic narrative is all autobiography, or autobiography "as told to" a therapist (i.e. co-authored by the therapist)—but having it written up, then read to or by the therapist seems a bit manufactured, especially if he is expected to read it after hours. So while the exercise in self-exploration is important, this format tends to make it a quasi-literary endeavor, outside of the therapy hour and therefore potentially outside the therapeutic relationship. In therapy, a particular therapeutic story of one's life is being created anew within the interaction.

The degree to which a therapist may wish to take a full-scale, medical-psychiatric history or even a mental status exam sometimes may depend on how medical-psychiatric the patient appears to be. But again, taking a history tells more than the facts of the patient's situation across various dimensions: the patient shows and embodies the story itself. Because patients are communicating all the time, directly and indirectly, a history-taking is a good time to be open to this. Sometimes responses to the act of getting facts are themselves telling. For example, some patients secretly feel taken aback or distanced by a therapist who takes notes; others experience this as careful concern. Some experience a careful questioning as intrusive and anxiety-provoking, rather than an attempt at understanding.

At any rate, from taking a history of some sort the therapist begins to get an idea of what kind of person the patient is and, furthermore, not only what it is like to be with this person but what it is like to *be* him. A therapist needs the history in order to imagine the patient in the present. The story of his prior life is a quite obvious orientation or embarkation point for such fantasizing, indicating not just historical data but possible causes and locations of the patient's wounds. Further specifics will be filled in later by statements and interactions in the therapeutic relationship. During the historical survey, the therapist also tries on his empathy, that is, his ability to identify with this person as he hears his story: is it a story he can understand in some way, is it a story he wants to try to understand, is it too difficult a story, or too close to home in a negative way? This goes into his initial judgment about suitability for therapy. The style of history-taking also tells the patient something about the therapist—how responsive he is, how sensitive or understanding he is, how precise he is, what he is interested in, how trustworthy he is, what sorts of questions (if any) he will respond to from the patient, how professional he seems (in the best sense). All this indicates how he does therapy and what a therapeutic relationship with him might be like. Thus, the history-taking process itself may be diagnostic for both parties.

Taking a history

A fundamental choice at the outset for the therapist vis a vis the patient's history is whether to actively ask questions, which is "taking" a history, or whether to simply let the patient tell his story in his own way without much guidance. One does not preclude the other (and, again, what the patient does with this is suggestive). Given free rein, some patients go nowhere; others into their pain; others into formality. For the therapist, two kinds of information are important. The first category is basic information: presenting problems and their history, family psychiatric history, previous therapy, medical issues and medications, substance abuses (alcohol, drug, eating), physical or sexual abuse, depression/ suicide attempts or ideation, current and past relationships, friendship and support systems, family history and relationships. The second dimension is the patient's version of his life story over time—how he tells his current autobiography—which will indicate a good deal about his style and about the nature and quality of his relationships. These two kinds of data intersect, and positive answers to certain questions require further questioning. For example, if the person has had previous therapy, a therapist will want to get some idea about who, when, why, and how it went. Or if a patient is depressed, this and his symptoms should be explored fully. The therapist needs all the information he can get so he can begin to form a picture. What is being created is version one of the patient (and, for the patient, though perhaps less consciously, version one of the therapist).

There is some potential tension between getting basic information and the patient's spontaneously telling the story of his life. How the therapist structures initial interviews affects the information he receives and how he gets it. An unstructured situation may touch on only some of the above categories, which the therapist then must sort out and organize, if he so wishes. He usually finds gaps, which he can come back and fill, though that can be a bit disruptive. A more active, question-and-answer format fills in the categories as you go, though it also may formalize the situation, externalize it, or establish it as one where the patient waits for the therapist to set up the session's contents and direction. The latter impression can easily be rectified later, however, as previously noted.

Regardless of whether the therapist's approach to history-taking is active or passive, he always wants to be alert for the inner story as well as the outer story. The history-taking is a kind of informal psychological testing, where a considerable amount of assessment is going on. In addition to getting the facts and an impression of the patient's manner of self-expression, the therapist can also get some idea of how upcoming therapy might work by trying out some things. He can float an interpretation, observation, or confrontation toward the patient, or prod a defensive posture, and see what the patient does with it. Is this patient insightful, receptive, passive? Does he ignore it, or feel threatened or confused? Can he disagree with it? A therapist can even at times say something deliberately anxiety-provoking to see what happens. Thus there are indicators about suitability for treatment from the story itself, the way the patient tells his story, and the initial responses to some of the therapist's commentaries on the story.

Early days in therapy are a series of first impressions. After the initial calls, pretherapy fantasies, and waiting room contacts, history-taking makes the first concrete impression

on the patient. The therapist is indicating *that* he wants to know about the patient's life and to some extent *what* he wants to know. The process is outside in and inside out: the therapist wants to know the externals and is clearly checking for probable damages on that level, but then wants to hear, too, the patient's specific subjective take on his life. That narrative is the main story, but by hearing the other data (and indeed, the patient's responses to it), the therapist is getting a wider view and is able to form, perhaps, a different view.

ASSESSMENT

A patient comes to a therapist for this different view, at least theoretically, but may balk. While usually he is sufficiently engaged with his problem—bothered enough by it—to have come in the first place, he naturally also wants to avoid problems and pain. While Freud's view—that resistance accompanies the process every step of the way—seems somewhat cynical, it is worth remembering that change is disruptive, and strains most people. Big changes have a downside and a cost, however obviously fitting they might seem to the outsider. (Consider, for example, the personal, financial, intergenerational, and parenting effects of a divorce.) Even the most engaged and gung-ho client will at times retreat from or defend against consciousness of his troubles. People usually come in to psychotherapy when their coping mechanisms or defenses—their usual ways of managing life or discomfort—have failed, or are about to fail, or else when they have become seriously symptomatic. Simply put, they have been overwhelmed by events, an internal sense of pain, or dysfunctional behavior.

The Jungian approach to psychopathology places less emphasis on formal diagnosis than on what might be called the "informal," but what is actually the real, diagnosis (i.e. the unique psychological situation of the patient). What psychotherapy is about is helping people deal with and resolve their psychological-emotional pain, and the therapist wants to know how much the patient acknowledges his difficulties. Such acknowledgment is to some degree a measure of the patient's defenses, to some degree a measure of the patient's capacity to work constructively with what is bothering him, and to some degree a measure of what the therapist can see and how much he pushes for it. The Jungian perspective is that pathology potentially leads to meaning, and this means the therapy ultimately needs to go to those painful places underneath or behind the more overt symptoms.

Psychological pain

Psychological pain, oddly enough, can be awkward to talk about. "Oddly," because most people like to complain about things. Still, collectively, psychological suffering is either unfashionable ("just get a grip"), or embarrassingly overindulged or manipulated (as in talk-show exhibitionism). Jokes, either sympathetic or bizarre, also are used to deflect pain. But deep down, most people's favorite subject is themselves. Self-concern or narcissism usually carries the day, and if the circumstances are right, most people like or need to talk about what is wrong. This is not a bad thing and why therapists are in

business.

Pain is *the* great and obvious indicator that something is wrong. This applies of course to physical pain, where the concrete sensations verbalized as "I am hurt" or "I feel sick" are straightforward (though the subjective aspects of physical pain, as well as predispositions to pain sensitivity, are notable). Emotional pain is more difficult to localize, as it is not bodily pain in as clear a sense. The fact that humans feel psychological pain at all is intriguing: what is the point of the human capacity to feel such distinctly unpleasurable psychological sensations? In fact, pain without obvious physical sense or purpose appears to be a defining human characteristic, perhaps the price of being human. If psychological suffering has adaptive purpose, its first purpose would be to warn, and its second would be to seek cure or correction of the problem. From a less Darwinian perspective, the fact of human suffering encourages the deepest philosophical and metaphysical questions.

Psychologically speaking, there are two dimensions of pain. Some *subjective* or *felt* manifestations of psychic pain are fear, and its close cousin, anxiety; sadness; loss; lostness (confusion and disorientation); physical discomfort without apparent physical source; numbness or deadness; guilt; frustration and anger; helplessness; nostalgia (sometimes); "falling apart" (fragmentation); etc. Most of these blend together and are characterized by a subjective sense of discomfort. Some are related to specific symptoms and diagnostic categories—fear and phobias, sadness and depression, and so on. The second dimension of pain relates to behavior or avoidance of behaviors, that is, dysfunctional behaviors or behavior disorders. These are more *objective* in a sense, and slightly removed from the subject in terms of pain as such (though they may cause it or be a response to it).

The basically subjective nature of emotional pain, however, means that much psychological pathology—psychopathology—is not readily demonstrable in a medical-diagnostic sense. Accordingly, Jungian psychotherapy is not primarily a symptom-focused treatment. It tends to look, as just noted, to what is behind the problem. Not "why," as Jung remarks, but "wherefore." Psychopathology has its reasons and, in the Jungian view, the more recalcitrant the problem, the more demanding or complex may be its reasons. If a problem is embedded, it is harder to get at its meaning, and therapist and patient may have to look way beyond any symptoms per se. If pain does yield a meaning of some sort—that is, if there is a symbolic rationale behind it—then it is bearable. Pain without meaning, unredeemed suffering, is killing. From a therapist's point of view, if it's pain with reason, you console it; if it's pain without reason, you try to understand it.

Jung's statement on the goal and results of psychotherapy that was mentioned earlier is highly relevant to these considerations: "The principal aim of psychotherapy is not to transport the patient to an impossible state of happiness, but to help him acquire steadfastness and philosophic patience in the face of suffering" (1943, p. 81). This is a fine description of the hopes and limits of psychological work, and of the function of the therapist and the therapeutic situation. The emphasis here is on enduring and managing the difficulties so that some kind of new direction can emerge. Pain cannot be skipped over, but since it is a signal or warning, it must be observed and its redemptive challenge accepted. The religious-spiritual idea of suffering being the path to meaning—as C.S.Lewis would say, "the cross before the crown"—is probably true. (In today's jargon:

"no pain, no gain.") There is no learning, or the learning is limited, unless there is a good reason to learn, and as another saying goes, "The truth shall make ye free…but first it shall make ye miserable."

There is no reason whatsoever for a person to enter psychotherapy unless there is some pain or problem involved. (This applies as well to the future psychotherapist.) For the therapeutic relationship to engage, the patient has to bring in the painful issues and keep them in. Part of a therapist's task is helping a patient keep them in. This means a seriousness of purpose, a keeping to the agenda by the therapist. This aspect of the therapeutic relationship is encompassed by its professional nature. While a therapist's job is to some extent to comfort and understand (or to provide the comfort that comes from understanding), he must also hold a patient's feet to the fire. He reminds his patient, mainly through general attitude and approach but sometimes through direct statement or confrontation (see above), that the patient has come to therapy to wrestle with his issues. That's the sole reason to be there. Patients sometimes try to talk or charm the therapist out of doing therapy, and though it would be easier for the therapist to lighten up, his job is to help the patient return to his or her psychological troubles. This might seem obsessive or hard-nosed, but what it means is that the therapist must be firm at times in asking, "What's bothering you?" or "Where does it hurt?" Therapy is premised on the idea that talking honestly and being carefully listened to—such that one feels well-heard and understood—will bring relief and healing. It is as simple and as difficult as that.

The patient's psychological-mindedness

At the initial stages of therapy, and indeed throughout, part of what the therapist gauges is the patient's capacity to describe and live with his hurt. The therapist estimates and continually monitors what the patient seems to be able to assimilate of his pain. This capacity of the patient's is referred to as his "psychological-mindedness," meaning how psychologically aware and how motivated toward insight he is. A therapist can push a patient according to this appraisal of his integrative and introspective capacities, the speed of which is contingent on various, intertwining factors. In addition to psychological sophistication and intention, the patient's level of intelligence, intellectual or emotional, is important. A patient does not have to be smart or to know much, but it helps (especially if his intelligence is not used in the form of intellectualizing, which is a distancing maneuver). Experience in life also helps, though this begs the question of what kind of experiences and how well they have been digested. If the patient has been through or even simply survived certain developmental tasks, then he likely has better capacities to learn from current ones. Of course, the patient has currently come to psychotherapy because he is stuck, so understandings cannot be fully demanded ahead of time. There would be no need for psychotherapy if the patient could do it alone; psychotherapy happens when someone just can't do it alone anymore.

More specifically, in terms of life experience the level and quality of *relationship* experiences are crucial. The capacity to work psychologically is correlated with prior relationships, both familial and nonfamilial, because it is there that problems were originally formed and somehow addressed. Or not addressed. So in gauging a patient's capacity to deal with his pain constructively and how much he can take at one time, the

therapist looks at how and whether the need to be understood was met earlier. Close relationships cause pain and pathology, but a therapist also wants to know how or if at all the resulting emotional conflicts were managed. The unconscious emotional dialogue between therapist and patient, which is another way to define the therapeutic relationship, is determined not just by the difficult ins and outs of the prior relationships—the transference—but by whether there was any emotional containment and understanding in those relationships. These may be two aspects of the same thing, but it is relevant to differentiate the two components. Sometimes it is less a matter of whether relationships caused pain, which is to some degree inevitable, than whether the pieces got picked up effectively.

Occasionally a therapist will wonder if the patient has received *any* meaningful help before. Previous psychotherapy is relevant here of course, and especially relevant is whether it was helpful (or, worse, whether it was harmful). This will give a positive or negative tone to the patient's willingness to participate in the current therapy, because patients build on previous therapeutic experiences. This useful indicator can be deceptive, though, as therapists sometimes tend to imagine other therapists are just like them. In fact, each psychotherapy relationship is unique, even if the same emotional material is covered, due to the unique chemistry of the participants. The prior assistance need not have been from therapists, either. Were there any previous counselors, ministers, or mentors to whom the patient could turn and with whom he could work? Any friends or family who were helpful confidantes? Sometimes a person has had limited resources: there are patients whose only or best help was from their pets; for others, books were crucial companions. The therapeutic relationship is more delicate, if not impossible, if the person really could turn nowhere. If so, then the therapeutic relationship becomes the first place where this challenge can be met, though the prognosis is not good. In all this, the therapist tries to get some idea of the patient's capacity to heal, of how hard it will be to get to his inner self-care potential.

