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Jungian
Psychotherapy

A Study in Analytical Psychology

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Jungian Psychotherapy

A Study in Analytical Psychology

MICHAEL FORDHAM

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Contents

Preface	v
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PART I

1. The model	3
2. The development of Jung's thesis	11
3. Dreams	21
4. Amplification and active imagination	35
5. Jung's conception of psychotherapy	43

PART II

6. Analysis	57
7. The setting of analysis	65
8. Starting analysis	73
9. Transference and counter-transference	80
10. Resistance and counter-resistance	97
11. Some less-organized behaviour of therapists	105
12. Interpretation	113
13. The analysis of childhood and its limits	124
14. The origins of active imagination	138
15. Terminating analysis	150

16. Training	158
17. Some applications of therapeutic method	168
References and bibliography	172
Index	177

Preface

This book contains an exposition of therapeutic methods used by analytical psychologists. It is based on Jung's own investigations and includes developments in his ideas and practices that others have initiated.

Jung held that his work was scientific in that he had discovered an objective field of enquiry. When applying this assertion to analytical psychotherapy one must make it clear that, unlike what happens in other sciences, the personality of the therapist enters into the procedures adopted in a way uncharacteristic of experimental method. In the natural sciences study is different in kind and the investigator's personality is significant only in his capacity to be a scientist. By contrast, in analytical therapy the personal influence of the analyst pervades his work and furthermore extends to generations of psychotherapists; the way I conduct psychotherapy is inevitably influenced by my having known Jung, having developed a personal loyalty to him and by being treated by three therapists who came under his influence. This maintains however differently from Jung and my own therapists I conduct myself when treating patients, or whatever conceptions, models or theories of my own I have developed.

It is with these reflections in mind that I have called this volume *Jungian Psychotherapy* with the subtitle: *A Study in Analytical Psychology*. Thus my debt to Jung is acknowledged but it is also indicated that analytical psychology is a discipline in its own right. It is claimed that its ideas and practices can be assessed without regard to the persons who initiated them and in spite of personal influence, that it is possible to construct models and theories that can be tested against experiences recorded during analytical psychotherapy. It was, for instance, the theory of the archetypes and the collective unconscious that inspired my own investigations of infancy and childhood (Fordham 1969a and 1974). This field for study had been indicated by Jung but—in spite of the work of Wickes (1938)—had not been developed far by him, nor by any of those interested in his work, till my own studies. Alongside my investigations, and stimulated by them, for reasons that will later become apparent, analytical method came under scrutiny, especially in London. This book is the outcome of that study.

Jung's orientation was mainly social, historical and synthetic so it came to be thought that his method was somehow completely original; without its being clearly stated how this occurred, the idea of him as an analyst sank into the background. It will be maintained here that many of his psychotherapeutic practices, and his discoveries as well, were based more on analytical method than is usually believed. This thesis will be studied and it will lead to the definition of analysis as a starting point for investigations that will lay more emphasis than is usual on personal development in its social and cultural setting. It is an attempt to develop a neglected dimension of analytical psychotherapy which has been extensively studied by psychoanalysts. It is a matter of much satisfaction that it has been possible to make use of and evaluate parts of their work in the light of Jung's massive and masterly researches.

These reflections suggest two aspects to this book, which will consequently be divided into two parts: the first estimates Jung's contribution to the field of psychotherapy, psychiatry, psychoanalysis, the history of religion, anthropology and other related disciplines that were considered significant by him; the second will start with a definition of analysis and its relation to psychotherapy and will work out the consequences of applying the attitude required of an analyst.

Though the exposition aims at being a complete review so far as is possible, it requires a basic knowledge of analytical psychology which, if necessary, can be acquired from the books and references in the bibliography at the end of the book.

My wife has, throughout, listened, made suggestions and criticized. Without her this volume could not have achieved whatever clarity and coherence it may possess. In addition Diana Riviere's professional skill has done much to render it more readable.

Acknowledgement is made to Routledge and Kegan Paul for permission to publish numerous quotations from *The Collected Works of C. G. Jung* and for modifications in the diagram on page 221 of Volume 16. Acknowledgements are also made to the editors of *The Journal of Analytical Psychology* and the *Zeitschrift für Analytische Psychologie* for allowing revisions of papers previously published in their journals to be included in the text. Detailed information will be found in the Notes at the end of the relevant chapters.

PART I

CHAPTER 1

The Model

In the history of analytical psychology, observations came first and then theoretical constructions. Thus Jung started by making association experiments on normal and pathological persons, went on to practise psychoanalysis and later gained knowledge from his own self-analysis. On the basis of experiences derived from these sources he developed generalizations about the structures and processes within the psyche.

In this book I shall give priority to the practice of analytical psychology as an experience. To begin with I started off with the idea of leaving out generalizations and abstractions, but this proved difficult and misleading. Though, in the discourse between patient and analytical therapist, theoretical ideas are for much of the time eschewed so that the patient may have full scope to develop his own feelings, thoughts, fantasies, dreams, memories and so forth that come to his mind without intervention on the part of the analyst, it cannot be said that an analyst has no model at the back of his mind comprising the sum of past experience and reflections upon it. So I found it inevitable, in developing my thesis, to make reference to theoretical concepts whether or not I liked the idea. This chapter is thus a concession that I have made in the hope that it will assist the reader to orientate himself with greater ease. It is not intended as a comprehensive statement but rather as notes by way of introduction to what follows, and so that terms used in the text may be defined and placed in the context of an abstract model.¹

Originally a model became necessary for organizing and explaining data resulting from the application of a method, for example that used in abreaction therapy or psychoanalysis. In the course of time, however, there developed a reciprocal relationship between the two; not only did the model grow out of experience but reflection on and development of it enlightened the analyst and led to new experiences.

Jung developed a framework in which his findings could be ordered as follows. The psyche was divided so that there are conscious parts of it that are well organized. He called the organizer of these the ego, which is thus the centre of

consciousness. Unconscious and mainly non-ego structures and processes not having the attribution of consciousness were divided up into the repressed personal and the archetypal impersonal layers.

Repression and other defences

The repressed unconscious was conceived as coming into being during development because aspects of the personality were incompatible with the child's personal intentions, ideals and moral feelings, partly derived from the personal moral and ethical attitudes of his parents, also related to the culture pattern in which the family lived. The repressed unconscious was conceived therefore as composed, though not entirely, of rejected contents of consciousness and resulted from the personal interaction between the child and its parents. Consequently it was named the personal unconscious. The essential characteristic of repression is that mental and affective material is not allowed to become conscious and consequently is divorced from the ego. The personal repressed unconscious is thus of the same nature as the contents of the ego from which it has become divorced.

Consequently, as unsuccessful repression can lead to a neurosis, therapy will consist in undoing repression so that the unconscious complex may become conscious. Repression is evoked to explain one of a class of defences against parts of the whole person that are incompatible with others. They are important in therapy because they exhibit themselves in the form of resistances against the therapist's efforts to help in integrating the rejected part. Defence theory explains these phenomena. In the case of repression the incompatible element is prevented from becoming conscious, but there are other defences like isolation that rely on preventing the full significance of the conscious but rejected part being understood. A similar situation arises when projection is used: the patient denies the conscious content by attributing it to somebody else. The defences of each neurosis are characteristic and will be referred to as occasion requires.

Archetypal forms

The second layer of the unconscious, conceived to be essentially different, is represented in dreams, active fantasy and such cultural forms as myths, fairy tales, magic and religion. These forms derive from innate and probably inherited organizers called archetypes. They are structures not characterized by the quality of experience called consciousness. By interaction with the environment, however, they contribute to the formation of typical imagery that may have magic-like characteristics, to which Jung gave the term *numinosity*.

The two systems of ego and archetypes can optimally act in a compensatory manner, so that the psyche as a whole is said to be self-regulating and if this becomes disordered the result is a neurosis, a perversion, a psychosis or a character-disorder.

Whilst the ego is rather well organized, the archetypal systems can be considered, through observation of their derivatives, to be less so and to be difficult to separate out from each other. It is believed that they gravitate towards expressing the whole organism's functioning. Nevertheless Jung differentiated a number of them with the following qualification; 'It is a well-nigh hopeless undertaking to tear a single archetype out of the living tissue of the psyche; but despite their interwovenness the archetypes do form units of meaning that can be apprehended intuitively' (*C.W.*9, 1, p. 179). With this reservation he defined the following psychic structures: the shadow, the anima, the animus, the mother, the child, the spirit and such processes as rebirth. The following need further definition.

The shadow

This is the archetype nearest to the ego and is close to the repressed unconscious, with which it regularly becomes integrated. Its form, like that of other archetypes, is variable but it contains, besides the personal shadow, the shadow of society. By this is meant that in any particular society there are human characteristics that are not developed and become neglected or repressed. The shadow is fed by the neglected and repressed collective values.

The anima and animus

These two archetypes are the contrasexual components in any man or woman and become expressed in typical images: the anima being the image of woman that a man carries within him, beginning with his mother and enriched by his experience of other women during his life. The same applies to the animus in a woman, starting from her father and followed and enriched by her subsequent experience of men. The two archetypes are different, however, in that the anima tends to be a single figure whereas the animus is a plurality. Like the shadow, these archetypes are strongly influenced by culture patterns in which the view of what is masculine and what is feminine can be markedly different.

Synchronicity²

Jung became interested in the fact that, at periods when archetypal activity was particularly marked, events without cause took on special significance. He called them synchronistic and related them to parapsychological phenomena. It is probable that they are a kind of experience made accessible when regression is sufficient for orientation in time and space to become disturbed and when magical thinking takes precedence over rational thought. The designation covers not only regressive experience but methods devised in previous eras to assess the total situation and its implication to the individual and to social situations. Such a method of divination—the I Ching—was, for instance, used in China up to very recent times. In view of the extensive use of

such methods, Jung thought that synchronicity might be an idea that could introduce another dimension of experience to the rational and scientific one dominating our civilization. His idea that, in effect, chance can become meaningful and creative is in line with much biological thinking which identifies the emergence of new genetic variations with the operation of chance.

Symbols

Another conception especially characteristic of Jung's thinking was his conception of symbols in psychic life. It is easier to grasp when related to archetype theory. Symbols, Jung thought, were the best possible representation of unconscious, that is, archetypal data. They were thus the only expressions of unconscious mental life available to us. That they appeared to be overdetermined and contained a multitude of meanings, did not signify that they were analysable into their component parts, but rather that they had the capacity to stimulate consciousness to evolve new meanings from them. The conception was part of his theory of the evolving nature of unconscious processes. Symbols were the underlying generators of thought and the transformers of instinctual energy in multifarious and unpredictable forms.

The self

This concept will frequently be used in the present volume. It is sometimes classed as an archetype, but mistakenly so. Jung defined a rich symbolism of the self that referred to experiences of wholeness. The distribution of its symbols is widespread and for this reason it might be called an archetype, were it not that Jung conceived that the symbols referred to a wholeness of the personality that embraced the ego and the archetypes working in relation to each other and in relative harmony. Experiences of self-symbols tend to take place when the person is isolated from others and they consequently represent states in which the psyche is, as it were, gathering itself together without external interference. To express the defensive content of these symbols, there is very often a barrier round them, which can be thought of as like the defensive immunological systems of the body.

It will be observed that this model of the psychic structure and process requires a theory of energy in order to account for the dynamic nature of the structures.

Psychological types³

The theory of types became important in the development of analytical psychology because it defined the kind of differences that made for conflicts of a particularly virulent kind. It could also, Jung hoped, become an instrument for defining lines of therapeutic endeavour for, just as Freud's approach was analytical and Adler's educative, there might be other approaches that could be justified on the basis of types.

The theory depends upon the concepts of attitude and function. Persons have a particular attitude towards objects—they can be extraverted or introverted: the extravert is habitually orientated towards the external object with which he has a good relation so he tends to get on well with people, is sociable and at home in any occupation which involves relating to objects in everyday life. The introvert on the contrary is better related to his own psychic processes, is reflective and occupied with his own reaction to external objects, which he approaches only when he is reasonably sure that they are congenial to him; philosophers, mystics, some artists and many reflective people are introverts.

The function types define ways in which people operate in relation to objects whether 'internal' or 'external'. There is thinking, which is different in the extravert from the introvert, for the former only needs thought as a means of relating and doing something with the object world; for the latter thoughts are objects in their own right and can be enjoyed without reference to reality. Thinking needs to exclude values and judgements, which are in the province of feeling. Thinking and feeling, both conceived by Jung as rational functions, are therefore opposites. The same principle of opposites applies to the irrational functions sensation and intuition. Sensation defines things and situations as they are in the present; in short, it defines facts. Intuition, on the contrary, seeks out possibilities of a situation and so is essentially speculative.

When it is considered that each function may be introverted or extraverted, and may combine with two other functions, it is apparent that the system becomes exceedingly complex. Furthermore, no person lacks any of the functions and both attitudes are to be found in the same person, so how is a type of person defined? A person is a type if his habitual mode of life corresponds to an attitude and function, in other words the type is defined by the attitude or function of the ego. The opposite attitudes and functions are unconscious and therefore linked with infantile and archaic modes of action. The type of a person thus has a special meaning: it defines his superior attitude and function in the sense that they are the most differentiated. The inferior function and attitude are less developed and remain in a primitive state. Thus, in a thinking type, thought is said to be superior and feeling is considered inferior.

The conception of types is inherent in Jung's thinking and extends beyond the function and attitude types to archetypes as well. The idea behind this usage is to define regularities within the psyche that are relatively stable. The notion of types carries with it the idea that they cannot be altered and so are in a sense eternal. This was not Jung's conception for he allied the type theory with that of individuation, in which it is conceived that the functions and attitudes can be fully assimilated so that all of them are available to the whole individual. Nevertheless, it is the static aspect of typology that has received most attention and has been made the subject of experimental investigation. This theory will be referred to in subsequent chapters but, because I believe it tends to a static view of personality structures, it will not feature much in the development of psychotherapeutic practices that I want to emphasize. I recog-

nize the subtle and effective use of type theory by other schools of analytical psychology.

Process theory

By observing people and particularly the dreams and imaginative sequences that his patients produced, Jung came to the conclusion that a development takes place, especially evident in later life, called individuation.⁴ It was held to start in the unconscious, to gain expression first in dreams and imagery (especially active imagination) and it seems to direct the individual's consciousness towards a greater awareness of himself as an individual person at once separate from and yet also part of the society in which he lives. Individuation is at first an introversive development whilst the person re-evaluates his life experiences detached from environmental influence. Later, though sometimes concurrently, it leads on to an enrichment of personal and social relationships.

The concept of individuation informs all psychotherapy conducted by analytical psychologists. There is one important consequence of this proposition: the loss of a symptom is not so important as how it is lost. To be more precise, is it removed by repression or is it lost as the result of an increase in consciousness, and is the energy previously bound up in it used to develop the whole personality? These are essential questions that must be asked when considering therapeutic results. It follows that the loss of manifest psychopathology may or may not be desirable, for there is a positive aspect of mental disorder expressed by the formula that its manifestations are a failed step in the individuation process. In limiting cases it is even desirable for the patient to keep his symptoms for with them there is hope and without them there is none. Finally it may also be that the acquisition of symptoms is desirable. An example of this state of affairs is given by Jung. He treated a woman who had previously undergone several unsuccessful analyses. He penetrated her defences, however, and then she developed a collection of alarming symptoms that she did not have before, and out of which her development could proceed (cf. p. 111 for more details and also Jung, 1935). Without them this was impossible.

Maturation in childhood⁵

Jung mainly studied subjects in relation to cultural forms, making more reference to older people and less to those in the first half of life and childhood. It would, however, be false to say that he paid no attention to the maturational processes in children; indeed, many of his ideas about them were remarkably interesting.

His main idea was this: a child's ego was less of a centre of consciousness than a set of nuclei. He likened it to a number of islands in the sea which gradually coalesced to form the ego as he conceived it in his general thesis. At what age this took place is not usually made clear, but he seems to have thought that it had often happened by about five years of age.

The image of the sea suggests, in view of the meaning of the symbol given to it, that the ego grew out of the archetypal unconscious and so it would be expected

that, alongside the development of reality perception, ego nuclei would form in relation to emerging and developing archetypal images. This gains support from the evidence of children's dreams and fantasies in which parents, especially, feature in fantastic myth-like forms.

Besides this general proposition he also held that behind ego-formation lay the self, providing a sort of ground plan or matrix for the developing consciousness.

As to infantile sexuality, Jung was much criticized by psychoanalysts because it was thought he denied the infant's sexual nature (cf. Abraham, 1912). In reply he claimed to accept the 'facts' but believed that they were misinterpreted. He separated out an oral nutritive phase from anal and genital fantasies and impulses which, he thought, should more accurately be called presexual, whilst oedipal conflicts he thought of as archetypal in character, thus emphasizing their imaginary components. Sexuality proper, therefore, only began to manifest itself in adolescence.

In child therapy Jung laid great emphasis upon identifications between parents and children and so, because of these, as well as because of the unorganized state of the ego, psychotherapy consisted largely in treating the parents, whose unconscious influence was usually, but not always, the cause of neurotic conflicts and behaviour disorders in childhood.

Jung's view was, however, incomplete, and infancy has more importance than he recognized. He never organized his ideas about a child's maturation and paid little attention to infancy as such, even though he left behind him interesting ideas about it (Fordham, 1977). Yet his theory that archetypes are inherited almost demands investigation of the early stages in development, for an infant would be expected to exhibit activity adapted to his situation. There is growing evidence for this hypothesis.

The following model, developed mainly by myself, grows out of Jung's ideas but, unlike the model so far outlined, is not to be identified with his conceptions. The sketch presupposes sufficiently good parenting for the processes envisaged to be facilitated.

After birth, and during his previous intra-uterine life, an infant is separate from his mother and therefore his condition may be considered as representing the primary state or unity of the self. He then makes a relation to his mother by the activation of 'drives' conceived to deintegrate out of the self. They lead to his mother providing satisfaction for them, and the infant then reintegrates in sleep. This process recurs throughout life in an ever-widening context. Since the infant is largely unconscious, owing to the poor development of his perceptual capacity, he will tend to organize perceptual input according to archetypal systems. This means that he does not perceive the parts of his mother with which he comes in contact as they really are, but in terms of forms that organize his experience in unrealistic imagery, later observed as fantasies about what parents are like. This state of affairs is named primary identity because the fantasies are experienced as identical with his real mother. The psyche of an infant is highly plastic, but he responds and his rudimentary ego organizes his experiences in terms of whether they are pleasurable and satisfying or

unsatisfying and painful. His reactions are thus far more dependent upon 'subjective' feeling than objective assessment of any situation in which he finds himself.

Just how soon an infant begins to organize his perceptual input in realistic terms we do not know, but he certainly takes time to realize his dependence upon his mother. Good mothering involves being available so that the infant can experience her as part of himself in the first place and thus the foundation is laid for her to help her baby to make a bridge to reality by introducing tolerable frustration. It is mostly via frustration that recognition of dependence is brought about.

The growing maturation of the infant's perceptual apparatus, and the organization of his motor actions, gradually make possible a realistic appreciation of his position. His discovery of his mother as separate from himself, together with a kind of body memory of the time before she existed, provides the two motives for his progressive separation from her. In addition his gradual acquisition of skills gives the capacity to gain pleasure from his growing achievements; his capacity to feed himself, to play with his mother and with toys, and eventually to become a toddler, to gain an upright position, to walk, to gain control over his excreta and to begin to communicate with words are all additional factors in his maturation. When he has done all this he has achieved a perception and affective appreciation of himself as a separate person. He has achieved unit status and can go on to extend his relationships into the three-body oedipal situation.

It will not serve the purposes of this book to go into further details, which can be gained from the literature. I only want to emphasize that from the point of view of psychotherapy the early period of achieving unit status is important for its conduct. If material from the very early period comes to the fore, the therapist will have to conduct himself differently from when conflict arises after unit status has been achieved.

The progression in an infant from primary identity to unit status accords with Jung's definition of individuation, which he had studied in patients in the second half of life. The discovery of the same process in infancy contributes to a more coherent model of development as a whole from infancy to old age—it is the model that will be used in this volume.

Bibliographical note

These bibliographical notes are intended to supplement references in the text so that the reader may gain easier access to the literature. The usual method of reference to the general bibliography is used.

1. For an introduction to Jung's model: F. Fordham (1966).
2. For an account of synchronicity: M. Fordham (1957).
3. For a review of the experimental literature on introversion and extraversion: Dicks-Mireau (1964). Bradway and Deltoff (1976) consider later work including that on function types. For an interpretation of type theory: M. Fordham (1957).
4. For alternative views on individuation: Jacoby (1958 or 1967); M. Fordham (1958); F. Fordham (1969).
5. For a model of maturation in childhood: Fordham, M. (1969a). An alternative model, not used in this book, is provided by Newmann (1973).

CHAPTER 2

The Development of Jung's Thesis

In the early days of their investigations analytical therapists concentrated on recording the behaviour of patients. They assumed that their own influence was not primarily important in influencing the communications to which they listened. The patient was treated as a closed system which could be observed and investigated after the manner of medicine and surgery. It was then that therapists thought they were proceeding scientifically. Such was Jung's attitude when he approached psychiatry to conduct his experimental researches. It was in the same spirit that he became a psychoanalyst and learned Freud's method which he pursued in many of his later discoveries and in his critical assessment of Freud's work.

Jung always considered that analytical psychology and psychoanalysis were related disciplines and he persistently paid tribute to the importance of Freud's work in the scientific and therapeutic fields. There can be no doubt, for instance, that he understood the nature of the psychoanalytical method even when he challenged the uses to which it was put. He also grasped the importance of transference, in which the patient's perceptual experience of his therapist becomes distorted by images containing memories of the patient's experience of his parents in infancy.

In spite of all this Jung came to differ radically from Freud and relations between the two men broke down. The conflict was serious and Jung took different views on a number of subjects, of which the most important were the place of sexuality and the psychology of religion. Today there is no need to enter further into the now exhaustively documented controversy so I will proceed straight away to considering the definitive volume *Two Essays on Analytical Psychology* (1928) which describes what Jung did when he arrived at his then controversial conclusions. His argument was developed in relation to conflicts between Freud and Adler. He discussed how it came about that two interpretations could be given of the same material; there was the sexual interpretation, identified with psychoanalysis, and the ego interpretation, identified with individual psychology. He believed that the contradiction could

be reconciled through his theory of types, the orientation of psychoanalysis being extraverted and that of individual psychology being introverted. The reconciliation of these conflicting theories thus depended upon the development of a third theoretical system, defining different personality structures. It is a view that could not be sustained today because of the development of ego psychology in psychoanalysis, but it was important at that time.

Later on Jung considered that the different techniques of each type, the one analytical, the other educative, were relevant in the psychotherapy of persons in the first half of life, and he continued to think so, in principle, until the end of his professional and scientific career. He did not, however, believe that this was all that could be done, especially with the class of patients in whom he became most interested—those in the second half of life.

Myth and dream

To introduce his new method in *Two Essays* he described a development in the transference that took place in a female patient. At first her experiences were interpreted in relation to her history and her love life, originating in her infantile relation with her own father; so far he was in line with the views current in psychoanalysis. But her transference love towards Jung did not diminish, to his puzzlement. On the contrary, in her dreams his importance increased; he was depicted in ever more mythological terms, as follows: 'Her father (who in reality was of small stature) was standing with her on a hill that was covered with wheat fields. She was quite tiny beside him and he seemed to her like a giant. He lifted her up from the ground and held her in his arms like a child. The wind swept over the wheat fields and, as the wheat swayed in the wind, he rocked her in his arms' (*C.W.*7, p. 129).

Jung's initial interpretations had been made on the basis of the patient's reaction to real people in the past and so were defined as being on the 'objective plane'. Thus the dream just recorded might be understood as a glorified representation of an infantile memory. It might refer to the time—though Jung does not so interpret it—when the patient as an infant had actually been held in her father's arms and first experienced him as huge and herself very small, a discovery important in infant development because it contradicts early infantile omnipotence and introduces the environment as separate from the infant self. But Jung was not impressed with such ideas and thought that this kind of interpretation did not explain the myth-like quality of the dream and in particular the association of god with the wind. It is an association that a student of the Bible might root out, but not one that his patient, an agnostic, would know of. But even if she had done so the dream-image would have to be constructed out of the acquired knowledge. In addition Jung says: 'The god-image of the dreams corresponds to the archaic conception of a nature-demon, something like Wotan . . . god is the wind, stronger and mightier than man, an invisible breath spirit' (*ibid.*, p. 135). The patient had, in short, whatever the infantile origins of her dream and whatever her knowledge, hit on an

archaic primordial idea. This, he thought, must originate in unconscious structures and processes of the patient reacting and transcending personal relations so as to reach into a collective historical layer in which an 'objective' myth was being created. Jung himself was thus used by the patient's unconscious as an object through whom the transpersonal myth could be realized. In his own words:

A careful examination and analysis of the dreams . . . revealed a very marked tendency . . . to endow the person of the doctor with super-human attributes. He has to be gigantic, primordial, huger than the father, like the wind that sweeps over the earth—was he then to be made into a god? Or, I said to myself, was it rather the case that the unconscious was trying to *create* a god out of the person of the doctor, as it were to free a vision of God from the veils of the personal . . . (*ibid.*, p. 130).

As the treatment progressed; transference started to become less intense; gradually the analysis came to an end and thus Jung believed his conception received confirmation.

Besides this new interpretation on the 'subjective plane', as he called it, Jung developed a method of fantasy depending upon the psychic reality that he had postulated and that derived from his own personal experience. In many fantasies a patient may be depicted as in a situation in which there are objects, 'people' to whom he is reacting passively or actively, adequately or inadequately. Jung suggests that the patient should take the fantasy or dream drama as real, consider what he is doing in it and then, having reflected, go back to the fantasy and react in it according to the reflections. In this way a dialectic would be set up between the subject or ego and the objects and persons of the fantasy, the non-ego. This was the basis for what he later termed active imagination (cf. Chapter 4), and gave cogency to the theory of psychic reality.

Jung's personal development

How Jung arrived at his conclusions is important for understanding his subsequent development and that of his followers. First he became fascinated with mythology and made a large collection of myths from all over the world. It was a study inspired by psychoanalysis and designed to investigate the symbols that man had used for religious and magical purposes, also to be found in patients' dreams and fantasies. His investigations were eventually focused by reading a case study published by Flournoy: an account by a 'Miss Miller' of experiences with a near-hallucinatory character about a hero figure round whom she wove erotic fantasies. Jung took each bit of the fantasy and amplified it with mythological parallels, departing far from Miss Miller's material, to elaborate significant themes. He then drew conclusions (interpretations) from them. Thus he developed the short Miller text of a few pages into a book, *The*

Psychology of the Unconscious (1912), of over 400 pages. It provided material for his later theory of archetypes, which was written into the second edition, published in 1952.

So far his investigations were essentially objective. But then after he had finished writing *The Psychology of the Unconscious*, he wrote: 'I took it upon myself to get to know "my" myth', in other words, to reach into the roots of his personal involvement in his researches. This was an important step in developing an open-system view of psychotherapy and built on earlier ideas of the relevance of the subjective factor in research into unconscious structures and processes. This idea began even in the days when he was conducting association experiments, when he considered that the analyst's influence was important in bringing about therapeutic effects, expressing this in the demand that a personal analysis be made the centre of training in psychoanalysis.

To discover his own myth, then, Jung reviewed memories of his childhood. Most of the data he considered did not lead anywhere, but memories of games he had played, of buildings or villages, revived affects in him. He felt that these must be significant and, after overcoming a resistance to so doing, he started to collect stones and played with them just as he had done when he was a child. His imagination then began to work and become as vivid as it had been in his childhood. It gradually ceased to be related to play, and he used writing, painting and sculpting in stone to clarify and objectify the products of his imagination which, from time to time, reached hallucinatory proportions. From this exercise he became increasingly convinced that there was part of the psyche that should be regarded as objective, autonomous and archetypal. He thought that its investigation needed a considerable knowledge of the kind he had already acquired, but, as it turned out, he needed even more because he found that his imagination was remarkably like that of the alchemical 'philosophers'. His investigations into alchemy¹ thus largely derived from his need to relate his imaginings to a parallel source; in this Jung seems to have used alchemy much as a patient might use an analyst as a point of reference for what he was experiencing, and thus he could realize that there had been others who had made discoveries like his.

The experiences Jung went through and the use he made of them are essential to the understanding not only of him as a person, but also of his method of therapy. Indeed, it was from these that the practice of active imagination, dream analysis and amplification were derived. Separate chapters will accordingly be devoted to these subjects later on so here it need only be observed that Jung came to think that a grasp of the elements of mythology and cultural history was required of any psychotherapist.

The attack on Jung, based on the idea that his experiences were psychotic, is not justified but, from childhood onwards, hallucinatory and phobic states recurred that were often strikingly like a psychosis. It was this character structure, vividly described by him in his autobiography, *Memories, Dreams, Reflections* (1963), that had powerfully focused his psychiatric interests. His first research into 'The Psychology and Pathology of so-called Occult Phen-

omena' (1902) was a study of mediumistic data collected during a number of seances, from which an interest in parapsychology began. It was also a personal factor that promoted his studies on schizophrenia. He was one of the first, if not the first, to grasp the meaningfulness of the hallucinations and delusions of the insane, a discovery made possible not only through his psychoanalytical interests but also through the nature of his own psyche.

The disease of the psychotherapist

It may be surprising to say that essential features of Jung's work, and very much more, originated in personal affective disturbances, yet so it was. In this he was far from unique, indeed it is characteristic of other pioneering psychotherapists; they also went through experiences of being neurotic or otherwise deranged during some part of their lives, and so today the positive nature of psychopathology is implied in training: analysis, essentially a treatment procedure, being required of candidates. This seems to make psychopathology a necessary prerequisite to becoming a psychotherapist – and it would follow that it draws a therapist into his profession; it may be a neurosis, as in the case of Freud, or a capacity for dissociation, as with Jung. To exaggerate somewhat, it may be held that the psychotherapists who know about neuroses in themselves will treat patients who have equivalent symptoms; those with psychotic character traits will prefer to treat patients with comparable disorders. They will also tend to develop theoretical models suitable to each kind of person (a theme developed at length by Ellenberger (1970) in *The Discovery of the Unconscious*). There is a historical parallel in a group of myths depicting the physician as a wounded healer, to which reference will be made later on.

As more and more is known about how to penetrate into the substrata of mental life, however, it is becoming apparent that neurotic and psychotic traits are characteristic of many more people than was at first supposed; these can be discovered by candidates so that they can develop understanding of their patients, and prevent them developing damaging resistances against their analysts or running the danger of being infected by their psychopathology.

Open-system theory

In so far as the therapist is analysed so as to further his skills, the therapist's analysis is still in line with scientific method and follows the closed-system theory. Jung became intensely aware, however, of the way in which the analyst can become involved with his patient. Early on he had maintained that the therapeutic influence on the patient derived from the analyst and later he instanced examples of how an analyst's dreams may be useful when told to the patient. He also suggested that a therapist may even take into himself the patient's psychopathology and may appear psychotic through identification with his patient. In all this he was, without actually expressing it, moving towards an open-system theory in which the interaction between analyst and patient becomes the centre of study.

The exposition of Jung's thesis

A survey of the literature since Jung's crucial papers shows that emphasis has been laid by Jung's pupils on demonstrating material produced by patients with myth-like characteristics. A monumental volume by Baynes, *The Mythology of the Soul* (1955), describes and amplifies material produced by two borderline cases; another, less massive, *The Living Symbol* (1961) by Gerhard Adler, is similar and a third, by Frances Wickes, *The Inner World of Man* (1938), also deserves mention. In all of them the closed-system approach is pursued (though with minor concessions to his personal involvement by Adler) and the patient's material is treated as fitting into a prescribed model based on mythology. They all give prominence to dreams and fantasy and to pictures painted by their patients with non-ego characteristics: therapy, it is claimed, comes about through the action of primordial archetypal images on the consciousness of the individual. Compared to more recent studies, there is relatively little attention given to transference manifestations either as entering into therapy or as being in need of analytical intervention.

Individuation

In the case where Jung became depicted as a myth, he gives an illuminating account of the ending of the patient's analysis, as follows:

I saw how the transpersonal control-point developed—I cannot call it anything else—a guiding function which step by step gathered to itself all the former personal overvaluations; how with this afflux of energy, it gained influence over the resisting conscious mind without the patient consciously noticing what was happening. From this I realised that the dreams were not just fantasies, but self-representations of unconscious developments which allowed the psyche of the patient gradually to grow out of the pointless personal tie. (*C.W.*7, pp. 131–32).

Thus it is apparent that the transference resolved itself without the need for detailed analytical intervention. It was this observation that became generalized and led some of Jung's followers to pay scant attention to a difficult topic which could be resolved, it was thought, by developing knowledge and experience of the archetypal processes. The experiences of which Jung's patient provided examples formed the basis for his concept of individuation.

Jung held that this began in the unconscious and could be inferred from a progress in dream and active imagination like the one that has just been described. It was a process that required the close attention of the ego, but which continued relatively independently of it. The significance of this idea for psychotherapy is evident. Previously it had been thought that the most important therapeutic influence was the undoing of defences in the ego and making conscious the unconscious contents of the psyche. Now, besides this and the

influence of the therapist, was added an unconscious individuating or whole-making effect. It is true that awareness of its existence was needed but the dimension of experience was equally if not more important than the assimilation of the unconscious complex by the ego.

The nature of therapy

A book written by C. A. Meier (1967) goes into the subject in more detail. As is usual in much of the literature his approach is through the practices pursued in the past, which are thought to shed light on those of the present day because of the historical nature of unconscious forms. Meier studies the Greek cults of Asclepius as practised especially at Epidaurus and Pergamon, the character of the god as a wounded healer and the belief that the sickness, having been sent by the god, can only be cured by him through a dream or vision. This, Meier suggests, follows Jung's understanding that for a cure to take place conditions must be set up that give scope for unconscious archetypes to get as full expression as is possible so as, it may be assumed, to mobilize individuating processes.

The cult practices all fostered regression; after preparatory initiation the patient was, for instance, made to sleep in remote places such as sacred groves, and if he dreamed the healing dream or vision he would be cured. Experiences of this kind were not often recorded in sufficient detail to be worth quoting but Meier gives two examples that indicate their wide range:

(1) 'Pandarus, a Thessalian who had marks on his forehead.

In his healing sleep he saw a vision. He dreamed that the god bound up the marks with a bandage and commanded him, when he left the sacred hall, to take off the bandage and to dedicate it to the temple. When day came, he rose and took off the bandage, and found his face free from the marks; but the bandage he dedicated to the temple, it bore the marks of the forehead' (p. 82).

By contrast with this, which strains one's credulity but indicates the uncritical attitude into which the patient is induced, there are elaborate visions of great length. They follow complex initiatory procedures, as follows:

(2) At the oracle of Trophonius, the incubant, as the person was called, drank from 'the two springs, [then] he was shown the statue of the god' only shown to such persons; next he was 'clothed in white linen and wrapped in bands like a child in swaddling clothes'; finally 'he was given a ladder so that he could climb down into the cave. When he reached the bottom, he had to creep feet foremost into a hole that was only just big enough to allow a human body through. When in as far as his knees, he was sucked right in, as if by a mighty whirlpool. In his hands he held honey cakes, which he fed to the serpents living there, to propitiate them' (*ibid.*, p. 100).

Timarchus, a young philosopher, decided to go down into the cave of Trophonius and when he got there he lay a long while not conscious 'of whether he was awake or dreaming; only he fancied that his head received a blow, while

a dull noise fell on his ears, and then the sutures parted and allowed his soul to enter forth' (*ibid.*, p. 102). Then follows a series of complex visions which are explained at length by the voice of an unseen person. Timarchus returned after 'two nights and one day . . . he came up very radiant . . . and related to us the many wonderful things which he had seen and heard' (*ibid.*).

In Meier's small erudite volume he constructs a web of cult practices and myths and into this he inserts a number of dreams produced by his patients to show that the material from antiquity is relevant to modern man. His conclusion is explicit; though it does not take on so concrete a form, psychotherapy has a mysterious meaning like that contained in religion. He suggests that psychotherapy has characteristics of these cults in as much as conditions are provided for a patient to gain experiences in dream or vision of the type he describes and which are analogous to the procedure Jung used. He is at some pains, however, to disclaim any intention to produce them 'artificially' because the experiences must be spontaneous to be effective. He supports his position by quoting Jung when he asserted that all the problems of his patients in the second half of life turned out to be religious, but goes further than the master in asserting that if his views are correct then 'every physician must also be a metaphysician's a step which Jung was often reproached and criticized for not taking.