DIAGNOSIS

In the course of this assessment, the question of formal psychological or psychiatric diagnosis becomes relevant. The approach of current Jungian psychotherapy to diagnosis and psychopathology can be confusing, perhaps due to Jung's own ambivalent approaches to them. On the one hand Jung was a experienced psychiatrist who seemed to be a very good diagnostician. The field of psychiatry, whatever its current limits in terms of psychology and psychotherapy, has always put a premium on accurate assessment. Jung was even able to back up his psychiatric background and his native intuition with skills gleaned from his close studies of collective symbolism. Thus he seemed to make some accurate assessments simply through his knowledge of certain dream symbols and esoteric imagery.[6] But on the other hand, Jung flatly stated that "diagnosis is a highly irrelevant affair, since, apart from affixing a more or less lucky label to a neurotic condition, nothing is gained by it, least of all as regards prognosis and therapy." He went on to say that the "specific diagnosis seldom means anything real." The real thing is not the "Greco-Latin compounds," as he put it, in keeping with his renunciation of the

medical persona, but the specific psychological aspects of the issues at hand (1945, pp. 86–7).

Indeed Jung's devaluation of diagnosis is similar to his dubiousness about outward, persona-like things in general. For Jung, diagnosis, like persona, does not say quite enough about a person or his struggles. It is a surface consideration. Jung's conceptualizations about diagnosis also mirror, though in the opposite direction, his thoughts on the Self: namely, that the Self is a deeper thing, a "treasure hard to attain" that is *eventually* arrived at and discovered. Reversing the usual sequence of events, Jung (ibid.) states that "true psychological diagnosis becomes apparent only at the end" of treatment. The emphasis here is on the word "psychological," that is, on psychological understanding. And here again, Jungian psychotherapy gives prime consideration to the psychological over the overtly symptomatic. In other words, whatever attention is focused on symptoms or behaviors is primarily thought of in psychological terms—how these concrete matters are secondary manifestations of unconscious experiences or experiencing.

Jungian therapy's concern with the real diagnosis, with what specifically is happening or going wrong with a particular patient, inherently precludes a swift diagnosis, because understanding a complex, and complex-filled, individual takes time. In a sense it will take the whole time of treatment. From the point of view of a more complete understanding, a front-loaded diagnosis is somewhat presumptuous, and even potentially detrimental insofar as it is restrictive. The entire course of psychotherapy is, broadly speaking, an attempt to explicate things, which is one way of defining diagnosis.

The benefits of diagnosis

Despite Jung's humanistic objections, however, diagnosis can fruitfully be left at its original place at the beginning of treatment, rather than eliminated altogether as irrelevant. It serves the oft-cited purpose of allowing communication, if required, between professional parties, and it can and does suggest something of the patient's experience of his own life, not just his symptoms. Furthermore, diagnostic statements, unfortunately, are required for insurance purposes and by professional standards of practice, and are thus unavoidable. In terms of a Jungian perspective on therapy, however, diagnosis is relativized. It might best be seen as a preliminary conceptualization, inevitably based on limited data and understandings. The idea of a "provisional diagnosis" fits here; the Jungian attitude might be that all diagnosis is provisional. This is consistent with psychology and its field of study, because most of what psychology deals with is somewhat improvisational. As noted earlier, psychology, at least those aspects of it that are concerned with healing and psychotherapy, is the study of the subjective (better put, the study of a person's subjectivity). Attempts to quantify or categorize this will be limited, not exactly doomed to failure but doomed to frustration if one is not at ease with ambiguity. Subjectivity is not only *not* objec-tivity, so-called, but it is fluid and evanescent by nature. It is changing—it might even be defined as "change"—and very difficult to capture. Complete psychological understanding ultimately is like trying to catch and hold water in one's hands.

This does not mean that diagnostic efforts should not be made, but that there should be

a mature realization of their limits. A diagnosis is a type of theory, a theory of a person. More often nowadays it is, or tries to be, more descriptive than theoretical. This is appropriate but, as above, suggests its limitations as a psychological rather than behavioral understanding. Scientific or diagnostic preferences for concrete behaviors and symptoms are a kind of default position resulting from the difficulties of measuring the subjective. Psychology and behavior interact, of course: behavior is often, if not necessarily, considered to be a reflection of psychology, and psychopathology is a reflection of psychology gone wrong in some way. But a primary focus on the behavioral, or outer, manifestation, without the inner, or psychological, does not fit with a Jungian approach. Aside from gutting the psychotherapeutic utility of diagnosis, efforts to make diagnosis atheoretical or neutral about the inner life of the patient are difficult to achieve. Diagnosis always implies some sort of theoretical underpinning, and an evaluation of subjective matters.

In spite of Jung's use of diagnosis and his position that the ability to differentiate organic from psychological conditions (a difficult task) is important, his contradictory conclusion that diagnosis is "well-nigh meaningless" seems extreme for a post-Jungian psychotherapy. Healthy for its day, Jung's critique was directed at medicine's emphasis on diagnosis at the expense of the truly psychological. Accordingly, one can accept his critique of what might be termed "the dangers of diagnosis," while emphasizing the more accurate, psychological understandings that can only emerge over time. The result is a two-tiered diagnosis, one of the more traditional, psychiatric type, and one of the more deeply psychological type.

The final psychological reading may only emerge, as Jung suggested, at the end of treatment, if at all, but diagnosis serves no particular purpose at that point. However, psychological *hypotheses* emerge from the beginning and are continually being generated and modified. If a therapist can look at a diagnosis as a general hypothesis about a person, then diagnosis holds its proper place and weight and becomes more useful. It provides a general outline that will eventually be filled out or adjusted by the particulars of psychotherapy (one could say, overgeneralizing, that a patient is at first a diagnosis, then a person). Thus understood, standard diagnoses also serve as transitional understandings—initial thoughts about a patient that will gradually fade as more comprehensive understandings replace them. Also, because a therapist cannot fully position himself empathically with a patient at the beginning of their sessions, diagnostic impressions at least provide some idea as to what might be coming later. If held lightly, these impressions do not interfere, and may help. For all one's Jungian hopefulness, the psyche really can be twisted, really can be pathological. A therapist does well to be suspicious of pathology, to be on the lookout for it, and to expect it to arrive eventually, even if things are going swimmingly. Forewarned is forearmed. While the Jungian attitude looks on the bright side, with realistic hope for the psyche's self-transformative abilities within a therapeutic relationship, it does not deny the difficulties or, sometimes, the impossibility of transformation. Things do not always work out.

Diagnoses that address pathology alert the clinician to the psyche's probable condition and possible direction, sometimes negative, and also help brace the therapist for the impact of the patient's condition upon him. If the therapist "literally 'takes over' the sufferings of the patient and shares them with him," it is wise to have an idea of what one

is getting into—not just for the therapy's sake but for the therapist's sake. Part of the initial assessment of the patient's appropriateness for therapy is the appropriateness of therapy with the particular therapist involved, and diagnosis provides clues to this. For example, I once took on an extremely likeable and eager patient who had, nevertheless, a manic-depressive diagnosis with a significant history of past hospitalization and delusional, erotomanic transferences. Intensive psychotherapy, at least intensive psychotherapy with me, turned out to be too tall a task. Subsequently, I decided not to take on a very likeable and intelligent bipolar patient due, in part, to her diagnosis, which, combined with other important current features and history, gave me pause. Clearly, I remembered the previous patient in my reflections. While this was perhaps overly cautious or a disservice to the latter patient, it did not feel like a disservice to me. Being thus, it was not ultimately a disservice to the patient. The interaction between diagnosis, hard-won professional experience, therapeutic ambitiousness, positive personal reactions, rescue fantasies, and therapeutic naivete and realism is a complicated one. There is also the matter of therapeutic energy, that is, the therapist's therapeutic energy and how much "wounded healing" he wants to be involved in. Working with certain patients is going to be, quite simply, a great deal of emotional work, and a therapist needs to realize how hard he is willing to work and what sorts of patients he can take, and take on.

THE THERAPEUTIC FRAME

All the above falls under "beginning the treatment."[7] A massive amount of interchange is clearly going on immediately. The initial stages of therapy usually turn out to be good predictors of future success, and if the players get through them with a positive feeling, then the rest will likely work. The initial assessment, on both sides, lays the crucial groundwork, and sets the spirit of the situation. This is subject to change, of course, and indeed is likely to change in important ways, but the basic structures of the psychotherapy and the basic take on the other person are established. More so, the basic *conditions* for psychotherapy become established, such that the process can take over, or is trusted to be able to take over. Psychotherapy involves a setting up and then a letting go.

In initial sessions, on the exterior or outside level, ground rules begin to be established. The therapist, it should be noted, sets up the basic procedures, as if to say, "This is the plan." Part of his mission throughout treatment is to protect the therapy. The patient is then is expected to work within the given guidelines. The developing therapeutic relationship in part depends on these explicit procedures and externals, which are generally known as the therapeutic frame.[8] This reliance on the externals of psychotherapy has sometimes been underestimated by therapists of a nonpsychoanalytic persuasion, including Jungians. Perhaps Jung himself, with his anti-technique technique, introspective emphases, and intuitive style, inadvertently encouraged an undervaluing of the basic structural set-up. He also objected to the rigidity he perceived in Freudian technique.[9]

But Jung did not lose sight of the importance of the therapeutic environment; he merely emphasized its inner dimensions. Focusing on the inner world over the outer,

Jung came up with an important metaphor for the psychological space in which the therapeutic relationship takes place: he referred to it as a *temenos*. In ancient Greece, a temenos was a religious sanctuary, a sacred place dedicated to the gods. Today we know of a sanctuary as a central part of a church, but also as a place of refuge (as in "seeking sanctuary") or a protected place (e.g. a bird or wildlife sanctuary). The use of this sort of image is typically Jungian; it expresses therapeutic principles of Jungian thought both lyrically and in ancient, historical terms. The metaphor and its suggestions point precisely in the direction Jung wanted: psychotherapy as a sanctuary for the psyche, a special place where psychological developments can happen.

What has been added to Jung's symbolic thought in recent decades is an appreciation for the importance of the outer dimension of therapy that facilitates the achievement of the inner sanctuary. As a result of the influence of traditional psychoanalytic technique, where a firm, consistent, relatively neutral manner of conducting therapy is taught, and specifically from the work of Robert Langs (1976, 1978), present-day Jungian therapy generally pays closer attention to ground rules and to how the therapeutic frame is created and managed.[10] While psychotherapy should be basically patient-centered, the therapy framework is basically therapist-centered (or, at least, therapist-directed). This is not for the therapist's sake precisely, though he too benefits from a consistent set-up, but for the emotional sake of the patient. The idea, in terms of the therapeutic relationship, is that something like a fort is created, a safe and free space in which anything may be said, thought, and experienced; the existence of this containing matrix permits the free evolution of the unconscious and conscious therapeutic elements within it.

Alchemical symbolism is here quite a propos. Jung refers to the *vas Hermeticum*, which is the alchemical basin or vessel within which the "transformation takes place" (1946, p. 203). This bowl contains the "divine water" and is also known in some alchemical texts as the "uterus." These are apt metaphorical images for something that contains within itself the fusion, growth, and sometimes the volatility of the therapeutic relationship and situation. The frame is quasi-maternal but also quasipaternal. For if paternity—to continue with gender stereotypes—has something to do with setting rules in a so-called masculine way, then the limiting aspects of the therapeutic framework are important. Boundaries are set; there is an inside and an outside. Jung, although not referring precisely to external aspects of therapy, nevertheless draws attention to them by referring not just to the holding vessel but to the *vas bene clausum* (the *well-closed* vessel) of alchemy. He quotes alchemical scripture that states: "And take care that thy door be well and firmly closed, so that he who is within cannot escape, and—God willing—thou wilt reach the goal" (1944, p. 167). There has to be not only a "magic circle" or container in therapy, but the enclosure has to be tightly shut (the fortress maintained, the circle unbroken). Just as a baby cannot grow well outside the uterus, a vulnerable patient or a delicate therapeutic relationship cannot evolve safely or well if overexposed to the outside world. This idea is connected to what is sometimes referred to as "leakage" in therapy: where the therapeutic relationship, or transference, gets spread out or "diluted" by too much nontherapy, outer-world contact by the patient (e.g. discussion of one's therapy with other parties; hopping around to other therapists or quasi-therapeutic situations; even, in some instances, getting emotionally involved with other individuals as substitutes for, or unconscious enactments of, deeper engagement

with the therapist). Leakage and contamination are inevitable, of course, and a pure therapeutic culture is an ideal, not a reality. In fact, it is a slightly obsessive-compulsive ideal, for psychotherapy thrives on the imperfections of reality. Working them out is what is healing, and a therapeutic ideal might be to strive to do this, rather than being rigidly bound to the ideal per se.

Protecting the therapy

Therapeutic care also needs to be given not just to barring the door of psychotherapy against intrusion but to the day-to-day structures of psychotherapy.[11] Therapists do not only set up rules of thumb for how the therapy is conducted; they also protect it from interference from within. This would include areas typically thought of as patient resistance—lateness, missed appointments, failure to pay for therapy—which are dealt with by setting up the initial guidelines and then discussing the aberrations when they occur. Therapists sometimes collude with these issues by not confronting them or, for example, by going over time or starting late themselves. When the therapist is part of the problem, an opportunity arises for personal exploration of why this might be happening. Why, for instance, do I give this patient more time? Why is it hard to say no to him? Why do I feel like cutting this patient some slack, but not this one? Why am I glad when this person does not show up? Why am I afraid to confront this patient about something? Countertransference attention is thus part of protecting the therapy, and each of these Countertransference situations has some psychological meaning vis a vis the therapeutic relationship. Interference with the therapeutic process can also include more subtle resistances from within the therapeutic relationship and from the outside: patient requests for convenient time changes or special treatment; therapist contacts with the patient outside of therapy or discussions with his family members; insurance company intrusions (perhaps the greatest of all complications in a private practice context). None of these is necessarily a problem, but each of them can be, depending on the individual context.

Health insurance

Dealing with insurance companies is a problem, one that is central to psychotherapy today. Nothing is more bedeviling to a therapist, particularly one trying to work within a therapeutic *relationship*. Insurance companies are probably not inherently evil, they are simply profit- and business-oriented. In America at least, the spirit of psychotherapy is threatened by a corporate, technological, indeed managerial ("managed care," for example) climate arising from its interface with the insurance business. This appears to be true elsewhere. The soul of psychotherapy ("soul-healing") does not jibe well with that of business and the vision of psychotherapy propounded in this book does not fit well with it either.

Yet private psychotherapy is itself a business service and exchange, among other things, so one tries to think of a positive aspect to the limitations insurance companies generally place on it. The emphasis on getting the patient up and out, "better," is fair enough, and perhaps can be some sort of inspiration to therapists and patients to keep on task. Insurance companies also pay therapists and sign them up to work with them as

"providers" in what is characterized as a team effort. These are good things, on paper at least. Unfortunately, therapists' relationships with most insurance companies and their managed-care affiliates are usually adversarial, and the team aspect turns out to be an illusion. In a pinch, companies typically show marginal support for, and sometimes a glaring insensitivity to, the subtleties of psychotherapy.

Therapists at the outset need to make a fundamental decision about whether or not to accept health insurance at all. While it would be preferable to avoid insurance altogether, this choice is rarely possible in any private practice situation or even in nonprofit ones, so most therapists have to come to grips with the issue. Although, or because, the health insurance industry has become demonized to some extent by psychotherapists, which is understandable, it is necessary for a therapist to try to see what it represents to him. That is to say, a therapist should explore his countertransference to health insurance. As a therapist comes to see what that relationship feels like to him, he can then make a better decision as to how to deal with it.

The objection to insurance most often raised by therapists is about confidentiality violations. When a therapist reports not just a diagnosis but some particulars of a patient's life to an insurance company, the patient's privacy is invaded or lost, and hence the core trust upon which psychotherapy lies is co-opted. This is a serious matter, and puts pressure on the basic integrity of therapy. Many patients and therapists operate in a kind of strategic denial of this, as the therapist does the billing and report-writing and tries to minimize his communication or not to think about it, while the patient does not know or does not think about it.

The question is: how subtle, and how fragile, is the spirit of psychotherapy? Compare, for instance, discussing a patient's case with a colleague or a supervisor, which is in a purist sense a violation of confidentiality, with discussing a case with an insurance company. The one feels benign, while the other feels detrimental; the first is designed to help a patient, the second helps only in the sense of potentially procuring further treatment for him. Do these kinds of communications damage the therapeutic relationship in some ways, or is it more resilient? If there is no other alternative to insurance use, is it more ethical, or less, to participate in the process? Does a therapist not participate at all, or does he go to war with a managed-care operative? What effect does it have on the therapeutic relationship if a therapist feels either underpaid or locked in to an aggressive or advocacy relationship with a patient's company? The answer to the last question, of course, is "detrimental." The answers to the previous questions are debatable. I, personally, feel less concerned about insurance usage per se than about writing reports and, especially talking about a patient with case-managers. It is not illegal or even (formally) unethical to do so, yet it feels like a betrayal of a patient's trust. By virtue of their corporate responsibilities and their usual lack of therapy skills, case-managers typically have marginal understanding or appreciation of a therapy situation and its subtleties. Judging by their decision-making processes, they often appear to pay only superficial attention to information on a patient, anyway. The arbitrariness and unpredictability of their decisions prevent a therapist and patient from knowing where the treatment stands, as it can be summarily terminated. This destabilizes and distracts the therapeutic relationship.

However one answers the hard question about the fundamental flaw—the basic fault—

in using insurance at all, it may be that therapists are as concerned about their own confidentiality as that of their patients. A pernicious source of therapist anxiety is the invasion of the private space of therapy, a penetration that is unsympathetic and unknowing, yet powerful. Not only a patient's personal secrets but a therapist's privacy and private work come under scrutiny by an unfriendly force. This potentially paranoid situation is a so-called indirect countertransference (Racker, 1968). An insurance company can seem to stand over a therapist like a guilt-inducing parent; a critical, perfectionistic superego; an omnipotent, immovable Big Brother. A therapist may feel rushed, or as though the sword of Damocles hangs over his head, or abandoned when a patient is in crisis. I have found on several occasions, after prolonged exposure to managed-care attitudes, that it is increasingly difficult to hold them at bay *psychologically*—they start to perch on my shoulder and I begin to think like them. The infection is insidious, and a disincentive to the work.

Most of the time, however, the annoying thing is having someone from the junior varsity or left field suggesting how a therapist should work. Either way, insurance companies and issues can be disturbingly present in a therapist's psyche and hence in the therapeutic relationship. Because of this quasi-borderline dynamic—borderline in the diagnostic sense—a therapist, again, needs to work through his unconscious relationship with the insurance issue in a fairly differentiated way. The contact can cause either frustrated rage or helpless despair if one tries to work within its bounds. Some therapists sardonically joke that managed care is really managed cost. This is true, but the fact is the care is totally managed, that is, limited—doled out in small increments, not really caring or careful with patients or therapists, nonsupportive in nature, nontherapeutic. It's like a bad but powerful mother (or a rigid, withholding father), and this spirit and its difficult realities account for therapists' anger at it.

Trying to manage managed care has driven some individual therapists out of private therapy altogether, or into group practices, and it usually leaves a bitter taste in the mouths of therapists who remain. It takes much of the fun out of doing therapy, which is already a stressful business. This insidious effect on the heart and soul of a therapist is not good for a therapeutic relationship, nor for a patient, who, like a sensitive child, will feel the effects less directly but fully. A therapist's degree of insecurity or rage about things in his life is, naturally, an important part of his personality, and in Jungian psychotherapy, as we know, "In the final reckoning it is not knowledge, not technical skill, that has a curative effect, but the personality of the doctor" (Jung 1942, p. 140). Almost always when psychotherapy goes over the line and intersects with the collective matters outside its own arena, it becomes a fish out of water (e.g. insurance, the court system). It loses its spirit and gets lost; it loses its frame in fact. All the gyroscopes go wrong and the mood turns sour.

A therapist's key job, when insurance derails it, is to get the therapy back on track, which sometimes involves hard personal and professional decisions, also some straight talk with patients. This is best done by being clear about one's position ahead of time and informing the patient of the potential problems with insurance use, so that, together, a realistic decision can be made early and surprises limited. Some have opted to forgo insurance altogether, which can be a difficult but necessary sacrifice. A therapist needs to be careful with massive fee reductions, however, as they may help a patient start or

stay in therapy but can breed resentment in a therapist down the road.

Unconscious commentaries on the frame and the treatment

As the insurance question reminds us, while the patient is more or less in charge of what will be discussed, the therapist is the main protector of the therapy framework. One influential Jungian analyst, William Goodheart, has even suggested that Jung was "quite clear that safeguarding the vessel is the major task" of the therapist (1980, p. 13). Accordingly, Goodheart understands many communications from the patient as indirect, symbolic commentaries on just these failures to properly reinforce the therapy situation. While it is debatable whether Jung himself saw this as the therapist's primary task, it is undoubtedly an important task, and Goodheart describes one very important way of "hearing" a patient's statements.

For example, if a therapist agrees to an unnecessary time change and then the patient talks about how inept his wife is at getting the children up and ready for school, the therapist might hear this as a critical reference to agreeing to the time change. He might understand this as a displaced reference to how the frame is being managed (or mismanaged). Another example, from my work, refers perhaps to the therapeutic relationship and treatment as a whole. Following an intervention by me, a patient brings up the idea of an apparently shaman-like European doctor, ("more mature" than her just-mentioned boyfriend), with whom she hopes to take a healing psychotropic drug, a bold act for her to consider. I ponder this two ways: (1) as a reference to her need or desire for a healing relationship with me and (2) as a reflection of a need to go deeper in therapy into the quasi-hallucinatory realms of her past, which included incest, and of her complex relationship with her current partner. I settle on and say something about her desire to penetrate more deeply into the unconscious with a doctor, namely, with me.

This method of listening is sequential, retrospective, and interpretative: the patient says one thing, but it is translated as unconsciously referring to another issue—the frame failure or some other therapist comment or intervention. Its usefulness is based on the idea of a superior unconscious that comments on the treatment, which is one way it fits with Jungian assumptions. It is also a possible countertransference indicator, a red flag. This technique is quite valuable, but because it reinterprets a patient's statements along sometimes preconceived narrative lines, it requires care. It is one important option among several, and is perhaps particularly appropriate when the therapeutic frame has come under some sort of pressure. It can indicate positive responses from the patient's unconscious as well, such as when a patient responds to a therapist's refusal to alter the frame with a favorable image of containment or security.

This type of sequential listening also raises a general question about empathy and interpretation: if a therapist hears a patient's statements as pointing to something else, is the therapist missing the point? Or, on the other hand, is he being ultra-empathic by ferreting out the patient's unconscious, obliquely expressed feelings? This dilemma is part of all interpretive activity, because a therapist who in effect says to a patient, "You are not talking about what you think you are talking about" or "You don't mean this, you mean that" is out of the patient's point of view and into his own (even if it is his best guess about the patient's). Most interpretive activity is less extreme than this, more a

collaboration than a revelation from the therapist, but any therapist explanation runs this risk if the patient is not ready for it.

The only way for a therapist to know if he is on track is to ask, or to listen to subsequent, subtle responses from a patient. So it is in just these cases that the therapist floats interpretations or, perhaps more appropriately, tentative observations. In the final analysis, all therapist statements about a patient must be tentative, for only the patient can truly know or confirm what he is feeling. This is especially so when the patient is not referencing the same material that the therapist is (e.g. when he is telling a story about a dog who was carelessly left out to roam in the streets and the therapist thinks this refers to the therapist's going on vacation). A therapist can only make suggestions, realizing his understandings are based on theoretical assumptions that may not be shared by the patient. A good deal of psychotherapy consists of the patient's coming around to the therapist's theoretical perspective, which after all is most of what the therapist has to offer, at least interpretively.

Therapeutic structures and reliability

The frame of psychotherapy is like a boat, and the therapist wants to keep it in good repair so that in stormy weather he can rely on it without thinking about it too much. The patient wants to feel this too. The frame both carries the therapeutic relationship and, to switch metaphors, dictates the very forms of psychotherapy. The externals of psychotherapy shape its internal aspects, undoubtedly. But the therapeutic superstructure is not purely formal, nor is at an arbitrary or persona-oriented consideration. It is, rather, a rock foundation, and over time its reliability is itself a healing factor. When it is said that therapists, like parents, should be consistent, a crucial aspect and source of this is the established, ongoing internal and external frame of the therapy. Patients get used to it; it is like a familiar old house. They introject it, and when it is also suggested that a therapist gets introjected, this means not just his personal qualities—empathy, insight, his mind, wounded healing—but the structure of therapy. In other words, the patients absorbs the whole psychotherapeutic situation.

Patients (and even therapists) respond differently at different times to these structures. Frame-setting or -following is a lot of work, and therapy demands a special discipline for both participants. Rebellion occurs, or boredom, and sometimes people want or need to grow differently. Some patients, like adolescents, do not want to fit into the frame right away or get with the therapeutic program right away. On those occasions when therapy structures are immediately challenged, the therapist needs to explore this with the patient, and it almost always seems important for the therapist to hold the line. Instead of negotiating and modifying the frame, the therapist can both solidify and demonstrate its worth by asking the patient to examine the sources of his intended or inadvertent challenge to it. Here the therapeutic frame becomes not just a container but a baseline or standard—a foil against which issues may be compared. Sure stances about it set the tone for psychotherapy, though they can seem empathically jarring for the patient. They establish a tone of rather constant and serious exploration within a steadfast procedure, which is ultimately reassuring. While it may seem humorless or uptight, this is simply the therapist doing his job. For example, a therapy-wise patient who had rage at men and the

"patriarchy" referred to me by my first name at our first meeting, then paused and asked how I liked to be addressed. I said, "As Dr Sedgwick." She looked askance at this and countered, "What will you call me?" I said, "Ms___." She said something more about my need for this and let it go, but my apparent formality was useful later when I could ask her, as she condemned patriarchal attitudes, if she had any responses to my earlier use of "Dr."

As repeatedly mentioned, the fundamental structures and strictures of psychotherapy house the therapist too, not just the patient or the relationship between the two of them. The emotional intensity of the therapeutic relationship extends to the therapist, and the externals and traditions of therapy support him there. The limits alone are vital, for without them a therapist could not sustain his emotional engagement with patient after patient. As noted earlier, therapy is not parenting, and the emotional engagement is not always pleasant. Jung reminds us, "Man is not fundamentally good, almost half of him is a devil" (1973a, p. 84). This holds especially true for patients, who, as they bring their lifelong suffering and pathologies into the therapeutic relationship, sometimes get into a lot of complex interpersonal nonsense. A clear and consistent set-up helps the therapist bear up under this. Within the therapy hour, where things may be confusing, the therapist relies on the steadying influence of the therapeutic frame to organize himself as well as the patient. A therapist must let go of himself to some extent to be empathic and occasionally may come under attack by a patient or fall apart inside during the hour. The vessel allows him to work on his anxiety and countertransferences within it. Therefore a stable container is for the therapist just as much as the patient, and given the nature of the therapeutic relationship, this stands to reason.

Responding to the pendulum swing towards formality rather than looseness that "frame analysis" or frame emphasis embodies, some Jungian therapists point out that it is the picture, not the frame, that is important. This is true; however, psychotherapy is not art (even if it is fitting to speak of the art, rather than the science, of psychotherapy).[12] Art without a frame or boundaries can be liberating, or perhaps anarchic in an interesting way; but that's art, not psychotherapy. Therapy has different, nonartistic intentions that need and are enabled by free expression within a solid frame. Though creative, therapists are not artists, just as they are not quasi-parents.