To underline the importance of the therapeutic influence and benefits derived from these cultic practices, Meier reminds us that they survived longest of all other pagan cults into the Christian era and were only comparatively lately integrated into Christianity at Lourdes; their underlying principles have, however, also expressed themselves in psychotherapy.

It is clear that Meier seeks to underpin Jung's thesis about the importance of the patient discovering his myth as an expression of what is controlling his life, his illness and his health. By giving its historical perspective Meier assumes that his thesis is strengthened. If cults have persisted over the ages, then they must be significant.

Meier's claim is a large one and so it may be worth looking a little more closely into the nature of the analogy that is drawn between Jung's concept of therapy and the ritual at the oracle of Trophonius. It is evident that in each case the person, patient or initiate (incubant), must be motivated from within himself to undergo a rigorous discipline in which consciousness is reduced and brought into relation with dreams and imagination in such a way that ordinary rational thought is at least temporarily suspended. In the Greek cults this was done by arranging a situation and enacting a ritual both known to have magical, religious and mysterious meaning; through them the initiate is removed from ordinary living. As to the ritual meanings which Meier elaborates in detail I select the following: Timarchus would have known that the waters he drank were those of Lethe and Mnemosyne given him to 'forget everything that had been in his mind until then' and 'to remember what he was about to see when he made his descent' (*ibid.*, p. 97). Clothed like an infant, he descended

into the womb-like cave and must have further enhanced the regression by performing symbolic acts. These would further reduce consciousness till the lengthy visions, as it were, burst upon him. The aim is very much like the therapist giving special attention to dreams and fostering active imagination, analysing rational defences and focusing attention on archetypal images. It may seem that such analogies, though interesting, are not particularly forceful. This is partly because I have only extracted a sketch from a more erudite text which Meier elaborates in much more detail. The analogies are strengthened, however, in another way; as a result of much more sophisticated analytical work, his patients dream or imagine proceedings like those described in the Greek healing cults.

A significant conclusion from this, not gone into by Meier, is that the cultural history of a patient can as it were be stored in the individual and exert a far-reaching influence: 'the unconscious is a great storehouse of history', as Jung put it in a striking metaphor, which gives depth and meaning to the experience of patients when its existence is brought home to them. Deeper still is the notion that the basic patterns of human existence are always the same—they are archetypal and even though the patient's conscious attitudes can be modified they cannot be changed basically. Informed with such ideas, many analytical psychologists have concentrated upon the past and have endeavoured to make its 'wisdom' available to modern man by interpreting religious texts, myths and especially alchemy as depicting the basic structures and processes of the psyche. The large and growing literature on this is often fascinating and part of the cultural education of psychotherapists, but excessive concentration upon it can lead to it being interposed between the therapist and his patient, who only invokes the therapist's full attention when he is manifesting archetypal material. This is unfortunate because firstly the data from the past are all fragmentary or highly condensed, compared with what can be collected in the present from patients. But, further than this, it was from the dreams and fantasies of patients that myth, history and religion have been illuminated; there has been a feedback in that myth and legend can be used to detect archetypal material and give meaning to it, but it has been less significant for psychotherapeutic practice.

Meier's book is an illustration of the point of view stating that therapeutic effects are brought about basically by impersonal forms of human action and reaction, and it is characteristic that there is very little mention of therapeutic method or the behaviour of the therapist, while the significance of transference is scarcely mentioned and the therapist's influence is not included. No doubt Meier would say that to describe and conceptualize these matters was outside the scope of his volume, but nonetheless it is still characteristic of the main bulk of the literature and it is this omission that I hope to redress in the course of my essay.

Note

1. References will be made from time to time to the obscure subject of alchemy to which Jung paid much attention. It is commonly known as a precursor of chemistry but full of

misconceptions; what is not so well understood is that it has considerable psychological content.

Jung became interested in the rich imagery through which the alchemists expressed themselves and extracted it from the confusion of thought in order to make sense of it all. He noticed that some alchemists conceived that they were really making gold out of base metals and that others realized that this was not the point and that they were, in fact, developing a mystical philosophy expressed in chemical and cosmic mythical symbols.

By applying his theory of archetypes Jung made an important discovery; he showed that the alchemists were projecting archetypal images into the chemical operations that they devised, and further that alchemy could be understood as a precursor of the psychology of unconscious structures and processes. It even contained indications of the individuation process.

This ingenious interpretation of alchemy occupied much of Jung's later interest and three volumes (12, 13 and 14) of the *Collected Works* are devoted exclusively to it. In addition, references to alchemy are to be found in other volumes, especially volume 16, in which he used an alchemical text to focus his conception of transference (cf. Chapter 9).

Without some introduction to the subject and some familiarity with the alchemical imagery, it is difficult to follow Jung. Fortunately there is an excellent, profusely illustrated paperback by S. K. de Rola (1973) that provides the necessary data.

CHAPTER 3

*Dreams*¹

Dream analysis became to Jung such a central feature of his practice that a separate chapter must be devoted to the subject. His position is made especially clear in his autobiography in which the importance of dreams is emphasized over and over again—indeed it may be said that at every crisis period in his eventful life, a dream or a vision provided essential sources for furthering a solution.

Yet Jung was sceptical about the possibility, or even the desirability, of developing a general theory of dreams and in expansive moments even prided himself on not having one. There can, however, be no doubt that he worked on a number of basic assumptions: in the first place he held that dreams expressed unconscious structures and processes personal and archetypal; secondly, that they contained a meaning that could be deciphered if the dream context could be established; thirdly, they revealed a compensatory process in the unconscious; and, fourthly, that they showed a purposive trend towards individuation in the psyche.

Though it may be said that in effect he unearthed a latent dream content, he preferred to attribute the difficulty in understanding dreams to his own inability to translate them; so he did not go along with Freud's view that the dream was the guardian of sleep, and that the facade of the dream was constructed by the dream work in order to conceal forbidden wishes. He did not seem to think that this is impossible, but rather that there is more to dreaming than that. In addition, he preferred to take a dream as a whole rather than dissect the components of which it is made up. Thus in the theory¹ that the dream has a facade, likened to the facade of a house, an essential part of it is that facade which gives indications of what is inside and how it was constructed; from his point of view there is little point in laying emphasis on the fact that it is made up of bricks, mortar, metal, wood and so forth. Roughly speaking Jung claimed that Freud examined the bricks and mortar whilst he was interested in the house as a whole and its contents. This analogy should not be pushed too far: it is static and is not altogether fair, for Freud's theory was more subtle and far-reaching.

To show the dynamic process in dreams Jung was interested not only in single ones but in a series of them, especially as in a number of dreams he could discern the processes in the unconscious leading to individuation. This he demonstrated in *Psychology and alchemy* (1944) where the 'centralizing process', which interested him so much, could be observed taking place. That particular series is composed of only those parts of the patient's dreams that contain archetypal imagery; the personal matter is removed as essentially irrelevant for his purpose. It is a demonstration in which the images partly amplify each other, thus providing the dream context, but where this is incomplete additions are made to fill in gaps with parallels from other sources. The combination shows what aspect of the unconscious is being depicted and is rather like locating the dream figures in the places where they are known to live habitually; in other words, which rooms in the house are theirs. In this way, however, one aspect of the context is established. In order to arrive at complete interpretation it is necessary to know more: what kind of person the dream is dreamed by, what is the problem with which he is concerned, and what associations he can give. Here Jung only pursued the associations in so far as they were necessary to provide a clue to the dream's meaning. He did not urge the patient to pursue them because he claimed these only lead to the parts of the self and so tend to cause disintegration in the person as a whole. In order to focus attention on the unconscious process it is advisable to collect a dream series, and the patient may be recommended to write them down and keep a 'dream book'; he may add to this record any associations that occur to him and any interpretations that he can make. The results may then be brought to the analyst and studied further. The writing down of dreams—it may be noted—was used by Freud in his self-analysis. They were recorded and analysed in *The Interpretation of Dreams*. Jung himself did the same and indeed kept two books: the 'black book' and the 'red book'. In the former he wrote down his dreams together with his active imaginations, in the latter he perfected and worked up parts that he considered especially important. Thus the method is derived from his self-analysis and is in line with the aims of Jungian therapy to increase the patient's capacity to conduct his own therapy. In this way it is believed that focusing on the self, the most important feature of the process, is fostered; to this end it is thought that interviews should not be multiplied: after the initial period, and when the archetypal processes begin to appear, once or twice a week is usually deemed sufficient. By recommending the patient to write down dreams he is inducting him into an ongoing process, and regression, with its accompanying dependence on the analyst, is limited.

A dream analysis

For the details of Jung's method, a brilliant example can be found in his Tavistock Lectures (Jung 1935a). There he describes a man who came from humble origins (his parents were Swiss peasants); he had worked his way up to being the headmaster of a school and had ambitions of getting a professorial

chair at Leipzig. At this point he developed a neurosis: attacks of vertigo accompanied by palpitations, nausea and feelings of exhaustion and feebleness. The patient recognized this as comparable to mountain sickness.

The first dream (*ibid.* C.W. 18, p. 79) was about a visit to his native village. He wore his official dress, a long black coat, and carried books under his arm. There was a group of young boys whom he recognised as having been his classmates. They looked at him and said 'That fellow does not often make his appearance here'.

This dream, Jung notes, referred to his origins. He did not often remember where he came from because, being in the grip of his ambition, he was trying to struggle ever higher. That idea fitted into the meaning of his symptoms.

The next dream (*ibid.*, p. 79ff) started by stating 'He knows that he ought to go to an important conference', but endless delays got in the way of his catching the train to his destination and he was late. As he arrived at the station he saw the train pulling out. He perceived that the railway line went in a snakelike curve before reaching the straight line ahead. As the train pulled out of the station the patient thought, 'If only the engine-driver, when he reaches point D [the straight line ahead], has sufficient intelligence not to rush full steam ahead . . .'. The engine driver, however, did not exercise the necessary care, he accelerated and the train ran off the rails; the dream became a nightmare. Once again the dream can be understood in the light of his ambition and is a warning against implementing his aims incautiously. So far the dreams have a fairly clear meaning, and knowledge of the man and his conflict is sufficient to make sense of them. Next, there was a big dream (*ibid.*, p. 86), as follows:

I am in the country, in a simple peasant's house, with an elderly, motherly peasant woman. I talk to her about a great journey I am planning; I am going to walk from Switzerland to Leipzig. She is enormously impressed, at which I am very pleased. At this moment I look through the window at a meadow where there are peasants gathering hay. Then the scene changes. In the background appears a monstrously big crab-lizard. It moves first to the left and then to the right, so that I find myself standing in the angle between them as if in an open pair of scissors. Then I have a little rod or a wand in my hand, and I lightly touch the monster's head with the rod and kill it. I stand there contemplating that monster!

Again the dream referred to his ambitious plan. Jung asked for associations as follows: 'The simple peasant's house': that, he learned, referred to the 'lazar-house of St Jacob near Basle'. This, Jung explained, is a leproseries . . . The place is famous because in 1444, against orders, a band of 1300 Swiss attacked an invading Burgundian army of 30,000 men—the Swiss were killed to a man but they stopped the further advance of the enemy. 'The heroic death of these 1,300 was' writes Jung, 'a notable incident in Swiss history, and no Swiss is able to talk about it without patriotic feeling.' Here again was a reference to unguarded impetuosity having personally disastrous consequences.

To continue with the associations:

The elderly motherly peasant woman: 'That is my landlady', the man replied. Jung did not follow this up but understood her as the inferior feeling of an intellectual thinking type (cf. p. 12). When asked about the woman being impressed by his plan the patient replied, 'Oh well, that refers to my boasting. I like to boast before an inferior person to show who I am . . . Unfortunately, I have always to live in an inferior milieu'. Thus, Jung concluded, he defended himself against his feeling by projecting it onto the landlady.

Jung then reflected that the peasants gathering hay referred to the 'fruits of honest toil' as understood in the patient's childhood, and were in the dream because 'he forgets that only decent simple work gets him somewhere and not a big mouth'. The patient's association, however, referred to a picture hung in his present home which he identified as the origin of the dream image. In this way, Jung reflected, he treated it as unimportant. In reply to a question the patient then associated to the crab-lizard: 'That is a mythological monster which walks backwards . . . I do not understand how I get to this thing—probably through some fairy story or something of that sort'. He went on to decide that the monster was the mother and that 'the angle of the open scissors the legs of the mother, and he himself, standing in between, being just born, or just going back to the mother'.

Now the dream has reached the archetypal level: there have been oblique references to the hero and so here is the monster. This Jung pointed out and the patient recognized it: ' . . . I felt surrounded on either side like a hero who is going to fight the dragon'. No fight took place, however, and the monster was done away with by a touch from the magic wand (patient's idea). Now because the archetypal level has been reached Jung can introduce his knowledge of mythology; he knows that the monster is the mother, and, because there is a danger in the dream, he amplified with reference to the terrible mother who eats her children—the 'mother sarcophaga, the flesh eater'—and so the mother of death, Matuta. Next he introduces an idea of his about the mother as a crab which he believes refers to 'organic facts'; it is abdominal and refers to the autonomic nervous system; in other words, it is as if the dragon were representing an internal part of the patient's self to which he paid little attention and imagined he could magic it away with his rational thinking. In support of this Jung drew attention to the close relation between heroes and monsters, especially snakes: the hero has snakes' eyes because he is the snake: he cites Cecrops, who was man above and snake below, etc.

So, Jung concluded, this man's situation was fraught with danger which he believed he could dispel by magical, omnipotent thought. The patient came to think that he had an incest wish which he has now got rid of, so he can go ahead because it was nothing but an infantile relic. When Jung asked him why he contemplated the monster if this were so, he replied that 'It is marvellous how you can dispose of such a creature with such ease'. To which Jung replied 'Yes, indeed it is very marvellous!'

Jung then summarized or interpreted the dreams as a whole, emphasizing

the childishness of his attitude and ended up: 'Your dreams contain a warning. You behave exactly like the engine-driver or like the Swiss who were foolhardy enough to run up against the enemy without any support behind them, and if you behave in the same way you will meet with a catastrophe'. He also stated that the 'best way to deal with your dream is to think of yourself as a sort of ignorant child, or ignorant youth, and to come to a two-million-year-old man, or the old mother of days, and ask "Now, what do you think of me?". She would say to you, "You have an ambitious plan, and that is foolish because you run up against your own instincts."'.

The patient thought this understanding was much too drastic and so he left Jung after this diagnostic assessment. Jung ends by saying; 'He went on with his plans, and it took him just about three months to lose his position and go to the dogs'.

Discussion

In this demonstration Jung used his model of the psyche which showed him the way to approach dreams and was the base from which his interpretations were made. There is first of all the idea that the symptoms are an expression of the compensatory relation between the conscious and the unconscious: the symptoms state that he is too high up and, by implication, needs to come down, relinquishing his ambitious aims—consequently the dream contains matter about the patient's lowly origins and his childhood. In the next dream the theory of compensation can be pursued: the dream-image of the train running off the rails can then be understood as a warning. In this dream Jung also employs his theory of symbols: it gives significance to the curve of the railway line which reminds him of a snake. In the final dream it is clear that the theory of types is being deployed: the patient is a thinking type and consequently his feeling is inferior; for this reason the 'elderly motherly peasant woman' can be interpreted as representing his inferior feeling. Finally the mythological 'crab-lizard' is an archetypal form which can be amplified and understood on the basis of Jung's extensive knowledge. It is also clear that the summary and advice to the patient aimed at initiating active imagination in that he recommended the patient to consider the archetypal imagery as a fantasy, and that, in fantasy, he should go to the old woman and admit his ignorance and childishness and 'listen' to what she had to say: Jung helped him by giving an impression of what she would say.

The patient's refusal to accept Jung's approach, and the sadness of the patient's end, though scientifically interesting, is therapeutically unsatisfactory. This was taken up in the subsequent discussion at the Tavistock seminar at which the demonstration was taking place; Jung was asked whether the patient could not have been treated differently so that he might have been able to accept the interpretation. Jung replied in effect that it is wrong to try and cheat a patient by clever means, that he could have said to the patient "'Yes, that is a mother complex all right", and we could have gone on talking that kind of

jargon for several months and perhaps in the end I would have swung him round. But I know from experience that such a thing is not good . . . Perhaps it was better for that man to go to the dogs than to be saved by the wrong means' (*ibid.*, p. 96). This is a bit of what may be called 'natural wisdom' and is seldom absent from the work of an analyst, though he may think it better to protect the patient from it!

It should be noted that Jung did not always take such a cavalier attitude. Indeed in 1934 he said: 'The analyst who wishes to rule out conscious suggestion must . . . consider every dream interpretation invalid until such time as a formula is found which wins the assent of the patient' (*C.W.16*, p. 147). It may be, however, that Jung thought that suggestion was necessary in this case, but it is also possible that, since the importance of transference has been increasingly understood, more attention to it might have made a great deal of difference.

On this subject Jung makes no comment but it does look as if the patient had magicked his conclusion away, just as he had dismissed the monster. This is made more likely by Jung's impersonation of the 'two-million-year-old man or the old mother of days' which would probably have drawn a projection from the patient upon him.

The use of amplification

Jung chose a case that was a good one for demonstrating the use of amplification. In practice its use by therapists varies within wide limits. Von Franz (1972, p. 12) records how she saw a patient who was inaccessible but who had a dream: 'I saw an egg and a voice said "Mother and daughter"—that was all'. Von Franz states that she was happy and gave a long dissertation on creation myths in which the origin of the world was an egg, and followed this up with another account of the Eleusinian mysteries in which mother and daughter, Demeter and Persephone, feature. The mysteries are essentially related to feminine rites and so von Franz could tell the patient, who was 'possessed by the animus', that everything would come out all right because a new start was being prepared for her in the unconscious and this new beginning would be on a feminine basis. The patient went away without having understood a word but presumably feeling that von Franz knew what was going on. All this might be understood as a way of initiating a transference, but it may be questioned whether simpler methods would not do this just as well, for one is left with the impression that no space was provided for the patient to say anything!

Some analysts do not agree with giving so much information and only give an outline of their knowledge to the patient: others will recommend books to read giving knowledge relevant to the material that the patient is producing, but little that is more precise can be culled from the literature or conversations with therapists, so it must be left that the principle is clear but the application of it shows individual variation.

Over the years I have almost given up using parallels because I find that they tend to isolate the material from the patient's day-to-day life. Furthermore,

it complicates the elucidation of the transference. It may be noted that von Franz's procedure is not how Jung proceeded as far as can be ascertained; his analysis—except when demonstrating archetypes—was always closely related to the patient's personality and his situation in life.

Environmental influences on dreamers

If a patient went to Zurich or any other place where dreaming was especially prized, and if he knew that this procedure was used regularly, then this atmosphere would be favourable for a group feeling to develop, especially as the patients meet and attend lectures and seminars. Then to be dreaming archetypal dreams and collecting information from books makes for an archetypal impersonal transference which carries the patient along.

No doubt aware of this, Meier (1967), as we have seen, compares modern psychotherapy with the Greek healing cults in which their location was significant. But even in these cults the patients were selected and it is also like this in psychotherapy. The cult element in this discipline cannot be left out or assumed and, in my opinion, close analysis of the transference is needed if its influence is to be kept within bounds.

The therapist's influence

These reflections lead on to the idea that the dreams of a patient may depend on the kind of therapist to which he goes. Thus it is said that patients who go to Jungians have Jungian dreams, whilst those who go to Freudians have Freudian dreams. This notion is at first sight attractive and plausible, but it cannot happen unless the patient has sufficient capacity for dreaming the right dream. Furthermore, is it not necessary that the transference be virtually ignored?

Example

The following case helps to shed some light on these questions by showing what happens when there is a change of therapist. The demonstration involves understanding my attitude towards dream material. Whereas I value dreams highly, I hold that any material brought should be treated as relevant. If some of it turns out to be more important than others that depends on the course of the interview: thus dreams may or may not be important at any particular time. Secondly, I pay consistent attention to the transference, and my own counter-transference, and lastly I have a particular interest in the patient's childhood—developed in this book—which I keep in the background as far as possible. This cannot be eliminated, however much I am aware when a patient starts bringing interesting material from childhood as a transference manifestation. I may fully interpret and this does a great deal to eliminate the influence of my interests, but not altogether. This brief definition of my procedure depends on sustaining an analytical attitude (for detailed definition of this see Chapter 5).

A patient, a married woman with a family, had previously been to a well-known Jungian analyst who laid considerable stress on the importance of dreams. She wanted them written down and the patient had typed out two copies, one for herself and one for her therapist. She was given to understand that the analyst liked it done this way because the analyst claimed she could understand a dream better if it were written down. The patient asked me whether I too liked it done that way so I made it clear that I did not mind whether she wrote them down or not. She then stopped doing so as she said she easily remembered dreams anyway. The writing down had done little more than accommodate the analyst and underline the special importance she gave to dreaming. Nonetheless for some time my patient consistently started off her interview with a dream and, having done this, she would stop as if expecting me to analyse it. They were all lengthy and impressive. It transpired that this was how she had behaved with her previous analyst. The patient would sit back once she had presented the dream to admire the alchemical, astrological and other analogies that were presented at considerable length, and she was given books relating to her own cultural background. Amongst what the analyst said were statements that she found stimulating and these she would use—the rest she set aside without, however, telling her analyst that she did so. She obtained much benefit from the work that was done, which also included making pictures and diagrams. All this made her feel, however, that though her therapist could give useful and practical advice and be personally supportive, she was remote from the patient's more down-to-earth nature, and was a kind of admired seer living in a house high up above the rest of humanity. This tendency was balanced by accounts of appalling behaviour of other therapists she knew of—she did not connect the two accounts, though to me they indicated a splitting process in the transference. Therefore I paid particular attention to her anger about my behaviour, especially my use of the couch to which she had violent objections.

Gradually, as her analysis with me proceeded she dropped the practice of starting with a dream, and would only tell those that seemed relevant to a particular conflict that she was working on. In this way they made much more sense to her than before though nothing like systematic analysis of any dream took place. She still, however, continued to prepare what she said, and a great deal of her conflict-ridden material was worked on away from the analytical interview which she continued to regard in many aspects as a teaching situation. Consequently much more work on the transference had to be done before she could arrive at a more free expression of her affective life. A feature of this analysis was that the dream material became less rich, and more understandable; thus the images became less aggrandized and split off, to become more of the kind for which the patient could take responsibility.

Now this patient had always felt dreams were valuable, especially during her childhood and adolescence, when reality was difficult or disagreeable. They were regarded as a creative storytelling process, like fairy tales, and so were a pleasure, a thrill or a delightful horror, but their meaning was not important.

Her first analyst's pleasure in them, and her amplification of them, enriched and supported this attitude, which was already there before the therapy, and restored her self-esteem so that her depression lifted and she could reconstruct a nearly broken marriage. Therefore she dreamed dreams that both she and her analyst liked, and so long as the transference was not pursued it could continue. The therapeutic effect was not, however, enough for this patient because she felt that her childhood had not been sufficiently dealt with and was indeed pushed aside as unimportant. It was held that what happened in childhood could not be altered and far more important were the creative archetypal processes leading to 'individuation'. The patient, however, believed that the patterns of her childhood were relevant and without understanding of them she could not take full responsibility for herself.

Discussion

Her case therefore suggests that there is a relation between the kind of dreams dreamed, the transference and analysis of childhood, and that unless these are investigated the dream images pile up, as it were, and their content cannot be assimilated, they remain at the storytelling level, and are simply treated as 'objective'. I do not wish to assert that the objective view is undesirable; it can indeed, at some stages in development, be important in bringing split-off aspects of the self into consciousness, nor that the creative attitude taken is not valuable, but rather that it can be used to conceal a sense of inadequacy and personal failing and so is not enough. I want, in parenthesis, to state that what I have described in relation to dreams is not peculiar to their management but can take place with any other material whether it be day-to-day affairs, fantasies, historical data or active imagination.

What, however, can be concluded about the type of dream dreamed by a patient? It is too simple to say that it is decided by the attitude of the therapist. My patient already dreamed 'Jungian' dreams long before she came to a Jungian therapist of any kind; this was indeed a significant factor in her choice of therapist. Thus the type of dream had already been decided. This view accords with my own impression for the wide variety of dreaming or not dreaming in my patients suggests that it is their own predisposition that is important rather than my influence, which may be considered minor.

Attitudes towards dreams

My patient had consistently felt her dreams to be important and helpful and this led me to consider attitudes towards them. One pays attention to whether they are agreeable or not, another can treat them as objects in themselves. Particular dreams can be considered good or bad, big and significant, or small and trivial, and in general they can not only be highly valued as helpful revelations, but bad in the aggregate, and then they will be denigrated as useless, rubbish to be got rid of, dismissed as nonsense. It may be that an analyst who thinks dreams are essentially valuable, when confronted with a patient who

believes they are no use, will be able to engage his patient's interest by conveying his own sense of their importance. Thus he will modify his patient's hostility towards them, but the general attitude also needs to be understood in relation to the patient as a whole, in which the overvaluation or denigration plays an important part. The notion, for example, that dreams are good or bad is essentially childish and needs to be estimated as such, so the need for analysing childhood becomes clear and is better than using the patient's regard for the analyst to manipulate or modify his attitude. To me the analyst's best attitude is to consider dreams as part of the patient, and estimate them equally with other parts.

Example of a personal dream analysis

I now want to consider a dream in which archetypal elements are not in the forefront but discernible. Its analysis will illustrate a way of handling them which many therapists use, myself amongst them. It illustrates what happens if an analytical attitude is adopted and will estimate the idea, noted above, that the patient's assent to an interpretation is the essential validation of it.

The patient was a man in his thirties who seldom remembered his dreams. At the interview that I shall describe, he started by saying that he had had a dream; it ran as follows: 'My wife is riding a bicycle down a slope to a large empty underground garage, I follow in a car and park it in the garage. My wife urinates at the entrance. A huge dog appears. The dog gets into the car but I pull him out. The dog gets in again, once more I pull him out, and I shut the car door. My wife and I then walk up the slope'.

The patient made attempts to think about the dream without much success. As a child he had a dog. His wife has a bicycle which is used by both of them for short excursions like shopping. After further such associations he tried to make out that his wife, in the dream, was a part of himself but without much success, and somewhere along the line I pointed out that the garage seems to refer to a depersonalized element, but this did not produce anything and the interview seemed to be running down to a full stop: the patient was silent. The associations were so far surface ones; he seemed to be looking at the dream from above in my presence: remembering that it had ended with his walking up the slope, it was as if he were continuing the dream, looking at what had gone before and reflecting about it.

After the pause had continued for some minutes and the interview was drawing to a close, he drew a breath and stated animatedly: 'I think that this dream has to do with my wife not getting pregnant'. I knew that both of them were keen to have a baby and felt that an intervention of some kind was required and especially because the patient's affect was coming through, as indicated by his breath and his animation—these suggested that he had, as it were, taken the plunge downwards. I decided with spontaneity on an interpretation as follows: 'Is it not your anger and contempt that cause you so much distress? You feel worried about her not becoming pregnant and feel that all she can do

is piddle'. That produced relief of tension and something like satisfaction that I had got the point. Shortly afterwards he stood up—it was the end of the interview—saying 'What a cesspit the unconscious is!', and walked out.

It will be noted that only a bit of the dream had been interpreted and no attempt had been made to go into it as a whole. No interpretation of transference was given and nothing was said about the sexual and infantile aspects, because neither were affectively charged. I could have considered some analogies with myths as follows: the descent downwards with a dog at the bottom of the slope could be compared with the underworld in Greek and Egyptian myths. Each have mythological dogs (Cerberus and Anubis) at the gate into the underworld. The patient was interested in such analogies so on a later occasion I did point them out. But it would not have done in this interview because if I had launched into these parallels his impersonal defences would have been reinforced, and so it would not have been valuable as far as going into the dream affect along with the patient to arrive at an insight that was emotionally satisfying.

Considering the progress of the interview in more detail: in the first part of it, that is up to the time when the patient produced his decisive clue, he appeared to be dutifully producing associations that, though indicative, all led to a dead end. I was impressed with this as a possible transference manifestation, for he seemed to be obeying the rules of dream interpretation as if to ward off some reproach from me if nothing came of them—this made me consider whether he was not feeling shame and guilt about something, hence a transference anxiety. Then there was the way in which he seemed to be protecting his wife by trying to make her part of himself (in other words, his anima). Other associations seemed to be emotionally neutral, as if he were filling up the time and so my comment did not produce anything. It was, furthermore, significant that towards the end of the interview the crucial statement was made, as if he were feeling that at last it was safe, for whatever I said subsequently the interview would have to end soon and he could escape.

Had he accepted my interpretation? In retrospect I consider that there had been a partial acceptance but his depersonalizing defences were being used to ward it off. Thus he said, 'What a cesspit the unconscious is!', rejecting his personal anger and contempt: full integration of his affect was not possible. It made sense to reject part of my statement because it did not include the defences nor the transference and it did not include the infantile root from which the affect derived. For these reasons full acceptance of an incomplete interpretation cannot be expected and is not required. Full acceptance would even be a special kind of defence for it could be aimed at disarming me altogether if I were blind enough. The important element in the procedure is thus not acceptance or rejection but that the patient has sufficiently modified his defences for him to recognize the partial truth in the interpretation, thus leaving the way open for a continuing dialectic in the future.

This example shows differences from the method of furthering self-analysis away from the analyst by writing dreams down, together with associations and any interpretations that the patient may be able to make.

The differences are as follows:

(1) There has been no suggestion that the analyst likes dreams more than other matter that the patient brings to him.

(2) It was, therefore, clear that the dream had impressed him and this was confirmed by his not remembering them often. This would not be so clear if he were making efforts to write them down and so bringing along many more of them.

(3) He was allowed to communicate the nature of his defences and to show how his own self-analysis went, eventually arriving at the affective level with which he wanted help. It may be maintained that this could have been abbreviated if he had done the work at home but then the shared transference experience would have been lacking.

(4) The transference could be discerned in the way he ordered his material and, even though it was not interpreted, useful information could be gained for interpretation when its affective content came nearer the surface.

Discussion

The use of dreams to foster self-analysis by writing them down has led to the accumulation of useful knowledge about them and the processes they reflect. It has provided information about archetypal themes and movements in the unconscious towards individuation. The method is, however, different from the kind of therapy that seeks to deepen the dialectical process between therapist and patient in which transference and counter-transference are included in detail. Once this becomes the focus of therapy then it is easy to assess the place of dreams in the process: it varies from patient to patient.

It is possible to conduct a rather systematic analysis of a dream series (p. 22ff.); it is equally possible that they be used as a beneficial background story which is not for investigation (p. 28ff.); and it is also possible to consider dreams as a part of the therapeutic interview as a whole. In the last eventuality aspects of the patient will be brought under review which would otherwise be overlooked, and the therapist may be able to understand that the dream is being worked on even if no reference to the images are made because he will observe that the themes in the dream are reflected in the patient's talk.

To illustrate from my patient's dream: the trend in his talk was to start from above hinting at memory fragments and abstract theory (wife in dream = anima = part of himself) downwards to his wife's body. The impression that the patient was protecting his wife is expressed in the garage which protects a car, and the dog which is pulled out of the car where it ought not to be and so on.

Such reflections are more important than they may seem. I have given a surface illustration because the attempt to bring a patient back to the dream images (which is sometimes done) makes what the patient is talking about seem irrelevant. It is just as important to give time for working on resistances as it is to reach the unconscious content; I would indeed go so far as to say that if

time is not given, the unconscious content may be named but not experienced. To my mind it is essential to take whatever a patient brings as relevant and this applies equally to dreams. It is important not to press them on to a patient who is working on a conflict or process that may have been expressed in a dream but now appears in a different but analogous form.

This raises interesting points: the difference between a dream experience as dreamed and its memory; the difference between being awake and being asleep. The difference between waking consciousness and dream consciousness varies a great deal and my two examples illustrate it: Patient One could easily get into the dream images, Patient Two had to do much work to get there. So dreams, sleep, waking and being awake are all matters of interest to a therapist even though he may not be able to use them therapeutically. Sometimes they may be important, but mostly not. Little attention has been paid to these states by analytical psychologists, yet the subject has not passed altogether unnoticed for Jung found ways of bridging the gap by inducing active imagination from dreams, and transference is another way that a patient 'dreams' in an interview. In these ways what is dreamed in the night has been expanded.

If a patient brings a dream and starts off with it as a ritual in which the analyst colludes, it is more or less inevitable that the affect in the dream will not be accessible. This is partly because the dream is not brought as it has been dreamed: first of all, it has been converted into words when it was mainly a visual event—it is unusual for words to feature much in a dream; secondly, there is a time lag between the dreaming of the dream and its communication to the therapist, so it becomes a memory. The analytical therapist, however, wants a dream that is alive. There are, it is true, sometimes those who have not yet woken up enough so that the images are still active in the patient's mind when he arrives at a session and in a sense are still being dreamed; then dream analysis becomes vivid. If a patient is being seen daily, it is more likely that the dream will still be alive than if there is a gap of several days between interviews. If the patient is seen daily the time-lag between dreaming and reporting is less than if he is seen once or twice a week, but in any case a variable amount of experience will have been interposed, which inevitably needs attention. So many therapists prefer to wait for the time during an interview when a dream is spontaneously remembered: for instance, when the patient is working over some experience and will include a dream in this. It is then that the dream is more likely to become truly meaningful and good work can be done on it. This procedure also gives space for a live dream to be introduced at the start and worked on at once.

This discussion cannot be ended without making some reference to the use of dreams as a resistance in two characteristic ways:

(1) The whole interview can be filled up with lengthy dreams, usually considerably elaborated upon and combined with associations that lead nowhere. In this case the dreams are therapeutically negative, they cannot be analysed and their use as a resistance will need to be gone into.

(2) Auto-analysis of dreams. In this case the patient will bring dreams and display remarkable ingenuity in interpreting them. He will take them to pieces, amplify them, turn the parts round and end up in triumph, but to what purpose? There can be no doubt that he gains enjoyment of a sort from his expertise which, however, has become an exercise in its own right and so is not productive of change. It will be observed that there is no space for the analyst in this exercise and only that his admiration seems to be demanded!

Conclusion

Dream analysis, inaugurated by Freud and used by Jung in ways that have been described, is still, as it was originally, the royal road to the unconscious. But as time has gone on and as further experience has been gained, especially of transference, it seems that less emphasis has been laid on dreams, and analyses of them have been less frequent in the literature of analytical therapy. I believe that the idea that they are given less significance than previously is incorrect: dreams are just as important and remain an essential component in therapy. What then has taken place? As it has become known how to bring unconscious processes into the analytical session, these have become a more living experience between therapist and patient. Thus their significance has been enriched by the contents being brought more effectively into relation with the rest of the patient's life within the transference. It is this that makes it look as if dreams have become less central to analytical psychotherapists.

Note

1. Almost any publication of clinical material by a classical analytical psychologist will contain dream material. Jung (1964) contains his last comprehensive statement on the subject though the example in his *Tavistock Lectures* (1935a) is the most vivid. A good paper on dream interpretation is given by Lambert (1978) who relates the dream to its transference setting.

CHAPTER 4

Amplification and Active Imagination

Amplification and active imagination are especially characteristic of Jung's work. It is interesting to note that before starting on the intensive investigation of his fantasy life he first made a comparative study of myth and folklore. This preparatory intellectual exercise, used to amplify the Miller text (p. 22), preceded his affective 'confrontation with the unconscious' in active imagination. I shall follow him in taking these two interrelated subjects in the same order.

Amplification¹

Amplification is a method derived from philology. To decipher an obscure text philologists compare it with others whose content and meaning are known and which are sufficiently like the document under examination. By studying the identities, similarities and differences, meanings can be ascertained or inferred when the two texts are identical or when they are sufficiently alike. Dreams and fantasies can be elucidated in a similar way. For example, a hero-like figure appearing in a dream can be compared with the hero figures of mythology to see whether this one is sufficiently like any of them for the analyst and patient to draw conclusions about the dream figure. Assuming that a patient dreams of 'Hercules', this will indicate that, in common with other heroes, the patient is given to conflicts of the heroic type, so the way he behaves is not just his personal style but one characteristic of mankind. It is known, for instance, from myths that the hero's achievements reach a climax and then a disaster follows. Hercules, for instance, after accomplishing his labours, was condemned to slavery by the Delphic oracle and bought by Omphale of Lydia for three talents. When his debasement was ended he had more adventures but was eventually brought to grief by donning a cloak soaked by his wife, Deianeira, in Centaurs' blood. Consumed by an inner fire, he was rescued by Zeus and admitted to Olympus—a fitting end to his heroic adventures. The Assyrio-Babylonian hero, Gilgamesh, likewise performs many astounding feats in

company with his friend Enkidu who eventually dies. Fearful for himself, Gilgamesh determines to seek the herb of immortality. He retrieves it from the bottom of the ocean, only to have it stolen from him by a snake. He returns to his home town, Erech, haunted by the fear of death and the shade of Enkidu. It is the end of his heroic achievements and the poem recording them finishes in gloom and dejection.

In this way a prognosis for the dream or fantasy might be made or, if the patient is identified with the myth, the dream can warn the patient of what is to come. This was no doubt one root for Jung's attitude to the patient considered in Chapter 3.

The use of amplification during therapy

The use of amplification in therapy depends upon the theory that the basis of the psyche is universal and that individuals need to be put in touch with this layer called the collective unconscious. It is conceived that an important characteristic of a neurosis is its tendency to isolate an individual from his fellows; therefore, it is believed that to show a patient that what he thinks is a horrid secret is in fact part of every man's experience of himself modifies the isolation. Another application to therapy depends upon the idea that knowledge of myths by the therapist is useful in initiating active imagination: the analyst is helped by knowing when the patient is near the level at which fantasies can be objectified in the way that will be developed later in this chapter. It has already been referred to in relation to dreaming.

Surveying Jung's works as a whole, it will be apparent that he used amplification very extensively in the elucidation of myths, religious practices and especially alchemy.

A geography of the psyche²

By using amplification Jung aimed at mapping out characteristic features in the common basis of man's symbolic life, and constructing what might be called a geography of the psyche. He set out to study mythical systems in detail, comparing each with the others, initially with a view to finding out where they were identical or significantly like each other. In this exercise the differences were to be left out or ignored for the time being. Thus Western, Eastern and so called 'primitive' cultures could be studied comparatively to elucidate the archetypal foundations on which man has developed often widely different culture patterns.

In clinical work the assumed common basis justifies the use of experience from other cultures to elucidate dream and fantasy material from patients. A classical example is the comparison between mandala figures produced by patients with Eastern ones used for meditation. Jung collected pictures with common characteristics drawn by himself and his patients; they tended to be circular, to contain at the centre some object of special value, and might be

divided up into four by diagonal lines; they were elaborated in different ways but the essential characteristics were always the same. Jung thought of them as symbols of the self. He knew that the Eastern religions lay special emphasis on what they also call the self, alternatively called Atman, Perusha, etc., and he had worked out their relevance to his own concepts in *Psychological Types* (1921). The existence of mandala forms of expression in different cultures points to the common foundations on which the differing concepts are developed.

Myths, it is evident, contain forms that, being different, can be investigated separately: witches, magicians, kings and queens, children, heroes, or symbolic flora (trees, plants, etc.) or metals, stones and jewels. Study of these differences led to defining archetypes: the parents, the anima and animus, the shadow and a number of less organized systems too ill defined to separate out. It was a geographical approach and the aim was the building of a map of the psyche. This idea has inspired a considerable literature, which makes the study of myths primary. Into this map patients' dreams and fantasies are inserted, to illustrate that the mythical themes are still as active today as they were in the past, a state of affairs reflecting the transpersonal nature of patients' material (cf. especially p. 12).

There are, however, differences between the mythical forms, due to the varying directions of cultural development. This is a complex subject and psychologists here encroach on anthropology. It can be said, however, that each development results in the specialization of some functions of the psyche at the expense of others.

Jung developed this thesis by a study of Western civilization somewhat as follows.³

Jung's study of Western civilization

At the beginning of our present era a reaction took place against paganism as manifested in the Roman Empire. As the belief in the old gods began to fail and as the violence and sensuality of the rulers began to make them fall into disrepute, there appeared a new religion, Christianity, which emphasized an ethic of behaviour and a kind of religious life which valued love in its spiritual form. As it gained popularity it became less spiritual especially when it was institutionalized by Constantine. The church took over many of the Roman institutions and partly used them for its own purposes which were solely spiritual but accumulated considerable wealth in the process. From the cultural point of view, scholasticism was to be far more important. It became a technique for refining the use of intellect in rational discourse applied to spiritual matters. Then, however, some men of genius used it to study the material world as well—science thus received a considerable impetus from the labours of theologians. The results were not at all in line with Christian dogma, as is well known, for they overthrew essential parts of church doctrine.

Inasmuch as Christianity was a compensation for those aspects of the human psyche represented in paganism, it would be expected that its rejected

or neglected parts would seek expression in one way or another, and these Jung looked for and found in gnosticism, the various heresies and especially alchemy. In some respects idealistic and seeking the perfection of man, as in Christianity, these movements nonetheless all showed indications of the attempt to achieve wholeness. This meant an attempt to accept man as he is and not as he ought to be. The idea of wholeness can therefore initiate the scientific study of man, and it is from this that analytical psychology derives: alchemy is, to particularize, a root not only of chemistry, but also of analytical psychology.

This sketch of an historical construction implies that a new view of man is coming into being at the present time, and that psychotherapy is a manifestation of a development that focuses its efforts not on improving a patient along lines that his or his analyst's ideals may dictate, but on discovering more of what he is like. What is called analytical psychotherapy is an offshoot of this endeavour.

This brief outline of the geographical and historical dimensions of Jung's work and what is defined as 'the problem of our time', controversial as it may be, is important because it implicitly lies behind the activities of 'Jungians' and leads them to focus on the movements in the patient's psyche which have collective significance, whether historical or contemporary. This can, but need not, overlook much that can be important in a patient's conflicts, thus leaving him alone with his psychopathology, in spite of protestations to the contrary.

Active imagination

Active imagination is a method of studying the self. It may take place spontaneously according to patterns starting in childhood, or it may be induced during analysis by concentrating on the archetypal imagery and urging the patient to treat it as real and objective. The patient may thus become interested in symbolic imagery, either on his own or with the help of his analyst, and may want to draw or paint it.

The analyst will encourage him in this and in developing fantasy in any way that seems appropriate: thus a story or drama develops. Once started the method can be extended and used to investigate and resolve states of mind causing distress—for instance, a mood.

Example 1

A man in his late forties became aware of a mood that he could not control, so he went off on his own and started to concentrate by sitting down and writing what came into his mind. The following fantasy developed:

'A large magician was able to reduce the sun and the moon to a small enough size to go into the holy mountain, but he could not get them into the maze that lay inside because his hands were too big. He wanted to get the sun and the moon inside into the centre of the maze because if he did so unlimited energy would be provided. As he was a hermaphrodite he made out of himself a tiny man who did the trick.' At this point the patient 'became very much upset

because the little man got so above himself at accomplishing a feat which the magician could not that he nearly went up in flames. The patient then experienced an excited feeling that went on for several days and he 'began to care desperately what happened to the little man. After some time an old man with a long beard appeared; the little man liked him and climbed into his hair to fall asleep'. After this the mood was more tolerable but still had not gone, so the patient decided to take a more active part in the fantasy: 'I confronted the old man, who I found was very much enjoying a tickling in his beard caused by the activity of the little man. I reprimanded him for insufficient care of his charge. The old man, however, was stuffily contented and paid no attention, so I took the little man away from him and gave him to the large magician who had large breasts. The little man turned into a baby and nestled down contentedly. This really was the end'.

This example illustrates the way in which a highly complex fantasy can be treated objectively and allowed to develop. All goes on smoothly until the patient gets feelings inside him; he 'began to care desperately' but still he did nothing about it, though a change in the fantasy took place in the form of an old man appearing. It was only when the patient took an active part that a solution was found. The first part of the fantasy is passive imagination, the last part is active imagination proper.

This fantasy has in it a large number of images and sequences that call for amplification: the sun and the moon, the holy mountain, the magician, the little man, the maze and so on. In addition the bringing together of the sun and the moon in the maze is what alchemists called a conjunction, from which further parallels would be arrived at. It would not serve much purpose to enter into all these here; the patient was intellectually aware of them and his knowledge must have facilitated the fantasy. Without that knowledge the episode might have been much shorter, but the amplifications are clear enough for the fantasy to be treated as archetypal. But this must not be used to overlook that it also contains personal material; one association led to his father who had helped him over a period of erotic frustration and excitement in which he could not sleep, by sitting beside him and stroking his head until he really did sleep; another led to adolescence when a traumatic introversion was not resolved — and much more besides, revealing the infantile components in the mood. So it reflects layers of experience, all of them complex, that he worked through before arriving at the symbolic solution in imagination. There are clearly two complementary lines of approach.

The whole process was a bit grandiose and at the same time childlike, the symbols interacting with each other, and as this was allowed to take place the patient discovered an acceptable way of resolving his mood.

In active imagination the symbolic attitude is an essential ingredient. If, for instance, the patient had tried to start analysing the contents of his fantasy as it emerged, the whole sequence would have been interfered with or even stopped, because the symbols would have started to come to pieces at the time when it was desirable to preserve them.

It is because of the capacity of symbols to combine so much in them, to hold the affective and intellectual content of any experience, that so much emphasis has been given to them as synthetic, ongoing and creative. It was noticed that material produced in active imagination was particularly rich in archetypal symbols. Even more than this, the patterns that emerged often showed a development—also found in dreams—which led towards the centralizing process already referred to but now depicted in mandalas. It was therefore believed to reveal individuation processes forming in the unconscious and consequently it was erroneously held that in order to individuate active imagination was necessary.

Because of these considerations it came to be thought that only the amplification of the symbols was indicated. With this there is general agreement while the process is developing, but it is a mistake to leave it at that and so prevent further insight into the self and integration of self-systems with the ego. Not to work out the personal implication of symbols can risk severing the patient from his personal history and so from an important dimension of the self. Jung seems to have recognized this when he gave specific attention to the child as an image in mythology and concluded that it was a symbol of the self. But this is more than symbolically true in that an infant has the potentiality for realizing his own self and if self-representation never takes place effectively it becomes essential, if any attempt at radical therapy is going to be made, that the very early periods in a patient's life should be explored in detail.

Active imagination may occur as described as an ongoing process that can be used by a patient over the years as part of self-analysis; it may also take place during therapy, when the patient will conduct internal dialectic between interviews with an introjected analyst, thus linking the whole process up more closely with the transference and the personal history, as the following examples suggest.

Example 2

A patient who had been in the habit of using active imagination with a previous analyst would bring her conversations with a 'wise old man' typed out on a piece of paper and present them to me. For some time this went on until it struck me that much of what the old man said was not especially wise and might easily have been said by her without recourse to an impressive figure. On one occasion I had made an interpretation, and next time she came back and told me that the old man had become angry about it and said that it was wrong. It did not seem to me that she required a wise old man to support her in this unless I had become dangerous in her feeling, and this led to exploring why she used this method rather than the more direct one. It then appeared that from her childhood onwards she developed an inner secret world in which she had employed this method of preserving her identity in relation to her parents and family. Though necessary for her then, it was no longer so.

Example 3

A middle-aged patient, who used painting to express her feelings, painted a long series of pictures of peacocks. They were interesting to me at the time because Jung had written about the peacock, a symbol in alchemy, heralding the end of the work, which would mean the assembly of all the colours, the psychic functions, before their union in the self, so I wanted to see how it worked out with this patient. It did not, and it was only when the material had lost its fascination for me and I had come to see that both her transference and her infancy were important, that she told me that in one of the pictures she had secreted an arrogant screaming baby peacock located in one of the feathers of the magnificently spreading tail. It was so small that it could scarcely be identified without a magnifying glass, and for this reason I had overlooked it.

There can, I think, be no doubt that the prestige active imagination gained through Jung's advocacy facilitated such activities and that patients exploited them so that the objective psyche could seem to become more important than the patient.

There can be little doubt, now that the first flush of excitement is over, that relatively few patients exhibit the capacity for active fantasy, but little has been written about which kind of patients can use it.

In 1916 Jung stated that 'The reason for evoking such aid is generally a depressed or disturbed state of mind for which no adequate cause can be found' (C.W.8, p. 81) or again '... a general, dull discontent, a feeling of resistance to everything, a sort of boredom or vague disgust, an indefinable but excruciating emptiness' (*ibid.*, p. 83). This certainly puts the patient outside neurotic manifestations and possibly into the field of normal mood swings; he cannot have been considering depression, as clinically manifested, for a depressed person does not exhibit active imagination whereas a schizophrenic may do so to an undesirable extent.

If the literature is scanned the result is as follows, taking into account those cases in which sufficient data are supplied:

- (1) Baynes (1955) published two cases who used active fantasy at length; they were both borderline cases.
- (2) Adler (1961) demonstrated a case who was claustrophobic.
- (3) Marjula (1961?), herself a schizophrenic patient, gave an account of how she most ingeniously organized her delusions into a social thesis based on a rather grandiose revelation about the role of woman in present day society, a favourite Jungian theme at the time.
- (4) Weaver (1964) demonstrated a woman who seems to have started from a rather healthy depressed state.

It is probable that the lack of information usually given is because the practice of active imagination is believed to lie outside the field of psychopathology; indeed Henderson (1955) claimed that it was part of the post-analytical phase

and should be considered as a continuing method of self-analysis after the person had ended his personal therapy and left his therapist. This conception would not meet with general agreement.

If we survey the classes of people—scientists, mystics, magicians, alchemists and artists—for whom creative imagination is important, the part that the objective psyche has played in all religious life and the importance that myth has taken in man's existence, it is not possible to treat it as a pathological exercise even though some of the examples in the literature are clearly from unstable or unusual personalities. Perhaps the most interesting feature of active imagination is that it gives a person a respect for the reality of the psyche and can lead on to creative achievement because of this. To gain through direct experience a conception of the psyche as a relatively autonomous and helpful apparatus, which can produce its own ideas, feelings, revelations, and can be related to living, seems to be therapeutic.

But though optimally active imagination is an ongoing process and leads to self-knowledge, it is not alone in creating this state of affairs. Study of all the activities of the psyche can do this, whether they are day-to-day living, fantasies, thoughts, sensations, feelings or dreams and transference experiences in analytical therapy. What makes them fruitful is not the activity but whether they are felt to be good and positive or negative and threatening in relation to the inner life and environment of the patient or person.

Thus active imagination, considered in relation to the patient as a whole, is a valuable source of material for revealing the cultural and personal history and the patient's creative potential for individuation. It can be placed under the headings of confrontation and elucidation, though it also assists in working through conflicts. Looked at in this way, it may provide matter for interpretation, though most reports omit this.

Note

1. Hurwitz (1968) gives a very good demonstration of how this method is conducted by a thoughtful scholar. Jung's usage is very much less methodical and he often seeks to convey the atmosphere rather than elucidate the text as Hurwitz does.
2. Examples of how Jung set about constructing a geography of the psyche can be found in Vols. 5 (1952) and 12 (1944) of the *Collected Works*. For a more fanciful example cf. Franz (1972). Many essays on symbolism do this in effect: *The Mystic Spiral* (Purce, 1974) is an example that was influenced by Jung but relatively untouched by psychology.
3. Jung's historical thesis has been set out well by Lambert (1977). In *AION* (1951a) Jung goes some distance towards stating it, with much erudite material. It is also to be found in his controversial investigation of the 'crisis in civilisation', (see volume 10 of the *Collected Works: Civilisation in Transition*).

CHAPTER 5

Jung's Conception of Psychotherapy

The patients to whom Jung's ideas applied represent a section of those who come for psychotherapy. They are the ones to whom experiences of rather dramatic and myth-like nature are important in giving meaning to their lives. The method used in such cases cannot be applied to all patients, nor did Jung think that it could, so I now want to consider other aspects of psychotherapy starting from Jung's thoughts about them.

To begin with it is necessary to define, as clearly as possible, the class of person to whom it is relevant to give so much importance to dreams and active imagination. It is clear that the patients need to have the capacity to dissociate enough for imagination to be treated as 'objective'. This can be found amongst cases commonly called 'borderline' because they show severe abnormalities, which suggest a psychosis, though this diagnosis cannot be made; then there are schizoid character disorders and the narcissistic neuroses, while schizophrenia itself also exhibits the necessary dissociation. Jung was indeed in the vanguard of those who attempted treatment of that condition, occasionally with success.

Defining the class of patient by using the categories of psychopathology is, however, only partly successful. It will for instance be clear from the description of Jung's work that a patient would need to be intelligent if he were going to understand what Jung said to him—indeed there is no doubt that most of Jung's patients were gifted. In addition, there are other characteristics, less easy to define, that are necessary for analytic therapy to be undertaken with any prospect of success. They will be considered later, especially in Chapter 8 so I will not detail them here.

Mention must, however, be made of another class of person who came to see Jung from the start: well adapted, often successful, middle-aged or elderly and for whom life had lost its meaning; the sort of person who, it might have been thought, would have consulted a priest, but did not do so because they had no confidence in religion. Some might show neurotic or even psychotic features but whether they did so or not was a side issue. It was for this reason that Jung

asserted that when he treated persons in the second half of life their problem was religious. To these persons Jung's concept of individuation, with the aim of self-realization, often provided a solution. It may be reflected, however, that the patient having or developing an understanding of his own nature is not what is usually understood as religious; so why did they need to undergo a long and often painful experience? Could it not be that some developmental anomaly had taken place?

Looked at in this way, the problem that Jung defined in relation to persons in the second half of life can be expanded. He discovered what is now commonly called 'the neurosis of our times' and this, as Erikson (1963), amongst others, has said, applies not only to the second half of life but is also a common feature of adolescence: he identified the problem as one of identity, which means finding one's place in society. As this could obviously not be achieved satisfactorily without having a capacity to know enough about oneself, the problem can be considered in terms of individuation and self-realization. This has also been applied to very early stages in infant and child development (cf. Fordham, 1969).

I do not want to pursue this topic at this point and only mention it because I believe that, though different manifestations are encountered, the central problem Jung defined can be seen to apply to psychotherapy as a whole, even though the techniques so far considered will need to be modified and supplemented.

Methods of psychotherapy

However much Jung's thesis can be extended, however, it is quite clear, and it was so to Jung himself, that psychotherapy is not to be restricted to a single method and by 1929 he had formulated four stages in psychotherapy that may be taken to indicate the procedures he habitually used. The stages are: catharsis, elucidation, education and transformation.

Catharsis, elucidation, education and transformation

The first, confession or catharsis, he says, can be sufficiently effective and would sometimes be enough were it not for the tendency of patients to develop a transference, by which is meant that the patient becomes attached to the analyst in irrational ways with infantile origins. This cannot be resolved without elucidation, by which he means psychoanalysis. Even this is not enough because the demonstration and remembering of childhood situations, from which the transference arises, only leads to some patients remaining infantile and thus prolonging the treatment: these people need education in social adaptation. When each stage has been gone through and failed, a fourth begins—the stage of transformation which is Jung's special contribution.

I have introduced these stages not because I believe that they are gone through with any degree of regularity but to indicate the methods that Jung and his

close associates used in their practices. It is more or less inevitable for the stages to overlap; indeed, as described by Jung, some are roughly compatible with each other and may be used concurrently: though the interpretative method, in itself a learning procedure in its wider sense, does not go well with formal educational or overt methods of reassurance. The stage of transformation of analyst and patient, though at first conceived as a separate approach, can, as I shall show in this book, be considered a continuing therapeutic process that only sometimes becomes central to therapy. It may be of interest to note that the stages Jung formulates can be arranged in an historical sequence.

- (1) Catharsis corresponds to the early stages in the development of psychoanalysis, most used when Freud was collaborating with Breuer.
- (2) Elucidation corresponds to the introduction of the interpretative method by Freud.
- (3) Education refers to Adlerian methods and others employed by Jung, to be considered later.
- (4) Transformation is a notion introduced specifically by Jung and applied to suggest the importance of the therapist's part in his operations.

The use of theoretical models

All these treatment methods, except the last, imply the application of a theoretical model to the material presented by patients. On this subject Jung held a number of views but perhaps the most forceful and evocative was that each patient needed a new theory. In this he challenged the notion that a therapist should use a standard model as the one basis for therapeutic interventions. This subject will be taken up later (p. 63ff.), but as it is relevant here it will be considered briefly.

When he threw out his suggestion he probably had in mind that models were originally built up in the course of treatment and that the process of model-building is a recurring one. There is always an element of research in the conduct of radical analytical therapy and the individual nature of the procedure will ensure that the model has unique characteristics in each case. Because of these reflections, as well as to mitigate the danger of imposing an inappropriate model on a patient, Jung admonished therapists to divest themselves of theoretical preconceptions whilst treating patients; by implication he thus opened the way for the personal involvement of the therapist.

It would, of course, be foolhardy to imagine that no theoretical model is in the analyst's mind when he treats a patient, and that it is of decisive importance in interpreting a patient's material, but it must only come into operation when the material is truly illuminated by it. Furthermore, to be useful the model must be one that relates to the analyst's own personal experience either in life, in his personal training analysis, or in his experience with patients. As we have seen, Jung's model was based throughout on his own experience in relation to others and in his 'confrontation with the unconscious'; it was these that gave

meaningfulness to what he said to his patients. Thus his own experience was decisive in their treatment.

On being unsystematic by intention

Whilst Jung laid importance on method, and it must be understood that he could listen well and could use the principles and methods of psychoanalysis which he learned from Freud, he claimed to have developed and cultivated a systematic non-method, an attitude of adaptability, open-mindedness and ability to react.

Very little has been written about the behaviour to which this formulation refers, except in so far as it is reflected in his theoretical papers, and to some extent in his autobiography. There he emphasizes the importance of what would now be called the analyst's counter-transference and his total reaction to the patient (though he did not use these terms), each of which were sources of information to him and a therapeutic influence on his patient. It is evident that if an analyst's behaviour became as individualistic as Jung seems to believe possible, no generalized description could be given. It is unlikely, however, that there was no characteristic feature of his practice during the stage of transformation. Nevertheless, apart from Jung himself, there has been a marked lack of literature in this area, sometimes justified by the idea that personal details of therapy should not be published—it being a breach of professional confidence. The analogy of the closed vessel of alchemy is evoked in support of reticence: in that art the adept is enjoined to seal the alchemical vessel carefully to ensure that the spirit shall not escape from the transformative process going on within it. This recommendation is interpreted to mean that only archetypal matter may be reported because it is the part of therapy of general significance. This view does not, however, hold because the contents of the vessel are conceived to be archetypal, so archetypal matter should not be reported either—but it is. In this book I shall therefore disregard the policy of reticence. It may not seem all that important to know what Jung did in detail, but there is the disadvantage that if it is not made public parts of it contribute to the secret body of knowledge handed on from analyst to pupil which has been the bane of psychotherapeutic 'schools'. Also, until we have a good idea of exactly what he did, the bare bones of his practice as recorded in his writings will remain in a sense dead, and the effects of his therapeutic style will become manifest only in the behaviour of those who were nearest to him or who have assimilated his attitude.

Jung's personal style

I intend now to piece together a sketch made up of what I have read or gleaned from personal discussion, from many years' personal acquaintance with Jung and from experience of meeting others who knew him well or worked in therapy with him. It will be observed that I quote frequently from a paper by Henderson

(1975) because he is the only patient, now an analyst, who has attempted to say publicly what it was like to be 'analysed' by Jung. I fully recognize that this will give a somewhat biased account, but under the circumstances there is little else possible.

In treating carefully selected patients Jung's aim was to give them maximal opportunity to develop in their own way so as to individuate: he wanted to keep his own influence out of the way for considerable periods. As he tended to be an active participant in his treatments, he could do so by reducing interviews to once or twice a week and by taking long holidays. As a result the patient was encouraged, even compelled, to continue with his own dream-analysis and active imagination, and was given time to digest what Jung had given him.

During his interviews Jung could create an atmosphere of sophisticated informality in which the patient could feel held; it was therapeutic in a way hard to define but I had personal experience of it (Fordham, 1975). Though I was never analysed by him, I took problems of my own to him from time to time. He always seemed to be available whether he saw me in Zurich, Bollingen or fitted me in for a half-hour, as he once did, in London when his time was already fully booked up. Once my problem was clearly outlined he could be very direct, but at others he would deliver a discourse which started from something I said and which did not at the time seem very relevant. It had, however, the effect of stimulating lines of thought new to me that I could develop afterwards.

Henderson describes very well what it was like when he was active:

'... he would pace back and forth, gesticulating as he talked, and he talked of everything that came into his mind, whether about a human problem, a dream, a personal reminiscence, an allegorical story, or a joke. Yet he could become quiet, serious and extremely personal ... delivering a pointed interpretation of one's ... personal problem ... And yet he made some of his best life-challenging observations indirectly, off hand, as if they were to be accepted lightly, even joyously' (Henderson, 1975, p. 115).

This gives a clear picture of Jung being active. To balance this impression others report very differently: he was quiet, passive and attentive, and analytical throughout. It is difficult to bring these contrasts together; it may be, as Henderson says, that Jung hated attempts to put him in a frame and if anybody tried to do this he burst out of it. There is, however, another understanding of how he behaved: he reacted openly, but intimately related to the patient before him. Since he held that patients' requirements differ, contrasting pictures would be expected.

What Henderson described may be said to illustrate how he amplified material brought to the interview. This was not just matter culled from mythology but derived from Jung's own experience of life. It was impressive to listen to Jung using myths for they seemed to come right out of him so that, even though much of it was quotation, it was never dry and academic.

When he was active he would amplify and interpret to emphasize the archetypal and impersonal foundations of the patient's personality, thus bringing him into relation with his cultural background. But Jung evidently adapted amplification to a variety of other purposes. Henderson gives an example: when he was in a state of 'conflict between different courses of action' he was told the story of Buridan's Ass who stood between two stacks of hay and, unable to decide which to eat, perished of starvation. 'My supposed conflict was at once completely demolished and, with relief, I contemplated my immediate position in an unknown territory where there was nothing to fear from an unnecessary and morbid strife of opposites' (*ibid.*, p. 115). Again (in a personal communication to Henderson) Jung described how he handled a rationalistic defence in a scientist who contested his theory of the collective unconscious. The patient brought a dream with an alchemical-like image in it; Jung took a book from his bookshelves and showed the patient the duplicate of his dream. This made a dent in the resistance and helped communication between the two men.

Henderson's example is interesting because Jung might well have said, 'Well, I don't see that it makes any difference which course of action you take and you had better just take one of them', but if the idea was to stimulate the patient's imagination then this story from antiquity was felt, by Henderson at least, to have been a better method of relieving his conflict.

What I have described here is an application of Jung's idea of educative method by storytelling, and accounts of being 'analysed' by him lay stress on it. To this may be added that patients attended weekly seminars in which there was extra amplificatory material; they were extremely vivid and show Jung ranging over his subject, reacting to questions and speculating freely. The subjects he chose to develop to English-speaking audiences were dreams, visions, and a very long seminar on Nietzsche's *Thus Spake Zarathustra*. An important aim in them all was not only to teach the wide spectrum of members of the seminars, but also to provide material that would assist patients in understanding their experiences and prepare them for what might come in the future.

The transference

In the light of the foregoing, and in the light of what is known today about the subtlety and complex implications of transference, it is interesting to gain some impression of how Jung handled this manifestation of therapy. Sooner or later it cannot be avoided and indeed usually takes 'a central position'. In the first place he analysed it, but it seems that he also managed or used it and it is to this aspect of his practice that attention will now be given, leaving fuller discussion of this important subject to Chapter 9.

Jung held that, apart from its origins, transference was an ongoing process, and could be considered as a means of constructing a bridge to reality. This seems to have been why he would give examples, including his own experience, to suggest steps that the patient could take. An indication of how far he would

go in this is given—once again—by Henderson. When talking about the symbolic meaning of architecture, Henderson retold a dream in which he was ‘trying to create some style of architecture and furniture that would represent a natural link between my family’s colonial past and a contemporary American style. In the course of interpreting this Jung took me on a tour of his house, showing me how he and his wife, Emma, had solved a similar problem in their own mixture of traditional and contemporary styles in Kusnacht’ (*ibid.*, p. 116).

Apart from the idea of the transference as matter for analysis, or as a means of providing a useful bridge to reality, another example of Jung’s handling of it is given once again by Henderson. The example may be unusual for he was training in Zurich to be an analyst, so that education may have entered more into his sessions than with a straightforward patient. Nevertheless the description does not seem to me so much out of line with my own experience and other personal communications (cf. Fordham, 1975).

Henderson says that he felt that during one period in his analysis ‘There was always a sense of something withheld, like a curtain drawn across a secret truth . . .’. Now in Jung’s study, where he was being interviewed, there actually was a curtain drawn across a recess and Henderson eventually ‘got up the courage to ask what was behind it’. Jung drew back the curtain and revealed ‘. . . a photograph of the head of Christ as represented on the shroud of Turin’ (*ibid.*, p. 116) and he proceeded to give a long dissertation on the subject. In this way, it would appear that Henderson’s feeling about Jung was never explored and he was instead shown Jung’s actual willingness not to conceal anything that he might have either in his study or in his mind. That, however, only leaves Henderson with the real Jung and so the contents of his projection can no longer be seen in relation to him. Henderson was thus, it must be inferred, left with it to handle on his own.

My own personal experience of the way Jung handled a transference was somewhat different. In my case I found that Jung bypassed the projection in such a way that the real Jung could be met. At the same time he provided the appropriate archetypal framework into which the withdrawn projections could be fitted and thus the transference was not so much analysed as transcended.

It appears, however, that my favourable interpretation may either be incorrect or else not so effective as it suggests, for Henderson relates: ‘Whenever his (Jung’s) analysands seemed to be too powerfully transferred to him he would send them to his assistant, Antonia Wolff . . .’ (*ibid.*, p. 117), from whom they would receive reductive analysis.

The idea that there was a need for more than one therapist in any particular case was to have important consequences. It grew out of the problem of transference, if Henderson is to be believed. His statement also underlines the important idea that one ‘Jungian therapist’ could proceed on essentially different but complementary lines from another according to his individual capacities.

There is one addition to this account that must be made: the use of type theory. When it was introduced every patient was assigned to a type and this

assignment was checked again and again during the treatment in relation to conscious and unconscious attitudes as represented in dreams and fantasies. Thus in the midst of a changing scene there was, it appears, a model available to which reference was recurrently made. As time went on my impression is that, though this theory continued to be used, increasing emphasis was laid on the model built up from the study of myths.

The picture I have constructed is of necessity incomplete and applies only to patients in the 'stage of transformation' in which the analyst's involvement becomes far more 'equal' than in the other stages. In Jung's later work, however, it was this aspect of therapy that became more and more important to him. It was an emphasis with significant consequences for the development of analytical psychology.

There is perhaps no necessity to repeat again that in my sketch I am not giving a comprehensive picture of all that Jung did and certainly do not wish to imply that he was unable to be a good analyst, but it is so often overlooked that I do so without apology. The conclusion that Jung was essentially multifaceted as a therapist seems inevitable. Nonetheless his own interests and his own experiences led him more and more away from analysis and towards studying the possibilities he could discern in the unconscious. An additional movement was away from a closed-system approach to that of open systems, and this involved a change away from the technique and towards the art of psychotherapy. In doing so he no more forgot his technical knowledge than would an artist: techniques were to be used for further understanding and benefit of the patient considered as a unique individual, who was at the same time part of a historical process having both personal and collective roots and with a potential for individuation. He left considerable scope for variations in style in the therapist and included psychoanalysis as a necessary method, even if he did not agree with many of theoretical conclusions arrived at.

It is consistent with these reflections that Jung did not want to start a new school of 'Jungians' and frequently expressed his dislike of disciples (cf. Bennet, 1961) in the sense of persons who followed in his footsteps without having his experience. When asked about what he meant by a Jungian analyst he could be very emphatic: 'What is a Jungian analyst? There is only one and that is me!'.

The schools of therapy¹

It has, however, all turned out differently from what Jung hoped. Therapists who thought that his ideas, methods and discoveries were important needed to discuss and develop them and it was only amongst themselves that they could do this. Furthermore the ideal which Jung put before them began to lead to excessive individualism and lack of discipline, which needed checking. Therefore schools of analytical psychology have gradually formed which have tended to lay emphasis upon some aspect of Jung's work, omitting or playing down others.

The Zurich school

At the C. G. Jung Institute the features of Jung's later style have been emphasized. In particular its members have developed the seminar technique extensively so that, throughout the terms, lectures are given on a rather wide variety of topics relevant to Jung's work. In place of Jung, members of the Institute give lectures and guest lecturers are added from amongst the learned professions and other schools of therapy. These seminars cater for the growing number of students who come for a variety of motives: interest in Jung's work and its development, personal conflicts, and a minority who wish to become therapists. For the latter there are extra clinical seminars and case discussions.

It is a condition for attending the seminars that the student shall enter 'analysis', by which is meant something rather different from what I shall describe later in this book. The student must attend sessions relatively infrequently (once or twice a week) and he is enjoined to go to one or more analyst in the course of his studies. If the student aims to become a therapist he has to go to three analysts, one of which must be of the opposite sex.

The rationale behind these procedures is not clear but it evidently makes use of Jung's idea that the patient needs to be thrown back on himself and given a technique of handling his dreams and active imagination. In Hillman's view (1962) the procedures are designed to constellate the self. He also lays stress on the 'emotional climate' generated at the Institute as a positive factor in the life of students, whether or not they are training to be therapists.

It may be that there is a correlative factor in this style of therapy. It has been mentioned to me in a personal communication that many of the students only come to the Institute for short periods and there is anxiety about their developing too strong a transference. If it is believed that a change of therapist can reduce its strength then changes of analyst are to be recommended.

The developments in Zurich are derived from an interpretation of Jung's work as I have outlined it. If it is assumed that all patients are suitable for this kind of treatment, however, it would run counter to the wider attitude that he adhered to—especially the idea of different kinds of treatment for different cases.

Very little has been published on the treatment techniques used by contemporary analytical psychologists of this group. Yet there are attractive theoretical possibilities in 'multiple analysis'. On the basis of self-theory one might conceive an analyst becoming a sort of specialist in the treatment of particular aspects of the personality, and patients could go from one analyst to another for particular purposes as occasion arose. This practice was used to some extent by Jung, who would see patients for a few interviews or a single one in order to work on an especially important dream that the regular analyst found himself incapable of understanding. The results of such procedures are not, unfortunately, recorded, so it is difficult to assess with so few details available, but it does appear that the transference implications of these activities are largely, and perhaps advisedly, neglected or even deliberately ignored.

The London school

In London transference is given far more attention and so the effects of the analyst's personality have been investigated in some detail. There the problem of how many analysts the candidate or patient requires is so rare as to be almost non-existent. But there is one difference, which may be additionally significant; the Society of Analytical Psychology is a training body only and candidates must be either permanently resident in London or must stay there for at least five years. Thus there is a different situation from Zurich, a more professional and less of a cultural atmosphere, so there need be no anxiety about the transference developing.

It will be clear from this statement that there are significant differences between developments both technical and cultural in London and Zurich, so that one can speak of a London school of analytical psychology. This school has been far more active in publishing and describing its researches; so it will not be surprising to learn that it is from London that two books have appeared emphasizing the scientific nature of the discipline and the importance of technique in the practice of analytical psychology. The titles of these volumes are in line with that approach: *Analytical Psychology a Modern Science* (Fordham *et al.*, 1973) and *The Technique of Analytical Psychology* (Fordham *et al.*, 1974). The second volume of this Library is mostly made up of studies of transference and counter-transference, that is to say of that aspect of the analytical process in which the affects of both patient and analyst are engaged. It is a collection of essays which include, by implication, the open and closed-systems approaches as two aspects of the analytical-interpretative method. It might be said to lay emphasis on one aspect of Jung's work only, were it not that the transformation process is included in the everyday work of the analytical psychotherapist.

The present volume is an exposition of practice in the 'London school', though even amongst its members there is considerable difference in detail. It will be of interest to state briefly how the group developed.

When the Society of Analytical Psychology was formed in London its members wanted to define more clearly what therapists actually did in their work. Apart from Jung's essays, many of which had not then been published, there was very little to go on. It was also noted that there was virtually no account of maturation in infancy and childhood, though a start had been made (Fordham, 1944) in showing that archetypal images and processes could be found in childhood. So there were two lines of investigation that the members wanted to follow.

As to what analysts did, investigations were soon directed to the study of counter-transference as a correlate to the patient's transference. And, since transference could be understood best in relation to the patient's history, its study fitted in well with applying Jung's concepts to the study of maturation in the early months and years of life, somewhat to the consternation of the more conservative members.