Frame considerations, or pressures on the frame, continue throughout therapy. While there may be temptations to change it, it is more the case that the participants change within it. The therapeutic picture, the therapeutic relationship, may (will, one hopes) evolve over the course of therapy. But it seems wise in general to maintain the basic frame for the duration of therapy, however conservative this stance may seem. Although a therapist may be tempted to go and sit in the park with a patient or chat a bit about his personal life, the therapeutic relationship continues to be a particular kind of highly personal engagement within, and dependent in a crucial way on, a professionally managed therapeutic framework. So the therapist sails the same old boat right into port, because it is the one that got them there.

"PATIENT" AND "THERAPIST"

Issues of readiness, assessment, diagnosis, and frame hold sway during the early phases of psychotherapy—all are in service of the developing therapeutic relationship. After initial meetings where the externals have been presented and perhaps some initial frame-maintenance is required, the "real" therapy begins. Again, the therapeutic relationship has begun even before the first meeting, and has now collided with reality. Initial fantasies and first impressions coalesce to some degree; the real therapeutic relationship, an amalgam of fantasy and reality, takes firmer shape. The therapist and patient now start to truly see how they work together; each begins to see and learn what the other is like. These impressions of the other are ongoing, and the therapeutic relationship will gradually deepen as they get to know each other as "patient" and "therapist".

Boundaries

It is important to remember that psychotherapy consists of two people becoming known in a particular therapeutic context.[13] The therapist gets to know the patient specifically as a person *in therapy*. Similarly, the patient sees a person in the context of therapy—"my therapist." This is a very specialized environment, and individuals are quite different in different environments, which is why it is sometimes disturbing for therapist and patient to meet outside the psychotherapy situation. Their relationship and their visions of each other are highly dependent on that situation. It is not exactly that outside contact fouls up the transference; it is that there is, suddenly, no transference (though fantasies may go on) or an entirely different transference context. What was a therapist in the therapeutic frame is now a person at, let's say, a cocktail party. This cocktail-party therapist on some level is no longer the same therapist the patient knew in therapy; it may seem positively weird to the patient to see him in this civilian context.

To repeat the obvious perhaps: the transference and the therapeutic relationship are an artifact of the psychotherapy situation. Projections and fantasies always exist between people, but they are in no way as condensed, crystalized, and contained as in the therapeutic relationship. Also, the level and type of discussions that ensue there take place almost nowhere else. Outside therapy, the therapist becomes a real person to the patient, not a therapist. Not that a therapist is not real in psychotherapy, but he is, again, a different person in that special, healing situation, different to himself and different to the patient who experiences him. The patient, in the psychotherapy relationship, needs to have a "therapist," and the therapist a "patient."

This, incidentally, is why talk- and radio-show therapy do not work. The advice is nice, but it is not therapy, as there is no psychotherapy relationship or situation (to put it mildly). Similarly, when therapist and patient meet outside the ring, so to speak, it is awkward. It may be intriguing to the patient, who in his curiosity gets to see the real therapist, but it is usually not so beneficial to him. These contacts can be worked through—grist for the proverbial mill—but they require considerable grinding to be positive. They are better avoided, because the patient does not require the real person in the usual sense but rather the amalgam of a real person and his therapeutic identity that is a therapist.

Applying these considerations to a larger, less redeemable situation, we can see why boundary violations by therapists ruin psychotherapy: they dissolve the therapeutic

situation and the therapeutic relationship. (This is alongside the other disturbances—psychological incest, boundary confusion, betrayals of trust, potential retraumatization—that occur in that situation.) The therapist is no longer a "therapist," and a real relationship destroys the therapeutic one. A therapist needs to have needs, which is human, and to bring his real self into the treatment situation, but when he crosses a boundary-line into a nontherapy personal relationship with a patient, the gears have slipped. The therapist here has failed to manage therapy's difficult paradox of intimacy with limits.

In a similar way, the psychological reasoning behind ethical prohibitions against seeing one's own family or friends as patients makes sense. I personally find it confusing, or at least complicated, to see even acquaintances of friends, even if I don't know them at all. I'm too aware in the counter-transference of the friend's psychological presence. For example, a friend and colleague referred his ex-girlfriend to me—not ostensibly to deal with their ex-relationship—but I felt somehow it would not work (especially when this woman showed up wearing an outfit exactly like one of my wife's): I knew him, I'd find out more about him (and them), I didn't know her but she looked like my wife, etc. Rather than tackle all the rich countertransference possibilities of this threesome or foursome, my feeling was, "Why not let this patient start therapy with an unknown, maybe clearer therapist with a cleaner slate?" In instances like this, other psychological parties crowd into the room.

Do therapists need to hide out? Of course not, but their profession does complicate their social lives, and they need to be aware of the subtleties. If therapists sometimes seem to band together socially (Malcolm 1982), it is not simply because they have unique knowledge or background or because civilians are afraid therapists will pick their brains and reveal their secrets; it may be because therapeutic circumstances and a need for anonymity tend to isolate psychotherapists a bit.

While therapists may always have to be "therapists," patients do not always have to maintain situation-specific identities. However, in therapy, as both participants settle into the post-preliminary phases, the ball is in the patient's court: he becomes a "patient", and the therapist slides into his more receptive, reserved, empathic role. Presenting oneself as a patient sounds at first like a fraudulent way to present one's personality. What is not meant, however, is a compliant, deceptive, or otherwise inauthentic self-presentation. Therapy is not about acting, hustling the therapist, or creating a false self or persona. A patient's self-description and evolving self-definition in therapy take place at a deeper level, where the *interactive* nature of self and other is acknowledged. That is, while the personality, depending on its nature and sometimes its pathology, is relatively consistent in the sense that one has (or exhibits) a basic character, the experience and the portrayal of this character is affected by both the person interacted with and by the situation obtaining. This adjustment to the other person and context is a factor in all relationships. In this case, the patient interacts with a *therapist*. And it is a *therapeutic* relationship, which typically has the requirements mentioned earlier of attempted honesty, introspection, noncensorship, focus on painful issues, goal of healing, relative one-sidedness, etc. It is therapy, and these are things that make it work.

But there is more to being in therapy than the semiconscious shifts in communication style that occur by virtue of two people rubbing off each other. The new, self-in-therapy

of each participant is, in fact, not a conscious invention, just a situationally affected one. There are also the unconscious versions of each other that the therapist and the patient have.

ANONYMITY, RESERVE, NEUTRALITY

The separate images of therapist and patient by therapist and patient—which are really internal, psychological and feeling images of the other rather than literal, visual images—have a fascinating history. As noted before, they have a prehistory, which is the anticipated idea and feeling of the therapist before therapy has begun. This imagining is composed of the transference factors and needs cited earlier in this chapter. These fantasies or expectations come into contact with the realities of the therapist and therapy itself. Thus, for example, the fantasy or need for a friendly, openly accepting therapist may clash with the therapeutic reality of a therapist who does not speak much or is not "supportive" in the needed way. Or, let's say, a patient may find out or think that his therapist is homosexual, or divorced, or whatever, and these realities may not fit with the patient's hungry unconscious. Alternatively, a therapist may be a dream come true. The patient's unconscious wants to create what it will, or what it needs.

Part of the value of a therapist's being relatively anonymous is not just to protect himself or to provide a blank screen for projection, but to allow a patient to create what he needs. In transference the patient creates what *was*, which is usually a negative transference of prior relationships that were unfulfilling or conflicted in some way. The patient also creates what he would like to have, which may partake of positive elements of earlier relationships and of the not-yet but potential self. (All this of past and future takes place in the present, in the therapeutic relationship, it should be noted again.) What a patient would like to have might seem regressive in one way, let's say a mother who would take care of everything, but might also be an idealized version of something necessary developmentally. This is what Jung meant about the childish having both infantile and embryonic aspects.

Anonymity and answering patients' questions

So in order for a patient to be able to create what he must, a position of anonymity or reserve is called for in the therapist. Anonymity here does not mean being nameless but, rather, not filling out too much of the patient's fantasy with the therapist's extratherapy reality. Patients often put pressure on therapists to reveal more about their lives, a push that can have several motivations. In initial therapy phases, some of this is simply a conversational habit at the beginning or end of sessions. I find it a little unnatural and potentially detrimental to stonewall a patient, so I finesse this through a minimalist response or, if necessary, by gently noting that therapy tends to work best under conditions where the therapist does not share too much of his personal story.

On later occasions, some inquiry can be made as to the patient's fantasies about the therapist's life or thinking, or what might be moving him to ask questions just now about the therapist. (The therapist, meanwhile, may be entertaining fantasies himself about what

the patient is fantasizing about and why he is asking, which may in turn lead to some hypotheses about what the patient is feeling.) Patients' questions usually are efforts to bind anxiety or, more specifically, to connect or orient themselves to the person of the therapist. Later in therapy, especially if it comes up in the middle of a session, a silent response (silence is a response, though here not a scornful one) may be appropriate, because the patient now knows the ropes: he introspects and explores his fantasies about the therapist's life rather than expecting the therapist to reveal his private life. By not directly answering personal questions, the therapist sets a tone for the therapy, and certainly sets a guideline. The onesidedness of psychotherapy is implicitly emphasized at such times; the patient is reminded that it is not mutual in the usual way and that the casual exchange of personal information does not take place. A therapist needs to have an ear out for the patient's reaction to this refusal to communicate in friendly social forms. Psychotherapy, as stated earlier here, is a paradoxical proposition involving mutual involvement but within certain limits. Patients' reactions to this unbalanced set-up are important. A therapist's recognition of this shows he is tuned in to the patient.

Aside from being a social habit, curiosity about a therapist may be a threshold phenomenon at the beginning or ending of sessions (which are sometimes difficult times for patients), a kind of entrance or exit strategy designed to ease the transition and anxieties of coming in or going out the door. Some patients want to get to know the therapist's outside life out of a genuine or transference-based curiosity, others to take a rest from their own work or from the glare of the therapist's attention, still others wish the therapist to reveal more so they themselves can (in a kind of quid pro quo). However informal, chat is still an effort to link with a therapist in some way. For example, when a patient politely asks, "So where are you going on your [just announced] vacation?" (the vacation itself being an event that probably has import for the patient), something is happening in the therapeutic relationship, or trying to happen. A simple factual question can carry emotional weight. It is an attempt by the patient at a deepened personal connection—or an attempt to comment on the connection—and also marks a change of stance, role, and tune because the implicit rule in psychotherapy is not just modified free association but that the patient talks about himself while the therapist does not. Pressures in the direction of therapist disclosure may come when the patient is feeling vulnerable or alone and wants some sort of reminder that the therapist cares for him, which would be embodied in the therapist's willingness to reveal more about himself. While the patient may be resisting his own anxious tasks, he is more likely to be seeking reassurance that the therapist is with him or can get with him on the particular issue he is exploring.

This question "Do you have kids?", for instance, may be a plea for the therapist to really be able to understand the patient's problem with his or her children (or, a bit more symbolically, with the patient's childhood or the childish in him). The meta-questions in patient questions are usually "Do you know what I mean?" or "Are you going to leave me?" or "Do you know who I am?" Sometimes, too, an information request relates to the patient's idealization or identification with the therapist, whom the patient wants to be like or to feel he can comfortably merge with emotionally. One patient, inquiring about my background, found out I had attended a university he respected, which made him feel that he could respect me, that I could understand him, and that we were blood brothers on the same intellectual wavelength. (My private fantasy in response was that we were both

bright guys united together in intellectual superiority over others, which was in fact a defensive stance he tended to take.) It also gave this nearly fatherless young man something, or someone, to idealize, I think. Subsequently, when we resolved a sticky insurance question for which *he* took the credit, he seemed to become in my mind "the one who gets results" (and, in addition, "the victorious son"). This transference/countertransference competitiveness marked a developmental shift in him and in the therapeutic relationship.

At these times of revelation, as at the cocktail party, a therapist takes on a new reality for the patient, which at certain times in therapy may be appropriate. But at other times the disclosure of personal information—certainly voluntary, unprompted disclosure—tends to constitute the kind of frame break or leakage from the therapeutic vessel that was noted above. In a way, a therapist should generally "be a nobody," at least as far as outside information goes, though a sense of his personal presence in the therapy is crucial to the patient.

In fact, a therapist can never really be a nobody; he is revealing himself all the time, even by nonexpression. The way he talks and responds, feels, what he judges important, what he wears and how he decorates the office, how he handles the billing—all are expressive. He is constantly cuing the patient as to who he is; it is impossible not to and he can only minimize this, not eliminate it. Furthermore, while the tension between anonymity and therapist self-disclosure is relatively clear cut regarding the therapist's outer life, self-disclosure about feelings and responses to things within a session is more complex and subject to technical debate.

Neutrality

The concept of the therapist's having a "neutral" attitude toward the patient's feelings or points of view has received a fair amount of attention and encouragement in psychotherapy, and is naturally relevant to any discussion of the therapeutic framework, the participants' images of each other, and the therapeutic relationship. Neutrality in one sense entails not being emotionally invested in a patient's point of view or with one side of ambivalent feelings. For example, if a patient complains about his wife, neutrality means not necessarily saying, or even thinking, "You're right" and taking his criticisms as objective truths (though it does tell the current truth as experienced by the patient). It is his version of the truth; his wife might have a different opinion. Therapeutic neutrality is like a neutral country, a neutral observer. The therapist does not judge, nor can he accurately judge, the veracity of a patient's complaint, nor does he impose his point of view on the patient. Furthermore, neutrality dictates that he does not direct, guide, or give preference to certain feelings over others. The idea, essentially, is essentially to be a disinterested observer.