It will be clear that this study brought analytical psychologists much nearer to psychoanalysts, many of whom were developing ideas of interest, which stimulated and facilitated the investigations. In particular the Kleinian school, with its emphasis on unconscious fantasy and counter-transference, made a fertile interchange possible.

The San Francisco school

A similar interchange with psychoanalysis has taken place in San Francisco, where analytical psychologists have been teaching alongside psychoanalysts for many years, so that some of them like to style themselves Jungian psychoanalysts. This has resulted in an interest in childhood and in the transference, though there are also analysts who practise more along the classical lines discussed already. In keeping these two trends together the San Francisco analysts have been more successful than elsewhere.

This is not, however, their especially characteristic feature. The use of type theory has played a much more active part in their therapeutic endeavours, and a number of experimental studies have been undertaken to investigate the predominant type of analyst and to study marriage conflicts, which it has been suggested sometimes derive from typological elements (cf. Dicks-Mireau, 1964). Once again, however, very little has been written on the details of therapeutic techniques or indeed on how analysts behave.

The German school

From Germany—where there is also a relation with psychoanalysts—has come work on the behaviour of therapists. The investigation depended upon setting up a group to study the effect of archetypal material produced from patients on therapists. This interesting departure is in its early stages but has already produced results (Dieckmann, 1976).

Conclusion

Surveying this scene it will be observed that there has been a considerable diffusion of Jung's work. There are centres in other parts of the world, especially New York, France, Italy, and Israel, and there has been a tendency for dogmatism and reaction-formation to enter into investigations: as might be expected, the Zurich school has tended to react to the departures from the norm in London dogmatically; with this has been combined idealization of the master. There has been a rather marked reaction-formation in London and it has led to the setting up of a group concerned primarily with psychotherapy, since the main body of analysts wanted to stick to their hard-won analytical gains.

Note

1. Very little has been written on the development of the various schools of analytical psychology that have grown up. There is, however, a good account of developments in Great Britain (Prince, 1963).

PART II

This part of my essay represents the result of my own investigations developed within the context of the London school of analytical psychology.

I began studies with children themselves and went on to the childhood and infancy of adults. When I started my work the theory of archetypes and the self had not been applied to childhood in any detail, nor was it held that individuation could take place in childhood.

The theoretical issues have already been worked on and developed in three previous publications (Fordham 1958, 1969 and 1976) on child analytical therapy, and a number of papers have been read to scientific societies.

Beside this interest, which is already apparent in Part I and will be more so in the second part, another has been in the analytical method and its limits. On both subjects I go into considerably more detail than is usual for 'Jungians' to do. My aim is to fill in omissions rather than to refute the value of their work. (A basic knowledge of psychoanalytical method is desirable but not essential in understanding Part II. Of the many volumes on the subject Greenson (1967) is recommended.)

This personal statement has seemed to me necessary, though I fully acknowledge my debt to other members of the London Society and to those psychoanalysts who appear to have moved significantly in the direction of analytical psychology.

CHAPTER 6

Analysis

So far the terms analysis and psychotherapy have been used but not defined. The term analysis commonly covers all the different methods that have so far been listed, and an analyst is then thought of as a person who uses one or more of them. This wide application is of little scientific value and only distinguishes a group of psychotherapists. It therefore becomes necessary to define the essential meaning of the term. As I shall show, it corresponds to the 'stage' of elucidation in Jung's scheme of therapy.

Analysis means: 'The resolution of anything complex into its simple elements' (*Oxford Dictionary*). In analytical practice it is a method of thought, combined with observation of data produced by patients, aiming to define simple entities, called primary, which explain complex symptoms, character disorders and normal psychic functioning.

Arriving at and defining what is primary is complex. In the early stages of psychoanalysis it was discovered that the root of hysterical symptoms could be located in an emotional trauma in childhood. Yet it often appeared that the traumata need not necessarily have been traumatic, indeed many of them might have been surmounted by a different child; so it was assumed that patients had a predisposition to experience events in their childhood as harmful: that was the primary cause of the condition. Freud was not content with this idea and thought 'predisposition' was complex. By scrutinizing the data and analysing them further he concluded that he could replace predisposition by moral standards that were in conflict with infantile sexual fantasies and impulses; he tested this conclusion, developing the techniques of free association and interpretation to assist him. For his part Jung studied the parental images from which collective standards emerged and he concluded that there were primary entities that lay behind the personal ones. They had historical, impersonal and social (collective) reference. He did this by studying data from dream and fantasy in relation to ethnological material to define a number of primary entities called archetypes (the shadow, anima/animus and the self). In all this he and Freud both proceeded analytically.

Full analysis

Full analysis means, then, that the primary entities have been reached and the patient's psychology explained in terms of them. Freud defined the end of analysis in this sense with relation to penis-envy in woman and passivity in a man as follows: 'We often have the impression', he writes 'that with the wish for a penis [in females] and the masculine protest, we have penetrated through all the psychological strata and have reached bedrock, and thus our activities are at an end' (Freud, 1937, p. 252).

Another indication of when analysis of a patient is complete is given by Jung when he says 'But when the thing [analysis] becomes monotonous and you begin to get repetitions, and your unbiased judgement tells you that a standstill has been reached, or when mythological or "archetypal" contents appear, then is the time to give up the analytical-reductive method and to treat the symbols analogically or synthetically, which is equivalent to the dialectical procedure and the way of individuation' (Jung, 1935, p. 20). These classical formulations show how full analysis has been understood. What is complete or full, however, depends upon the state of knowledge at any particular time, and so is provisional.

Today a great many would not agree with Freud's statement but would think that the wish for a penis and the masculine protest are quite complex and can be analysed further. Thus the wish for a penis rests on earlier forms of deprivation—the need for the breast as the source of life. Again, though Jung's model of archetypes stands, many would not agree that his empirical criteria for deciding that analysis is at an end are at all reliable. I am, however, concerned here with a basic principle and will not translate further what Freud and Jung said into their modern equivalents, for in principle it does not matter. If, in the course of time, data show that what one analyst previously thought to be complete was not so, that is the consequence of increasing knowledge: the principle pursued in each case is the same.

The definition of a primary entity, then, is provisional. All the same the definition is cogent and any analysis depends on experience linked to theory and the contemporary working model. Freud's theory of the mental apparatus (made up of ego, superego and id), and Jung's ego–archetype–self model, are each based upon experiences of a compelling nature abstracted for use within the field of experience; each aimed to extend it, so as to form a theory with general validity in psychology and the family of human and natural sciences. It was not enough to construct a model based on experience alone, it needed relating to current scientific theory and particularly to that of biology. When Freud attributed so much experience to the sex instinct he found that there was no satisfactory biological theory available and so he invented a psychological one of drives derived from sexual libido. Similarly, Jung also paid attention to biological theory and, like Freud, tried to incorporate instinct theory. Other ideas were also used and especially evolution, the theory of inheritance and so forth. These attempts were not altogether satisfactory but

it is important that they were made so that better formulations may be arrived at as biological and psychological knowledge increases.

The principle of analysis looks rather different and more complex when related to analytical practice because the intellectual exercise comes up against affective processes that do not accommodate themselves easily to it. In the first place it is necessary to gain the patient's co-operation in a process which can be, and indeed usually is, painful. Therefore there needs to be sufficient confidence in the analyst himself as a real person, as somebody in whom the patient has adequate trust. If this maintains, he can identify himself with the analyst's directions and interventions and use them as a basis for reflection about himself. The therapeutic alliance is complex but is the basis upon which ordinary analysis can proceed. This alliance is usually distinguished from the transference in that it contains realistically based perceptions of the analyst.

On the basis of a therapeutic alliance there are four processes that can be defined: confrontation, elucidation, interpretation and working through. The first of these means that a feature of the patient's behaviour is identified; it may be a defensive attitude or something that is manifestly and recurrently odd or unadapted. The next step is to elucidate this by obtaining reflections or associations to it; and once these have been collected, and the nucleus has been sufficiently amplified, then an interpretation can be made about the unconscious nucleus that the analyst and patient infer lies behind the odd behaviour. The final process of working through means that time is given for the accommodation of the insight for, if grasped, it will mean that some of the patient's attitudes will change and defences be modified. If one has been altered others tend to form: their value will be assessed in the light of the new insight.

The historical nature of analysis

In the process of analysis emphasis is laid on the genesis in infancy and childhood of the symptoms and other characteristics displayed by the patient. This itself can have a therapeutic effect besides the purely analytical one of reducing complex into simpler patterns. For analytical purposes we focus on the simpler systems because it is easier to construct a model from them of the patient's behaviour as a whole; in infantile states of mind the nucleus of later structure is to be found.

The investigation covers both the personal history of each individual and the culture pattern in which he has lived, together with more or less of its history. So both aspects will be considered together and it is valuable to do so, as Jung emphatically claimed. Indeed he developed a historical theory that would shed light on the personal field.

The importance of the patient's history can give rise to the idea that analysis is essentially a historical process and that analysis is to be thought of as nearer to the methods used by historians than any other discipline. This is an interesting view, indeed the historical dimension is certainly valuable enough to make it usual to aim at achieving a rather complete reconstruction of a patient's

development. At the least it may be hoped that significant gaps in it, which are often apparent at the start, will be satisfactorily filled in as the analysis proceeds. Reconstruction of the past can, however, only be incomplete, because of the extreme complexity of development and the therapeutic irrelevance of investigating healthy growth processes. Work on the patient's history is also useful because it helps him and his therapist to achieve a perspective and so evaluate the degree of maturity or immaturity of affective life; an experience may, for instance, have been relevant in the past but not in the present.

The reconstruction of a patient's history is a complex operation. One construction may be useful at a particular stage in the therapy, only to be revised or discarded at another when more information has been gained. Again the significance of memories can change with the state of the transference and the patient's analytical development.

As a result of this work a change in attitude towards parts of childhood can take place. A patient may collect memories to prove how badly he was brought up as if he had no part in the process at all. Later, as he recognizes, usually through transference analysis, that this view is in part an exercise of his destructive potential, the emphasis will shift so that his parents' failings become less important and he will recognize that many of them were not their fault and were anyway not so bad after all. Progressive shifts of this kind may eventually lead to a more realistic assessment of his development and eventually to the clear emergence of parts of the self that had been split off or repressed.

These remarks, which suggest why childhood can play such an important part in the analysis of the individual, should not be taken to mean that analysis is to be identified with the investigation of childhood. It will be apparent from the preceding argument that such a conception would be false.

The destructiveness of analysis

It is sometimes said that analysis is destructive; this means that a patient's mature feelings are reduced to their infantile equivalents and so the personality as a whole is devalued. This is called reductionism and depends on the notion that the primary entities are the only important part of the whole person; consequently everything secondary is insignificant. The falsity of this argument was well illustrated by Bertrand Russell who once reduced chemistry to a single sentence; that was not the end of chemistry, however. No more is a reduction of human behaviour to a number of primary entities the end of human beings with their unpredictable creative capacity. Reductionism, usually attributed to psychoanalysis by analytical psychologists, is equally an illusion that can just as well be attributed to those who lay excessive emphasis on types, whether they be attitude and function types or archetypes.

There is another aspect of analysis that can, with more reason, be thought of as destructive. It is true that a patient's defences, amongst them the idealizing ones, may need to be modified. It is a change that may be fiercely resisted by the patient because, if the defence is lost, many supposedly, and sometimes truly, undesirable characteristics will come into view and result

in apparent or real disaster. The patient therefore feels endangered; he cannot realize the benefits that can result from the relief of inappropriate guilt and the consequent re-evaluation of his situation. Thus the interpretation of inappropriate idealizing defences, combined with showing the patient what is being defended against, may seem to be destructive. There is an element of truth in the patient's feeling, exacerbated if he loses sight of the analyst's good intention, but it is essentially the patient's destructive wishes that are being made conscious so that they may be changed and built into the patient's self. Thus, though apparently destructive, the therapist's aim is synthetic and he relies on unconscious synthetic capacities in the patient which he predicts will come into operation later.

To illustrate these propositions, consider a typical situation that may arise when a patient in regression is faced with his analyst taking a holiday. The patient may bemoan the event and complain that he cannot 'survive', that his therapist is ruthless, does not care about him and then he may enquire about where the analyst is going. This may lead on to fears that the analyst will meet with an accident, be killed in an air crash and the patient will never see him again.

Now the significant ingredient in all this is the patient's exaggerated fear of his murderous feelings towards his therapist, evoked by jealousy of his going off with his wife or enjoying himself in other ways without him. These dangerous feelings are denied, split up and turned into a phobia; something other than he will be the cause of the therapist's death: an aeroplane crash will cause it, perhaps. The patient's ruthlessness is evidently attributed to the analyst and so he is left feeling the helpless victim of a heartless analyst. The analysis of this state of affairs takes time and its various components can only gradually be sorted out, but it can be seen that the aggression has oedipal roots from which jealousy and rage are evoked.

Interpretation of the situation both in relation to the analyst and in relation to the past is essential if the patient is to separate without undue distress. It will be necessary to show how and why the aggression has been projected and turned into a phobia. Now this will lead to the patient's idea of what he ought to be, that is, a lovable and loving person only, so his ideal of himself will be threatened and will have to be modified, and in the process it may seem to be demolished, leaving the patient as nothing but a bundle of jealousy evoking destructive rage—just a horrible creature to which he has been reduced. So long as the analyst holds the situation securely during his seemingly destructive analysis of the situation, the patient will be able to work through his emotion, and he can end with an increased capacity to recognize the relation between love, hate, jealousy, envy, and gratitude so that each enriches the other. That is not possible if the ideal is only love.

I have deliberately given a dramatic situation to illustrate the need for an analyst not to fear the seemingly destructive nature of what he is doing because it will lead to transformation and to a new synthesis. It is a feature of analysis all the time but is usually less manifest.

Analytical attitude and its consequences

The analytical attitude is that of a therapist who consistently restricts his activities to sorting out and reducing complex behaviour into its simpler components. He will use for this purpose situations in which anxiety in the patient is manifest or easily accessible. Under suitable circumstances he will communicate the results of his conclusions in the form of interpretation of the patient's behaviour.

The analytical attitude is difficult to sustain because it involves the analyst's affects in relation to the unconscious life of the patient. To put it another way, analysis, having as its instrument the mind, at the same time requires the active participation of the analyst's emotion, as will be developed later (Chapter 9). If anybody claimed to conduct himself according to the analytical attitude all the time he would correctly be disbelieved.

Since the analytical attitude is essentially impartial to the material produced by the patient, the question of whether dreams, fantasies and transference, current events, memories, etc. are most important depends not on the analyst but on the patient. The analyst must not, as some therapists tend to do, focus on one of these elements and so slant the patient's own style of presenting his material. For instance, it is sometimes thought that Jungian therapy is primarily dream analysis, and indeed there are therapists who put dreams in the centre of their approach; again, others focus on transference-analysis and others on spontaneous fantasies or active imagination. Whatever the merits or demerits of these approaches, an essential component in the analytical attitude has been sacrificed. It will be evident by now that to conduct an analysis requires rigorous discipline.

During its early stages the analyst will introduce the patient to the necessity for him to talk freely in the presence of another person who will behave in a most unusual way: he will not engage in friendly conversation, he will not reply to many of the patient's questions and he will make a new sort of communication, interpretation, unique in the patient's experience. Moreover, he cannot be shifted from continuing to do all this day after day, week after week and, if necessary, year after year. He will have to struggle much of the time to prevent his own interests and his own emotional limitations from finding expression and thus introducing distortions that hinder the developing analytical process.

Analysis and psychotherapy

Because analysis and therapy proceed concurrently, it can well be claimed that to abstract analysis from therapy is unreal and it is therefore better to refer to analytical therapy. The advantage of the abstraction is, however, to provide a standard by which to consider the more complex situation of a therapeutic contract. In addition, it makes for a discipline that defines techniques of listening to patients, making inferences, communicating them and working out their effect.

In this the analyst must be sufficiently flexible, and will act as a screen for the transference to take place with the kind of patient who needs to make use of him in this way. The disciplines of analysis have the further advantage that they can be taught in training and, when they have been mastered, can make comprehensible the way in which analysis runs concurrently with therapy, and how it can form the basis of treatment strategies. Furthermore, it will be possible to decide about the limits of analysis and when the total non-analytic reaction of the analyst is relevant and desirable.

The use of theoretical models

In his published works Jung showed repeated concern lest the application of a generalized model in the conduct of psychotherapy override the patient's individuality. Yet he also held that this could be required when a patient was so individualistic as to be unadapted: then it was necessary, he claimed, to reduce behaviour to more acceptable cultural norms. He believed his own method did not apply to individualists but rather to those whose individuality was underdeveloped. Then he claims to have leaned over backwards to criticize the assumptions on which he worked and proceeded by giving hints and suggestions so as to pursue a principle of uncertainty. In this way, he conceived, the patient would be given ample space to develop in his own fashion. It was an attitude developed from treating patients for whom analysis was unsuitable, but the idea of not imposing a model, whether it be typological, structural, topographical or any other is valid for all cases whether or not analysis is being used. To impose one is indeed essentially contrary to good analytical method, which begins from the analyst's or patient's understanding of particular material brought to any interview. When Jung says that every analysis requires a new model or theory he recognizes the need for a model and also the need to construct it afresh in each case so that individual characteristics shall not be left out. If the 'new' model has a way of turning out very much like a previously known theory that is hardly surprising, though it has been variously understood.

The idea that every case requires a new theory can, however, become idealized and unreal. I have already shown it to be so by discussing a case in which Jung used his own theory in the analysis of a patient's material (p. 41). Twist and turn as we may it is inevitable that an analyst uses his theory, for analysis cannot begin without some point of departure based on the analyst's previous experience, his emotional capacities and the model of the mind on which he works. The problem is not therefore whether a model is used but rather whether it is applied appropriately or not. To impose a model is to use it wrongly.

That the individual model turns out to be familiar may be taken to confirm a general theory, and this, having respect for the nature of analytical model building, is the position that will be adopted. It is however, sometimes taken by others to be evidence of indoctrination and that analysts, having submitted to the process themselves, then pass it on to their patients. To some extent this is correct, and is a problem of which analysts are aware and which is being

constantly worked on. It is true that members of a school of analysis sometimes give the impression of rigidity and even cult formation, comparable to that openly aimed at in religious communities. This is not, however, peculiar to analysts, and is also to be observed amongst scientists, who will adhere to a theoretical position and sometimes refuse to accept observations that contradict that position—they may do so in the end but it will take time. It would be wrong therefore if analysts conceived themselves immune from this characteristic. Refusal to retract from a position is, however, not necessarily bigotry. Suppose the pioneering analysts had not held fast against the attack on their discoveries—how much would have been lost. The formation of groups to develop a theory or defend a valid position is therefore more or less inevitable and desirable. Firm affirmation of a position that analysts display derives from the need to have a framework that is more than intellectual if they are to conduct themselves as analysts and perform useful therapy. Their affirmation is, at its best, based on their knowledge of themselves and their real natures and on their limitations. If the analyst self is recognized it leads to a sense of security that optimally leads to greater intellectual and emotional flexibility within their personal limits.

Having said this, I must add that there are, however, processes taking place during a full and detailed analysis that involve the patient incorporating a part of the analyst into himself. He introjects and identifies himself with his analyst as part and parcel of his transference. It is by making this and the analyst's counter-transference clear that indoctrination is reduced, and not furthered as is usual in education, where it can be an aim. Thus, though not always successful, analysis can reveal the roots from which much indoctrination takes place, and this mitigates the analyst's undesirable effect on his patient. How difficult this can be is illustrated during training: when the trainee starts taking cases under supervision it will soon become clear to the supervisor that the candidate starts off by following the path taken by his own analysis. It will take him a long time for this effect to wear off.

Analytical therapy starts by assuming that two personalities—analyst and patient—become, as Jung expressed it, geared together in a kind of chemical process; this cannot and ought not to be avoided. Taking this view, the following features can be sorted out: what does the analyst aim to do, and what does he actually do? He aims, as I have said, to confront, clarify, interpret the patient's communication, and understand the patient's need to 'work through' what he knows. If he adheres to these disciplines the problems to which I have referred can be kept within bounds.

CHAPTER 7

The Setting of Analysis

To pursue the practice of analytical psychotherapy it is necessary to create a situation in which the patient can bring complex and highly charged affects, struggle with them and find a solution better suited to himself as a whole. In this he will need to get into fluid states when he will be uncertain of what is happening and become confused or temporarily disorientated. So there is need for a stable setting. This is partly expressed in the analyst's provision of a room that is quiet, warm and reasonably comfortable where he will be found at regular intervals. Furthermore he will maintain his analytical attitude whilst the transference neurosis is being worked on.

In part the framework is impersonal but it is full of personal but non-verbal communications that derive from the analyst having chosen and furnished his room; the furniture, pictures, decorations are arranged to suit him, to make a setting in which he feels comfortable, and which express the parts of himself that he likes to have on view. In arranging his room he will have had patients in mind and so nothing very unusual may be expected in it.

This may scarcely seem worthy of comment were it not that sooner or later patients will include the room and the objects in it as part of their transference projections; so just as the analyst needs to be aware of his inner world, so does he need to be aware of the parts of himself that are outside him in the room. If he is not, then he may well be swayed undesirably by his patients' comments, favourable or unfavourable, and he may have difficulty in estimating their implications.

Chair versus couch

Though Jungian analysis can be very much like that conducted by psychoanalysts there was one respect in which Jung was very emphatic that it should be different: analysts should sit in full view of their patients. From this position, he claimed, the patient can witness his effect on his analyst and the analyst will not be able to detach himself from his patient. He states: 'I reject the idea of

putting the patient upon a sofa and sitting behind him. I put my patients in front of me and I talk to them as one natural human being to another, and I expose myself and react with no restriction' (1935a, p. 155), and again, 'I have to sit opposite them so they can read the reactions in my face and can see that I am listening. If I sit behind them, then I can yawn, and I can go off on my own thoughts, and I can do what I please. They never know what is happening to me, and then they remain in an auto-erotic and isolated condition which is not good for ordinary people' (1935a, p. 157). This gives the sense of Jung's objection to using a couch; beyond this and other short evocative utterances there has never been discussion of his proposition, so I shall spend some time discussing it and why, having conducted analysis with the patient in a chair, I have changed to providing a couch. My reasoning may have begun from noting that the use of the couch by psychoanalysts does not appear to have produced a class of people 'in an auto-erotic and isolated condition'; and it may be doubted whether Jung really did react 'without restriction'; indeed he seems to contradict this in the passage where he says that if he used a couch he could 'do what I please' which suggests that he did not do as he pleased when facing his patients: though, as detailed in Chapter 5, his behaviour varied within wide limits.

The quoted passages are taken from a posthumous publication—the Tavistock Seminar, in which he was speaking spontaneously, and not from a prepared text—yet he says very much the same in *Memories, Dreams, Reflections* (1963): 'The crucial point is that I confront the patient as one human being to another. Analysis is a dialogue demanding two partners. Analyst and patient sit facing one another, eye to eye' (p. 131).

It is apparent that the two-chair procedure is part and parcel of Jung's open-system technique, which he contrasted with the tendency in psychoanalysis to treat the patient as an object separate from the analyst and to think involvement of the analyst an undesirable counter-transference neurosis—this would be the closed-system approach. In emphasizing the effect that a patient has upon the analyst Jung was right, but he laid too much emphasis on the physical position. It is interesting that he did not always take this stand. His first recorded 'psychoanalysis', published in 1906, was conducted with the patient sitting in a chair with Jung behind her 'so as not to confuse her [the patient]' (*C.W.*2, p. 304).

Estimation of Jung's position

The couch is used by medical men and women as a convenient way to examine parts of their patients, especially the abdomen, and surgeons use an operating table for most operations. It was also used by hypnotists to induce relaxation, and this may have been how Freud came to use a couch that was more like a *chaise longue* than the flat analytic one, with a pillow or cushions and a rug on it, that is usual today. These considerations all fit in with the medical approach.

The couch, however, need not be used thus; it can indeed be put to a variety of purposes. But before entering into these there is one reason for employing

it that needs special mention. It is a manifest indication that the analysand is different from the analyst in an important respect: he comes because he is in some sense a patient who wants treatment, so he is not just an ordinary person. The use of the couch recognizes this, and it is useful in making it clear that analysis is not just a social occasion, nor is it going to handle only 'human' subject matter.

Jung's idea that it detracts from the aim of creating a natural situation has importance, but all the same analysis is not natural. Of course Jung must have been aware of this and furthermore that it is not 'human' either, whatever the relative physical positions of the two participants: the transference and counter-transference prevent this. Neither is it natural, since physical exchanges are largely proscribed, and do not allow expression of the sexual, erotic, and aggressive affects that are going to be experienced. The reason for his attempt to maintain a human relationship was, however, probably different and arose from the contrast between human and archetypal experiences. Jung insisted on the need for them to be differentiated; he was keen to keep this distinction going in the midst of the transference. It corresponds with a more recent formulation: the need to maintain a therapeutic alliance. This is difficult or impossible when there is a delusional transference, but since this is infrequent insistence upon the human element can be overdone.

Jung does not consider any of the undesirable effects on his patient of observing the analyst's reactions stark; yet there are a number of occasions when the patient does not want to confront his analyst 'eye to eye', not to mention that the imminence of the analyst can be traumatically intrusive. It is true that the patient can avoid what he fears by looking away, but it will be obvious, and suppose he wants and needs to sustain an illusion about his analyst, and does not wish to have it contradicted by visual evidence, or suppose he needs to conceal his state of mind from his analyst, what is he to do?

On the couch the patient can relax and he can easily treat his analyst as if he were not there. This may be the auto-erotic state that Jung deprecated, but that can all the same have an important place in the analysis. It may be supposed that Jung was referring to what is sometimes called 'classical psychoanalysis', in which the analyst sits behind the patient and says very little, if anything, and maintains a passive reserve, for he says in relation to the previous analyst of one of his female patients: '... her analyst had been ... a mystical cipher who was sitting behind her, occasionally saying a wise word out of the clouds and never showing an emotion' (Jung, 1935a, p. 139). To a large extent this practice, if it ever really existed, is historical and was used with a restricted type of patient. It derives from the time when knowledge was scanty and analysts felt that they needed to learn a lot before intervening, or when they wanted to force the patient into reflecting about himself, or to unearth resistances and repressed memories. It was different from the object-relations attitude that Jung was one of the first, if not *the* first, to initiate. That the couch itself need not have as much to do with it as Jung seems to maintain is evident, for even if the analyst sits behind his patient's head, it is quite possible for the patient

either to turn round on his stomach to look at his analyst, or to reverse the position of the cushion and be at the other end.

Advantages of the couch

This brings me to specific advantages of the couch:

(1) Relaxation is easy and there is room for ease in movement as well: the patient can lie out straight, curl up on his side or lie face downwards. Then there are the cushions and the rug which can be used in a variety of ways as he feels inclined. All this has nothing to do with whether the analyst has emotions or not—nobody doubts that he has them but whether he expresses them or not depends upon other factors than whether the patient is lying down or sitting up.

(2) Another advantage of the couch is that it makes for greater freedom for regression, so that infantile affects can be reached with greater ease, and there is little doubt that transference can be more easily detected in the analytical situation. Sitting in a chair makes it difficult for the patient to express it and for the analyst to detect it; consequently, the interchange between analyst and patient is inhibited.

That the couch is useful to facilitate regression can be rather well illustrated by patients who have been in analysis and return for a few interviews: some will go straight to the couch and regress, others will not do so but use the chair. The difference is sometimes striking; those who use the chair work on a problem which is rather well defined and organized; they do not need to relax like the others who regress and almost continue the analysis where they left off.

(3) Patients on the couch may say that they cannot organize their thoughts as they do in other, especially social, situations or that their thoughts come out in fits and starts in a way that reminds them of dreaming. If this is so then one would expect that they are nearly asleep and indeed patients on the couch do sleep much more than when sitting up, or if they do not actually sleep they doze or struggle with sleep. So lying down relaxes consciousness and reaches more nearly to dreaming and the unconscious than sitting up.

(4) Following on this idea it has been observed (Davidson 1966) that the transference takes on a form strikingly like active imagination in that the patient carries on an imaginary dialectic with another person, the analyst, as if there was no need for him (the analyst) to say anything.

(5) I have already referred to the way some patients move about on the couch. Considerable movements, like the ones described, are unusual but the account highlights another feature of lying down: body feelings and impulses, muscular and instinctual but especially hunger or sexual impulses, come to the fore. Genital feelings become sufficiently obvious for them to be interpreted and patients can report movements in their sexual organs, overcoming their embarrassment at so doing.

(6) From the analyst's point of view, with the patient using a couch, it is easier to keep track of his own mental and physical processes. This can be especially important when he develops resistances. He is not under the eye

of the patient and when they are a matter private to him, which it is his job to deal with, they are easier to overcome. And does it result in his becoming less related, less human, less natural? It can be the reverse: the human part of his relation is made easier because the real differences in his position as analyst *vis-à-vis* his patient is given explicit and continuous recognition; the couple can exist as two people who do not have to pretend equality and who have come together for a special purpose.

I have spent time discussing furniture because the provision of a chair for a patient has been adopted thoughtlessly by many analytical therapists. It is agreed that whether chair or couch is used analysts should not interfere with the patient's effect upon them as this is an essential element in developing the analytical process. In London mostly the couch has become preferred, but this does not exclude the use of a chair for patients who show strong resistances that do not yield to interpretation.

Once the issue between chair or couch has been decided upon with any particular patient it is advisable for the analyst to stick to it because of the patient's need for stable and reliable surroundings. The ritual element in analysis extends not only to the room, but to the arrangement of times, holidays, etc., and within this frame flexibility can be achieved. All this, however, would be of no avail if it did not represent the reliability of the analyst, and his ability to remain essentially the same throughout the vicissitudes of the analytical process.

The issue that Jung raised and insisted upon has much more importance if formulated in this way. It presents the question of whether the analytical situation is to be conceived in terms of open or closed systems. A patient coming for treatment of a part of himself implies a closed system, though if it were really valid there would be no need of the Hippocratic Oath, which covers the involvement of the physician with his patient and sets limits on it. Yet in spite of this the techniques of diagnosis, prognosis and treatment consider the patient as essentially separate from the physician. The attempt to apply this outlook to psychotherapy has, however, limited success, and the involvement of the therapist has become evident, leading to recognition that analytical therapists themselves need to undergo a personal analysis, with a view to controlling and limiting the counter-transference neurosis and forming the basis for the analyst's capacity to understand his patient. Through allowing and following his affective involvement, through projection and introjection with his patient, he could achieve a far greater and more true understanding of psychic reality by recognizing the basically interactive nature of analytical therapy.

In Chapter 9 I shall develop the theory that the basis of interpretation lies in this projective-introjective interchange: it was this to which Jung was surely referring. In 'ordinary analysis' the frame, the structure of analysis, is not under attack and does not need to become modified. In these circumstances it can seem as though the closed-system approach is operating; but this is not the whole picture.

Even, however, when it is much more apparent to the two members of the analytical enterprise that both are affectively engaged, it still remains important for the analyst to maintain the frame in which he conducts his work, but it must be such that both partners can operate within it. The material setting reflects and is a representation of the frame and becomes especially important when the provision of time, the space of his room and his continued existence can become the only thread that keeps the therapy in progress.

An unusual use of the analytical frame

There is little that need be said about the ordinary use made of the setting provided by the analyst because irregularities in its use will usually become subject matter for analysis and are all manageable, though not always; I want to illustrate this by describing a case in which I set up a definite frame and made my taking on the case at all conditional on the patient's agreement to it. The patient's use of my conditions was particularly striking and profitable, though far from usual. It provided much food for thought, since she was a 'Jungian' case for whom I thought an analytical approach might be possible and I decided to make the attempt. I shall describe behaviour that highlights some consequences of adopting that approach.

In using the word 'providing' for what the analyst does in relation to the patient I mean that the obligation rests on the analyst to sustain provision, regardless (within limits) of what use the patient makes of it. When I made my conditions I had in mind that making five times a week available would provide a secure frame on which the patient could rely. I was under obligation to continue providing that amount of time and a couch.

The patient was a young, attractive, clever woman in the middle twenties. She had married young and rapidly produced four children by a brilliant and unstable husband. She had been depressed, made a suicidal attempt and had twice been hospitalized. In the first instance she had partially recovered quite rapidly. When I saw her she was in hospital once more but was going home for weekends. As her relationship with her husband was very strained, she found this difficult, and her psychiatrist had recommended treatment for the husband as well as the wife. Neither wanted this and that was the overt reason for the referral.

In the history was an account, given to her by her father, of a psychotic episode on the part of her mother soon after the patient's birth. What this meant in detail was obscure. Her father, like her husband, was a brilliant but violent man, and the patient was scarcely on speaking terms with him at the time of referral. The patient expressed very considerable hostility, not only to him, but to doctors as a whole, and particularly to her psychiatrist who had pressed her to reveal her sexual conflicts, which she was not ready to do.

I said that if she came to me I made it a condition that she come five times a week, and when she agreed the analysis started. She complied with the suggestion that she use the couch but the result was almost complete silence and after a few sessions she sat up crosslegged—it was a position she often adopted at

home when sitting on the floor. Then she could begin to talk and some analysis was possible.

It was clear to me that she had taken lying down on the couch as a more drastic effort on my part to pursue the policy of her psychiatrist. Lying down was designed to make her realize and talk about her sexual feelings by putting her in a sexually vulnerable position: she was not going to be seduced by my mind-penis. So when she became more certain that this was not my intention she lay down again. When she did so, however, she seemed to drop through a hole: she became acutely depressed and silent until she jumped up and left the room, threatening suicide. There followed a period in which she would not come for some of her interviews. At first it happened without her giving notice, later she telephoned me to tell me why she had not come on a particular day. At first this was without apology, but gradually she began to express regret at what she had done. In the next phase she came regularly, but was not comfortable on the couch until she had acquired a lover.

During all this time I maintained my analytical attitude, did not attempt to exert any control over her comings and goings, nor did I interfere with the way she used the couch, and this she subsequently appreciated. My not taking action turned out to be important because it had been the panic of her husband at her depression and suicidal threats that had resulted in her being sent to a mental hospital. I knew that her acting out was based on the expeditions that she had with her brother during their childhood, a memory that contributed to the situation, and also the story of her mother having suffered from a psychotic episode soon after her birth: in addition I was sure that there was a growing germ of a therapeutic alliance. It was these interlocking factors that combined to make her behave as she did to test out my tolerance and trust of her. Though the therapeutic result may not prove anything, the changes in her life were remarkable in that she began to build up a life of her own, her relation to her father and her husband changed out of all recognition even though the marriage eventually broke up.

The point I am making is that the frame of the analysis was apparently attacked, but it was important, even essential, that it remained there so that the patient could use it when and as much as she needed it.

I have chosen this example, which is unusual, to illustrate how the analyst's propositions can be used. If the patient does not always comply with them, that at least leaves the analyst with the knowledge that he has been ready for them to be used and he will not fill up times at which the patient does not attend and which the patient may be using better. The knowledge that I was there was used by the patient to build up an image of me which she carried about in her mind nearly all the time, and it made possible a more or less continuous self-analysis, as she told me after the acting out had stopped.

Professional confidence

Another aspect of the analytical setting involves the question of professional confidence. It extends to the subject of publishing case material—to discussion

of material being produced by patients in analysis, and discussion of personal matter revealed during their own analysis by candidates for training. When the candidate applies for acceptance as a qualified analyst a committee will need to know enough about him to arrive at an assessment of his suitability. It can be maintained that even though the candidate knows that the material will be revealed, he is not in a position to understand fully the consequences of others knowing essentially private data unsuitable for public discussion and on which a judgement is going to be made. These issues have been the subject of heated discussion and in some training centres the training analyst simply submits his final judgement about a candidate, and nothing else. If this applies in revealing matter to a small and responsible committee how much more must it apply to analytical material used by analysts in their publications.

The disadvantages of this position are particularly apparent when it comes to training, for no supervision of the candidate's first cases would be possible, and no case material could be used in teaching. Even if there were some disadvantages, however, the advantages of discussing case material seem to be overwhelming, so long as it is undertaken with due sense of responsibility and discretion.

There remains the question of publication during the analysis or after it has been completed. There are fortunately standards that can be defined and need to be met. First of all it is important that the patient cannot be recognized; this means that all easily identifiable matter must be removed. This is no disadvantage to the sense of the discussion because the data being made available need to illustrate general characteristics that could apply to a considerable number of other patients. There remains the effect of publication on the relation of the patient and his analyst. Here again there are sufficiently reliable criteria that can be applied. In the first place the material used must be sufficiently worked through so that the patient has assimilated it and is no longer in the grip of the conflict depicted. Secondly, the analyst must take responsibility for the publication, and be sure that the patient can react about it, if necessary, directly and personally. If these conditions are fulfilled it does not seem that there need be any hesitation in publishing material produced by patients that is of scientific importance and that furthers the communication of knowledge. It need not injure the analytical frame and will not disturb the patient's trust in his analyst, which is the essential point of the discussion.

CHAPTER 8

Starting Analysis

Before considering the suitability of a patient for analytical therapy it is necessary to be sure that the condition for which he has come for an interview is not due to an organic disease such as brain tumour, disseminated sclerosis and so forth. Organic disease has usually been already excluded but must be kept in mind in case an error in diagnosis has been made. The subject of psychosomatic disorders, such as asthma, eczema, migraine, is more difficult, for though it appears that they are sometimes helped by psychotherapy, the grounds for so thinking are empirical and not well understood. So treatment for their physical aspect must be ensured, and additional evidence looked for when considering the desirability of analytical therapy.

It is in line with anxiety about missing an organic disease that, at one time, psychotherapy was recommended on a negative diagnosis: if the cause of a patient's distress was not physical, then it was thought to be psychological. Today, however, an analytical therapist does not think this sufficient; he will want to arrive at a positive assessment as to whether the patient is likely to benefit from the long and often arduous treatment.

In making his positive assessment he will take into account his patient's intelligence, his likely capacity for growth and change and the degree of regression needed. More precise indications of the possibilities are given by the psychiatric syndromes, for the outcome of analysis is better in the anxiety states and in hysteria than in the other categories. That does not mean that the obsessional disorders cannot benefit, while analytical therapy can be applied with advantage in the wide range of phobias, character disorders, sexual perversions, borderline cases and to a selected number of the psychoses; but whether help can be given is dependent upon other factors as well, for some individuals in each category are suitable whilst others are not.

It is useful to consider this fact under the heading of motivation—a difficult subject. By it is meant that the patient asks for help from somebody whom he can trust sufficiently for him to persevere in whatever is proposed. It may be reflected that the word 'help' is most ambiguous for there are many others

besides analytical therapists who offer help: psychiatrists, a great variety of psychotherapists with differing qualifications, not to mention priests, gurus and the like who promise salvation. Consequently the patient may come with a confused idea of what he is coming to and will, indeed, sometimes ask for clarification of what is proposed by the analytical therapist.

Style of the first interview

This legitimate requirement makes a point of departure for considering the style of the first interview. Fortunately it is a good procedure to arrange it so that the patient can gain a positive impression of what he is going to experience should therapy be deemed valuable for him; the meeting may be constructed so as to resemble any analytical interview, though the procedure must not be too unfamiliar and use of the couch is not indicated.

Having sat down, some standard data may be asked for: age, occupation, whether the patient is single or married are usually sufficient both to provide the analyst with information and to give time for the patient to begin settling into the interview. The next step is to convey to the patient that the analyst wants him to talk in his own way about his condition and anything else that he deems significant. Anything the patient says will be of interest and this will be demonstrated, as the interview proceeds, by the analyst: he will give close attention to what he hears and will help in clarifying the patient's communications. He may also offer interpretations but with caution since it will not be possible to go far in working through their consequences. So right from the start the patient is put in the centre of the proceedings by being asked to tell what he thinks and feels, and he will discover that his views are taken seriously and responded to. At the end there is one deviation from other analytical interviews. The analyst will sum up and say what he thinks ought to be done. It is important that the patient can see the logic of his conclusion and recommendation so that the conclusion is arrived at through a dialectic interchange and is not made *ex cathedra*.

Assessing motivation

There is a kind of patient who has given considerable thought to his decision to come and see the analytical therapist. He has read about what is involved, may have discussed it with others and met persons who have been or are now in analysis. Consequently he will know that analysis takes a long time and that it will involve financial provision. When such a patient comes to the first interview and is asked to talk freely about himself, he will be able to give a good account of the reasons for his decision which may include the actual distress from which he suffers, its history, his fantasies and his dreams, and he may have brought a dream related to this first interview. The analyst has little to do but observe how the patient reacts to anything he says and to decide whether he is going to agree with the patient's clear and informed wish to be analysed.

Such a patient will appear manifestly well motivated and indeed nothing, it seems, can be said against it. The way, however, in which the account is given varies enough to suggest the patient's character-structure and the sort of difficulties that are likely to arise later on. It is possible, and occasionally important, that a patient who can produce such a coherent account is strongly defended and has developed insights to serve his omnipotence. In marginal cases it is a sign of a latent psychosis. Therefore the analyst cannot just accept the patient's account without reflection. It is especially valuable to note the capacity of the patient to engage in a dialectic. This can be tested by observing how the patient responds to interventions designed to test the depth of and flexibility of the patient's insights.

It does not follow that a patient who is well prepared for the interview necessarily has better motivation in a deeper sense than one who is less sure of what he has come for. The avenue of approach is then significant and influences the way a patient presents himself. It may be that the referral has come through a medical practitioner. In that case the patient may have become used to presenting his symptom and then waiting for the doctor to ask questions, deeming his own thoughts and feelings unimportant. Consequently, he may have great difficulty in collecting his own thoughts in the novel situation created by the analyst. The analyst may then test the patient by remaining silent for a while, waiting—but not too long—after which it is better to meet the patient's need in any way that seems suitable. He may, for instance, ask questions in the hope of getting the patient going. When the patient starts talking, the result may be different from that of the first patient in that it is much less organized. Bits and pieces of information may be presented and there may be shifts backwards and forwards between symptoms and ideas about what has caused his state, and perhaps some statements about what other people have said. It may become apparent that the patient is trying to find out what the analyst wants from him and if so then an interpretation of this state may be useful. It may then happen that the patient talks more freely and the interview becomes much more of a dialectic than in the first case. As a result the patient begins to develop his thoughts and feelings with greater facility. Such a development is a good indication of what can happen later on and though information may be unsatisfactory yet the capacity to use analysis may be easier to test. It may turn out that the difficulty in expressing himself is itself the reason for referral and may be a general characteristic of his relation to others, particularly evident in stress structures such as the interview itself.

By way of contrast, once the analyst has said he wishes to hear what the patient has to say in his own way the result may be an outpouring. A never-ending stream of talk will result and any intervention by the analyst only seems to increase the flow. It seems almost impossible to end the interview because there is always more to say, which finally changes into a flow of doubts and questions and it may be necessary to arrange another interview, which may also be necessary with the inhibited patient.

I have said enough to suggest the wide range of problems that will be presented

in the first interview, which differs from any other analytical interview in that a decision has to be arrived at. So it is advisable to provide sufficient time: an hour and a half is preferable to the later, shorter interview times. In an hour and a half it may be possible to work through enough with the inhibited patient and it may be easier for the verbal deluge of the other patient to exhaust itself. But the well-prepared patient may also benefit from the longer time and it will give opportunity to exclude the rather rare dangers that can accompany it. If this is not enough, it is much better to propose a further interview so that the patient will have time to reflect on what has taken place in the first.

In each of these examples the patient's style of presenting himself needs to be assessed and not taken for granted as valid. The surface impression will depend upon previous experience of being interviewed by doctors, psychotherapists of one kind or another, or upon the milieu in which the patient lives, especially in these days when psychotherapy and analysis are widely discussed. These superficial influences, however, are not insignificant for they give indications of the kind of transference that may develop.

Transference and therapeutic alliance

Motivation is related to transference, which can readily be thrown into relief when a patient goes first of all to an analyst who has a good reputation, but is there also when he is referred to one who is not known to him. There are of course likely to be good reasons why the first analyst has gained a reputation for himself but it does not follow that he is necessarily the best analyst for any particular patient. Supposing the well-known analyst refers a patient to one of whom the patient has no knowledge; at once the negative transference becomes manifest and the referral can be put in jeopardy. The less-known analyst needs to recognize the patient's anger and hostility to the well-known analyst for apparently rejecting the patient, who is felt to have fobbed him off onto this incompetent substitute. From this example it can be seen that the positive transference tends to be constellated by the analyst who first sees the patient. It is, however, a splitting process that is liable to take place and because of it all the patient's resistances can sink into the background. Thus transference enters importantly into the first interview. It is not difficult for the analyst who has extensive experience of the subject to assess it but it is almost impossible to go into it. It will be taken up and analysed once the analysis has begun.

Alongside his transference the patient will be accumulating realistic impressions of the analyst's competence and checking these against knowledge he may have collected before the interview. Supposing this is good enough to tie in with his transference then sufficient trust will have developed for further interviews to take place.

The analyst's influence and interpretation

So far motivation has been discussed as a feature of the patient's behaviour and especially of what he says. But motivation is not only dependent on the

patient but also on the analyst's conduct of the interview and sometimes the interpretations that he makes.

The use of interpretations as a means of assessing motivation and the patient's suitability for analytical therapy is interesting. For many patients their motivation seems, indeed, to depend upon the analyst's capacity to intervene appropriately and if necessary interpret. So the use of interpretations as a means of mobilizing the patient's motivation needs to be assessed: how much is a patient able to make use of them? It is a subject that has already been introduced (see p. 24). It will be remembered that when Jung made interpretations, his patients, thinking them off the mark, sometimes left. The result need not be, indeed is not usually, so negative and there is a wide range of patients whose motivation can be increased by interpreting in a way that need not be especially sophisticated. If, for instance, a patient, after an interview he felt was well-managed, and during which he has benefited from interpretations, is told that he is much more ill than he believes and that he should start analysis right away, the result may be very satisfactory. The conclusion will have accorded with his own secret belief. Thus an ambivalent patient may be converted into a good one. The analyst's management of the interview and his grasp of the patient's needs, as well as the patient's transference and his capacity to form a therapeutic alliance, influence the patient's motivation and his capacity to sustain a therapeutic alliance in the future.

History taking

It will have been noted that no reference has been made to history taking except in so far as the patient has referred to possible causes of his distress in the past. Whilst it can be useful to take a history it will be evident that this does not give a true picture of the patient's development, which can only be constructed under analysis itself. Nevertheless, a history may be useful in ascertaining gaps in it and may also indicate, through the gaps, the level at which the infantile origins of the condition derive. A gap between the years of four and seven may for instance suggest an oedipal root, or an account of pathology in the mother after birth may suggest that the disorder has a much earlier origin. In view of the unreliability of a history given under the stressful situation of an interview, it does not appear desirable to stress it above other communications.

Two questions

Once it has been agreed that analytical psychotherapy is indicated then a number of interlocking factors come into view. The conditions for a full analysis to be undertaken have already been reviewed: the patient must come regularly and continue to do so over a variable but often long time. Many patients may then ask two questions: what is meant by analysis and how long will it take? Neither can be answered adequately but some reflection about each may be given.

One advantage of conducting the first consultative interview as a dialectic led by the patient is that the analyst can say, in answer to the first part of the question, that analysis is a more intensive form of what the patient has already experienced.

It is well known that if the patient has doubts about what he is going to submit to or if the therapist is uncertain about how to proceed, the analyst can follow Jung's practice by referring the patient to the literature, suggesting a book on his own method, one on that of Freud and another by Alfred Adler, to see which appealed to him most. Jung would take this as an indication of how to proceed in any particular case. It is a procedure to keep in mind but not one that, in my experience, has seemed necessary because I prefer to work out, in a dialectic with the patient, the kind of treatment that he needs.

The patient's second question—how long the analysis will take—seems to be straightforward commonsense. But it cannot be answered directly, because it usually has behind it the idea that analysis is like a prescription which, if followed, will result in a cure. Since analytical therapy is not like that, an explanation is called for.

How long an analysis takes depends not only upon the analyst but also on the patient's wishes and needs, which will come very much into the picture: indeed the end of an analysis will depend ideally as much on him as on the analyst. Therefore the length of time will be decided by both analyst and patient together. The explanation given to the patient will depend upon these reflections. In giving his answer the analyst may have been noticing indications that the question is loaded; there may have been signs that the patient is looking for quite a different solution, such as that provided by medication or other, more sensational, forms of therapy like LSD or hypnosis. This needs to be handled in such a way as not to close the door to his exploring such methods but making it clear that analysis is different in its nature.

Fees

The question about the length of analytical therapy and frequency of interviews also have implications for the financing of the joint project that is being undertaken. It is important that fees be arranged that lie within the patient's means and, if capital is going to be used, this must be enough for a reasonable time to elapse before the treatment has to be ended for lack of cash. It is much better for fees to be charged which can be met out of current income and this is the more usual arrangement.

Because it is costly in the long term, it is commonly believed that analysis is the indulgence of the rich. This is untrue, indeed the majority of analytical patients come from the middle-income groups: professional persons, especially doctors, social workers, psychologists and so forth. It is they who feel the financial sacrifice is worthwhile.

It follows from this that an analyst will not charge a fixed fee. Market factors come into the picture but the essential consideration is that an analyst is able to

live a life that is sufficiently satisfying to himself and his dependants. Since the styles of analysts' lives vary so will their fees, but it is in effect necessary for each analyst to decide what fee he cannot go below in his particular circumstances.

The subject of fees interrelates with the question of interview frequency. Let it be said that if a patient be assessed as one for whom a full analysis is essential then it will not do to suggest less frequent interviews. There is, however, a wide range of patients for whom three times a week will be sufficient, though it is liable to lengthen the treatment; others may do quite well on four times but would do better on five times a week. Less than three times makes analysis, as it has been defined, almost impossible and the considerable range of other less intensive psychotherapies available must be considered.

The beginning of analysis

Once analysis has been decided upon, what happens next? Times of attendance have been agreed upon and a fee arranged. The patient enters the room.

There will be a couch and two chairs and the patient will have used a chair before so how can the idea of using a couch be introduced? It may be enough to explain that the analyst thinks lying down on the couch is the best way to proceed and the patient will accede to this proposal without further ado. Suppose he does not like the idea or would prefer to sit in a chair? Alternatively he may sit on the couch and feel that he cannot lie down. These responses need to be gone into but a good deal depends upon the analyst's convictions. Being convinced of the couch's value, I find it easy not to give way and to work out the patient's anxieties with him, but trainees, who will have met analysts training them who continue to think a chair does equally well, may hesitate even though their own analysis has been conducted on a couch. Given sufficient conviction the investigation and interpretation of the patient's anxiety about using a couch is usually, but not always, sufficient for him to lie down. What is he to do then, he may wonder.

Analysts differ on what line to take but it is usually best for him not to be too precise so that it is enough to explain that the object is to get as free an expression of what the patient thinks, feels and notices as possible and then note what happens. The analysis has begun.

CHAPTER 9

Transference and Counter-transference

Once analysis has got under way a number of features will begin to appear to indicate a transference is making difficulties for the patient: he may go silent for no apparent reason, or he may start not hearing what the analyst says, or he may start distorting interventions in characteristic ways. What the analyst says may be felt as criticism or condemnation, or as an expression of love, or his interventions start to be admired, or it becomes apparent that the patient does not feel they are relevant. These are a few amongst a large variety of responses characterized by being exaggerated or inappropriate to a situation in which the analyst listens and aims to help the patient in understanding.

Though it has been contested and though many attempts have been made to diminish its importance, the transference and its accompanying counter-transference remain the central affective component in analytical psychotherapy.¹ It is for this reason that attention has been given to the setting of analysis for this provides the framework in which transference manifestations can be safely and adequately elucidated, interpreted and worked through. It is essential that patient and analyst know where they stand in real terms since so much that is illusion, delusion and hallucination will be encountered when instinctual and destructive impulses are reached and struggled with. Because of the intensity of the emotion a patient can only manage with regular help and continuing contact: four times a week is adequate for some, others require more, and yet others can get enough from three visits. This view is not accepted by the Zurich school who practise on the notion that transference can be dealt with by throwing the patient back on himself and providing him with a method of handling his dream and imaginative life. Nevertheless, though practices differ, there appears to be agreement as to the phenomena except when it comes to the enactment of early infantile experience in relation to the analyst.

The difference in management suggests that the development and flowering of the transference depend on the behaviour of the analytic therapist. It is the analytical attitude that provides the necessary condition: it creates a space between the two parties to the contract; the patient, and, as will be seen, the analyst too, though in a different way, fills it up with projections.

For the purposes of exposition the transference will be divided into the transference neurosis and the archetypal transference conceived by Jung as taking place in individuation. The division reflects the historical developments though further research has suggested that in many cases the two processes interlace.

The transference neurosis

The kind of transference depends upon the sort of patient who is undergoing analysis and the transference indicators vary from patient to patient. Inasmuch as they are part of a transference neurosis they stem from features of the patient's past history and are essentially infantile phenomena containing the patient's psychopathology. Once initiated, the transference neurosis provides the possibility for him to re-enact those parts of his past that are alive in the present and causing unnecessary distress.

Transference indicators can be handled in the ways available to the analyst: the patient can be confronted with the signs he is showing, they can be explored and they can be interpreted and worked through. There is no special technique that needs to be used when transference signals begin to show themselves, but the analyst must not obtrude himself on the scene and stop the patient developing or expressing his feelings by giving grounds for the belief that what he feels about his analyst is true in the present. It was for this reason that the idea of an analyst as a projection screen became so important and still remains so.

Having chosen a suitable case, what are the conditions for transference neurosis to be analysed and worked through? They may be defined by reference to the history. A rather well-organized personality development is required, which must have proceeded sufficiently well up to about two years of age when he will have mastered the skills that will make him a viable being, and sufficiently independent of his mother for him to take an adequate place in family life and later on in society. By the age of two he will have been able to feed himself, he will have gained control over his excreta, he will have considerable independent mobility and he will have mastered the rudiments of speech. To put it another way, he will have developed a sense of himself sufficient to separate from and be independent of his mother. By then he will be able to tolerate considerable frustration and will recognize that his mother is not only a good satisfying person, but also a bad frustrating one. Satisfaction and frustration will have become part of his everyday life—he will have achieved ambivalence and be ready to go further on into three-person relationships between mother, father and himself, to which may be added siblings when they arrive. It is at this stage that the conflicts begin which will give rise to his neurosis.

Transference is usually but incompletely characterized as projection. This means that a part of the self or the past is experienced through the analyst. A projection can take place for a variety of reasons, but it cannot be fully withdrawn until its reason for existence has been ascertained. Thus an analyst may be built up into an ideal figure because the patient has a great difficulty with his aggressive drives and stops these coming into the transference relationship.

Analysis is a more or less painful operation that requires a lot from a patient and it cannot fail to play on angry and aggressive feeling when an analyst urges a patient to face painful topics. If, however, the analyst is felt to be ideal he cannot, in the patient's view, have created the pain, or if he is felt to have caused it he must be doing it for the benefit of the patient, thus the patient's aggression is held in check and hidden. Under the circumstances of analysis a patient cannot stop feeling hostility at some time or other, but with an idealized analyst he can only feel guilty at so doing. Therefore it is essential for the analyst to reveal the patient's hostility to him so as to set in train the negative or ambivalent transference by means of interpretations.

Not all exaggerated reactions to an analyst can be understood as projection of a part of the self because the reaction by the patient may also be a displacement. Then the patient behaves in a way that has been appropriate in the past to a person or persons who have been important to him, and this style of behaviour may have continued through his life. Then, interpretation on the objective plane applies but it may be that a therapist's intervention, drawing the patient's attention to guilt-laden wishes, is immediately understood as an admonition of the kind that is well known to the patient, whose parents behaved in just that way when controlling their child. Such admonitions may not have been introjected, in other words, built into the patient's emotional life and digested, so as to represent his own moral sense; then they remain reflections of the past and are not projected but displaced.

The transference neurosis takes place in patients who are sufficiently developed for experience of their therapists to be understood as a false impression of them. It can be recognized and so lead to understanding the situation. The illusion may continue but it can be worked on in the knowledge that the therapist is not really as he seems. Analysis of the transference neurosis will result in its disappearance as a controlling feature of the patient's relation to his analyst and concurrently there will be a change in the structure of the patient's mental life.

Patients often claim that the analytical situation contributes to the formation and fostering of the transference neurosis, since frustrations of various kinds are inevitable. One may make itself manifest right at the start if the couch is used. Patients may have difficulty in using it because it suggests seduction without satisfaction—no intercourse will take place when they may want it. Then there are other frustrations that centre round the analyst's passivity, his use of his mind instead of his penis or imaginary breast, if he is a man, and so forth. An additional frustration stems from his refusal to treat the analysis as a social situation or discuss matters with his patient on an intellectual or personal level. All these contribute to a situation which is unusual and provokes projections. These are not, however, the essential root of the transference but only provide the conditions for it to develop and to reveal itself as the repetition of infantile situations. At first this notion may be vigorously resisted by the patient, who will point to any other cause, especially the conditions imposed by the analyst. But in the end it will become apparent that the transference is essentially a

repetition, with modifications, of infantile patterns. Recognition of them alone makes full sense of the transference neurosis. The necessary memories to substantiate this interpretation may or may not become available. If they do not, a reconstruction may be introduced and prove convincing to the patient.

The transference, then, is a powerful instrument for gaining access to a patient's childhood. Sometimes, if the transference illusion is gone into, an additional gain may result in that doubt can be cast on the truth of memories and it may become apparent that the real state of affairs has not been recorded, or only a segment of a particular situation which left out components giving quite a different meaning to what was previously remembered.

A typical situation is as follows: a patient feels herself to be the analyst's victim because he never understands her and yet she needs him and cannot get away from him. Transference interpretations directed to unconscious processes are treated as proof that her analyst has not listened to what she has been saying. This feeling has some basis in reality because the interventions go beyond the subject matter of which she is conscious even though in reality they depend upon very close attention to it. There is one set of interventions, however, that change her feelings completely: if the sexual content of her talk is interpreted she stops objecting and accepts it with anxious and thinly veiled sensual pleasure which sometimes leads on to genital excitement. So it is her sexual wishes that she needs to have appreciated.

It is not surprising to find in her childhood that, though her father claimed to love her, something important was lacking—she could not understand what at the time. By relating the transference feelings and impulses to this past situation, her childhood conflict could be illuminated. Either in reality, or in her feeling, her father had left no room for and paid no attention to her oedipal wishes. Having got so far she could find memories that confirmed this understanding. Thus the transference interpretation illuminated the past. It can, however, happen the other way round: the patient may talk about her childhood as it is conceived to have been, as an indirect way of saying how she feels about her analyst. Thus the patient might have talked about how her father never listened to her but regularly misunderstood her love for him because she was afraid of telling her analyst how she was feeling about *him* in the present.

The archetypal transference

The personal and historical aspects of transference occupy much of the time of any analyst treating patients whose conflicts can be classed as neurotic. I have emphasized them because in the literature of analytical psychology they tend to be either omitted or glossed over. The collective symbolic significance of the phenomena are, on the contrary, given much more attention because they are related to Jung's special thesis. Perhaps this might be expected but all the same it can give the impression that analytical psychologists as a whole not only neglect but even know nothing about the transference neurosis.

Since it is the parent images that are projected in the transference it is inevitable that their analysis will reveal collective characteristics, and these may or may not prove important. Parents are influenced by and indeed live in a particular culture and its standards are usually accepted by them. Its influence begins in infancy in styles of infant feeding and care to continue as development proceeds. The phenomena are particularly easy to observe if a patient comes from a different culture pattern from the analyst, but they will not be overlooked if the patient lives in the same country and has been brought up in the same milieu as he. But it is not just social factors that are the basis for the development of an archetypal transference.

The archetypal transference has two characteristics that the personal one has not: the projections are more clearly parts of the self that need to be integrated. They are also progressive and contain material through which individuation can take place. Recognition of these features is conceived as important because analytical interpretation cannot be applied: the primary entities have been reached. At this point a division of opinion arises about management. Some, though maintaining the analytical attitude, will simply be aware of what is happening and allow the process to go on. Others will add some form of education and amplify the material with analogies from religious and mythological sources, or will suggest reading matter. The addition of education, however, has the disadvantage that it emphasizes the analyst's predilection for symbolic material, and the patient will put it, usually unconsciously, to all sorts of uses that do not further the resolution of his conflicts in the transference neurosis. He will tend to replace them with a kind of religion in which the study of symbolic material takes first place. It is often accompanied by an illusion that the personal transference has been completely resolved when it has only been glossed over.

There is a further consequence which arises from the display of erudition and the skill with which the therapist matches analogies with the patient's material. This can induce in the patient the feeling of his being especially important to the therapist whom he consequently idealizes. In addition, since the analogies relate to cultural processes, the patient receives the impression that he is participating with his therapist in a social process of great importance. In consequence the symbolic study becomes a powerful source of exclusiveness and leads to group formation which tends to centre round the personality of a particular analyst. I do not mean to say that this phenomena is reserved for those analysts who employ educational methods, but the tendency is increased because the personal roots of the transference are habitually bypassed.

Emphasis upon the symbolic meaning of transference leads the patient to discover his cultural roots. This can have therapeutic effects in that the patient, who had previously found himself isolated from religious, political or other institutions, can rediscover and re-evaluate their significance in relation to the structure of his individuality.

This may be enough, but not always. Some patients with a 'problem of our

time' have it for a different reason: they have never developed adequate self-feeling to reach unit status (see p. 10) in their infancy and so have become identified with their persona. They also have the problem of finding and giving form to the core of the real self. These two aspects of self-realization need to be kept in mind during the analysis and management of the transference. In both cases there is insufficient core to the personality and the patient will need to develop a transference psychosis. It presents problems of management that differ from the transference neurosis. To illustrate the contrast, Jung wrote to a colleague about a very unintegrated patient: 'In such cases it is always advisable not to analyse too actively, and that means letting the transference run its course quietly and listening sympathetically . . . No technical-analytic attitude, please, but an essentially human one. The patient needs you in order to unite her dissociated personality in your unity, calm, and security. For the present you must only stand by without too many therapeutic intentions. The patient will get out of you what she needs' (Jung, 1929a, pp. xxxii–xxxiii).

It will now be evident that manifestations of transference vary within wide limits, the patient's psychopathology and his type will contribute to its form, but the essential elements remain the same. The transference has personal, social and archetypal characteristics. The sequence of its development reveals the features of individuation and the patient will develop increasing capacity to take responsibility for his life and his mental and emotional capabilities, if the transference is well handled. Individuation comes about in various ways and the amount of development that occurs during psychotherapy is by no means the end; indeed, individuation is conceived as a process which, once started, continues after the meetings between analyst and patient have terminated. It can even be said that the most important consequence of an analytical psychotherapy is that the patient develops a method of investigating himself.

Archetypal transference in individuation

Jung produced a scheme of how the archetypal transference looks in cases for whom individuation is important. He did so by interpreting an alchemical text. This makes for considerable difficulty if the reader has not acquired a modicum of knowledge on that subject. Jung also includes references to religious practices, fairy tales and anthropological studies. The rationale of this complex and erudite procedure is that the alchemists projected archetypal images into their chemical operations, just as patients do into their analytical psychotherapist. Therefore what alchemists describe can be taken as an amplification of analytical experience. Inasmuch as the transference is reflected in social processes, it would be expected that social organizations and rituals would likewise be contributed to by projections from individuals. This is the reason for Jung's complex and otherwise incomprehensible procedure.

I do not intend to enter into the alchemical process on which Jung bases his argument but will pick out of it some essential elements. His exposition does not cover all the features of transference; rather he gives an account of

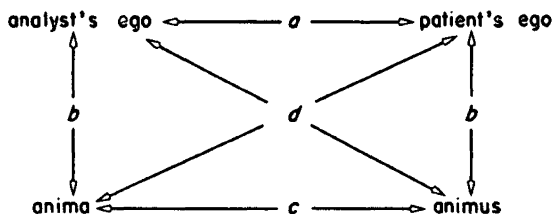


Figure 1

transference as it appears when the individuation process has been set in motion. This means that the personal unconscious and the transference neurosis are essentially irrelevant and the patient is one for whom the development of the self is mostly under consideration; he has, in short, come to the point when he has an idea at least that the contents transferred to the therapist are parts of the self, and so interpretations on the subjective plane will soon have been made.

(1) The first part of the analytical therapy consists in obtaining an overall view of the patient's condition. This would correspond to the stage of confession.

(2) Gradually the analyst and patient become engaged on both conscious and unconscious levels. This state of affairs is presented in a diagram of a heterosexual transference (Figure 1).

The anima and the animus are conceived as the contrasexual representatives of the unconscious archetypal process in the two persons. The arrows indicate the possible forms of relationship that Jung says produce 'the greatest possible confusion'. The diagram may be interpreted as follows: *a* represents the therapeutic alliance in so far as it is conscious; *c* and *d* the projections and introjections that take place between the analyst and the patient, it being assumed, but not represented, that a part of the ego is unconscious. It will be observed that the diagram is symmetrical so as to express the idea that the analyst is just as much in analysis as the patient and this is widely interpreted to mean that the two are equal in all respects. That is false because the relation is asymmetrical in the following respects: the analytical therapist has already gone through his own analysis and training and may in addition have more or less previous experience of analysing patients, his relation with his anima (*b*) is much more firmly established and his ego is stronger. It follows that his perceptions of the patient (*a*) are greater and the degree of projection and introjection, *d* and *c*, considerably less, more flexible, and open the way for the analyst to obtain information about the patient's unconscious processes. From these considerations the idea of the analyst being as much in analysis as the patient must be qualified: he is much less liable to fall into the same quandaries as the patient. For the patient's part the projections *c* and *d* cannot become introjected because of unconscious resistances, which need to be worked on before they can be withdrawn, and so the diagram must be modified as follows. (See Figure 2). The patient's animus is projected (*d*¹) onto the analyst's ego and cannot be withdrawn because of the internal resistance *R* which prevents the patient

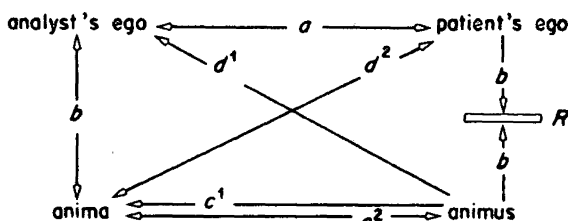


Figure 2

becoming aware of her animus so d becomes a one-way process, d^1 . Likewise c can be divided up into c^1 and c^2 : c^1 represents the patient's irreversible but unconscious action, c^2 the analyst's reversible projection. If this state of affairs is recognized the 'greatest possible confusion' will be greatly diminished.

(3) As a result of the engagement between patient and analyst (which includes conscious/unconscious elements), the formal conduct of analysis becomes eroded and there is greater freedom of expression by the two persons. The patient gradually discovers how to express himself and how to work over resistances that arise before revealing his wishes, which may be highly unadapted, shameful, etc. And because this has happened the analyst can make interpretations with greater freedom. As a consequence of this state it is much safer for the necessary regression to take place.

(4) The *conjunctio* takes place. This is depicted in the alchemical text as intercourse between the royal pair. Jung here draws parallels with the *heiros gamos* and the *unio mystica* in Christianity, to show that it represents an incestuous union that finds symbolic expression at any level from the sexual impulses and accompanying fantasies to the highest forms of idealized relation between the pair. At this point the transference intensifies and may become either more openly sexual or spiritualized.

(5) The regression proceeds and there is a fusion of the pair which clearly indicates the bisexual components in the transference: the analyst could be experienced as either male or female or both (the symbolism is complex and overdetermined). According to the alchemists a deathly stillness reigns and Jung interprets the situation as psychic death of the ego, or union of the animus and the anima, as if the analyst were unconsciously drawn into the whole process. It is, according to him, his feminine parts that contribute essentially. In this he seems to identify himself with what the patient may believe and wish, but this maintains only to a very limited extent if the arguments I am presenting are correct. I would rather understand the situation as follows: the emergent bisexuality leads to uniting the patient's animus with her idealized image of herself. At this stage it presents an incipient union of opposites.

(6) This is called 'the ascent of the soul', in which fusion and death of the 'royal pair' has taken place and the soul, a child, ascends to heaven. Jung interprets this as the transference psychosis, analogous to 'the schizophrenic state', for the patient's ego has been virtually destroyed and there is disorientation akin to the loss of soul from which primitive people can suffer. In that the condition is a transference psychosis Jung maintains that rational 'scientific'

methods do not work and the analyst, because of the diverse and pregnant symbolism of the material, tends to find himself at a loss. Here I may let Jung speak for himself as to what can be done.

The kind of approach . . . must be plastic and symbolical and itself the outcome of personal experience with unconscious contents. It should not stray too far in the direction of abstract intellectualism; hence we are best advised to remain within the framework of traditional mythology, which has already proved comprehensive enough for all practical purposes. This does not preclude the satisfaction of theoretical requirements, but these should be reserved for the private use of the doctor (*C.W.16*, p. 268).

Jung's prescription 'to remain within the framework of traditional mythology' does, however, carry with it the danger of intellectualization and I would lay much more emphasis on the analyst's experience than on the use of mythological knowledge.

Hereafter there is little help from Jung with rational or ordered presentation. The transference psychosis is analogous to the *nigredo* in alchemy, which seems to indicate a schizoid depression. There follows the whitening (*albedo*), which is a purification of the dead and decayed bodies. It is followed by restitution, or the return of the soul and the birth of the self. Jung quotes at length from alchemical texts to show how they experienced rebirth and incest as the necessary condition for the birth of the 'new man'.

In justification of his procedure, Jung says:

An exclusively rational analysis and interpretation of alchemy, and of the unconscious contents projected into it, must necessarily stop short at the above parallels and antinomies, for in a total opposition there is no third—*tertium non datur*! Science comes to a stop at the frontiers of logic, but nature does not—she thrives on ground as yet untrodden by theory. *Venerabilis natura* does not halt at opposites; she uses them to create, out of opposition, a new birth (*C.W.16*, p. 303).

This looks as if Jung was charting an area in which science was to be excluded. There is, however, the saving phrase 'as yet' to encourage us, and indeed today progress has been made into the difficult area that Jung is delineating in the last part of his exposition.

Discussion

The distinction between the transference neurosis and the transference in individuation, an essentially archetypal process, has been modified as the result of studies in the analytical process. It has become apparent that, in analysing the transference neurosis, archetypal patterns emerge in a personal setting. It may be inferred that, though Jung almost completely excludes them from

his essay, yet in actual analysis personal features must come into the picture in the archetypal transference also. His essay may be understood as giving a framework rather than depicting what really happens in any particular analysis. In his essay he follows a procedure used in recording the dream series in *Psychology and Alchemy* (1944), where he also deliberately excluded personal matter from the discussion. 'The Psychology of the Transference' (1946) presents an archetypal framework and at the same time demonstrates how it was, and how it still functions, in various institutions and cults. It is therefore incomplete and especially so as it leaves out the way in which the archetypal forms have developed in the patient's history from childhood onwards. It has been shown that transference features of the kind Jung described can be related to infancy and are relevant to those patients whose self-feeling is defective. Thus transference management has acquired another dimension.

Jung's account depicts a very radical transformation which involves a step-by-step dismantling of the personality, reaching into areas in which words cannot express the patient's experience adequately. It is from this area that the self emerges. It is usually assumed that this sequence of events involves a radical reorientation in the consciousness of the individual and is to be thought of as a healthy step in development. This is another reason why information about childhood tends to be omitted or deliberately played down in treatment. I shall later on present material to show that this can be unfortunate. Jung himself related his later experiences to his own childhood, which was distinctly unusual, just as his later self-analysis also showed abnormalities.

These reflections have led the way to reviewing the relation between the features of transference in individuation in later life, conceived as an unusual achievement, and the individuating processes in infancy and childhood. It is often hotly contested that these two forms of individuation are essentially different but there is growing recognition that the two can be fruitfully related.

There can be no doubt that in borderline cases, in the narcissistic neuroses and in character disorders there are many patients whose self has not developed satisfactorily, or even that the patient has no true self-experience. In such cases a dismantling of personal superstructures can be needed because they are based on behaviour patterns of other people or on collective forms. These patients who made a false start in infancy need the sources of the failure to be traced. In their case the stages are like those described by Jung: they pass through a transference psychosis to a state where words and interpretations are much less important than the continuing existence of the analyst and his holding function. It is with patients of this kind, treated analytically, that frequent interviews are essential because just as an infant needs his mother's presence so do patients need their analyst, and just as a mother's too long absence can be disastrous so can the analyst's make progress impossible.