In a sense, neutrality is the opposite of empathy, which involves an immersion in another person's point of view. A therapist rapidly shifts between empathy and neutrality: identifying with the patient's point of view and imagining what that might be like in an effort to understand it, then disengaging from the patient position, shifting into neutral, and thinking about it himself or from some other's point of view (not with the patient's mind-set). This is an especially complex oscillation when a patient is talking about his

therapist. If he is critical of a therapist's behavior or personality in some way, empathy is obviously more difficult to maintain; in fact, so is neutrality. The neutrality-anonymity concept, along with the therapist's own therapy, were originally designed both to disallow the possibility of such criticisms being valid—they are projections because the therapist has provided no basis for them—and to encourage a therapist not to retaliate. However, neutrality, in a more evolved and interpersonal form, is a position a therapist can also strive to take toward himself, not just the patient. As opposed to the stance that what a patient says about him is necessarily false, the neutral viewpoint is truly neutral: we'll see if that's true; and whether true to some degree or not, we'll see what is important about this in the patient-therapist dyad. Neutrality, in the final analysis, facilitates empathy if it allows a therapist to be nondefensive and simply to go directly to what a person is saying.

Therapeutic neutrality started off as an ideal derived from Freud's early technique papers. Also, in Rogerian client-centered psychotherapy, which originated in part as sort of the anti-Freud, a nondirectiveness similar to neutrality is emphasized (though it is compensated by a therapist's implicit or explicit expression of authenticity and unconditional acceptance). In Freud's case, however, neutrality turned out to be a case of "Do as I say, not as I do," because Freud was later shown to be less than neutral in some of his conduct of psychoanalysis. Nevertheless, a quasi-scientific, "surgical" ideal became the norm in psychoanalysis.[14] A negative feature of this analytic neutrality-anonymity as it evolved was that it sometimes seemed to convey a lack of concern, a lack of interest rather than the desired scientific disinterest. The idea of the analyst as being cool and almost expressionless—a "blank screen" or "mirror" for the projecting unconscious of the patient—held considerable sway for decades, at least in many psychodynamic circles. It also gave rise, in other circles, to considerable backlash.

SPONTANEITY AND SELF-DISCLOSURE

Jung was one who responded sharply to the idea of hyper-reserve in the therapist. "I put my patients in front of me," he reported, "and I talk to them as one natural human being to another, and I expose myself completely and react with no restriction" (Jung, 1935a, p. 139). As a therapeutic rule to live by, this sounds exaggerated, and although Jung trotted out examples of his being sort of a loose cannon at times—one patient, for instance, said she would hit him and he then threatened to hit her back—the overall impression he gives is of being a therapist who was gentlemanly, sophisticated, and certainly tactful when necessary. For Jung and many Jungians, if there was any directiveness in psychotherapy, it came from the unconscious. (Regarding Jung's bold statement above—in itself an example of a spontaneous emotional reaction—therapists will recall too the way some of their colleagues will occasionally imply how tough they are, that they don't take any guff from their patients, etc. Parents tend to do this too, usually with reference to the way other people should raise their children.)

Controlled self-disclosure

A therapist needs to be himself- indeed, can only respond from there—but also needs to gauge the effect of what he says and how he says it. This depends very much on the patient and his state of vulnerability, of course. The therapist's personality also plays a key role here, as some therapists are naturally more forceful and expressive by nature and some more reserved or gentle. The overall sense of rapport or personal connection—the state of the therapeutic relationship—is also important. Over time, increased comfort and spontaneity naturally develop, as some of the edges have worn off the therapeutic marriage and it has proved viable. At the same time, a therapist does well to maintain his role and therapeutic mission, so to speak, rather than use therapy as a platform for spontaneous expression, whether that be general pontificating on various matters, including a patient's life-choices, or discussing his or others' life or problems.

Currently, there are multiple trends in psychotherapy in general and Jungian psychotherapy in particular around self-disclosure. In classical psychoanalysis, the most close-mouthed of therapies, self-disclosure has been on the increase for decades and especially so with the recent influx of newer, "relational" approaches (i.e. approaches like this book's that emphasize the therapeutic relationship). Other therapies have for the most part always been more self-disclosive, depending on the practitioner; or rather, other therapies have not had a rigid injunction against self-disclosure. Jungian psychotherapy is difficult to characterize in this regard, as Jung seems to encourage maximum self-expression; but the subsequent influence of psychoanalytic technique on many Jungians—and their different, perhaps less charismatic personalities—may have led them in the main to a more reserved approach. It is undoubtedly individual and situation-dependent. Jung's example and above statement about the therapist being free with his reactions, or at least his intuitions, has of course influenced Jungian psychotherapy considerably; the downside of unlimited freedom has also shown up occasionally in Jungianoriented therapy when a too-loose creativity has led to uncontained, not particularly therapeutic situations. Hence the emphasis on the therapeutic framework and more standardized techniques has helped balance things out where necessary in some quarters.

Controlled self-disclosure seems to be the trend, but how to gauge this is unclear. A wait-and-see attitude almost never hurts. If there is hesitation, then why not hold on? A therapist can come back to his reaction later or digest it in the meantime. On the other hand, the interpersonal dynamic or flow between patient and therapist can be thrown off by delay, which may connote disengagement to the patient. The conversational rhythms in psychotherapy are different from others, though. (Patients sometimes hate it that a therapist is "just their therapist.") When a patient asks directly for a response from the therapist about something, however, some bouncing back to the patient is usually appropriate. That is, the patient can be encouraged to reflect further on his request for feedback; the therapist subsequently may provide a response if he thinks he should (or may respond first and ask the patient to ponder his request second).

Also worth examining is when the therapist spontaneously feels like giving his reaction. A therapist is reacting and making internal judgments all the time, and sometimes may want to speak out. For example, several pregnant patients of mine have told me the prospective names of their children. In one instance, I thought to myself, "That's a horrible name to give a child," and I worried that the child would be teased. It

was none of my business, of course, but I also felt exasperated that this long-time patient of mine couldn't make a sensible choice (that is, the one I would have made), thereby demonstrating the sound decision-making which, furthermore, would have indicated advances in our work together. So I wrestled with my quasi-parental, therapeutic ambitions and narcissism for a while before saying anything. However, when it came up again in a subsequent session, I casually invited the patient to consider some possible ramifications of the particular name she had in mind.

With another patient, who wanted to give her daughter a name that, while gender-ambiguous, was typically a male name, the patient herself noted the issues in the naming. Her thoughts flowed into her own doubts about her femininity and self-hatred around her gender, as well as her fears for her daughter in a masculine world. So here a therapist does not have to say anything, perhaps only a minimal reinforcement ("That is interesting what you are saying there about naming your daughter"). This kind of underlining of the topic a patient brings up is in itself a self-disclosure, an indication or seconding of what the therapist considers important. It is a non-neutral intervention. But if this particular patient had not proceeded herself, I doubt in this case I would have pursued the naming issue. The real issue, which she addressed, was her sense of self-doubt as a woman, a sense she reportedly shared with her own mother. In the first naming case above, my thoughts were about the mother's carelessness or latent hostility in giving her child a funny name. I disclosed my response in the elliptical form of a question, essentially hiding the emotive elements of the self-disclosure. Again, a total, no-restriction disclosure might have begun with something, like "You must be kidding." (In retrospect, I wondered if she was trying to get a rise out of me, which relates to the therapeutic relationship rather than the naming phase). Still, the further questioning was a voluntary leaving of a neutral position, though this departure was couched in a neutral tone.

Requests for validation

In the case of a direct question from a patient, or a direct request for validation, what does a therapist do? This is where the rubber hits the road, and a therapist is in a bind between honesty-authenticity and anonymity-neutrality. If the patient in my first example above had asked me point-blank what I thought about the name, how might I have responded? (The name was something like "Buckwheat.") This might have been especially difficult if the patient were enthusiastic about it: "We've decided to name our child 'Buckwheat,' which is a name I love. What do you think?!" Options: (1) support the patient's choice ("Very nice"), (2) toss it back ("Let's see what your thoughts are about it"), (3) invite some associations ("What does 'Buckwheat' bring to mind?"), (4) cautiously encourage mature exploration ("Buckwheat—that's a rather unusual name. I wonder what that might be like for your child?"), (5) give one's own associations to the word ("Buckwheat? You mean like in 'The Little Rascals'Z"?"), (6) guide the patient ("Well, you might want to rethink that name, as it might subject your child to future ridicule"), (7) straight self-disclosure ("Bad idea."), (8) blunt self-disclosure ("Buckwheat?! How unconscious are you? Don't you think that might be a little rough on your child?"), (9) critically confront ("I think that's rather alarming and might cause your child to be shamed. I wonder what might cause you to think, or not think, of your future child in such terms?"), (10) interpret

it ("I wonder if this choice of name does not belie some hostility toward your child, your pregnancy, or yourself), (11) confront the resistance ("Why, now, are you turning questions about your naming of your child over to me?"). And so on.[15]

Although every therapeutic choice is a self-disclosure indicating something about the therapist, that in itself does not prove the rightness of self-disclosure per se. It is merely self-disclosure, broadly defined. Self-disclosure, more precisely, is when a therapist says something specific and explicit about his own feeling states or himself. An empathic response is a kind of self-disclosure, in which the therapist in effect says, "I know what you mean. I understand how you feel." The disclosure is that the therapist has been thinking about it or feeling along with it. But that's a disclosure of having tried to follow someone else (the patient), not really a revelation of one's own internal processes. A self-disclosive aspect of empathy would occur if the therapist said something like, "When you described your loss of your mother, it reminded me of my own mother's death" (and thus I was able to resonate with your feelings). This, in the example, would be a parallel countertransference position of the therapist's, a drawing on his own emotional experience to more accurately imagine the patient's experience. These processes in the therapist largely go, and should go, undisclosed. The therapist does not have to tell the patient what he is doing all the time, especially if the therapist's internal responses are highly emotionally charged. So if I have not recovered sufficiently from my mother's death, if it upsets me too much, then it is better not to mention it. It need not be mentioned anyway, because the self-disclosure is not necessary. Understanding can be conveyed with a look, or with one's silent but true presence, or by a word or two ("yes", "of course"), or, if necessary, a simple statement ("I can see how painful this is for you"). Such understanding is grounded in the therapist's personal experience and from that its conviction is expressed. The self-revelation in the case above can be all right—a demonstration of a shared humanity, which, after all, is what empathy is—but it can almost be a distraction: the sharing of experiences shows solidarity and perhaps relieves some pain, which is a good thing, but also potentially refocuses attention on the therapist and may cause a sensitive patient to start ministering to him (or to be irritated).

The process self-disclosure

Another sort of self-disclosure is more educative in nature and can be interpretive as well: the process self-disclosure. This controlled self-disclosure of intratherapy feelings or fantasies is highly specific. In this instance, a therapist may choose to say that he feels a certain way with the patient; for example, "Listening to you today, I find myself feeling kind of tired." Care is necessary here, because the therapist may actually be tired. Also, tiredness can be a measure of negative countertransference, a reaction indicating a therapist's resistance to the emotional issues at hand. Third, it is potentially insulting. On the other hand, if a therapist is otherwise feeling alert, his lassitude could be saying something about the level of discussion or the patient.[16] Perhaps the conversation is superficial; perhaps the patient is tired or being tiresome in order to, like the therapist in resistance, avoid an emotionally difficult topic. Perhaps this is a typical relationship dynamic, one where the patient subjects others to boredom or one where, vice versa, the patient himself is or was the object of a certain superficial monologue that made him

want to sleep. It could be aggressive, it could be defensive, it could just be the therapist. The point is, the therapist can raise this as a process issue. A process issue means: it is not *what* you are talking about, but *how* you are talking to me or how I am hearing you that is important. That is, the issue is the therapeutic relationship itself.

Just as a patient is invited to attend receptively to whatever is crossing his mind, so is the therapist, who relies here on his feelings and intuitions as indicators and then uses self-disclosure to promote consciousness. Some Jungian therapists understand their feelings to be primarily the result of the patient's projections, and the process as one of "projective identification" (Klein 1946). Projective identification as a theoretical perspective is a complicated issue with a sometimes unclear definition and history. It has been viewed as a diagnostic indicator, a defensive operation, and a communication device. But the basic idea is that the therapist is experiencing something of the patient's personality or feelings, which the patient has, somehow, "put into" him (projected, or in its Latin root, "thrown forward" into him). Hence it is loosely related to empathy as well—the therapist's empathy, that is, or what is correspondingly termed the therapist's "introjective identification." Unlike empathy, however, where the therapist consciously takes in and projects his fantasy of the patient back to him, in a patient's projective identification there is usually less sympathetic intent. The assumption is that the patient is communicating something that "wants" discharge, understanding, or, from a defense perspective, to be gotten rid of, and that projective identification is a relatively primitive psychological mechanism. Its roots are thought to be in early childhood emotions, fantasies, and modes of expression. Its adult usage is thought to be the result of developmental arrest, sometimes due to innate processes and sometimes due to empathic or anxiety-management failures by a child's caregivers. Generally speaking, the more the individual's early environment has responded effectively to his needs, the less he interacts later with more archaic, volatile projective-identification processes.

The psychological basis of projective identification assumes a sort of mental transfer that in part can be understood in terms of the contagiousness of emotional feelings or complexes discussed in earlier chapters. In other words, the Jungian perspective assumes projective identification to be potentially active in all relationships, though the description of its contents differs from Kleinian explanations (except among those Jungians who are Kleinians). Jungian therapy, as compared with some others that make use of these or similarly described mechanisms, brings the therapist's side of the equation more to the fore, such that the therapist himself may be communicating in this way as well. Ideally, he does not do so—the therapist is thought to be more conscious, less unknowingly projective—so it is more the way the therapist monitors and manages his own unconscious communications to the patient *and* the way he receives a patient's projective identifications emotionally that are the key dimensions in this communication process.

The fact of feeling something from or about a patient can result either in its self-disclosure to the patient (for purposes of further understanding) or in its interpretation (in which case the understanding is provided by the therapist, usually without the self-disclosure). The two can be combined; a self-disclosure may lead into the interpretation. That is, the therapist provides the background for his interpretation by noting how the patient made him feel. Thus, in the above example, a self-disclosure of the therapist's

tiredness may be presented, in the past tense, as the basis for his going on to suggest that the patient was trying to make him feel as the patient himself felt when listening, let's say, to his narcissistically demanding mother. Or, depending on the circumstances, it could be seen as a way of punishing the therapist who is standing in now as that mother. Or it could be suggested that the patient is avoiding something (which might connect with the previous hypothesis about transference anger).

Process self-disclosure usually takes place in the present tense, however, without the therapist offering a well worked out explanation for it. He is simply telling the patient that he is feeling such and such now. In lieu of interpretation, then, there is simply this information, presumed to be valuable, on which therapist and patient can now ruminate. Self-disclosure without interpretation is more here-and-now, more feelingoriented, and more egalitarian in stance. This does not necessarily mean it is more valuable, but it does set a different tone for the therapeutic relationship. Depending on the patient, this kind of information can be useful or, on the other hand, puzzling, distracting, or even tantalizing. What does the patient do with such responses? How does he respond to them? Those are the questions. Furthermore, and often more important, what does the patient do when the therapist has responded personally in this fashion, whatever the content of the response? Self-disclosure immediately draws patient and therapist into some sort of focus on their own relationship. Before that, it draws attention to the therapist.

Therapeutic intention

The therapist's intention in self-disclosing is therefore important, in addition to the way he does it. While therapists, like anybody else, do not need to know and cannot know exactly why they are doing something, they probably should have some purpose in mind for self-disclosing. They might at least be curious that they are inclined to select and respond to certain information in this way (by self-disclosing) and at this time, when at other times they might not. How does the therapist decide this?

Unless directly asked by the patient—a therapeutic situation addressed earlier—a therapist self-discloses out of some sort of unconscious impulse. The fact of its being impulsive and unconscious is not against it; a spontaneous motivation may be just right. By providing his own reactions, the therapist not only refocuses the discourse but very much personalizes the therapeutic relationship. His disclosure indicates to the patient that the therapist is reacting to him and his material. It reveals the mind of the therapist. Therapists' main fears in this regard are that by thus revealing themselves they will influence patients away from their own perceptions and feelings. In other words, therapists are anxious to avoid being directive, and fear diverting or limiting patients' free expression and spontaneity. Because a therapist is in a position of influence, he may overly influence—that, at least, is the concern. The other, correlated concern is that the therapist will thereby have responsibility for the patient's feelings and life when the therapist is implicitly (or explicitly) encouraging the patient to handle those things himself.

Self-disclosures critical of the patient

The therapist's influence on the patient is a central and inevitable dimen-sion of treatment and, though Jungian therapy emphasizes the "reciprocal influence" (Jung 1929a, p. 71) of the patient, the therapist's influence is usually more potent. In conjunction with a compliant, vulnerable, or dependent patient, a therapist's leverage may be all the more dominant. In other terms, the therapist, by virtue of his position, the patient's position, and their respective strengths and weaknesses, carries considerable authority. Accordingly, almost all nonbehavioristic psychotherapies, and especially the dynamic and aptly named client-centered therapies, emphasize the patient's autonomy and a receptive rather than directive therapist. His words being so important to most patients (except, apparently, to narcissistic or schizoid ones, though this may be questionable), the therapist needs to take heed of their possible effects. This is why therapists need to take special care when what they say to a patient is critical, or might be taken as critical.

Patients hear criticism as much from tone as from actual statement, and, to be sure, they are often oversensitive in this regard. The sensitivity may come from experience, from an inherently fragile sense of self-esteem, from feeling totally vulnerable, or from all of the above (usually and interactively). To some extent, every understanding or interpretation the therapist shares with the patient is a critical one (in the neutral sense of the word "critical," i.e. evaluative). A judgment is made about something, about the patient's personality and life really. So there is potential for this to be taken badly, depending on the patient's state of mind and the resilience of his sense of himself. I personally can recall, for example, the absolute vulnerability to personal rejection I felt at one time upon finally stating my erotic feelings and fantasies towards a therapist; I thought I would die if rejected, and simultaneously did and did not want a response. Most patients want their therapist's acceptance, and the more of this they feel, the more they can accept his judgments. Trust is a prerequisite, therefore. Psychotherapy is not all that complicated at the center—trust—but trust is immensely complicated, particularly for a wounded patient who feels, somewhere or other, betrayed in his or her trust. Because most patients have had some difficulty trusting others or had reason to doubt others' trustworthiness, a therapist's comments can be a blow to a patient's ego or to his stable sense of identity. Hence a self-disclosure that is judgmental may be difficult to swallow even if it has been requested. Confrontational interventions by a therapist are particularly hard to swallow. This is another reason why therapists prefer to be reserved: they don't like to hurt their patients' self-esteem, presumed to be vulnerable.

The therapist's hostility

Is a therapist always to be gentle, accepting, client-centered? How can he be so and yet be authentic (if he is not feeling gentle, accepting, etc.)? A core dilemma for therapists is how to manage their own hostility, whether it be an appropriate feeling or not. It is generally thought to be inappropriate to feel less than caring for a patient, and it may surprise or disorient a therapist to find that he feels that way. Once, a strong, female patient in a psychiatric hospital where I worked punched me hard, out of the blue, in the solar plexus, and before I knew it, I rapped her firmly on the breastbone with the heel of my hand. It was an instinctive reaction that took me a while to justify to myself on several levels.[17] I was somewhat shocked that I had hit her back, however reflexively.

Assaultive patients do not appear too often in most office practices (though a Jungian analyst I know was shot by a patient in his office). I once took a rather antisocial patient, who had some vague linkage to organized crime, to small-claims court for his unpaid bill, and had terribly fearful fantasies that he would retaliate against me or my family. What I eventually understood, however, was not that I was scared that he would come and get me, but that I really wanted to go and get him. I was much angrier at him than he was at me. Realizing this, I felt considerably more relaxed; he, in fact, was bizarrely cordial and noncontesting in court, greeting me like an old friend as I garnished his paycheck. Nevertheless, it was a strange revelation to find myself in this noncaring and adversarial position toward a patient.

But whatever hostility therapists do develop, they frequently unload it, as previously noted, by talking tough about patients outside the hour, or by attacking insurance companies (which is sometimes justified), or by fierce attacks on each other or on therapists of other theoretical orientations. Civilians would be amazed and probably frightened at how unconscious and unempathic professionals can sometimes be toward each other, almost as if therapists had split this off from their work with patients. Though they value and handle straight talk, they sometimes speak to and manipulate each other in ways they never would with patients. All this back-biting and aggression is modified when directed toward patients, or should be.[18]

Most often, hostility toward patients takes the form of impatience, which often is the result of strain over time. Psychotherapy can be frustrating work, with rewards that are sometimes nebulous—success being dependent on someone else's improvement, and improvement being difficult to measure. It takes a lot of time, and it's in *their* hands, ultimately. Sometimes patients do not cooperate by getting better. Self-disclosure of one's frustrations or impatience is not for the best, though also not fatal. Feeling tired at the end of a day recently, I commented to a patient, "You were even more passive with her [his reportedly aggressive girlfriend] than you usually are." This was not the height of empathy. Though this patient did seem to wear a "kick me" sign, he had also reported having an abusive father and a domineering mother (to go with his girlfriend, and now, his therapist). My empathic resources had left me, as had my usual attempts to understand this in terms of struggles with separation, masochism, anger, repetitions of parental dyads, projective identification, and dependency. To his credit, he was able in the next session to bring it up, to mention this impatience of mine to my face, if not to get mad at me about it.

It is an important event when a patient criticizes his therapist, and ultimately a necessary one. It is usually less than therapeutic for a therapist to criticize back. Some patients attack their therapists quite readily of course, too soon in fact, and this puts strain on a therapist. (It also tends to generate a more severe diagnosis from the therapist, which can be both accurate and retaliatory.) Relentlessly critical or uncooperative patients tend to generate either more critical self-disclosures from their therapists or the opposite, a cool neutrality and distance. Some therapists' confrontational style or approach is a way of dealing with such patients or their own critical feelings. Some patients, as mentioned earlier, are just plain difficult. As the psychoanalyst Harold Searles has said, "From time to time I have had the ironic thought that instead of healing souls, I am half-consoling heels" (1966, p. 30). Most patients, however, come to a critical, or maturely critical, view

of the therapist gradually, so it is notable and a sign of progress when this occurs. For this and other reasons, spontaneous self-disclosure by the therapist, when it is judgmental, is problematic.

The therapist's self-containment and holding functions

While therapists cannot be machines of perpetual understanding, they can try to differentiate whether a self-disclosure is a useful act or an "acting out." The way to do this is for the therapist to note how much emotion is in his disclosure—how hot it is, so to speak. On average, if it is an expression that wants to burst out, the therapist may want to wait. One hates to discourage free expression (especially when Jung seemed to recommend it). However, Jung may have been wrong about this, or was probably exaggerating somewhat in the course of a lecture. Maybe another great man, Thomas Jefferson, had it right: "When angry, count ten before you speak; when very angry, a hundred."[19] Whether it be anger, impatience, guilt, love, or anything else, a therapist does well to mull over his counter-transference a bit to see exactly what it is and where it might be coming from. Then, when some of the affect has been sorted out, the decision to disclose or not to disclose can be made. In fact, this decision becomes less difficult and revved up when the emotion is taken out of it. Whatever emotions have been stirred up by the patient have been metabolized, and a move from counter-transference to empathy, understanding, and perhaps interpretation can be made. This is also a move from present to past; that is, the emotion has simmered down and is not fully in the here-and-now but is contained and now reflected upon. So, whenever an inclination to speak forcefully has been stirred up, it is generally better to sit it out. If it's a hurricane, ride it out. All this is difficult, sometimes impossible, certainly trying. While it is less anxiety-producing to just get into it and release it, that is not the therapist's role.

"Keep your temper," said the hookah-smoking caterpillar to Alice in Wonderland. While psychotherapy encourages the discovery of deeper feelings and to some extent their spontaneous expression, it especially encourages distance and understanding—self-reflection, in other words. This philosophical rather than cathartic aspect is where the wisdom is, and certainly where the therapist takes his stand. Psychotherapy is about the refinement of emotions; in Jungian alchemical terms, the transformation of the *prima materia* into the gold. Accordingly, some Jungian therapists point out that retaliatory responses to patients, however justified on a personal level and however relevant to the interaction of patient and therapist, should never be made (Lambert 1972). That does not mean they should never be felt. They, or anything else the therapist feels in response to the patient, are so important, so much the meat of the therapy, so much the active element in the therapeutic relationship. They are exactly what is happening. Because of this, the therapist wants to study his reactions, not simply enact them. Once again, the discrepancy between therapist and patient positions becomes evident: patients are asked from the first to be spontaneous in their speech—to say whatever comes to mind—while therapists are not. In the long run, patients respond favorably to a therapist's consistent, sober presence.

A therapist should not want to be a cipher to a patient, but at the same time a therapist can be known by his style and comments without getting into a consistently self-disclosive style. In the final analysis, it is less the therapist's feelings about psychological

events than the patient's that are important. (What's more important to the patient is the sense that the therapist has feelings for him, and that he can affect the therapist.) After therapy, the patient may never know what happened or much of what the therapist was going through or thinking, and that is perfectly fine. The patient is paying, in effect, for the therapist to take care of his needs at his end.

The content and style of the therapist's communications

All this points to the general question of how much of the therapist's thinking overall is shared with the patient. Self-disclosures, interpretations, what the therapist selects to respond to either minimally or maximally via observations, questions, or asides—all are stylistic preferences but, at the same time, instruments in the therapist's therapeutic bag. In other words, all of them are potentially at his disposal. Their precise use is a matter of a generic therapeutic style, of a therapist's versatility, and of timing, the latter taking into account the therapist's view of how the patient likes or needs to be communicated with. In the therapeutic relationship, the therapist subtly adjusts the way he communicates—really, the way he is—to the relationship with the patient. This does not mean the therapist is not himself but that he and the patient find the language or way of being in a therapeutic relationship that fits. Sometimes this is an unpredictable dance. Specifically, on the level of communication, it means for the therapist speaking in ways the patient can understand and using tones and words that the patient can connect with. In a way this is like speaking or learning a new language, though it is more subtle and perhaps more unconscious than thought out. A therapist tries to find a way to get through to his patient, and vice versa, and they form a mutual language. This is little different, after all, from any close relationship.

Therefore, psychological jargon is out. Some therapists, unfortunately, simply speak their own professional language and expect the patient to get with the program. Jungian psychology, though nontheoretical in intent, has as much potential to be guilty of this as any other theory, as it has a ready-made set of codewords, symbols, and signifiers (shadow, anima, animus, mandala, Self, synchronicity, archetype, etc.). Talking about "the shadow", for instance, is meaningless as such; it has to be specified in terms of one's jealousy, greed, competitiveness, rage, passivity, weird sexual tastes, or whatever. Then it means something. Any form of psychotherapy is an influencing process, but some therapies seem to involve, sometimes covertly, an educational agenda that the patient gradually learns. Some case histories really show a patient talking the talk.

In contrast to this, Jungian therapy has a well worked out theory of psychological types—introvert/extravert, thinking-feeling-intuition-sensation—that the therapist can use to orient himself to patients. These attitude and function types speak to the natural preferences people have in processing experience and information, making decisions, and generally living life: some think about it, some just act, some see what's there fairly concretely, some tend to imagine, some are inner-directed, some are people-oriented, and so on. Jung (1921a) brought this form of nonpathological character-diagnosis to psychotherapy. His followers have made use of this typological grid in direct or indirect ways, some Jungians using it actively and others in effect using its guiding principle—that people really are different—without getting into the specifics of a person being, for

instance, “an extraverted thinking type, with sensation as an auxiliary function.” In its less useful form, this manner of expression can devolve into a Jungian shoptalk that patients pick up on or use superficially. In one of its positive forms, typology has relevance to thinking about the match or chemistry between therapeutic participants.