Counter-transference

The history of counter-transference is a long one. It may be said to have started from the time when Breuer fled from the patient who fell in love with him to

give up abreaction therapy. This was the point that Freud turned to good advantage when discovering the transference. There was a result that needs close attention; analysts became reserved with the idea that if they acted as a projection screen then it would be easier to detect the transference projections and interpret their roots in childhood: thus they would succeed where Breuer failed. The patient was to do nearly all the work and his analyst did relatively little. In line with this practice was a much later idea of the good analytical hour as depicted by Kris (1956, p. 446): a good patient requiring minimal intervention by his analyst. The reserved behaviour bore rich fruits, especially as it defined a style of analysis that has been already outlined in previous chapters but which I will now briefly repeat.

An analyst was to provide a room and see the patient reliably and regularly; he was to listen with free floating attention, restricting his activities to elucidating the patient's communications, interpreting them and allowing time for working through. This concise statement of familiar behaviour is sufficient to introduce two points:

(1) With the aim of treating the patient as the subject of an investigation the analyst needed to maintain objectivity. To do so he had to keep himself separate from his patient. Any involvement was considered undesirable and was treated as a counter-transference neurosis—which he was under obligation to master.

(2) The standard required makes very high demands both on the analyst and the patient, whose capacity to maintain it sufficiently so as to follow the basic rule of free association is required. Therefore the number of patients able to subject themselves to this psychoanalytical treatment was and still is restricted.

It will be apparent that this attitude is essential if a therapist is going to conduct analysis as described in Chapter 6. If it is only applicable to a restricted number of patients for the whole time that they submit to it, nonetheless it is applicable to many more patients for part of the time.

As the position of analytical psychologists is often radically different,^{2,3,4} I want to point out here that the description is macroscopic and I shall argue that microscopic examination of the analytical situation with special reference to counter-transference leads to a different picture. In order to show this it is necessary to start from a different position.

From the start analytical psychologists have held that the analyst is involved in his work and that his personal qualities are more important than any technique; analytical therapy is essentially a dialectic between two persons and so it is not only the patient who is affected, but also the therapist through his involvement with his patient. Jung emphatically underlined this proposition and gave indications of what was referred to. He says that the therapist may become confused and disorientated, refers to his being a 'wounded healer', to his becoming 'possessed by the demon of sickness' when he takes over the illness of the patient, as well as responding in false, defensive and inappropriate ways. These are strong words tempting us to find out more. Today it is possible, in a large measure, to understand the nature of the involvement.

At the start of an analysis there is a period in which the therapist is seeking for a relation to his patient which is going to be stable; he seeks to form the therapeutic alliance through which he can work in helping the patient to understand his distress. If this therapeutic alliance is not found then analysis will run into serious difficulties, but assuming that he succeeds, a beginning can be made. Soon the analyst comes across the patient's psychopathology and makes some relation with that, knowing that it will not be resolved for a long time and will form a negative or ambivalent nexus.

This dual situation can be expressed by saying that the analyst becomes engaged with his patient. When that has taken place the analyst will have already made projections onto his patient and unconscious processes will have been set in motion. They will continue in varying form throughout the analysis. Where he differs from his patient is that he will rely on the operation of the unconscious elements in himself. It is in order to ensure that he can do so sufficiently that he has himself undergone a personal analysis and taken cases under supervision. It is during his training period that he will have become familiar with that part in the analysis of patients called counter-transference.

The unconscious processes that are most important to rely upon are projective and introjective identification. They underlie the feeling that is called empathy and through them a therapist is able to put himself inside and feel along with his patient or experience in himself what it is like to be his patient. This is a basic condition for him to intervene appropriately, the projective and introjective processes providing the raw material for so doing. It is by integrating them with knowledge of the patient derived from what has been communicated in words and behaviour, and by relating his past experience, that he can arrive at appropriate interventions.

It may seem far-fetched to assume unconscious projective and introjective processes at work in an analyst of which he is scarcely aware, so I will say more about it. It has long been understood that a counter-transference neurosis can interfere with the progress of analysis. Owing to the amount of guilt involved, examples are not easy to find in the literature. A very good one was, however, reported by Kraemer (1974) as follows. A therapist who believed in loving her patients and who had misinterpreted the idea that the therapist was just as much in the therapy as the patient, lost a patient because of her 'good' wishes towards him. She treated him as her special patient, she then started telling him her own dreams. In one of them: 'She saw herself standing hand in hand with her patient near the entrance to a big cave. She knew that she had to enter this and lead him through its labyrinthine maze. She felt that she would be able to do so successfully, and that they would both come out together at the other end' (p. 225).

Two days later the patient came for his session for which she made special preparations. When the patient arrived he was depressed and started by telling one of his own dreams to which he gave some associations. The therapist, however, wanted to tell him hers; she had 'something very happy to tell him', and she did so. The result was not at all what she had hoped for; the patient did

not want the dream and said so. The therapist, keen that he appreciate the value of what she was giving him, sought to overcome his objections; she insisted on continuing the session over the prescribed time, even sending another patient away. When the patient tried to end the session the therapist would not let him go, eventually becoming angry with him. As a result of all this the patient became even more depressed and went to another therapist, who wrote insisting that she should stop writing to her ex-patient.

Because this kind of counter-transference presents such a gross error it may seem that it has nothing to tell us. It is, however, the uncontrolled, unadapted component in it all that brings about the disaster, not necessarily the core of feeling about the patient. Thus one might say that though the therapist's action was manifestly inappropriate, the feeling that had been invoked was not essentially wrong; depressed patients are very often lovable but what they need usually is analysis of their guilt and of the aggressive and destructive emotions that are contained in the depression—to work at these would have been the therapeutic way to love the patient, though hate would be involved as well.

Depressive pathology highlights the affects that a patient can evoke, though one might hope that a well-analysed analyst would know about them sufficiently not to act so as to deluge the patient with them, as Kraemer's example depicts: the analyst had developed a fixed counter-projection complementary to that which she had received from the patient, and as this was not withdrawn it interfered with and indeed terminated the analysis.

But this is not the only reaction that can take place, for its opposite is equally possible: the analyst can introject the patient's projection and so act like a receiving set to the patient's unconscious. When this happens the analyst will find the solution to a patient's conflict, not by listening—though he will continue to do so, alongside his personal reflections—but by finding out what it is in himself that refers to his patient. He will need to ask himself why he is talking or being silent in a way that seems foreign to what he knows of himself. It is out of that discovery that he may well find the solution to stalemate in an analysis.

Many years ago now I formulated the idea of a syntonic counter-transference to cover that introjective experience. One case was especially relevant to my understanding of it. A female patient developed an especially persistent way of asking questions in large numbers. Finding that I never answered any of them, I started to wonder why and could not find a way of understanding it. I had no principle against answering questions, as some analysts have, provided that they are real questions that can be answered and do not contain a concealed motive. I considered the patient's questions in more detail; their content varied, some might have been answered, others were evidently attempts to start me talking about myself. I got as far as noticing that I had developed a resistance to answering when my patient began talking about her father, a particularly quiet man. She would find his silences difficult, and, prompted by her nurse, she used to try and draw him out. One of the ways she used, albeit unsuccessfully, was to ask him questions. This made me understand that the reason for the persistent questioning lay in the situation of her childhood: she did not expect

an answer but went on hopelessly asking questions. Looking back, I could see that many of the questions were asked in such a way that no answer could be given, and this had made me respond as her father had done. When I drew the patient's attention to the reason for her questions little headway was made, for a special reason. I was thought and felt to be in love with her and I only made interpretations out of my integrity as an analyst. She did not want interpretations but a declaration of love, just as she had wanted it from her father. The understanding gains support from the patient's repudiation of my incomplete interpretation.

These examples are the crude matter out of which the conception of counter-transference could be developed. Projective and introjective processes can take place in the process of analysis as undesirable events, unless resolved by re-introjection or rejections respectively. The gross examples are clear, but the subtle ones are only sometimes noticed; they go on frequently, and probably all the time, as non-verbal communications, and underlie the picture of the reserved analyst that I outlined at the beginning of this section of the chapter.

The processes can be observed taking place if an analyst proceeds as follows in any particular interview. He starts with as open and empty a mind as is possible and simply listens to the patient's talk. This attitude is difficult to acquire, and cannot be fully achieved because it means treating oneself as if one hardly existed and the patient as if he had never been met before so that what he produces is fresh. With these reservations the talk, the looks and behaviour of the patient will start to affect him, he will notice how information is being presented, what is its content, and to whom it is being addressed. The feeling of a projection taking place may occur because the material is familiar (by this time the analyst's memory is coming into the picture) and one can, as it were, move about inside it. The complement is when the feeling arises that the patient is referring to his analyst without saying so: it is as if one is somehow being distorted inside. At these times it is only necessary to go on paying attention for it is not yet clear what it is all about. As more information accumulates and the analyst's previous knowledge of his patient becomes conscious, the projective and introjective processes will start to resolve and they may do so for no precise reason, though if the patient expresses her transference feeling or gives sufficient indications of it an interpretation may be made. Before this the analyst should not focus attention on what is going on, but remain half-conscious. It is important for him to know that the processes can be relied on and that if left alone they will contribute an essential element to the communication he makes to the patient later on. In being outside his control they provide the affective and spontaneous element in his communication.

The importance of following the attitude described is this: it not only gives space for unconscious perception of the patient but it also goes far to prevent the 'knowing beforehand' attitude which Jung so often decried and which does not give space to the unconscious. On the contrary it imposes a model or theory on a patient without including the changes that take place from interview to interview.

I must add here that it is undesirable to act while the engagement with the patient is taking place through the operation of projective and introjective processes. The interventions by the analyst at these times may be correct but if they are they will scare the patient too much, whilst if wrong they will disrupt the development taking place in the patient, as in the first case described above.

So far my description of counter-transference has been rather general. It has been further refined by the psychoanalyst Racker (1968). He defines one in which the analyst is comfortable and in accord with his patient. There are some patients who are easy to like and understand because they are like the analyst, but it is not this to which he refers, but a transitory feeling that may change overnight. There is usually a feeling of love and affection combined with pleasure in the work being done and satisfaction that all seems to be going so well. This is a concordant counter-transference. After some time the patient may seem different and the analyst begins to find himself at a loss; he cannot find material from the patient to interpret, the patient seems to be concealing too much and this can lead to feeling that his love is being frustrated, and he feels irritated or angry. This is either a neurotic or a complementary counter-transference, due to the analyst having introjected the patient's projection. If this can be discovered, then the complementary as well as the concordant counter-transference can be made use of. It is, for instance, very often that the complementary feelings of the analyst represent the beginning of the patient's negative transference which he now feels safe enough to begin to reveal and develop. The analyst's feelings are therefore relevant and will put him on the alert for such manifestations on the part of the patient, and prepare him for making an interpretation of them. Once he can do this the interpretation may lead to a deepening of the patient's positive transference, combined with feelings of gratitude on the patient's part for the analyst's help. The two kinds of counter-transference will oscillate.

Technique⁵

Some analytical psychologists have reacted against the use of formal techniques such as the 'basic rule' of free association, whereby a patient is urged to say whatever comes into his mind with as little reserve as possible; likewise it has been thought reprehensible to employ rules for the interpretation of symbolic material.

The ideas and practices that this attitude has led to are somewhat confused and contradictory (see Fordham, 1969); they were powerfully influenced by the idea that the use of a technique was liable to impose a system of thought on a patient with too little regard for his individuality. The rules, it was thought, might also lead to undesirable splitting in the therapist who would consequently become impersonal and use the patient as an experimental object. He might, as in the natural sciences, attempt to set up strictly controlled conditions in order to test a hypothesis. Such behaviour, or anything like it would not, it was claimed, provide conditions for the patient to develop his individuality; all

standardization was therefore to be avoided so that the patient might develop in his own way: hence Jung's idea of a therapist being 'unsystematic by intention' (see p. 46).

The unsystematic attitude could, however, only be a guideline for the conduct of therapy since, as I contend, it can only be applied for part of the time. It can be used if the analyst conducts himself as I have already suggested he should at the start of the interview; but once he has become engaged with his patient and has collected information supplied by the patient, he will inevitably find that much of it is familiar to him and that he will react in ways that have become standardized through repetition. These ways of reacting constitute, I suggest, the basis for a technique which he inevitably develops.

In my view it is important for him to be clear about the use of such activity because, if well defined, a flexible and subtle instrument can be developed which, far from interfering with the patient's individuality, may further its maturation. It is when techniques are not made conscious and so become rigid, that a patient's development is liable to be disrupted.

Some of the controlled and standard procedures habitually used in the course of analytical therapy have already been described, especially in Chapters 6 and 7, and others will follow. So, without entering into these in detail, I will go straight on to consider technique in relation to counter-transference.

Projective and introjective processes take place spontaneously and outside the analyst's control and so cannot be classed as techniques. By contrast, when an analyst empties his mind so as to listen to and engage himself with his patient at the start of any interview, he has learned to do so. By behaving thus the analyst opens the way for projective and introjective processes to come into operation. When an analyst asks a question or makes a comment, goes on to interpret and work through the consequences of his intervention, his activities are to a large extent within his control and so may also be classed as techniques.

From these activities interpretation takes a somewhat different place. It is a complex and largely controlled procedure that will be considered in more detail later. It is relevant to note here that it is an intellectual inference containing knowledge of the patient that has been accumulated as time goes on, but it also contains and gives form to immediate information derived from the operation of unconscious projective and introjective processes. Thus it may be said that these mechanisms are an essential ingredient in an interpretation, and so sometimes are other interventions as well, all of which may be said to rely on counter-transference processes.

The criticism of using technique appears to depend upon the belief that it necessarily excludes uncontrollable processes. Study of counter-transference makes it clear that this is impossible. It is conceivable that a therapist might operate as if they were non-existent and imagine that he was controlling his relation with his patient altogether but, because there are therapists who erroneously believe this, that is no reason to abandon the use of controlled technical procedures.

Abstracting the situation may make for further clarification. Technique represents the operation of the analyst's ego. One of the functions of the ego is to relinquish its controlling functions so that unconscious processes may come into operation. It is that particular function of the ego that it is necessary for an analyst to have acquired so that he may let the projective and introjective processes work. The information collected in this way can be received by the ego which can organize it and, when necessary, communicate the result to the patient.

Note

1. For a comprehensive review of Jung's varying but basically consistent view of transference, see Fordham (1974a).
2. For a largely theoretical view of transference by an authoritative member of the Zurich school, see Meier (1959).
3. For an account of some findings of the London school see Fordham *et al.* (editors) (1974). The first contribution to the subject of counter-transference was made by Moody (1955).
4. Dieckmann (1976) contributes a research using group methods to study transference and counter-transference interaction.
5. For further discussion of the subject of technique, see Fordham (1969).

CHAPTER 10

*Resistance and Counter-resistance*¹

When Jung was conducting his researches into the associations of normal and pathological persons at the beginning of this century, he constructed a battery of 100 stimulus words. To each of these the test subject was asked to say the first word that came into his mind. Many of these associations were peculiar but could be understood as indicating the action of an unconscious complex. But why was it not conscious? Jung, like Freud, concluded that it must be objectionable and its becoming conscious must therefore be resisted. So attempts were made to overcome the postulated resistance by drawing the subject's attention to the anomalies in his responses, urging him to see whether he could say more about them. If this proved inadequate the experimenter would tell the subject his tentative conclusions about the contents of the complex. If the resistances were then overcome, the contents of the complex became conscious, thus confirming the result of the test. It may be reflected that compared to modern techniques the experiments were crude but with their help Jung had arrived at an important conclusion.

Apart from accepting the theory of repression to account for many of his findings, examples of other resistances on the part of the patients can be found in his writings. It is clear that he understood about internal ones from his test findings and he also knew about patients' objections to his interpretations—an example of this has already been given (p. 24) in which a patient rejected Jung's understanding of a dream series. He also knew that informing patients about the contents of a complex could produce therapeutic effects—he even reported the cure of a schizophrenic patient by so doing (Jung, 1935a, *C.W.* 18, p. 52ff)—but he never gave a systematic account of the types of resistance that came to his notice. It seemed enough for him to recognize their existence and to appreciate the important part they could play both in a positive as well as a negative sense; he held for instance, with reference to their positive function, that they could preserve the relative integrity of a personality, especially where there was a latent psychosis (Jung, 1963, p. 134 ff.). Another feature of his work was interesting: he appeared to decide on the suitability or otherwise of a patient

by a sort of test. He would give his opinion or initial interpretation, thus expressing the basis upon which he considered treatment could begin: if the patient's resistance was too strong that would be the end of the matter. An example of this proceeding is to be found in the dream series already cited: Jung analysed the patient's dreams, made a summary of his conclusions and conveyed them to the patient, who disagreed and left. Another example was of a man who brought a very complete self-analysis of his neuroses. He suffered from an obsessional state and presented Jung with a lengthy and apparently complete analysis of his condition, wanting to know why no cure resulted. In the document, reference was made to his taking holidays on the Riviera and at St Moritz. Jung enquired into this and found that he was taking money from an older impecunious woman who had fallen in love with him. She was almost starving herself to provide for him. The patient knew all about this but when Jung suggested that his behaviour might be relevant to his neurosis he could not agree. Jung had pointed to the way his behaviour had become isolated from his moral feeling.

These examples show a certain ruthlessness on Jung's part but they also reflect the earlier views of many analysts and therapists: a resistance is something to be broken down so that the unconscious complex could become conscious. Therapy could then take place.

Apart from these experimental and diagnostic examples much more was learned during analysis about the patient's internal resistances by listening to the way in which he talked, where he hesitated or where he was not talking—about something that he did not wish to reveal. By drawing the patient's attention to such features of his communications and urging him to overcome his objections it became clearer that they were usually based on shame and guilt. But perhaps the most impressive feature was the apparent aim of obstructing the analytical therapist's efforts to further cure; indeed it seemed sometimes that therapy was the last thing that the patient wanted to facilitate.

As the study of resistances progressed, attempts to clarify them were made, taking their common feature to be that some painful or supposedly dangerous affect is being denied.

Types of resistances

Without claiming that the following is complete or that such resistance mechanism can be separated out as clearly as it would seem, I offer it in the hope that it may be found useful.

(1) There are those resistances that prevent a painful affect becoming conscious. This may be expressed by the patient as a block in his mind; nothing comes into it. Alternatively, trivial matter is thought of and dismissed as not worth retailing. If these 'trivia' are followed up, various mechanisms may be discovered that aim to conceal the affect connected with them. Suppose the affect is directed at the analyst, the patient may displace it onto somebody with

his characteristics but who at the same time is not him. This device may link onto another related resistance: projection. Again the affect may be prevented from becoming conscious because shame and guilt are so strong that a communication of them cannot be made. Another device depends upon converting the affect into its opposite: thus if the patient feels love for his analyst he will conceal it by expressing anger or hate and vice versa. All these manoeuvres are characteristic of neurotic persons; they occur especially in hysteria, in which others like dramatization or regression to evade something in the present may be added. Perhaps the most important is transference itself, which can become a formidable barrier to the analytical process; the patient's love or hate of the analyst as a person may be used to prevent any analytical interventions becoming effective, because all is said to be useless unless the analyst loves the patient in the desired way. The analyst's interventions may be rejected outright or more subtly accepted with suspicious regularity; nothing happens as the result of them—they are overtly accepted, to be secretly denied.

(2) The next group of resistances is of a different order: they do not seek to keep the affect from becoming conscious but rather deny its significance. This is found especially in the obsessional neuroses, as Jung's example showed.

(3) Next there are those resistances that depend upon introjections. They are particularly evident with depressed patients for whom everything is turned against the person of the patient, who then becomes absorbed in his own guilt. In this way the patient's affects—mostly aggressive—are directed away from the true external object and all sense of proportion is lost.

The resistances so far cited are easy to detect and can be managed and worked through with suitable patients by persisting with the analytical attitude, exploring their roots, keeping in mind the probable nature of the affect being resisted.

(4) As the analysis progresses, especially in more difficult and more disturbed patients such as those with character disorders or borderline cases, the resistances become more drastic till, when the transference psychosis develops, projection may extend to all the interventions of the analyst. Idealization may appear, in which everything the therapist does or says is put out of reach by becoming ideal and wonderful and so far beyond the comprehension of the patient: thus hostility to the analytical process is concealed. Just as fantasy contains defensive ingredients, and is indeed almost a normal form of resistance, very evident in the neuroses, so can slavish adherence to reality become equally a powerful method of preventing any form of imaginative insight into the effect of affects originating within the patient.

(5) In some cases with severe failure in the development of self-representation resistances seem to become total so that nothing the analyst says is acceptable—it is to be denied, attacked, misunderstood or confused, and the patient may behave as though his mental and emotional existence depended upon resisting with the utmost vigour everything that is brought to his attention however firmly, tentatively or tactfully. The patient does not, as might be expected, leave the analysis but, on the contrary, claims that his one hope lies in its continuation.

Management of resistances

At first it was thought that a resistance was inherently undesirable and an obstruction to the progress of therapy. The analyst's objective was therefore to urge the patient to overcome it so that the affect could become conscious or become integrated with the rest of the patient's personality. Attention was therefore directed to the affect in question and the resistances were given less attention.

As their importance became increasingly realized, however, a change in technique took place. It was thought that the resistances themselves required analysis so that, when this was completed, the original affect would come more easily to the surface and become manageable. Rank initiated this technique and defined what he called the character armour. It was developed with considerable success.

Resistance and counter-resistance

These two procedures consider resistance from the closed-system point of view: the patient exhibits characteristic behaviour and the analyst observes and interprets. The importance of resistance, greatly developed by psychoanalysts, was a powerful support for Jung's assertion that they be taken 'seriously'. He claimed even that he would give support to them over prolonged periods if he considered that their dissolution would endanger the personality as a whole.

Jung had also laid stress on the analyst's part in generating resistances by his own wrong attitude to the patient: in this case some resistances could be fully justified. Just what he meant was never gone into but it is now fully realized that technical faults must be one cause of them. Indeed, by directing attention to the unconscious affect and trying to override the resistance, an analyst could be in part generating or at least provoking it since he tended to ignore the patient's susceptibilities, his shame, his guilt or other more primitive reactions. In addition, the imposition of a model could likewise produce justified resistance. All these faults on the part of the therapist must therefore be kept constantly under review.

Just as resistance was at first thought to be a characteristic of patients, the faults of analysts then became overemphasized. When the analyst, by focusing on his own attitude, failed to take the conflict seriously, the patient showed signs of resistance. The analyst may be said to have developed a resistance to analysing the patient.

The concept of counter-resistance (corresponding to counter-transference) was an important new step in understanding, for the analyst's interventions or failures to intervene may be considered in relation to the resistance phenomena. As this idea is comparatively new I will present an example.

Example

A married woman coming up to middle age had been in a productive analysis for over a year, following an incomplete previous analysis. She then started to

read books and go to lectures about psychoanalysis and related disciplines. She would retail what she had heard in a rather fragmentary way as if she were assuming that I would know all about what the lecturer said and also, it soon appeared, to find out whether I was as well informed as she imagined I ought to be. Each new theme was enthusiastically received or absolutely rejected. If it were accepted it would then be incompletely assimilated; it seemed, and was so understood, as if she were 'running a line' rather as an advertiser would do. Each time this happened the patient got some bit of insight but the 'line' tended to fade out and a new one would take its place, only to prove once again unsatisfying; she had not found what she was seeking.

During this time the patient was having ideas about ending her analysis but she could not find very good grounds for so doing. It seemed that by collecting information about therapeutic practices she was getting support for implementing this idea, yet she gave the impression that she did not really want to end; the idea seemed to be that she only had to know a bit more and then she could do just as well, if not better, without me. Work on this could be done. There was her rivalry with me and the sense of helplessness and dependency which were beginning to appear but only as feelings to be overcome.

Now this behaviour could be well understood as characteristic of animus thinking as described by Jung, for each 'discovery' was in the nature of an opinion which, though partly digestible, lacked cogency and seemed eventually to vanish into thin air. With this in mind I never contested her views. I considered that she had a fantasy of herself as an inadequate male which it was best not to challenge directly.

Work had been done on her feeling that males always had the best of things; boy babies were preferred in her home, boys received preferential treatment, received more affection from her mother, did not have to do housework, their education was more important. When you went into the world there was the same unfair social prejudice.

All that was true in a way but it did not apply to her life as an adult or even as a child, for *she* had been the one for whom the family had gone out of its way to make higher education possible and it was *she* who had rejected the opening. Later on she had become outstandingly successful in her profession, indeed her difficulties had lain more in her feminine than in her masculine identifications. She professed to be jealous and envious of men but this did not have much grounds in reality for she had competed successfully with them. So the question remained as to why she suffered from attacks of resentment during which she would feel inadequate.

She first began to obtain more insight when she recalled how, as an adolescent, she had come top of her class in examinations. It came as a shock and she believed that there must have been a mistake for it was 'impossible' for a girl to have done better than the boys.

Reflecting on her memory led her to recognize for the first time that sexual differences might be relevant and be the additional factor at work besides social bias. The word 'impossible' used by her was particularly striking.

Against the background of this work I found a suitable occasion to interpret as follows; there seemed to be a confusion between her mental capacity and sexual differences for apparently the only impossibility was for her as a girl to have a penis like a boy. This did not matter to her now as an adult but it might have done when she was an acutely perceptive child. The lack of a penis might have been felt terribly unfair—a feeling which, relevant in the past, had persisted and influenced her today with very little reason.

This interpretation was immediately laughed to scorn. What should she want with a penis, she was a married woman and had children of her own. As to sex, it had always been natural to her and if she wanted a penis she could always get one. In her childhood her brothers and sisters had always dressed and undressed discreetly, the boys slept in different rooms from the girls and she did not even know that boys had penises till adolescence. As a final riposte she reproached me for having such ideas: penis-envy and castration were Freudian ideas and never found in Jung's books. I was just like all men, wanting to boast about having a penis myself.

I have somewhat condensed both my interpretation and her statement, which contained more about the social position of women and the preference for boys in her own family, which she had always resented.

The complexity of her denial is evident. It was dramatized, the whole topic tended to become displaced into the social field, it was markedly aggressive and one might say castrating in its aim. Its complexity made further analysis difficult for it tended to produce doubts about the appropriateness, adequacy or timing of my intervention. The display with which I was confronted was producing a counter-resistance. I tended to fall back on the well-worn adage that it was enough to get a denial at this stage and so was tempted to say nothing; there was also a tendency to feel flattened (castrated) and depressed and to overlook that this feeling was probably one she half intended to produce.

At the time I simply pointed out that she was unusually keen to prove me wrong and was ready to leave it at that. She would not have it, however, and while admitting that she had been envious of boys and men she emphasized that this was entirely due to social convention and had nothing to do with physical differences. The counter-resistance that I then had to struggle with was to start asserting that I *had* taken social pressures into account and to argue about it. Her misrepresentation of my idea irritated me and inhibited an interpretation that I might have launched, but did not, as follows: her aim was to render me mentally and emotionally impotent (just as she herself felt underneath this barrage) and then to use this to show her in an active and penetrating way that the analytical situation contained a sexual frustration in that my penis was not available to her for sexual acts, thus reflecting the situation she had been in as a child with her father.

Looking more carefully at my counter-resistance:

- (1) it inhibited further interpretation;
- (2) it made for an ineffective passivity.

I have no doubt that the idea that an analyst's resistance to making interpretations is suspect came into the picture, for it is truly desirable not to withhold them for wrong motives, for instance if the patient might not be able to stand them. In this particular case it was important to be ready to make one when occasion arose, so as to modify the intensity of her resistances. Previous work on them had, I thought, been sufficient but the response proved that it had not been enough.

My counter-resistance contained passivity, and following that up could lead to the possibility of making it effective. It was difficult because, in her distortion of my position, she was provocative and was forcing me into the danger of becoming a 'male chauvinist pig', a phrase that she hesitated before using. It was that projection, however, that needed to be contained, for the time being anyway, if only because it was just here that she must feel especially vulnerable. If I could contain it productively then it could be gradually sorted out later. In this way I need not withdraw the interpretation nor contest her provocation but only hold the projection, using my female (anima) nature to do so. Thus my passivity would develop activity and might gradually be felt as motherly and less intrusive than the first interpretation.

Though my resistance continued and made me sometimes defensively overactive, becoming actively passive (to express the attitude in a paradox) was sufficient for her gradually, piece by piece, to bring evidence that she could understand to what I was introducing her. Eventually she reached memories of her childhood that showed how the image of it as sexless was untrue and in fact that sexual differences between its male and female members had been important and, at times, central in her development. Thus by working on my counter-resistance I was able to find an attitude that slowly became productive.

Discussion

I have given this example to show how resistance and counter-resistance operate in actual practice. The procedure might, however, have been described as a tactic as follows:

(1) I started by accumulating data about resistances to her feeling that passive dependence was the equivalent of castration. There was clearly a powerful reaction formation against infantile feelings of this kind. After working on the reaction formation for some time, I considered that this was becoming shaky and ineffective.

(2) I therefore made an interpretation of the infantile nature of her feelings of inadequacy. This set the stage for

(3) More work on defence structures so that in the end repressed memories of her childhood could emerge.

This account is incomplete. It leaves out my engagement with the patient and the affective processes that not only the patient but I also went through.

It is probable that the processes described have always gone on from the earliest days of analytical therapy, though usually unrecognized or shamefacedly hinted at. It was not until the concept of counter-resistance was developed that the full description of what goes on in reality between analytical therapist and patient could be furthered.

Note

1. A comprehensive review of the literature on resistance in psychoanalysis and analytical psychology will be found in a paper written by Lambert (1976).

CHAPTER 11

Some Less-organized Behaviour of Therapists¹

The centenary of Jung's birth brought a spate of anecdotes about him and his behaviour as a therapist. They were almost all unusual and do not apparently fit in with concepts already advanced about the setting of analysis or about counter-transference. They led me to contemplate the unpremeditated behaviour of analysts and therapists, which was outside the usual practice and, one might say, idiosyncratic in the sense that the analyst's affects appear more significant than those of the patient. I found that when I remarked on these to a few analysts and therapists of my acquaintance they tended to tell me of an occasion when they also had behaved in a similar way, the result not being as unfavourable as might have been expected. Though these anecdotes were my point of departure, I shall use examples from the literature, for I cannot recall that anybody has discussed these or others like them.

In *Memories, Dreams, Reflections* (1963) Jung records that an obsessional patient had contracted, presumably as part of her compulsions, the habit of slapping her employees, including her doctors. He writes:

She was a very stately imposing person six feet tall—and there was power behind her slaps I can tell you! She came then and we had a very good talk. Then came the moment when I had to say something unpleasant to her. Furious, she sprang to her feet and threatened to slap me. I, too, jumped up and said to her 'Very well, you are the lady. You hit first—ladies first! But then I hit back!' And I meant it. She fell back into her chair and deflated before my eyes. 'No-one has ever said that to me before', she protested. From that moment on the therapy began to succeed.

Such spontaneous and even violent behaviour came to be thought of as wrong when counter-transference was conceived as a danger; analysts became

reserved and the patient ideally did nearly all the work, the analyst saying relatively little. In line with this practice was a much later account of the good analytical hour as depicted by Kris; a good patient required minimal intervention by his analyst.

The need for reserve and counter-transference

It was not so much to deny the usefulness of this attitude of psychoanalysts, nor the need for reserve on the part of analysts, but a too rigid application resulting from its idealization that made Jung protest as follows. He instanced one of his patients who had previously been in analysis with one of these reserved analysts; she accused Jung of having an emotion when he reacted to what she was telling him, he 'swore or something like that'. After some work on this Jung ended up 'Well, your analyst apparently had no emotions and, if I may say so, he was a fool'. That, we learn, transformed the situation: 'Thank heaven', the patient said, 'now I know where I am. I know there is a human being opposite me, who has emotions' (Jung, 1935, p. 139). Jung explained his treatment of the patient on the basis that she was a feeling type, but does not add anything about her psychopathology. The contrast, however, with the reserved attitude is striking.

It was not only Jung who took this line. There is, for instance, an interesting discussion between Pfister and Freud in the letters (Meng and Freud, 1963, p. 110ff.), which bears on our subject. Pfister pleads the beneficial effects of his religious convictions: they make it far easier for him to establish a loving relationship with his patients without fearing seduction. He instanced the manifest benefit to a particular patient who had been referred to him from Vienna, where he had previously been in analysis. Freud defends the Viennese analyst to whom he had sent the patient originally, on the grounds that the analyst did not have the required convictions and consequently reserve was to be preferred.

In his letter to Pfister, Freud does not say why he considers reserve preferable in non-religious people, but we may safely infer that he was thinking of the counter-transference in which the analyst would cease acting as a screen on which transference could be reflected and then analysed in relation to the patient's past and especially his childhood. Instead of this he would start letting his own infantile feelings for the patient influence his analytical aim and letting them find expression in such a way that the analysis would be jeopardized (as illustrated above, p. 91f.).

Basic requirements of a therapist

Turning again to Jung and the slapping woman. His action would have seemed appropriate; the slapping was, however, a compulsive symptom and so would not have been 'meant' by the woman. Therefore retaliation would not have been appropriate and the analysis of the symptom would have been rendered difficult or impossible because it had been misunderstood by being taken

personally. A similar problem arises in the second case: what happened to the probable depersonalizing tendencies of the patient?

We are told, however, that, in each case, once Jung had established his position, the analysis went forward and suggests a further explanation that Jung's statements established the setting in which he could proceed. The first case could most easily be considered in this light: Jung made it clear that if the patient slapped him he would retaliate; a therapist does not have to tolerate everything. The second is more subtle, but it establishes his right to express himself in vigorous emotion when deemed appropriate by him. In each case Jung's assertions met a need of his patient.

The standard set up for maintaining the psychoanalytical attitude makes very high demands on both the analyst and the patient, whose capacity to maintain it sufficiently so as to follow the rule of free association is required. Therefore the number of patients able to subject themselves to strict psychoanalytical treatment was, and still is, restricted.

To be sure, a certain amount of latitude may be allowed on both sides and it was recognized that the analyst may make mistakes determined by uncontrolled or neurotically determined affects; these can be dealt with, recognized, and if that is done openly, patients will tolerate them and the analysis can proceed as before.

Dialectic in therapy—open and closed systems

Though Jung was against classical psychoanalysis being pursued indiscriminately, it is a concept of analytical therapy which is sometimes a true picture of what takes place and is also valuable as a model of the basic requirements of psychotherapy. It does not, however, give a complete picture of how analytical (in other words, Jungian) psychotherapists behave for more than part of the time.

In advocating his dialectical procedure Jung introduced a different idea of psychotherapy based on an open-system theory: the patient and analyst were conceived to interact all the time. That was the important reality that easily became concealed by the introduction of technical procedures based on the closed-system theory. It was this point that Jung drove home when he expressed emotion to a patient who had been to an uncommunicative analyst.

If the closed-system attitude led to excess of rigour which was liable to become persecutory, the open-system notion led to alarming lack of it, and then, for various reasons, to virtual refusal to describe what had taken place between therapist and the patient, as the following example illustrates. I once heard a lecture given about a case in which the treatment of a patient had to be short; the therapist contended that his taking this depressed person out to dinner at a restaurant played an important part in her cure. He made no attempt to tell why he thought this desirable and apparently did not believe that obvious critical objections were relevant: Did he not think that he might have fobbed off the negative transference with a seduction act so that the patient had only

apparently got well to protect him from her hostile and destructive wishes? He made it clear that such objections were, in his view, trivial.

The therapist's limit of tolerance

This type of attitude led to counter-transference being investigated and related to the subject of technique and the framing of interpretations. Once these subjects had been gone into, the apparently less disciplined acts of a therapist could be reconsidered. They do not necessarily take place only at the start of therapy, as Jung's examples suggest, but may occur or recur whenever the therapist's ability to tolerate frustration has been overtaxed.

It is in the open-system period when projective and introjective processes are active, that frustration for the analyst may take place. Fantasies or speculations may not become conscious, may not clarify or may not relate to the objective information, and the store of interpretations may be useless. So the end of the interview becomes unsatisfactory and it can require self-analysis on the part of the therapist, which may or may not resolve the internal conflict. Alternatively, it may lead to an act that is no longer analytical.

Example

During the analytical hour an especially frustrating patient was talking about wanting to be calmer and complained of her 'Karma'. As the end of the interview drew near she became increasingly desperate and started picking anything I said to pieces. She claimed I was muddled and in particular she could not tell whether I meant 'Karma' or 'calmer'—spelling out the letters. 'Which do you mean?' she demanded. To which I emphatically replied 'KARMER': I spelt it out, and felt particularly pleased with my malicious joke. It did not particularly matter to her for she had already decided I had fits of madness and so it was only to be expected that I could not spell.