The therapist’s overall take on the kind of person the patient is—how he talks, thinks, feels, and so on—is reflected in how the therapist talks to him. This will have bearing on therapist self-disclosure in the sense that some patients may not like it or may find it invasive, whereas others seem to want to keep in touch with the therapist in a give-and-take way. Sometimes, a therapist finds himself in a sort of complementary position with patients, emoting more with reserved patients or pulling back with overly engaging ones. Sometimes, as well, there can be a synergistic effect where each energizes the other in supplementary or even manic ways. All this is telling: what the patient seems to pull from the therapist—the “therapist” a therapist finds himself becoming with this particular patient—is information about the psychodynamics of the patient, about what goes on in his head and relationships. But it is also a function of the therapist’s psychological input and their mutual participation.

SELF IN RELATIONSHIP

Outside a person’s individual self in isolation, so to speak, there is the self in interaction with another, which modifies the individual at the point of contact. This is true, of course, for both therapist and patient. From the point of view of a subjective sense of oneself, I am a certain person within myself but a slightly different version of my basic self with you. Different things come out, different aspects of myself come out with you. In other words, people feel different with different people. At the level of a sense of personal identity, people *are* different people with other people. It might be fair to say: if people were not dissimilar and if their differences did not stimulate new experiences in us, then why make contact with others at all? There would be little pull or attraction.

Thus, the “relationship self that lies between two people is not simply the persona—the public self or social mask—that underlies good manners, or initial or formal social interactions. In therapy especially, the standard social fronts of the patient and, to a lesser extent, the therapist are dissolved within the session (although the structure and roles of “therapist” and “patient” are formally maintained and form part of the therapeutic frame). An interactive therapist-patient relationship—the therapeutic relationship—emerges in their place.

This could not happen unless the patient were not only in the therapist’s mind but, to some degree, in his heart (the same holds true for the patient). A therapist carries the patient around with him. In a certain sense this goes on outside of the therapy hour, whether the participation be unconscious or conscious, although usually it is an unconscious act. A therapist is psychologically available to a patient, even when he’s not in session. There are limits to this, personally, for the therapist, but some patients carry more weight, demand more, and maybe get more. This is why therapists sometimes speak of “taking on” a patient. Psychologically, everyone carries their close relationships around with them, meaning they carry a sense of connection to important others when

they are not present. This is like having one's child, one's friend, or—this is often the most easily recognized and acute—one's romantic partner in mind. We continue to exist in *their* mind, and they in ours. This means memory, being remembered (re-minded, kept in mind) by the important other, which provides a psychological feeling of being "re-membered" (as if having one's members, one's body parts, put back together) rather than dismembered psychologically. All this has something to do with feeling alone or not in the world. People, especially when very young, need other people's minds and memory to sustain them. But they need this as adults too (Kohut 1984), especially if they are patients. A therapist is the one who remembers you.

One of the problems patients often have is that this feeling of ongoing connection is tenuous. They cannot remember, emotionally, the other person, or feel the other person does not remember them (which is psychologically about the same thing). The linkage with others stops, and a person falls into an emotional hole. Almost all patients want to feel special, as if they are the therapist's only one and there is *nobody else who matters as much,* just as they wish (or wished) to be their parents' or their partner's only one. Some illusion is involved in this aspect of psychotherapy, a certain kind of benign deception, and sooner or later some disillusion too. Part of the reason for a therapist preserving his anonymity or a therapy-only identity is so these feelings of exclusiveness can be experienced, or not, and processed. The therapeutic situation and frame, not just the therapist himself, also provide for the patient's needs in this regard. This is why, for instance, a consistent set of therapeutic times is important. It's *their* time: patients more or less feel they have their therapist's undivided attention and the whole therapy situation itself (the whole mother, perhaps), at least for the therapy hour. The therapy becomes the consistent relationship (or object). For the therapist too, the consistent place and time of therapy is important, because he can leave his patients "at the office," knowing that the office, as it were, can contain and sustain them. This counteracts the overburdened sense of having to carry patients around with him.

THE MIDDLE OR WORKING PHASE OF THERAPY

The issues noted above apply not only to the beginning stages of psychotherapy but throughout. It is difficult to define the middle areas of therapy, because these early dimensions thread through and because the specifics vary from patient to patient. In ideal situations, there is a cozier middle phase in which a therapist and patient are "working together" or "working on" particular issues cooperatively. The so-called working or therapeutic alliance (Zetzel 1956; Greenson 1965) alludes to this relatively conflict-free area of therapeutic endeavor, though the psychoanalytic authors cited are generally speaking of something that is there, one hopes, from the beginning. The therapeutic alliance is more a spirit than an actual phase. The psychological-mindedness and general disposition of the patient, mentioned earlier, are relevant to this conception, as well as the degree or type of psychopathology the patient seems to embody. The therapist's contribution to the working alliance is assumed, part of his professionalism, although realistically it can fluctuate. (Therapists have good days and bad.)

The middle and majority phase of psychotherapy may involve mutual cooperation of

an anxiety-free type, but not necessarily. In this day and age, and in psychotherapy as opposed to analysis, ongoing patient motivation is not always so clear. Not all patients are "good patients," and, furthermore, the more conflicted, confusing issue of wounded healing is at the heart of psychotherapy. A patient and therapist often get into a kind of emotional muddle within the therapeutic relationship, which in turn can be the crucial part of the process. Impasses of varying degrees and types frequently provide opportunities, sometimes risky, for growth. One does not wish to be stuck there—unresolved impasse tends to break down the therapy, naturally—but it may be inevitable to be caught. It may be necessary to be caught. It is as if the patient's pathology demands the mutual stuckness (infection, woundedness) in order to be fully grounded and then healed in the here and now. A positive working alliance helps here, based on the patient's psychological-mindedness and also on the work the therapist and he have done over time. The result of successful prior work together is confidence that current problems can be worked out. Often, it seems to be not the easy cooperation but the successful wrestling with obstacles that generates true trust and satisfaction. Psychotherapy, like anything else, builds on its successes. Specifically, the therapeutic relationship itself develops resilience.

No two psychotherapies are the same, but all of them involve to some degree the mutual participation of the players and the infection of the therapist. The middle or working phase of therapy is when this kind of deeper involvement plays out. A therapist can usually feel this; the patient has become familiar—a regular. In Jung's words, "The case begins to 'fascinate' him" (1946, p. 176). Not only that, but the therapist has let himself become therapeutically "involved" with the patient and vice versa: this is the therapeutic marriage alluded to at the beginning of this book. Notably, some patients get the therapist involved right away. Instead of easing into the relationship, they start with the fireworks, and the therapist needs to brace himself. Sometimes this may be considered psychodiagnostic, sometimes it is simply the pressure of the patient's needs combined with an instinctive demand for attention, whether trust has been built or not. The patient can't wait for the therapist, but needs him to get up to speed and into the working aspects of psychotherapy immediately, which is fair enough.

More specifically then, what does it mean for the therapist to be therapeutically involved during the mid-phase of psychotherapy? He gets hooked, to one degree or another. Does a therapist only offer interpretations, which is a classical analytical ideal? Clearly not. He also offers attentive listening, clarifications, summaries, emotional and empathic responses, a certain kind of emotional involvement, and a continuity of presence and witness. Above all, he offers *understandings,* both interpretive and emotional—something for the mind and something, so to speak, for the heart or soul. When psychotherapy is working, it is not just the therapist's understandings but the relationship and the therapeutic situation overall that provide this psychological nourishment to the patient.

As part of this, the therapist monitors the progress and status of the treatment in general and the therapeutic relationship in particular. The best Jungian description of this is by Goodheart (1980), who describes three sequential phases or "fields" of therapy: (1) the *persona-restoring* phase, which is an effort to maintain superficiality, (2) the *complex-discharging* phase, which is the more volatile and sometimes muddling

projective-introjective mixing of the personalities described throughout this book, and (3) the *secured-symbolizing* phase, which speaks more to a lower-tension, even playful and creative, working alliance achieved by patient and therapist. While this description has the inherent limitations of all psychotherapy outlines—therapy processes are too variable to fit set schema very precisely—it has accuracy and excellent flexibility. It can be applied to therapy as a whole, to a single session, or to a single issue. Thus, therapy overall can be seen as moving from artificiality, to deeper emotion, to contained, creative reflection; but a successful single session will often show this same progression too. Furthermore, this model traces the pattern of an individual issue or point of conflict itself: the patient defends against it or hides from it; then fights with it and sometimes with the therapist and thereby infects the therapist; and finally the issues becomes metabolized and able to move in some new direction or into fresh insight, which is a creative act. Lastly, it is not just the therapy but the therapeutic relationship that follows this paradigm; the relationship moves from distance, to enmeshment, to comfort, to a healthy "being alone together."

This "defend-project-infect-reflect" model provides very useful orientation for a therapist, who can ask himself anytime during therapy where he and the patient are with regard to the session, issue, therapeutic relationship, or therapy as a whole. There is, of course, a constant oscillation between these dimensions of experience or even a near simultaneity, as the categories are not totally discrete from each other. Moreover, each fine point in the exploration of an issue or feeling will pinball around these dimensions, and patients will need to consolidate previous shifts or insights before immediately dismantling them, as it were, for the next creative reflection. That is to say, change has a natural rhythm, and it is understandable that patients need to restore their personae for a bit while they get used to their new senses of themselves. Consciousness has to sink in, organically, and any new configuration has to settle in. If a sense of oneself were a computer—heaven forbid—one could say the program has to be re-set or re-booted. A patient has to get used to himself, or to a shift in his self-image.

While the middle or working phase of therapy cannot be easily pigeonholed into one of the just-mentioned categories, usually the individual edges and boundaries of the participants in the therapeutic relationship have worn off. There is some degree of personality merger at an unconscious level. It is here, in the now shared area of personality overlap or infection, that the work of this main stage of psychotherapy takes place. The working alliance between the therapist and patient may be solid or variable, as may be the flow of events in therapy, which rises and falls also with the flow of events outside of therapy. Therapy is blown by different winds, some coming with a past reference, usually painful, from the unconscious of the patient, and some with a current reference point (which may in turn constellate past unconscious feelings, or new ones). A third energic source is the therapeutic relationship itself, which incorporates the other sources and the working alliance and has its own momentum toward healing.

THE END OF THERAPY

It is difficult to know how and when to end therapy, difficult for both parties. Perhaps

some of this difficulty is epitomized by psychotherapy's adoption of the word "termination" for the endpoint and end process of therapy. Although termination has neutral, merely objective connotations for therapists, it is without doubt a cold-blooded word. Nontherapists who are sensitive to language immediately note its hostile overtones. It is used by the military to mean killing and by employers to mean firing someone; then there are the "extermination" campaigns of the Nazis and others, the exterminator (of insects), and the murderous movie character "The Terminator." The word is heavily freighted, as they say. In a profession that should be sensitive to language, the use of such a word seems way out of character, even if it is only a temporary slipping into a kind of military shoptalk or medicalese. Its use speaks to a hard edge to the end of therapy, a hardness that is possibly required but also defensive. Separation is hard for everyone, including therapists, and part of the difficulty may be that the patient is doing the leaving. One way therapists deal with it is to get tough with language.

The endpoints in psychotherapy are often more sudden than expected. All too frequently, in any lengthy therapy, outside events foreclose current, internal ones. Patients move, get pregnant, change jobs, go to school, get married, divorce. Money or insurance runs out. For patients who have been in a crucial psychotherapy, their therapy often becomes a factor in decisions about any major moves, geographical or otherwise. The relationship is important, more needs to be done, and they do not want to start again, as they perceive it, with someone else. Then there are times therapy flounders in unforeseen ways, or at an impasse. "Premature terminations" exist, not just as a result of external, nontherapy factors but because of failures during treatment: patients deteriorate or get worse, anxieties get too high, original assessments turn out to be wrong. Some patients move into areas of feeling and complexity where a therapist simply cannot follow, and, as Jung so cogently noted, a therapist "can help his patient just so far as he himself has gone and not a step further" (1937a, p. 330). When a patient makes what seems to be a premature move to leave early, a therapist has to encourage attempts to discuss and understand what is happening or lacking. But if a patient really wants to quit, whether it is right or resistance, his reluctance to continue must be respected, even if it cannot be understood. A therapist can offer an opinion or recommendation against it, but once a patient is out the door it is difficult to bring him back. Usually, if patients are going to quit, they quit early, which all in all is better than if they do so later, because the emotional and literal costs have been less and a commitment in all senses has not been made. A therapist, like a patient, may feel disappointment or resentment when therapy does not work out. It is a relationship, a therapeutic relationship, that did not make it.

Generally, however, patients achieve some measure of their goals. As they get well, or at least well enough, some of the energy for therapy slackens relative to the cost and potential for future benefit. The intensity of the therapeutic relationship lessens. Less is happening, and with no real fire, there is no real incentive. They have done enough, for now. Jung points out, regarding this kind of benign imperfection at the end of psychotherapy, that "treatment may come to an *end*…without one's always or necessarily having the feeling that a *goal* has been reached" (1944, p. 4, italics his). He elucidates some "typical and temporary terminations" resulting from:

• good advice from the therapist;

- "confession" or ventilation of a problem (presumably he means in an atmosphere of acceptance, as Jung often makes reference to the therapeutic aspects of religious confession);
- recognition of a previously unconscious but potent psychic content that energizes the personality (this may refer to the aforementioned "not yet" conscious contents of the unconscious);
- separation from the childhood psyche (probably he means a normal separation-individuation, as it is now usually called);
- a new adaptation to a difficult problem (probably a presenting problem);
- a positive life-change or new life-event;
- return to a religious creed;
- beginning to develop a philosophy of life (in a deeper sense).

Jung's is a pretty solid list of possibilities for so-called temporary endings to what might be a shorter-term therapy. Indeed, some of these could mark permanent endings (for example, separation from the childhood psyche) of longer-term treatments. In a completed psychotherapy, however, the general psychological criteria for ending take the form of an improved self-care or self-therapeutic capacity, and a strength of personality in terms of weathering life's problems and conflicts. These were noted earlier. Relationships, too, seem deeper, or capable of being so, and while not precisely modeled on the therapeutic relationship, carry some of it forward in the form of better, more open communications and capacities to feel, express, and reflect on personal matters with important others. Overall, a graduating patient has a forward sense to him—hope and a greater sense of confidence that he can handle things—and has become psychological to whatever innate degree, and able more or less to do psychological work on himself, as necessary. He no longer needs a therapist.