We have arrived at the analyst's need to communicate with his patient considered as necessary to him apart from his patient's requirements. There may be an interpretation ready to hand as his means of doing so but here again styles vary. It is a matter of common knowledge that the amount of interpreting in which analysts engage varies within wide limits. With some interpretative ingenuity becomes phenomenal and there seems to be a store of interpretations ready for almost any occasion. At the other end of the scale is the idea that a good interview only includes a question by the analyst. Such variations are not to be accounted for by variations in technique because one analyst may be a bad analyst if he interprets as much as another, and vice versa. Perhaps one might think of either extreme as idiosyncratic behaviour. So how far can the needs of the therapist be taken into account?

The responsibility of the analyst

It is correctly maintained that once a patient has been taken on by an analyst his commitment is total, he will do anything that is in the interest of the patient.

This inevitably makes demands on the analyst, sometimes manifestly within his capacities and sometimes not.

This leads to the subject of shared responsibilities, sometimes at the start, sometimes for longer or shorter periods of therapy. A patient may be of the kind for whom responsibility *must* be shared, for instance if he is psychotic and is hospitalized when additional psychiatric care is inevitable. Sharing also takes place when there are physical symptoms and a general practitioner or a consultant is called in, but in most cases that kind of sharing is not considerable unless the patient develops a physical disease.

Because of the analyst's responsibility, which is far more complex in its application than other sorts of caring, because it is not prescribed and is determined by what he knows the patient needs or can take, it is important that he only accept a patient who he believes is within his capacity to understand and tolerate. This is easy to determine if the patient is within the neurotic area (that is the patient will produce enough well-structured material) and the analyst is clear about the conditions under which he is able to work flexibly. But it is much less easy in the case of borderline personalities, in the narcissistic neuroses, delinquency, or the addictions. These patients may very well tax the analyst to his limits and beyond them. This macroscopic reflection may be considered in detail with reference to a single interview. In the unorganized parts of the interview, organization may again and again not be achieved, and as this happens an intolerable internal confusion or conflict may build up within the analyst and he may find, if he does not take refuge in his store of interpretations, that further analysis, in the sense of repeated progressing from unconsciousness to consciousness, about some conflict in the patient, is impossible. One can invoke counter-transference, recommend more self-analysis or what you will. The analyst may even go into analysis himself, but this does not free him from responsibility for the state of affairs that he has built up between the patient and himself and which the patient probably knows about or has some intimation of, even if he does not refer to it.

'R': The analyst's total response

I say 'even if he does not refer to it', because I do not believe a patient does refer to it. The state of affairs is not referred to in all the ways in which a patient may attack the analyst for hiding, not being himself, being ill and in need of help, being mad and all other transference manifestations that are familiar, and so it devolves on the analyst to do something about the essentially unconscious influence by getting it across to the patient in a way that is understandable.

Not much can be done by confessions and heart searchings on the part of the analyst because these activities are efforts at maintaining control over the analyst's total response—'R' as Margaret Little called it, and in doing so called attention to the point that the analyst's affects may be a specific non-analytical response to the patient, as both Freud's and Jung's may have been.

Returning to my malicious joke: this was an attempt to let the patient know

how I felt. It was unsuccessful but it was spontaneous and said without regard for my patient. True it may have been an attempt to show that I was not so guilty as she about the expression of malice, and the belief that her need was for the analyst's feelings to be expressed in some form other than overt interpretation, but all that was unconscious and I would not lay claim to any such altruistic motive. There are, I think, times and indications about when the analyst's crude but specific feeling is required and Jung was good at this. First of all, there is the kind of patient, and it must be one in whom reality is defective, where there is a delusional transference of such a nature that transference interpretations are ineffective because they cannot be detached from the delusion. Patients are particularly liable to induce hate in the analyst, and it is here that Margaret Little introduced examples of how she handled it in a delinquent case. One of her examples seems to me also to illustrate very well the specificity that seems to be desirable.

Example

Her patient told repetitive stories about children who visited her and to whom she could not say 'No'. Little said 'I asked her what would happen if I refused to let her go on telling me these stories. I was as tired of them as she was of the children's behaviour. She "did not know" and went on into another story. I said 'I meant that; I'm not listening to any more of them'. She was silent, then giggled and said 'It's awful . . . It's glorious, to have somebody say something like that. Nobody has ever spoken to me like that. I didn't know it could be done like that . . .'. Subsequently the patient was able to say 'No' to the children.

Of course it is possible and even desirable to know the processes at work under these circumstances. On every occasion it would be possible to work out an interpretation. Let us refer back to my joke. I can get along with my patient so long as I can make it. I know the conflicts with which that patient suffers at the end of an interview well enough: she wants to end it lovingly and in such a way that her love will continue after the time of ending. She is, however, at the same time so fearful of the violence and rage leading to misery and despair that she can only denigrate and pick at anything I say, to produce confusion. Interpretations along these lines, however, would all be useless. They would be too long anyway and I have used bits of them again and again to little effect. There came a time when something different was required and my joke was the compromise between wanting to reject her and yet continue with her. Like her I did not want to end until it could be done satisfactorily.

Research

Many years ago, in 1937, Jung read to a conference a paper that he never published during his lifetime. In it he wanted to illustrate the nature of his therapeutic work by offering an example. He said of it: 'The case is not in the least a story of triumph; it is more like a saga of blunders, hesitations, doubts, gropings in the dark and false clues which in the end took a favourable turn'

(Jung, 1937, p. 337). No doubt he thought that to give his clinical demonstration more publicity by publishing it would simply evoke adverse criticism or neglect. Today I think neither need happen.

His patient's material was difficult for Jung to deal with and he writes that the work became 'tedious, exhausting and barren' whilst 'once I lost patience with her because I felt she was not making any effort. So here are the personal reactions coming out', he reflected. He continues: 'The following night I dreamt that I was walking along a country road at the foot of a steep hill. On the hill was a castle with a high tower. Sitting on the parapet of the topmost pinnacles was a woman, golden in the light of the evening sun. In order to see her properly, I had to bend my head so far back that I woke up with a crick in the neck. I realized to my amazement that the woman was my patient' (*ibid.*, p. 332).

Jung informs us that, when he told the patient his dream, the clinical picture changed totally and the patient developed a sequence of psychosomatic symptoms. First 'uterine ulcers', then 'bladder hyperaesthesia' followed by intestinal disorders with 'explosive evacuation of the bowels'. Finally the patient had a feeling that 'the top of her skull was going soft, that the fontanelle was opening up, and that a bird with a long, sharp beak was coming down to pierce through the fontanelle as far as the diaphragm' (*ibid.*, p. 334).

Jung makes it clear that he understood very little of the clinical states through which she was passing and he told her so. He says: 'The whole case worried me so much that I told the patient that there was no sense in her coming to me for treatment, I didn't understand two-thirds of her dreams, to say nothing of her symptoms, and besides this I had no notion of how I could help her. She looked at me in astonishment and said: "But it's going splendidly! It doesn't matter that you don't understand my dreams. I always have the craziest symptoms, but something is happening all the time"' (*ibid.*, p. 339). Thus she showed him that his holding frame (cf. p. 69f.) and his continued existence were far more important than his understanding.

The states of mind that Jung describes are not unusual, for short periods, in any analyst's experience. Indeed, in almost any interview he may experience hesitations, doubts, gropings in the dark and false clues that may lead nowhere, but it is usual for them, in the end, to lead to a favourable outcome expressed, in each interview, in one or more interpretations that his patient can use. In this an analyst learns from and reacts to his patient. Jung had, however, reached a state in which for long periods he could neither help nor learn from his patient and in consequence suffered from a sense of guilt. He tried to free himself from it by a confession of his supposed failure. That led the patient to reassure him and interviews could continue. The discovery that followed did not, however, come only from his patient but also from reading Arthur Avalon's book, *The Serpent Power*, about the Kundalini Yoga. The body centres depicted there corresponded quite closely with the psychosomatic symptoms and fantasies of his patient. Presumably he then related the facts to his knowledge about the collective unconscious and could go on to tell his patient about the analogy. Thus he could orientate himself and her in a fruitful manner.

Whilst Jung used this case to illustrate the nature of his ordinary psychotherapeutic practice, in which puzzlement and confusion feature prominently, it is hardly credible. He must, like other analysts, have treated cases in which he mostly understood what was going on and in which the material presented had, in essential respects, been gone over again and again. His case illustrates the occasions, sometimes of short and sometimes of long duration, when it is not like that, and then the patient may gradually show the therapist what is valuable till the therapist can find ways of evaluating it. Eventually, like Jung, he can use his experience to elucidate and understand the patient's conflicts and so help in his maturation. Thus, since the therapist's knowledge and experience has grown, he can undertake research.

This formulation contrasts with the notion that a research worker starts off with a defined project and formulates a hypothesis which he will then proceed to test. Sometimes it works that way but at others an analyst may be landed with a problem unexpectedly with which he then has to struggle to find an answer. The aphorism that a therapist cannot help the patient beyond his own experience is thus temporarily reversed. Jung's patient was content with that state of affairs and so Jung, whilst continuing to act as a containing frame, could learn from her whilst she developed. It was apparently almost by chance that he found a meaning for her alarming symptoms.

Note

1. A variant of this chapter was published in *The Journal of Analytical Psychology* (1978), 23, 2 with a different title: 'Some Idiosyncratic Behaviour of Therapists'.

CHAPTER 12

*Interpretation*¹

Interpretation is the most effective instrument used by a therapist to further the analysis of a patient. So long as it is applied under the conditions described in this book it has few hazards in the hands of a skilled therapist who understands the nature of analysis.

The technique of interpretation has, however, been subjected to a number of criticisms most of which have already been discussed: the danger of using interpretations to impose a system on the patient, together with the reproach that their use becomes a technique; next there is the destructive element in their application, especially when synthetic processes are operating, and finally there is their unreliability.

Only the last proposition needs further mention. It is supposed that any particular bit of material, especially when it is symbolic or archetypal, is so laden with possible meanings that no interpretation can claim to be correct. In support of this idea a patient's material may be submitted to a number of analysts who will, if they are daring and (one might add) foolish enough, all give different interpretations. The differences are not really surprising, partly because the material is usually inadequate, but also because an interpretation can only be true as an expression of an analyst's relation to his patient in a particular context and at a particular time and not at any other. Even so it will not exhaust other meanings inherent in the material; these can be taken up later, in other contexts and at other times, as they become relevant.

General propositions

(1) An interpretation is primarily, but not exclusively, an intellectual act derived from the experience of an analyst.

(2) It connects together statements of the patient that have a common source unknown to the patient. So when the analyst tells the patient about the source, he makes an inference that goes beyond the actual material at hand.

(3) To be effective an interpretation must be organized and attempts have

been made to define its structure, sometimes very precisely. Ezrael (1952), for instance, proposed that nothing can be called an interpretation that did not include the word 'because', to indicate the analyst's inference. This restricts the term too much, and without denying the value in such a precise definition, it omits the predictive element required when considering the effect an interpretation will have on the patient.

(4) An interpretation must have the purpose of helping the patient master anxiety, relieve excessive guilt or other obstructions to the smooth functioning of his mental life. It does so by bringing an unconscious process or structure into relation with the ego, thus enlarging the field of consciousness. If it fails to do so too often then the analytical procedure, and specifically the therapeutic alliance, will be damaged and the ongoing work of analysis may ultimately cease.

(5) A valuable interpretation represents an affect rooted in the analyst's unconscious. This provides that element of spontaneity in an interpretation which makes all the difference to its effectiveness.

(6) The validity of an interpretation can only be ascertained in the analytical interview. According to this proposition what an analyst communicates to his patient is essentially different from what he knows after the interview, or thinks he discovers about a patient when talking to a colleague, or when writing a paper or book in which material from an interview is being analysed further than took place in the interview. Any discovery he makes in these settings is not open to validation in the analyst-patient set-up because it is being addressed to a different audience; thus an interpretation can only be checked in relation to those addressed. I do not want to imply that discussions outside interviews are useless; they can shed light on difficult data, but what is thought cannot be validated in relation to the patient.

Classification

Interpretations may be directed to understanding the nature and function of resistances, or to making the patient aware of what in his unconscious is being resisted. The two directions of the analyst's intervention are tactical but their aim is not essentially different; at one time the resistance may be more important, at another the unconscious content may be so near the surface that the resistance can be disregarded; alternatively it may not be possible to define the resistance without indicating what is being resisted. But whichever direction be decided upon, the patient's consciousness must be taken sufficiently into account for him to proceed from the conscious to the unconscious.

Resistances are conceived to stem from the ego and repression is an important one; by it is meant that a particular affective content cannot become conscious because it is prevented from doing so by denial. It follows that acceptance by the patient of an interpretation only defining the repressed content is suspect because the denial is omitted—a more profitable result is a shift in the patient's associations indicating less resistance.

The here and now, transference and the past

A patient may talk about daily life, whether internal or external, about his past or about his hopes and aspirations for the future. Inasmuch as he talks to his analyst it is sometimes thought that, because of the transference neurosis, the material should be taken up as a manifestation of his unreal relation with his analyst.

The tendency to interpret here and now matter in terms of transference (and this can also apply to historical material) stems from the idea that transference is the main therapeutic agent in all analytical procedures; so its interpretation is the analyst's main therapeutic aim. It is then that he confronts the diseased part of his patient with understanding and tolerance of it, and with love for the patient.

The importance of transference interpretations in the here and now was greatly reinforced by Strachey (1969). In a complex and influential paper he suggested that the most effective interpretations are made when a patient's feeling and impulses are directed actively towards the analyst. As a result of fantasies and impulses becoming conscious, a situation is set up in which the patient can distinguish, for the first time, his real analyst from fantasy images of him. But for this to take place effectively, the analyst must interpret when his patient's affect is alive in the present and not at any other time: not, for instance, the day before nor after it has subsided during any particular interview; by that time, he argues, the energy for the interpretation to be 'mutative' will not be available.

This formulation has given rise to the idea, which Strachey himself is at pains to refute, that only mutative transference interpretations are therapeutically useful. It is a notion that has led to ill-advised practices which overlook the complexities of analytical procedure and the amount of preliminary work that usually goes into making an interpretation of the type Strachey defined. Though the giving of such an interpretation can be called for at any time, it is usually the culmination of many weeks, months, or even years of work with the patient.

Suppose a patient is talking about difficulties that he is experiencing with a person of the same sex as the analyst, and suppose that the person shows characteristics of the analyst; an enthusiast for transference interpretations will focus on the common characteristics and interpret the supposed transference meaning of the patient's communications. In doing so he may leave out of account two elements: first, the reality of the non-transference situation and, second, the reason why the displacement has taken place. Both these factors need consideration and because of them a transference interpretation can be premature and wrong. Premature transference interpretations are as useless as any other premature intervention: a transference cannot be forced into the open, it can only be fostered. The same principle applies to interpretation of a patient's communications about the past, which are often influenced by the transference. It is true that when analysing the past the analyst needs at the same time to have in mind the reason why he is being told about it. But in any

case, if he is going to foster the transference becoming conscious, he cannot interpret it without considering its resistance-content. In the limiting case all the 'memories' of childhood may be selected so as to give indirect information about how the patient is unconsciously feeling about his analyst, and recital of historical matter may be used as a defence against the transference becoming conscious. But even in this case it is essential to be clear about the reason for the displacement as well as the transference content.

Long ago, in 1913, Jung emphasized that historical material was only relevant if it referred to infantile contents active in the present, there being no point in working over historical material that had been adequately superseded and integrated. But if the patient is to obtain relief, infantile material active in the present needs linking up with the original situation so that what happens in the present can be compared with what happened before, and put into its right perspective. If the original situation is not accessible to memory it can be reconstructed on the basis that, in relation to the analyst, the patient is re-enacting a situation that can be referred to many years back and fitted into his history; thus the pain associated with it will be mitigated.

The same principle applies to dreams and fantasies. Because of it the writing down of dreams should be left to the patient's discretion—a dream that was dreamed last night can already have libido withdrawn from it by the time that a patient enters the analyst's room and so its communication becomes only a sign of transference. If this be ignored, an interpretation of the dream can become one of 'dead matter', just like historical data. In this way a false analytical game can be initiated which becomes remote from a patient's imminent conflicts.

Subject and object

The question of whether material produced by a patient needs to be interpreted in terms of persons or objects in his environment (past or present) or in terms of parts of himself—interpretation upon the subjective plane—was very important to the development of analytical psychology. It has been observed that the subjective interpretation was used by Jung for those patients for whom imagination needed to be uncovered and released. At that time Jung was discovering that transference could not be understood as only the repetition of earlier states of mind deriving from infancy and childhood. Since then the contrast between transference as an essentially infantile manifestation and a projected part of the self, so sharp at the time, has been modified and the relation between internal and external reality has been studied in more detail; the comparatively simple model then used has become far more complex.

It has been shown that, even in early infancy, what may be experienced as objective and referable to real parents is often an aspect of the self. An interpretation upon the objective plane, therefore, does little more than set the stage for relating supposed transference displacements to the past where the same problem is found. A dimension is added but that is not the end of the

matter and the 'displacement' of the parent image onto the analyst can either give data about how the child perceived his parent as he really was or as his projection made him believe he had been. So today interpretations upon the objective and subjective planes have become much more instruments for sorting out, all the time, what is self and what is not-self, whether it is in the context of the present or the past. In short Jung opened up a field which has been integrated into daily analytical practice rather than a technique to be introduced at a definable stage in it.

The supposed destructiveness of interpretations

It is sometimes supposed that interpretation upon these two planes—objective and subjective—is radically different. The one, analytical-reductive, is critical or destructive, whilst the other is positive and synthetic; the one reduces the transference to its sources, while the other builds it into the self. There are difficulties about this formulation: if the aim of all interpretations is to expand consciousness, they are synthetic. Furthermore, supposing a bit of experience is referred to childhood, where it belongs, this may be finding the best place for it to be located, and so provides the context in which integration can best occur. Once again such a process may be considered synthetic because the analysed material has been made available for use under suitable circumstances.

There is, however, one sense in which an interpretation may be thought of as destructive: when it results in the disruption of a defence system preventing the emergence into consciousness of a disturbing content; that is the only occasion when a sharp contrast between the two types of interpretation can be firmly based. But even then, the end result is, one hopes, synthetic because the action leads to integration of the previously unconscious content, and the defence system can then become better and more fruitfully reorganized.

Part and whole interpretations

An interpretation can encompass the whole of a conflict situation and its origin. It is a very considerable achievement to include not only the content resisted, the defence used against it, the way it fits into the transference situation and the origin of the transference displacement or projection in the past: such a complete interpretation is rare and only occasionally indicated. Therefore, most interpretations refer to that part of the whole complex system which is nearer the surface, be it the resistance or the content or the original situation from which it all arose. Nonetheless, part interpretations may be related to each other so as to add up in the aggregate to a whole interpretation that can be made when necessary and possible.

Timing

Interpretation implies that the analyst knows of the nature and sources of a conflict in his patient though the patient does not: when should he tell him?

It is difficult to say just when any particular interpretation ought or ought not to have been given. Therefore, it is sometimes said that it is an art, and so the timing of an interpretation cannot be reduced to rules. There is something in this, but it may be remarked that, just as there is a grammar of art, so there are criteria bearing upon the subject of the timing of interpretations. The following are some guiding principles.

First of all, there must be evidence that the patient's anxiety is sufficient for him to need help in managing it before an interpretation can be given. Secondly, there needs to be sufficient 'human' or real relationship in evidence for the patient to feel the communication has love in it. Under these conditions—which do not hold when there is a negative transference, for then only the human therapeutic alliance remains—the interpretations can be taken in and made use of, so that what was previously unconscious can, after a struggle, become more conscious. Thirdly, it is often best to analyse resistances sufficiently before naming the content that is being resisted.

All these propositions depend on treating the patient as a closed system in the sense that what the analyst interprets is conceived to be objective and, to all intents and purposes, nothing to do with himself. It is a procedure that works quite well with a skilled analyst but it is an incomplete picture.

How the analyst comes into the picture can best be seen during supervision of a trainee analyst, for he is not as skilled as his teacher: the trainee may describe a patient's communications, which reveal anxiety, but he may not be able to interpret because his counter-transference is preventing it; when this has been worked through then interpretation becomes possible. This principle applies to any interpretation: it is a two-sided process. But an experienced analyst is able to use his counter-transference and work quickly through any difficulties that he discovers in himself.

It would appear that much of the reluctance to investigate the timing of interpretations may stem from inadequate recognition of the open-system point of view, it being insufficiently recognized that analysts have anxiety and guilt over revealing what they often erroneously believe to be faults on their part. Their anxiety has, perhaps, focused upon the aspect of interpretations which is most difficult, that is, their timing.

The open-system view of timing interpretations depends on including the analyst as well as the patient in any interchange and this applies whether he is in training or afterwards. Therefore the seemingly simple formula—if you can perceive what is going on and if the patient is giving you enough evidence that you can use to express to him what you observe, then there is no reason for withholding the information—becomes quite complex.

The analyst's knowledge is inevitably related all along to his affects, related to the particular setting which the patient introduces. This varies, but even when it is not a significant variation, to grasp the individual content of each interview it is still desirable to start as if you know nothing about the patient; this cultivated openmindedness, this being unsystematic by intention, helps the analyst to engage emotionally with his patient and avoids the use of

standardized interpretations; it makes room for the analyst as an artist who can hope to paint a new verbal picture each time, and develop what started as a subjective sketch into an objective statement.

Under these conditions there need not be much, if any, deliberate effort to time interpretations correctly, and the desirable 'spontaneity', which comes from relying upon unconscious functioning, will develop into a conscious statement. Just as the patient seeks to make unconscious processes conscious, so also does the analyst: when he has worked through this process and the conditions are correct, the time for an interpretation has arrived.

Form of the interpretation

Apart from the verbal suitability of an interpretation, there is the affect in them expressed by the tone of voice to consider, and the manner of their presentation: their urgency or the reverse. These may be determined by extraneous factors such as the preoccupation of an analyst with his own affairs, but the most interesting are those which are controlled by the patient. J. T. Racker (1961) gives good examples of this, amongst which is the following: by taking up queries from a patient, she was led to give abundant and beautiful interpretations; in addition, by spontaneously using the word 'mama' (the patient's word for mother) the whole analytical picture changed. These often overlooked details are, Racker considers, of the first importance in schizoid or paranoid patients. It is clear from her description that it was the spontaneous adoption of a word, a style of expression or a quality of talk that counted, and this had an important consequence which may be generalized: variations in tones of voice, though not decisive, are significant also in 'ordinary analysis'. The form of a therapist's expression when using interpretations tends to contain his counter-transference whether it be loving or hating, and this may be needed, for without it the patient is left isolated with his affect when he needs it to be met.

What happens to interpretations?

Very little has been written in detail about what happens to interpretations once they reach the patient. It is known in a general way that they can help to resolve conflicts, and can be mutative; in these cases the patient understands them in the sense that they are meant by the analyst. This applies in the course of analysis when the patient's ego is essentially intact and where insight into the transference is relatively easy to induce. But it is not always so even when analysis of the transference neurosis is being conducted; it is less so when regression takes place, and not at all true when a delusional transference develops: then anything the analyst says is interpreted in terms of the particular delusion that the patient has about him. A situation is then approached to which Jung refers as follows:

The elusive, deceptive, ever-changing content that possessed the patient like a demon now flits about from patient to doctor and, as the

third party in the alliance, continues its game, sometimes impish and teasing, sometimes really diabolical. The alchemists aptly personified it as the wily god of revelation, Hermes or Mercurius; and though they lament over the way he hoodwinks them, they still give him the highest names, which bring him very near to deity (*C.W.*16, p. 188).

This state of affairs can often be clarified as the following case suggests.

Example

A married woman in the middle thirties talked freely and gave an apparently clear account of her present situation, skilfully linking parts of it up with her past and her childhood. My interpretations were welcomed, and stimulated her to new insights or were appreciated for their subtlety and perceptiveness, thus indicating quite a severe splitting of her personality, since no resistances were in evidence.

It was at first easy to disentangle the bits of transference that appeared and link them up with herself and her past. Gradually, however, all this began to wear thin; her analysis turned progressively into an attempt to hide the conflict she was in over her transference impulses: she wanted to throw her arms round my neck and was only restrained by her passive desires which made her want me to embrace her, and the fear that I would reject her if she acted herself. Then endearing phrases and words would push themselves into her mind, but she was too ashamed and angry about them to utter them. Her angry and hostile wishes were translated into fears that I would be killed, either on the roads but more likely in an aeroplane crash when I went on holiday. As time went on the previous and apparently easy development of the analysis became more and more interrupted though she struggled to keep the 'analytical work' going because she believed that I wanted it done that way. Therefore there was that additional motive for keeping feelings and impulses out of the picture as much as possible: they were much too dangerous and nothing to do, she thought, with analysis proper. But her aim of making love to me or, better, to make me do so to her, since she believed I was in love with her, could not be avoided and the dreadful state of her life became increasingly emphasized—she could not live without me, she seemed to be saying, and later burst out with it.

It was in this setting that she became confused and disturbed and this might have reached serious proportions had I not suggested that she was involuntarily using my interpretations in quite different ways from those that she had employed at the start. My approach to this situation began when I noticed that she stroked the arm of the chair; again, she curled up in the chair like a foetus, which meant that she was sitting curled up in my lap. It became important for me to interpret her physical impulses and wishes, but as her method became clear she changed her tune, for an essential component in her attitude was that I was not to know all of what she was up to. Further, the significant component in my verbal activities changed for her; only sometimes was the explicit meaning

of my interpretation important, tones of voice or anything that would stimulate her physically became far more significant because words had come to mean sexual acts. This led to the emergence of definable techniques which began to operate. She complained that she did not hear a lot of what I said. At first she thought I mumbled, and only later did she find that certain interpretations were automatically muddled or chopped up. Others, however, went in without her knowing it because traces of them could be found in the next interview. Here is an example: She had a fear of accidents when driving a car. Now she had given enough evidence for me to interpret that it was because she was afraid of having an orgasm when driving. She did not think she had heard this but the next time she came back and talked about there being trouble with the gear lever which had become stiff. In working over this material she could understand that she had heard but had immediately put my interpretation in a compartment reserved for ordinary 'analytical stereotypes', which were not worth anything to her.

Eventually, because she became puzzled about it all, I summarized what she did with my interpretations. First, she thought that she did not hear what was said to her so she could have no idea whether it was true or false. Secondly, she listened not to the content of the words but the tones of voice in which they were produced—the words then became the equivalent either of sexual acts or of being fed. Thirdly, though she did not believe she heard or paid attention to the sentences, some of them penetrated inside her and made contact with unconscious processes, so that what I had said would come back to her when on her own as 'Oh, now I see what he meant'. Fourthly, they went into her mind and corresponded closely with what she had been thinking, though not saying; then she would feel and say 'How did you know that I was thinking that?'

It will be apparent that what I have described can be understood in terms of defences against 'analytical work' which constituted the first part of her analysis, in which interpretations were needed when sufficient material had emerged but she was in control. This patient had an inability to understand the nature of her infantile erotic impulses. She was caught between efforts at being mature and adult, and the fear of feeling herself to be a helpless person like a hungry infant. In the main her effort to be grown up became defensive because she was manifestly feeling or behaving like an infant or a small child. It was, therefore, not surprising to find that a major component in her transference relationship to me was hunger—this was very well shown during one part of her analysis when she left feeling if not ravenous at least so hungry that directly after her interview she would have to buy some food to satisfy herself.

Discussion

This case illustrates the need to follow up what happens to interpretations once they have been taken in by the patient. In the first part of the analysis it was not important, but as the transference resistance developed and regression

began, it became essential to do so if any direct straightforward analysis was to proceed. From then the analysis focused on the transference and not on analytical work in the classical sense. To be sure about what was correct and what was not, we needed to know about the effect an interpretation had on a patient and work on that.

A number of attempts to set up criteria for correct and incorrect interpretations have been made, depending on how the patient responds to them (see Wisdom, 1967). It is insufficient for the patient simply to accept or reject what is said because this can be due to the overall transference content, or may be defensive. Furthermore if an interpretation contains an inference about an unconscious content that is being resisted it is not often that the resistance becomes unnecessary at once, so that an unqualified 'yes' is unlikely to express the patient's true state of mind. Likewise 'no' is likely to signify that the resistance has been mobilized.

When my patient was afraid of having an orgasm in the car she thought first of all she did not hear what I said, then she found she had dismissed it as 'an analytical stereotype', but the next time she talked about the gear lever being stiff. As the sexual meaning of parts of her car had been previously understood, the stiff gear lever was almost at once recognized as referring to an erection and so to the danger of sexual excitement. Thus the interpretation, without being consciously recognized, had produced a change which indicated less resistance against it and could lead to further work on it, and further insight into her conflicts. Thus there arose a continuous and ongoing dialectic in which the correctness or otherwise of an interpretation in all its aspects could be worked out.

The destruction of interpretations

I have chosen a case in which the positive transference emerged—its negative aspect was split off and converted into phobias. In the case of a negative transference predominating the same principle applies, only the defensive and aggressive nature of the interchange comes into the open. Interpretations are then openly attacked or obstructive tactics pursued like groaning, silence or open abuse. Interpretations may be ignored, spat out, muddled up, hollowed out, made empty, spoiled, distorted, twisted round and made unreal. But, as the patient's objective is not to end the analysis, it becomes rather important to find out what else is being done with them. This will not be discovered by listening to the main flood of communication but rather by incidental or occasional statements.

For example, a male patient in the early thirties spent his time denigrating my interpretations, which were directed towards showing him how his guilt and anxiety over his destructive potential, as expressed in fantasies and much behaviour, made him persist in feeling my victim. His negative transference was known to be a repetition of his fantasy, supported by some real evidence, that his present state was due to the failure of his parents to meet essential

needs in his infancy and childhood, and later to manipulate him into a profession he did not like. In spite of his conviction that I was repeating this situation and, in my interpretations, forcing onto him a picture of himself that was false, there was rather marked evidence of improvement. Alongside all this he held that analysis was an important part of his life and it seemed that there must be more to it than simply seeking to annihilate, with rare exceptions, everything I said. The idea that I was being a 'bad' analyst for him went some way towards making sure I was, for he could see that this experience might in some sense be a part of his reliving his childhood and refusing, this time, to have anything to do with the false self he had built up on the basis of what his parents expected of him, and which was expressed by interpretations treated by him as alien to his feelings.

This situation could be understood as a negative therapeutic reaction and interpreted as an envious attack on the combined parents who did not make available essential satisfaction for his needs any more than I did, but the importance that he gave to being himself or sometimes finding the self he did not know, shed a different light on it all.

He was, however, making much more use of my communications than he said, or perhaps even knew, for phrases of mine would slip into his associations and occasionally there would be indications that what I had said had been taken in and used productively.

Interpreting this splitting of himself by saying that his attack on my rigidity and manipulative skills was not the whole picture—for there was another self present who was loving, taking in and digesting what I said—made a marked, though temporary, change, in that he started to consider and reflect on interpretations and could admit their usefulness, because they made him feel as if he was somebody.

This case and others like him have stimulated reflections on the patient's need to destroy interpretations. It is sometimes held that if a patient cannot use his analyst's communications productively, take them in, reflect on them, and develop out of them, if his anxiety is not relieved and so forth, nothing useful is taking place. To be sure, it is often true that destructive attacks can be due to a transference which, when interpreted, can lead to further 'progress', but not always, and then the analyst is faced with a difficult decision: is he to go on interpreting and have what he does obstructed, ridiculed or rendered useless in any way the patient may be using at the time, or is he to desist and wait for a more suitable occasion? In my view he should continue interventions and have them apparently destroyed, and then work on that situation.

Note

1. This chapter is a revised version of a paper with the same title published first in the *Zeitschrift für Analytische Psychologie und ihr Grenzgebiete* (1975), pp. 277–93.

CHAPTER 13

The Analysis of Childhood and its Limits

So far the effectiveness or desirability of analytical interventions has not been in serious doubt. In this chapter I propose to reflect on the limits of analysis and to approach from a different angle the problems with which Jung was confronted when he thought that education and transformation could be more important than analysis. I shall maintain that analysis becomes problematic when self-representations and symbols have not formed sufficiently for there to be any 'person' there to whom reference can be made, when regression within the transference leads to the setting of therapy being challenged and the continuing existence of the therapist, as a holding person, becomes more important than the methods that have so far been considered.

I will start, however, by considering the analysis of repressed unconscious processes; then go on to consider what can be done when the emergence, through regression, of infantile impulses makes analysis seem largely irrelevant, in other words where impulses and preverbal communications become more important than insights or fantasies.

Analysis of the repressed unconscious

Analysis applies to the elucidation of defences and particularly repression. If repression has occurred, the structures in the patient are organized so that he has developed separate boundaries and he can be treated as a separate person, indeed he expects and has a right so to be considered. The prototype of a viable person can be dated from when the infant has control over his bodily functions and basic methods of communication.

The indications of repression are these: there will be symptoms whose structure and meaning can be ascertained by working on material brought by a patient to his interviews. In the earlier years of psychoanalysis this was conceived to be the object of analysis: the patient was encouraged in the work of discovering the origins of his neurosis. Today, though this 'analytical work' still takes a considerable part in analytical therapy, the focus of interest

has changed: instead of transference being a side-issue, more importance has been directed to it and so to the dialectic that develops between patient and analyst. It has been understood that the contents of the symptoms, when brought into the transference, create the best situation for the defences to be analysed and the earlier situations in childhood to which they refer can then be remembered or reconstructed. In this area the patient needs his analyst to act as a screen so that projections can be made by the patient, who can thus become aware, with the help of interpretations, of significant memories that emerge when the defences against them have been shown up and revealed as no longer necessary. To facilitate the process, the analyst will refrain from saying much, if anything, about the truth or falsehood of the transference projections; it will not be necessary because their nature soon becomes apparent to the patient when they are made conscious.

In this area the analyst can do his work in the assurance that the patient is able to synthesize the previously repressed component parts of the self, with the help of explanatory interpretations that link the repressed unconscious contents with the ego. They are then worn down by the process of working through.

In this kind of analysis, which is best conducted with the patient on the couch, analysts take into account all that the patient says, whether it be records of everyday events, dreams, fantasies or memories. All the associated data need to be taken as a whole and their transference contents continually kept in view, *and* related to childhood, because that is where they belong. Repressed data refer to oedipal conflicts and latency; but much earlier pre-oedipal states can be reached and the patient's personality is still sufficiently organized for their significance to be understood. Regression, when it takes place, can still be limited and temporary.

Infantile memories

In analysis memories of childhood may feature prominently. They can be complex and do not necessarily record events as they actually happened in the past so that they themselves can indeed often require elucidation and interpretation. Optimally memories change, develop, become more detailed, more significant as analysis of the transference proceeds, but all the same, though they vary, a very good idea can be obtained of what did happen in the past and when. It is often useful and important to go on until the infantile situations are clear, and it is also useful to keep a track on the age at which they took place, bearing in mind what is probable at any particular age. Thus, by relating the present to the past, the patient's ego is strengthened.

Reconstruction

I shall not give examples about the past that is already accessible to memory. But earlier periods that are not may require the additional method of reconstruc-

tion to fill in gaps. This procedure is the ontogenetic equivalent of Jung's cultural and historical method.

Reconstructions of the personal past from data provided by the patient aim to fill in memory gaps or extend the range of experience to parts of infancy where behaviour and physical acts have been more relevant than organized mental functioning. The content of reconstructions is variable, and rather than attempt the impossible task of making a list of them, the following examples will better illustrate what I mean.

Example 1

In his analysis a male patient fifty years old developed the clear attitude that I was there to help him make discoveries about himself, so there was a good therapeutic alliance. He was much interested in analysts' mistakes and had theoretical views about their incidence, that is, '70%' of a good analyst's work was making correct interpretations, the rest were wrong and could be discarded. In spite of his views, however, he seemed remarkably indiscriminating; indeed any intervention seemed to be 'swallowed' under compulsion. On the basis of this observation and his use of food to allay anxiety I suggested that his feeding in infancy might have been important to him and that his way of swallowing interpretations might be an indication of how he was fed as an infant. I also suggested that perhaps his mother had used breast feeding to keep him quiet. He then told me that he had been informed about his breast feeding by his mother; he had been fed 'when it was required'; he had been a prize baby and much admired for his good behaviour and consistent gain in weight. Thereafter he claimed that all the food he had at home was good. From this it may be inferred, though the patient did not make the point, that his mother had been up to date in pursuing 'demand feeding'.