Whether a treatment is complete or truncated, at the end the issue for many patients becomes how to leave a therapeutic relationship on which so much seemed to depend. An attachment has formed, cemented by time spent together. Therapy has also become a habitual aspect of the patient's life, something one does on Tuesdays, Thursdays, or whenever. Similarly, because he is emotionally connected, to whatever degree, to the patient, the therapist feels it too when the time comes for therapy to stop. He is different from the patient in this regard only in degree. Depending on the patient and on his own relationship to separations in general, the therapist sometimes may feel the end of therapy more. At the close of a fairly long or intense therapy, he may feel the loss even if the patient is not one of his favorites. (Sometimes there is a feeling of great relief as well.) There is not just a job well done, but the fact that a relationship, a commitment sealed by a lot of work, has ceased, and this patient will walk out and on to the rest of his life. It is a real goodbye and, for the therapist, a small death or a "letting go." In some ways this is a bit like being a parent, except that most patients are never heard from or seen again. Even if unconscious of it—and a therapist should be alert to a patient's avoidances in this regard—a patient will, somewhere, probably have similar feelings. Depending on the treatment's length and intensity, its ending may have an end-of-an-era feeling. It catalyzes whatever feelings both participants have about such things, and may recapitulate other losses. Termination is a *mutual* termination, though a therapist's expressed reactions may be limited by the fact this it is a therapeutic, not a regular, relationship. At the end as at

the outset, the therapeutic relationship remains a paradoxical blend of the intimate and the professional.

At the very last session, even farewell statements, handshakes, or hugs by the therapist can become important technical questions. Among my personal therapies, I still recall the hug my first, male therapist gave me, which surprised me as a young man. That was thirty years ago. On the other hand, a colleague of mine recounted a time when he gave a patient, a therapist, a big embrace and it was not reciprocated, not especially the right thing to do. Another therapist shared a glass of sherry with me at the end, or thought about it (I don't remember which; as I recall he may not have had any). With therapists both male and female I have left feeling lovesick. With one therapist I was pretty much just glad it was over. As a therapist myself, I know I am more inclined to hug a female than a male, which is partly cultural, partly an erotic question. Most of the time at the end I do not hug anybody but shake their hand; some of the time I give a heartfelt, two-hand handshake. All of the time, I try to let the patient take the lead in any of this. The end of every therapy is not necessarily like the end of a romantic movie, and as with all partings, a person's reflections and feelings after the fact, when alone, will also be a large part of the process. As noted above, much of the time the end of therapy is not the End; there is not a natural end, or the therapy is cut short of a final, fully realized conclusion with all the farewell trappings.

Aside from these final-session-farewell issues, for the therapist an awareness of the multiple ways he typically responds to endings is important. On the negative side, he may tend to ignore things until the last moment, check out early emotionally, get numb, get mad, feel abandoned, put the emotional responsibility on to the patient, not feel much until later, not feel much at all, etc. More therapeutically, he may attend to his emotional reactions and defenses as he goes, a process that may more or less coincide with the patient's own processes. Knowing his own propensities and his own current reactions may provide information not just on himself but on the patient's processing. The therapist's realization of his own struggles with separation, goodbyes, even death—"termination"—provides the proper grounding for empathy with the patient's, or anyone else's, struggles with these related issues. And each therapeutic relationship, we might say, will have its own style of termination, which may coincide with the relationship's prior character but may also encompass unique reactions to this unique situation.

It is often said that no one does termination well, because endings are rough and resisted. Psychotherapy, however, provides an opportunity to be conscious of one's reactions to final things. Therapy's keynote—the attempt to be understanding and to understand—holds here, as it does throughout the therapy process. That is why it is good to maintain standard therapy procedures until the end. Many therapists and patients get into a gradual loosening of boundaries or of the therapeutic frame. Sessions may become less frequent as the patient is, as they say, "weaned" from therapy; or the therapist may show more of his human face, telling more of his personal story. The relationship becomes more conversational perhaps, as if the therapeutic relationship is dissolving and a normal social relationship is taking its place. This seems to be part of an exit ritual, a *rite de sortie*, where the therapist lets his hair down and may reveal more about himself. It is not so much that a therapist must do these things, but that he can. The patient and he have spent a lot of time together.

Increased openness is natural at these points, as long as a therapist does not run amok and keeps an eye on his patient's communications, issues, re-enactments, and separation anxieties. A therapist needs to stay on the job and deal with the loss experience. A patient's ability to feel loss is in fact a healthy sign of a capacity for attachment and of his level of personality organization. I find it disconcerting, and diagnostic, if towards the end of a lengthy therapy a patient does not feel too much about its ending, or if I do not. The countertransference here is notable.

While the transition towards further, nontherapeutic relationship seems on the surface very natural both at the end and during the course of therapy, it potentially can serve as an avoidance of any negative reactions that may be lingering. Therapist and patient *usually* want to leave each other laughing as they go, and most of the time they do so in a successful treatment. Whatever affection is there, however, will be most genuine if the patient has been able to vent angry feelings and disappointments as well as happier feelings along the way. In the final reckoning, hate gives way to love, despite what Jung said about man being half "a devil," for, in spite of some seemingly congenital aspects of anger, most of it rises out of loss, frustration of love, or fear. In a deeper psychotherapy, this idea actually may become most evident at the end. If there is or has been a deeper relationship, then one natural reaction to its being over can be anger, simply because it hurts to give up someone or something one cares about. The feeling is something like: because I love you, I hate you for going. Childhood antecedents of this are very important, and may be activated at the end of therapy; some would say they are inevitably activated. Standard styles of leave-taking, derived from family systems and later development, emerge as well. Anger is sometimes one of these, used not in the differentiated way just mentioned, where ambivalence is coordinated with love, but in the form of a defense or deep confusion about how to detach. Thus, some people and families fight their way out of attachments, forcing an abrupt separation in high animosity and thereby making it, allegedly, easier. The unconscious logic of this is: it is easier for us to part if we don't like each other, it is easier to go away mad. The best defense, in other words, is a good offense. (Or rather, the best defense is to give or take offense.)

The potential for permutations and pathologies such as this makes it desirable to hold the frame of psychotherapy through to the end. At the end of therapy and at the formal dissolution of the therapeutic relationship are transferences, and countertransferences, from prior endings and relationships. These standard patterns often arise, and part of the therapeutic task is to pay attention to them. Some therapeutic viewpoints hold that the conclusion of therapy is the central dimension of therapy, because separation and loss are the central facts of life. This emphasis on separation as the core issue may be based on infantile-separation perspectives or adult existentialist ones, or both. In a sense, it would be nice if psychotherapy could just skip to separation. However, dependency and attachment have to be felt before separation can be felt; a therapeutic relationship has to be experienced before losing it can matter. Short of simply leaping to the final stages, some theorists note that prior symptomatic issues and character styles are sometimes revived during the "termination phase" of therapy. The patient seems to regress, as if taking one parting shot before leaving the old ways behind. (Or perhaps it is the "old way," the old introjects themselves, who rise up again.) The therapist may feel that all progress has been lost, or that nothing has really happened. The pathology has a second

life.

This recapitulation-in-termination is based somewhat on a conflict and symptom model that Jungian perspectives do not usually emphasize. However, though not always seen (by me, at least), this is a possible scenario, one that might indicate resistance to the end of therapy itself, a deeply unconscious or envious revenge upon the therapist in the transference, a last shudder which is the final breath, or an indication that the treatment is, after all, really not finished. It ain't over 'til it's over, and Jung makes the point that important problems are not so much solved as "outgrown" (1931c, p. 15). The psychological model is not exactly a medical model where the disease is removed. In psychotherapy, problematic feelings and patterns may be altered, or a new pattern may be evolved, both of which are based on a rise in consciousness and on experiential aspects of the therapeutic relationship. But the core problem as such may not be removed or excised; rather, a different relationship to it has been developed. This is why a spiral, double-helix model is sometimes suggested for psychotherapy, such that problems in living are continually circumnavigated but hopefully at a higher level of consciousness each time. And this is in part why going over one's history or the same emotional "material" with different or subsequent therapists is a relevant task. It is different each time around (and the therapeutic chemistry is different each time), just as a second, later reading of an important book brings new things to mind. Growth is not so much the destruction of the problem as a different, less intense, and further developed relationship to it. The earlier version sort of loses its point, loses its steam. In classical Jungian terms, the complex has been integrated or has lost its affective energy and compulsiveness.

No psychotherapy "termination" is final; perhaps that too is why therapists have taken up that word to indicate the endpoint of therapy. In this sense, the word, with its aggressive aura of finality, is wishful thinking. Feelings occur after therapy and can be processed, due to the successful treatment, without the formerly much-needed therapist. Just as patient and therapist carry each other around during therapy, their relationship lingers on, gradually diminishing. The therapy and the treatment become a memory, preferably a meaningful one. The good work done has become an implicit part of the patient's personality, or rather, is woven into it. The self-care dimension noted earlier is available and ongoing, and the therapist's part in its development fades away. Therapists are destined to be forgotten, though not always and not completely. When the therapy has worked, the patient feels a gratitude that can be longlasting. Years later, he may look back at his time with a therapist and say, "He really helped me."

NOTES

1 See John Haule's *The Love Cure* (1996) for an important discussion of this theme from a Jungian perspective combined with Kohut's. Hans Strupp suggests that "in the final analysis the patient changes out of love for the therapist," who has therapeutic leverage through his quasi-parental authority position (1973, p. 140). Strupp's ideas appear to be close to the ideas of early psychoanalyst Wilhelm Stekel, who wrote, "Neurotics never get well for love of themselves, they get well for love of the analyst. They do it to please him" (1912–13, p. 176).

2 Donald Kalsched in his book *The Inner World of Trauma (*1996) talks about an "archetypal self-care system," particularly as related to trauma victims.
3 This reminder comes from Jungian analyst Don Williams.
4 This example, with some variations, was used in a 1997 paper "Some Images of the Analyst's Participation in the Analytic Process" (Sedgwick 1997b).
5 The play on history (his story) led me to think that "history" might be fairly close to "histrionic." However, the words have different Latin roots, one related to knowing and one to acting. We want the history to be as accurate as possible, and we want true, rather than artificial, emotions to be there. It becomes clear that so much of psychotherapy consists of further evolving the emotions connected to historical, relationship "events."
6 See Jung's "Tavistock Lectures" (1935a) for some good examples.
7 This phrase comes from Freud, "Further Recommendations in the Technique of Psychoanalysis" (1913).
8 This terminology is not Jungian per se, but follows the work of psychoanalyst Robert Langs, who had a strong influence in certain sectors of Jungian psychotherapy at the end of the twentieth century, particularly vis a vis so-called frame violations.
9 Freud, too, seemed to be looser than his technique papers prescribed; see Thompson (1994). Also I think Jung was less concerned about Freud's allegedly up-tight technique—after all, they analyzed each other's dreams on a boat trip—than Freud's theoretical restrictions and differences.
10 See McCurdy (1995) for a good discussion of these issues, one to which the present discourse is indebted. The most influential Jungian work on the frame has been that of William Goodheart (1980, 1984), who assimilates the work of Langs into Jungian ideas and approaches.
11 This discussion owes a considerable amount to the work of Goodheart.
12 Psychotherapy is neither art nor science, but rather, sui generis. See my article "The Technique of Analysis: Reconsidering Freud" (1997a): "Analysis does not really have the forms or sensibilities of art nor, because of its subject matter, can depth psychology do much with the scientific, experimental method…. Too loose for the scientific mind, yet too restricted for the artistically creative, analysis seems to lie somewhere in between—sort of scientific, sort of artistic" (p. 5). Notwithstanding, Anthony Storr's *The Art of Psychotherapy* (1990) is a fine book. Freud wrote constantly of (and sought in vain) the "science of psychoanalysis," and even Jung sometimes wished for scientific standing. In his autobiographical memoir, Jung cites his "anima" for trying to convince him, during an imaginary dialogue, that his interior work was "art" (1963, p. 186). While Jung did not insist that it was science, "she" may, in fact, have been right. On balance, Jung's theory of personality seems to me to be more like art than science, which is true of personality theory in general and recalls the idea of the subjective confession in psychology.
13 Psychoanalyst Roy Schaefer takes up this idea, with slightly different emphases, in his notion of a better, "second self" that the therapist *is* while doing therapy. Schaefer further cites the "mutual construction of two analytic second selves" in the psychoanalysis (1983, p. 292). D.W. Winnicott also notes the "professional" part of the therapist—"the work he does with his mind"—that is part of the therapist's

identity in his work: “What the patient meets is surely the professional attitude of the analyst, not the unreliable men and women we happen to be in private life” (1960, p. 161). That is, the therapist is a different sort of, and probably better, person in the therapeutic environment.

14 See Paul Stepansky’s *Freud, Surgery, and the Surgeons* (1999) for an interesting discussion of the surgical metaphor in psychoanalysis and the place of surgeons in Freud’s personal and professional life. See also Thompson (1994) on the rigidification of psychoanalytic technique by Freud’s successors.

15 I realize that the tones of this fantasy example reveal the counter-transference difficulties of maintaining neutrality in this instance.

16 An interesting dissertation by a Jungian analyst (Soter 1995) suggests that the therapist’s sleepiness in session can be in order to get in touch with his unconscious, to sleep and dream. See also some of the work of family therapist Carl Whitaker (Whitaker and Keith 1981), who talks about falling asleep in family sessions and then sharing his apparently relevant dreams with the family in treatment.

17 I suppose this recalls Jung’s “I hit back!” threat.

18 Psychoanalyst D.W.Winnicott (1949) saw sublimated aggression in the therapist’s ending of the session, collecting fees, etc.

19 Lest we forget, there is also Mark Twain’s “When angry, count four; when very angry, swear.” Also, from the Bible: “Be quick to listen, slow to speak, slow to anger” (James 1:19).

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Index