From his transference behaviour and his habit of turning to food in periods of anxiety, the reconstruction can be adhered to against the more optimistic assessment, especially because he tended to overfeed by stuffing himself, a practice that contributed to his developing heart disease (coronary thrombosis). It also made his predominant lack of direct verbal aggression more understandable—his criticism of the validity of interpretations being a case in point. More direct criticism of what I said was not then possible.

If he had been fed not so much when he was hungry as when he made a noise or used other methods of expressing his aggression, then the development of his aggression would have been inhibited and bound up inside him, as appeared to be the case in the transference. The inevitable splitting off of his oral sadism seemed indeed to have been organized into other fields. To some extent this started to be reversed when he became 'biting' about mistakes, threatening to break off his analysis because of them, and my supposedly erratic timekeeping (I did not always see him at once when he arrived) was treated as an irritation with which he coped by bringing work to occupy him if he had to wait.

Reconstruction, then, suggested the infantile origin of his verbal behaviour,

to which there was another aspect: in response to my interpretations he would produce a mass of associations as if he were under compulsion to do so. I reconstructed this in terms of his mother's demand that he produce excreta during toilet training. He saw the point but, incredulous, wrote to his mother. She replied in a letter which confirmed in detail the main points of my reconstruction: he had been given daily doses of castor oil and suppositories from time to time so as to help the regular functioning of his bowels. This information evoked the first signs of anger against her.

Now, though these early situations had been related to the transference, there was no regression. On the contrary he made use of the insights productively. He did not become more demanding or possessive; he came four times a week and that seemed to be enough. He had no difficulty in departing, tolerated a three-day break without difficulty and he looked forward to and enjoyed his holidays. Yet it was understood that, within the context of his transference, I represented his stuffing mother who, when greedily attacked, fobbed him off with a feed and who required of him regular evacuations. My interpretations were thus equated sometimes with breast milk or, at other times, with castor oil or suppositories. His rich associative responses became the equivalent of motions satisfactory to his mother.

Discussion

I have said enough to clarify the way in which detailed reconstructions during analysis suggest factors at work that account for transference behaviour. In all this there need be no essential difficulties for the analyst, and no extra-analytical action is needed.

The aim of making links with the past by using memories and reconstructions is to help the patient to understand what is happening. Though the procedure can become ritualized and so defensive, it need not be so used and optimally facilitates the more direct expression of the patient's affects. From this point of view analysis can be seen as part of, and not separate from, the dialectical relationship.

A feature of the first reconstruction was that the patient's mother apparently used demand feeding during the patient's infancy, yet according to the reconstruction the feeding procedure was partly responsible for the patient's present-day feeding patterns and contributed to his coronary heart disease. This is an example of developing a theory out of the patient's material and not imposing one. If I had thought that demand feeding, in the sense of not feeding by the clock, was always desirable, and then proceeded with that theory, the development of the analysis would have been jeopardized. It must have been, however, that his mother was not able to distinguish a hunger cry from the energetic crying of a baby needing to be aggressive by making a noise, or simply using the expulsive capacity of his lungs. 'Demand feeding' would then have been misused if the mother fed him at these times to keep him quiet and so smothered his aggression.

I am not claiming that my example proves the reconstructions, even though

they became convincing to the patient because they did fit in with a picture of the mother reflected in other ways. Her control of his bowel movements and his feeding suggested a mother who brought up a baby according to her ideas of how he should develop and so gave him no chance to feed and achieve control over his body in his own way, and in his own time. It may be added that there was a pattern in his relationships with women in later life which was congruent with this view: he did what they wanted, often to his own detriment.

This example is presented so as to show how analysis can proceed, taking into account very early periods in a patient's life which have not been so traumatic as to interfere with the establishment of the central core of the personality, which was felt by the patient as his having become a person. The state of affairs is quite different when self-feeling has not developed or has become seriously damaged and cannot be assumed.

An infantile impulse

A feature of regression is that uncontrollable impulses may come into the therapeutic situation. My patient threatened to walk out but never did so. To show clearly the emergence of an impulse with very early origins, here is an example from a child. It was from children that I first learned most about them but they are equally present in adults, though usually in a significantly different and less violent form.

Example 2

A girl aged five suffered from feeding difficulties. They could be traced back to her breast-feeding which had been difficult; she was a baby who had to be coaxed, her sucking would tail off and much work had to be done by her mother to help her infant feed at all. During therapy her oral cannibalistic impulses became very clear. She was not to be put off with toys, bits of wood or material, she went straight for flesh and it was very hard to let her bite parts of my hand because of the pain. I never let her bite through the skin which, however, she would have done had I not found that she could understand when it was more than I could tolerate; but even so I had to take steps to withdraw my fingers or substitute more fleshy parts of my hand.

She showed the rudiments of concern about her impulses but her main feeling was of fear about what she was doing. Thus she could use my hand as a token for the breast she never attacked but wanted to. By biting she began to integrate her greedy attacks and bring them into relation with the good and satisfying feeds which she must have experienced when her destructive impulses were split off. These lay behind the symptom (feeding difficulties) which disappeared as the result of her acts and the non-retaliatory management of them.

Example 2 is near to what the adult male patient had organized into socially acceptable channels. He could recognize and manage his violence by representing it and so, with the help of interpretations, he worked on it, negotiating

depressive anxiety without massive regression. That he did not regress much was due to the mature parts of his personality which held the 'infant' satisfactorily.

Regression

We can now consider regression in adults in more detail. It leads to the activation of primitive infantile features of the kind that the girl child showed. The analyst will meet adult patients' physical impulses as well as disturbed states of mind. Affects are going to be roused which may compel him to modify his analytical attitude if anxiety is to be kept within tolerable limits. The regression need not be clinically psychotic but it may become so and this is the risk that may need to be taken when continuing analysis in some kinds of regression.

The syndrome of regression

Before considering a patient's behaviour in more detail I will summarize the syndrome of regression, though any particular case is likely to show only some of its features at any particular time:

(1) Words become inadequate because their agreed meaning cannot be taken for granted and sentences are regularly reinterpreted along the lines of transference fantasies, which develop the character of fixed delusions so that insight is not effective in resolving them.

(2) The sound of the therapist's voice takes priority over the verbal content of his communications.

(3) Sounds and noises become excessively important whether they be soothing or intrusive and painful.

(4) Time becomes flexible and not much determined by the clock so that an interview may become intolerably long or may be over before it has begun. Time may also become menacing. In such ways the patient's subjective feeling of time takes precedence over clock time.

(5) Separation from the therapist presents difficulties: if he is not available when the patient arrives this influences the conduct of the interview decisively; the end of the interview also induces severe distress and the times between interviews become hard to tolerate, especially at weekends or holiday periods.

(6) Physical contacts with the therapist are sought and acted on.

(7) The therapist becomes stirred up in one way or another, and tends to react with more affect than in cases such as the adult one already considered. It is indeed the patient's intention to do just this so that analytical work can be discontinued.

There are two main views about what to do in a severe regression. One is to continue analysis as before where it is possible, and if the patient needs special care then let him get it elsewhere: at home or if necessary in a mental

hospital or a nursing home. The other alternative is to devise additional token care for the patient because the provisions listed in Chapter 7 prove insufficient. There is, however, one essential prerequisite for the extra provision: both patient and therapist need to be clear about the nature of the experience being undergone, and this is why I have paid so much attention to the genetic aspect of analysis. By reconstructing the history of a patient more and more exactly through transference analysis, it becomes possible to know with sufficient certainty where care is relevant—the patient may make clear his need for it.

Token care and the management of primitive impulses

Consider a patient who has a fantasy of there being an angry greedy infant present and compare it with another one who is lying curled up feeling ravenously hungry and finding it impossible to talk. In the first case the patient can manage the state he is in and analysis can proceed; in the second case analysis is no longer possible and some therapists will provide tokens.

Giving physical tokens of care is not analysis, which has to be abandoned for the time being, because care of the patient has become the primary feature of the therapist's behaviour.

In regression to infancy the adult patient has for the time being let the infant part of the self take over and there develops a need for a mother-person in the analyst who will know what the infant's behaviour means and will act appropriately by performing the equivalents of holding him, nursing him and providing a good enough physical environment. In the case of a real mother and infant, physical bodily care is part of the mother's affective engagement. The question arises: how much can the analyst provide conditions for the patient to revive those experiences in the here and now? It is clear that he cannot do so in reality if only because the adult body is not that of an infant and developments, mostly distorted, have gone on which have made life as an adult possible. For this reason it would be delusional to suppose that the past can actually be recreated. Therefore physical tokens must always be a compromise required by the disparity between emotional needs and reality. They represent, modify, but do not satisfy the needs of a patient in regression.

The analytical situation contains objects that can now be thought of as tokens: time, the couch, blanket and pillows and the reliable holding existence of the analyst himself. So it becomes a question of whether there are enough and what may be added? The therapist may add more time, food, drink, paints, paper, chalks and parts of his body to be held, touched, bitten, scratched, etc. It is around these additions that discussion has focused, and especially on how much shall the patient be 'allowed' to involve the analyst's body. This, be it noted, is not an additional 'prop', to use a theatrical analogy, since his body is there in any case. On this often loaded subject it can be said: there is no need for a prohibition on touching, holding or biting so long as these acts represent needs derived from clearly recognized infantile anxieties that the patient cannot restrain. At the same time such activities can be due to lack of skill, insight or

interpretative ingenuity on the part of the analyst. But even with maximal skill I should not believe any analyst who stated that no form of physical contact had ever taken place between himself and a patient. As it is, however, as the main object of analytical work is to use mental functioning to arrive at resolution of conflicts, there cannot often be much advantage in 'allowing' other forms of activity if they deflect from the analytical aim.

It is not just the physical objects which are important, but also affective responses, and Margaret Little (1957) has included these aspects, calling them 'R'—the analyst's total response (see p. 109). The following is an example of what is meant. It can also be thought of as an analyst's idiosyncratic response, which has already been considered.

Example

A patient in a resistance to regression, because I was going away, talked about her mother in such a way that it made me angry and I said, 'She is such a wash-out that I don't see why you have anything to do with her', thus expressing something like the affect she was holding at bay without interpreting it. Much work had been done, this time and before, on holiday breaks in her analysis which she managed by splitting, so that my going away was treated by using the notion that I was no use to her and it made no difference whether or not I was there. This patient intended to visit her mother whilst I was away and she wrote a letter to London with no 'Please Forward' on the outside so there was a delay in my getting it. She asked for help with her personal relation to her mother. I replied when I got the letter that I was very much upset at not being able to answer and help in her situation at once and then added an analysis of the situation as she stated it.

Affective responses of this kind seem to me as much tokens as cushions, paints, food and to be part of the token method even though they are represented in words. A danger in using tokens to help represent the original impulses more directly is that the patient may develop a conviction that the original impulse is really being satisfied. Then, because of the appealing, demanding barrage to which the analyst is subjected, he can be drawn into this fallacy himself. Therefore it is important for the analyst to keep it clear in mind that the early situation can only be more or less closely represented and not actually repeated. The point of using physical objects—where it is not an attack on analysis with the aim of ending it—then begins to indicate that very early infantile impulses are coming into the picture. If there is a patient whose silence is violent it can be quite relevant to give him a cardboard box, which he can then rend to pieces with remarkable alacrity. It is not only violence that can need to express itself in non-verbal ways, but also sexual impulses, whether genital or pregenital. There are also silences that are true expressions of states of unity which the patient is needing to experience, and any intervention is then an impingement and traumatic.

The main objection to using tokens is that analysis is impeded by them

and that the patient seeks motor discharge rather than engaging in the struggle to put his experiences into verbal or pictorial forms. It is an objection that stems from the time when it was not recognized that regression to infancy could occur. When analysis is mainly occupied with oedipal conflicts, motor discharge truly mobilizes guilt because the libido has a much stronger genital cathexis and there is at the same time a stronger taboo on its discharge because of the infantile conflict in a physically mature body.

The transference psychosis

In regression a state of mind develops that is called a transference psychosis because it has characteristics that would be expected of a psychotic patient. There is a marked disturbance in reality and so, whilst he is with his therapist, the patient's communications appear to be based on delusions and hallucinations.

In a transference neurosis something of this can also be observed but the patient can distinguish quite quickly between his transference projection and reality so that he never lacks insight for long. This satisfactory state of affairs no longer maintains when a transference psychosis develops and, furthermore, insight, though often present for part of the time, tends to be intellectual and does not have the effect of dissolving the patient's projection.

There are a number of characteristics of this condition that are particularly important and will now be considered: alterations in the meaning of words, time disturbances, fixity of memories and crises over separation from the therapist.

Alterations in the meaning of words

Besides the emergence of impulses and the need for manifest evidence of verbal caring, another feature often occurs—words may cease having an agreed meaning and so confusion is liable to result if the therapist proceeds on the basis that the resistance is of an oedipal kind. If he understands that regression has taken place to a much earlier stage he will start to pay attention all the time to the effect his words are having because they are being translated by the patient into his own meaning in a delusional way so the different meanings cannot be clarified. What the analyst says may be recorded but each time given a different emphasis or put in the context of the patient's transference, again in a delusional way so that insight is absent. To interpret the situation in terms of organized defence systems is not enough because it cannot be directly analysed as in the more organized states.

Suppose an interpretation is read to mean that the analyst is defending himself against the truth about himself, and is trying to force his own anxieties onto the patient; or that the analyst is, in the patient's view, using his technique as a shield behind which to hide himself. In both cases a direct transference interpretation will be nullified.

Partly as a result of this situation commonsense is useless and sometimes, if reference is made to reality, the patient becomes convinced, as one patient put it, that I had 'gone mad'!

In its more dramatic forms the syndrome can develop so that the interview becomes filled with negative affects until the whole of the dialectic seems to break down. The time may be filled with groans, screams or tears whenever the analyst speaks: the patient seems to use every means at his disposal to prevent the analyst's interventions from becoming meaningful. Almost everything said by the analyst is reversed, turned upside down or subtly distorted so that direct communication becomes impossible. The objective of this sometimes becomes very clear: it is to keep the way open to regression or to maintain it as it is. But though seemingly negative there are positive aspects to all this. Though perverse destructive aims dominate the picture, the attack on what is good and the conversion of good into bad objects and vice versa, the delusion that the analyst is concealing himself and depriving the patient of himself, that he is ill or is himself so pathological and infantile that he needs the patient for his emotional survival, they all imply that the patient is making efforts to preserve the delusional 'true person' of the analyst or foster his growth. It may be noted in addition that a destroyed or perverted world outside the analysis comes into the picture. Parents are denigrated because of the transference situation, and their failings may be rigidly held to have caused the patient's condition, and the denigration extends to relatives, siblings and to parental images as a whole, to include civilization. All this can be understood as an attempt to ward off the patient's destructive attacks on the good person of the analyst, to split off the destructive processes and project them into the past, society and the cosmos. Therefore, in the situation on which I am focusing, the attack on the analyst by dividing him into a bad technical machine and a good hidden part, which it is the aim of the patient to unmask and get for himself, is a step forward in therapy even though the terror of the destructive aim is greatly increased.

Time disturbances

A correlate of this situation is disturbance in the sense of time. There seems to be no history, and so past and present are the same though references can be made to the past and be understood during periods when the delusions recede. They lack cogency, however, and are liable to be treated as academic niceties; only if the historical reference fits the patient's delusional system will it be accepted; when outside its scope it is denied: the analyst is said to have 'got it wrong' and the memory may be repeated with the amendments to fit the delusion.

Fixity of memories

It is characteristic that the memories of childhood that have been revealed do not alter and expand as analysis of the transference proceeds in an ordinary

analysis. And if there are screen memories their content is not accessible; they remain emotionally isolated from the setting in which they are known to have arisen.

There is also a true running together of past and present, but the patient will also exploit this tendency with a view to putting maximal emotional pressure on the analyst, aiming to split him up, or wear him out, going on to reversing the analytical situation so that the analyst 'becomes' the 'patient'. It can be on this basis that reconstructions are treated as an evasion of the analyst's fear of his own infant self.

Periods of separation

In these states, whether the analyst be approached lovingly or in hate, his physical presence is the main proof of his continued existence and so the weekends or holidays when he is not there present serious difficulties which telephone calls, or letters and postcards can help to mitigate. It is no use the analyst trying to analyse these situations as though they were an organized resistance; he needs rather to recognize the reality of the patient's distress. A way that can be used is to recognize that during the interview the patient is an infant in seeming confusion whom the analyst is willing to hold; when the end of the time comes he can say that he is handing back the infant part to the patient to look after until the next interview. In holiday breaks 'baby sitters' can be provided in terms of a substitute analyst, or if necessary inpatient treatment. Sometimes the offer of these substitutes is enough and the patient may not use them, but even if he does not the offer is needed.

Earlier on I expressed the view that it is desirable not to abandon analysis during regression to the level at which unorganized infantile status becomes prominent, that is, where there is little or no feeling in the patient of being a real person or self. There are two special reasons why:

(1) The impulse and confusion is seldom if ever simple and is linked with splitting, projective and introjective mechanisms with persecutory feelings and idealization. These need elucidating if confusion is to be kept under some degree of control.

(2) There will come a time when the regression itself gets used as a defence against later conflicts. Then analysis of these becomes truly urgent and the defensive future of the regression needs to be shown up.

Counter-transference

The pressure to which the analyst submits during a transference psychosis produces characteristic effects:

(1) The analyst can be led to participate in the confusion as Jung held was, if not desirable, at least an inevitable state of affairs.

(2) He can be pushed into masochistic acquiescence to become persecuted and guilty at not being able to help his patient, whom he may feel he is robbing, especially if the patient is relatively poor. This can lead to splitting along the lines that the patient is trying to achieve. If his guilt becomes too strong he may even make attempts to stop the analysis as Jung reports he once did though, characteristically, without success.

(3) Feeling frustrated and inadequate the analyst can seek to do something to mitigate the situation: he may more or less abandon analysis, submit to the patient's seductions by excessive use of tokens, or allow the patient to take more and more possession of him physically. This can lead to the danger of a sexual relationship being started. The transference contents are, as I have suggested, directed towards inducing helplessness in the analyst and this can change the patient into a threatening, persecuting beast.

If I lay stress on these effects, it is because they can become indicators of the patient's attempts to split the analyst and force his way into him. If this is not detected the analyst may collude with the delusion that it has happened. Thus an amalgam of analyst-patient is set up, and it can be very difficult to dissolve: it is a malignant form of syntonetic counter-transference.

If there are attempts by the analyst to avoid helplessness, despair and depression he can miss the essential point that he is reflecting the unconscious state of the patient. It cannot be sufficiently underlined that the patient remorselessly plays on any weak points he may discover in his analyst, his aim being to destroy the mature, nurturing feeling and creative capacities of the analyst which have come to feel invasive to the patient. All this may be translated to mean basically that the patient aims to destroy the analyst's internal parents, or the mother and her babies inside her. It can be terror and dread of so doing in reality that makes these cases so difficult.

Technical faults

It is interesting to review theories holding that the negative therapeutic reaction is due to faults by the analyst with the counter-transference in mind.

(1) The diagnosis was in error; the patient should never have been taken on for analysis.

(2) Technique has been faulty and in particular:

(a) interpretations have been directed towards the patient's bad objects and treated by the analyst as though they were really good objects. As a result, the analyst becomes the 'devil's advocate';

(b) as part and parcel of this faulty procedure the patient's defences have not been taken sufficiently into account, or perhaps not at all;

(c) interpretations of whatever kind have been so excessive as to induce persecution in the patient. It is these that drive him to hopelessness and despair; or

- (d) the analyst has made so many wrong interpretations that the patient's trust in him has been undermined.

Now these faults cannot be excluded; indeed most of them happen from time to time in most analyses, and they can usually be detected and rectified. The development of ego-psychology amongst psychoanalysts has done a good deal to help in avoiding them, though most of this work has been conducted in the field of the transference neuroses.

The feature of the syndrome described, which makes the argument about technical faults inadequate, is that the patient does not go away; on the contrary he often contends openly, but more often by implication, that his whole life depends upon the continuation of the analysis and its successful outcome. He so contends, even when he insists that for a solution to come about, the analyst must cure himself first of the illness that he has (in the patient's delusion). It is therefore hardly likely that the analyst's real faults come into the picture much.

Theoretical reflections on regression

There is a consensus of opinion that regression is valuable—it is also deemed to have therapeutic effects because damaged parts of the self can be reached, identified, understood and relived in token form. They represent those parts of the patient's life which were unsatisfactory during infancy and childhood. There are reasons to believe, however, that this conception is incomplete and that by establishing the continuity of past and present something essentially healing takes place.

Jung was one of the first, if not *the* first, to attribute value to regression, but he related it mostly to alchemy and secret cult practices of healing and renewal. In them, it is true, states of disorientation (chaos) are induced, often leading to a vision followed by rebirth of the initiate, but for patients described above a genetic model is needed. If it is not, the yet unidentified and often imperfectly formed self-images become lost in the complexities of myth-like forms. The model that developed here is that of the self conceived as a primary entity that can integrate and deintegrate.

The theory can help to orientate the analyst and sometimes the patient as well in the states of mind found in regression but, before going further into it, it is necessary to understand that the early stages of maturation do not appear in pure culture, but through a haze of later development, parts of which require interpretation. It is also important to keep in mind that the material which a patient presents is not a state of health but distorted because that patient's early life was disturbed and also because on the distortion much later development has been superimposed.

The state of an infant in integration can be thought of as a state of being without experience of existing, in other words, something like sleep. It is also a state that is accompanied by feelings of separation and there is intense resistance to impingements upon it. When this condition is being approached

the patient may therefore feel that he does not exist, or feel very separate from his analyst and as if there were a barrier between them—this can be recognized by the patient, who needs the analyst's tolerance and understanding of it. It is this state that requires management and care more than anything else so that it can be made safe enough. It also means that whatever happens that is significant will come out of the patient and that all the therapist can do is to provide conditions in which the next step, deintegration, can occur.

In the earliest deintegrations a state can be experienced without it being known what that experience is; it cannot be named and so the therapist must refrain from interfering with it, just as a mother knows how to meet her infant's needs signalled to her by her infant. It is here that counter-transference becomes the only source of information and tokens may be indicated. The analyst's perception that there is a person there even though the patient is sure there is not, must not lead him to believe that the adult-infant has any feeling of identity. Nor, as the adult-infant progresses to feel that good and bad things are happening (the beginnings of object formation) must he believe that the good and bad objects can be interpreted as parts of the patient. They are parts of the self but not of the ego.

When this state of affairs can be related to more structured functions that have developed as in projective identification, it becomes easier since objects are represented and appear as delusions or hallucinations in the transference as described above. But there is still no direct sense of existence but only an experience that the patient cannot exist without the analyst-mother being there, that is, the analyst contains for the patient the bit of self that is becoming realized. There is still no point in making interpretations which refer any bit of experience back to the patient as if he were a person with an inner world which is being projected. So an interpretation made on the subjective plane would be meaningless because any experience which the patient has of the analyst is experienced as true. Therefore, any intervention must be directed towards clarifying that delusional 'truth': can the patient say more about the analyst being 'mad'; can he develop the idea that he is ill and in need of treatment by the 'patient'? Or if the patient's account contains gaps or defensive features these can be inferred and communicated but the basis on which these interventions are possible is that what the patient says is true, in a delusional sense.

Next it may be assumed that bits of experience are given and placed within the integrate and after some months they are sufficiently organized to disturb sleep as a discomfort giving rise to a dream. When this happens then there is something to which reference can be made.

Before this in a sense there is no experience of the difference between waking and sleeping, now it is possible and there is the capacity to distinguish between self and not-self, introjection (eating), and projection (excretion).

In these early beginnings it may be possible to interpret much of this to a patient in periods when he has not regressed, but it will not go home to the infant part. During an interview when regression predominates care and reflection is all the analyst needs to provide and this may be taken over by the patient's mature part and help to mitigate the distress of being separate.

CHAPTER 14

*The Origins of Active Imagination*¹

The material in the previous chapter presents a different picture from the one presented by classical Jungian therapy. Yet it applies to cases of the kind treated by Jung.

The difference stems from viewing regression in two lights: the one, collective and social, is phylogenetic, the other refers data to infancy and is ontogenetic. Both reveal personal and impersonal contents though with different phenomenology. The two points of departure are complementary but the latter has become neglected for the understandable reason that one line of productive research has been concentrated upon.

Of all Jung's work, active imagination is perhaps the most characteristic but it was looked and worked upon as a compensatory mechanism with ongoing potential and so its origins in childhood and infancy were not given much attention. In this chapter I shall relate the two and suggest why it is important to do so. I shall start with material from a report on eight cases presenting the common feature that they all needed more analysis of their childhood than classical Jungian therapy would expect.

Definition of the class of patient studied

All but two of the patients were over thirty-five years old; they had been in analysis for between five and twenty years with one or more analyst. During that time they had all accumulated much experience in the analysis of dreams, and all of them had used sculpture, painting or writing as part of their active imagination. All had gained access to their imaginative life and all had obtained a good appreciation of the contents of it, and of the objective quality of the experience that its representations attained. All had developed in various ways in the direction of individuation; yet they all displayed the common feature of also needing detailed analysis of their personal life, their childhood and their infancy.

Neither their psychopathology nor typology was especially characteristic.

The psychopathology was diverse and ranged from an obsessive compulsive disorder covering an affective psychosis to hysterical character structures and schizoid personalities with depressive features. There was no phobic disorder among them, no case presented with sexual perversions, nor had any case been hospitalized for any kind of psychotic disorder. The typological classification was not homogeneous either. Both introverts and extraverts were represented; thinking, feeling and intuitive types were clearly in evidence, and one case may have had sensation as her superior function.

In three patients, treatment was separated into two parts, with an interruption varying from several months in one case to several years in two; in each the termination of treatment occurred by mutual agreement. Of the five remaining cases, three had been in therapy with Jungian therapists, who used synthetic methods focusing on dreams and active imagination, before coming to me. One at first came on a friendly basis for discussion of her problems; analysis was not contemplated, but the relationship broke down and there developed a very intense personal transference which demanded that it be interpreted in relation to its infantile roots, and worked through at length against fierce resistances. With the remaining two I myself changed the method after satisfying myself that it was needed and being asked for by the patients. This difficult operation failed in two other cases not included among the eight.

Treatment techniques

All the eight cases were treated in two ways. At first the constructive method predominated; later analytical technique was consistently used.

'Constructive' therapy

In the constructive part of the therapy, which came first, all cases were seen between once and three times a week. In all of them the chair was used with patients sitting facing or half-facing me. I treated the patients on a 'human' basis with emphasis on basic equality of status between myself and the patient, both conceived to be embarking on the joint enterprise of understanding 'the unconscious' when archetypal material presented itself. The notion that it arose between us made the matrix in which we worked much of the time. In each case the transference was not prominent but dealt with when it became obvious. I did not often identify it for the patient nor interpret it to him or her when it was unconscious. Emphasis was laid on the here and now relationship in which there was an underlying assumption that I was to be treated as a real person; it was an attitude that masked but could not eliminate the transference. Dreams were used and emphasis was laid on interpretations directed to the subjective plane, so as to relate dream and fantasy to the actual situation. The solution was expected to arise from dreams, symbols and fantasy, in terms of a symbolic union of opposites giving increased coherence to a personality which would be better equipped to cope with realistic living. In line with Jung's

reasoning, care was taken not to 'know the answer beforehand'. All the patients showed characteristic features, already sufficiently described elsewhere. Archetypal and self-images in dream and imaginative sequences were all in evidence.

As to amplification, my practice was to treat dreams, fantasies and rather formally induced associations as the primary framework of reference and introduce mythological analogies sparingly along lines current amongst analytical psychologists at the time. But, all the same, the way I behaved and the way I conducted the treatment was controlled by experience of my own on which intellectual knowledge had been built and of whose veridity I was convinced. It was only as time went on that it became increasingly clear that, however much I tried to avoid 'knowing beforehand', once the material was produced it was absurd to claim that I did not know what it was about in terms of archetypal forms, structures and processes; and however little I communicated this knowledge, the face-to-face position and periodically reacting rather freely represents, in a concealed way, a procedure that has quite definite limits and cannot be made to apply to patients as a whole nor to the same patient at different times.

Transition from 'constructive' to analytical therapy

Two cases will serve as a paradigm of the change in method.

Case one is that of a young professional woman who came for help because of difficulties in personal relationships. Though she soon developed an idealizing transference, neither its relation to destructive and hostile affects nor their infantile roots were interpreted or worked through. She took to the technique of introversion and a series of pictures developed which began to indicate the centralizing process in which Jung had become interested. These symbolic images, called *mandalas*, are circular symbols with some object inside which is particularly valued. As Jung had suggested that these indicated the possibility of ending therapy, I thought that the treatment was drawing to a close; but not at all: the patient developed a complex sadomasochistic transference that could not be missed, and interpretations of this on a subjective plane became irrelevant or a violation of her identity; they did not adequately take into account the infantile nature of the data, and the treatment centred on how to manage this very intense transference in which symbolic representation was often impossible and insightfulness periodic. It became clear that she had to be seen four times a week if analysis was to be possible, but acting out terminated the therapeutic endeavour. I did not use the couch, though nowadays I would so do.

Case two is that of a woman of over forty. Treatment proceeded differently though the elements in the transference were essentially identical, inasmuch as projective identification was a prominent feature. The introversion resulted in a characteristic picture series of peacocks whose circular tails exhibited features of *cauda pavonis* (cf. Jung, 1955-56, *C.W.*14, p. 287). The patient

became increasingly intolerant of my interventions and especially if they were at all off the mark or expressed with insufficient tact.

Her very dramatic and often impressive dream-life piled up and the way she used it eventually filled up the interviews almost completely. All this once again covered a masochistic transference which made further therapy intolerable to her. For several reasons I proposed that the interviews stop and that I would write to her when I could see her more often. I also told her that I thought that I could analyse her now (meaning parts of her) in a way that had not been possible for me before, but that she must come more frequently. When she returned I saw her three times a week and soon proposed her using the couch with my sitting behind her. She took to this with enthusiasm and the analysis, though often difficult, progressed rather well for a considerable time.

These two descriptions illustrate a development in my understanding for which I owe these patients gratitude. Without what the first case taught me I could not have arrived at certainty in deciding what was needed in the second. I had also learnt from other patients as well; indeed, a sort of shuttle service developed in which work with one facilitated my understanding of another.

In each case the changes in my attitude were required for analysis to take place. They were as follows:

(1) The expectation that a symbolic solution would provide the answer had to be abandoned. It did not truly represent individuation but rather a jumping-off ground for a different kind of experience which could only happen through analysis.

(2) It was necessary to increase the amount of time during which I listened to the patient's associations and made interpretations designed to elucidate what was said.

(3) In any interview it was vital to reflect about and if necessary elucidate and interpret its transference content and to do all that was possible to make it conscious. More frequent interviews were necessary—five times a week being optimal but not essential.

(4) It became clear that infantile data, the transference being the main one, needed to be defined and referred to their origins in infancy, either remembered or reconstructed.

(5) The change further necessitated abandoning the earlier attitude of equal status between patient and therapist altogether because it became clearly inappropriate to working through infantile attitudes in which the patient placed the analyst in the role of parent and needed him to reflect this position. The situation demanded frequent interpretation and management by an analyst who in reality is well equipped for the job.

This list makes it clear that, in the change from emphasis on synthetic processes to analysis, the transference became the frame of reference rather than dreams and imagination. Both of the latter continued to play a highly significant, often even more illuminating though less exclusive part.

Effect of the change

All the cases exhibited features which can be attributed to the different methods employed.

(1) In all cases the gains from the 'synthetic' approach were recognized by the patient even though it and the therapist came in for critical and often violent attacks during the analysis, for having delayed progress, prolonged the therapy, or failed to detect and analyse the transference, etc. These data show that parts of the negative transference had been overlooked.

(2) In all cases it became clear that the virtual absence of detailed transference analysis during the first part of the treatment had led the patients not only to repressing, but also to consciously suppressing (or consciously withholding) essential areas of their personalities which were felt consciously or unconsciously to be too mean, destructive or shameful to reveal.

(3) Prominent amongst these contents were infantile needs, aggressive and greedy, or sexual impulses and fantasies. Many of these had been repressed as well as consciously suppressed by the earlier therapy which, in spite of its 'democratic' aim, had not prevented 'authoritarian' projections.

Transference

The transferences concealed during the constructive therapy were all very intense and became a central feature of the subsequent analysis. Some of them reached delusional proportions.

To illustrate their content: one patient continued analysis because of the special position she believed she held in relation to my marriage—she felt she could not go away until she knew that my wife and I were satisfied with each other. This fantasy was not resolved until she could relate it to her feelings about her parents' sexual relations in a sadistic primal scene.

Another content was as follows: the patient believed that though I was not able to let her be a child now as she needed to be, if she waited until I had changed enough this would be possible since she 'knew' I had the potentiality to do it. In the meantime I was a child to her and had to be tolerated as such. This example is of especial interest because it was easy to believe that this was not a delusion but in some sense true. Indeed it was not until the analysis had got under way that the delusional content, lying behind the truth that I needed more experience before I could analyse her, could be appreciated and brought into the open.

In all cases the second or more strictly analytical stage in the therapy produced, then, dramatic transference situations, and I became openly the carrier of images. It became evident that it was an equivalent to active imagination but with the following differences:

(1) I was able to experience with the patient in the here and now what was before brought in pictures, written-down fantasies, sculptures, etc.

(2) As the result the content of 'the material' could be scrutinized step by step in the here and now. When presented with a conclusion—the equivalent of the report on work done between interviews—I could show the patient much more easily why he did this and what was his aim in doing so.

(3) The work 'on the material' became affective work related all the time to the two-person situation.

(4) As a consequence the interrelation between the subjective and objective worlds was never obscured since the external objects were always there represented in my person.

(5) Lastly as a consequence 'the material' changed and took on forms for which the patient could increasingly take responsibility.

Discussion

When Jung discovered the often overwhelming importance of the world of images, he presented his thesis as a development of psychoanalysis whose theory and practice he classed as explanatory and reductive. His special contribution, the technique of interpretation upon the subjective plane, was introduced as a supplement to it. This technique led to active imagination.

There can be no doubt that his underlying idea was to foster ongoing processes that contribute to individuation. Prominent among them was the aim of withdrawing projections, and to do this he showed that the method of active imagination, which objectified the contents of projections, was helpful.

The objective character of the imagery found in active imagination, and the fact that it is like that found by religious persons who believe that they are experiencing a spiritual world essentially separate from man, gave rise to a concept that archetypal forms could take on objective characteristics and so lay at the root of historical and social processes. This developed into a theory relevant to social development and change. But all the same there is still little to be said for believing that the character of the experience warrants postulating entities that are permanently separate from the ego and so from self-feeling. It seems more in accord with the data as a whole to conceive the objective character of the experience, the mystery, wonder, awe or horror that may go with it, as a part of a creative process belonging to the individual. The concept of individuation does indeed require this view to be taken.

The days are now over when it can be thought that individuation can only take place if there is active imagination. It is no longer possible to believe that all forms of fantasy can with sufficient skill be developed into active imagination. Indeed, amongst analytical psychologists there have been a number of studies in which fantasy and imagination have featured, but individuation does not take place as the result of them. Their findings are amply confirmed in my own experience.

Perry (1953) has given a series of papers describing synthetic initiatory processes including mandala symbols, in schizophrenic cases, but he does not consider that these result in individuation in Jung's sense. He claims to have

detected a restitutive syndrome in schizophrenia and prefers to replace the term *self* by the central archetype so as to underline his position. His findings and conclusions are what would be expected if the schizophrenic delusions not only reflect a state of disintegration but are themselves a partial attempt at healing splits in the psyche. The restitutive syndrome then represents an attempt at integration but not individuation because the deintegrate-integrative sequences have become arrested and distorted and there is insufficient ego-strength to make the experience enriching.

In discussing a group of cases under his care Dunn (1961) had described another kind of patient whose dreams and fantasies fail to integrate. The fantasies contained archetypal contents that might have been expected to lead to individuation, but in fact nothing of the kind happened. He claims that there was a lack of commitment due to ego-weakness and so a retreat into fantasy whose purpose, we may speculate, was to protect the self-image rather than to initiate creative developments.

In a recent paper Plaut (1966) has gone further and discussed different kinds of imagination in relation to the patient's capacity to trust himself and others. He has also underlined the overriding importance of childhood in the kind of imagination of which his patients were capable.

The transference

In all eight cases recorded here the images seem to have performed a dual function: their objectivity was not only creative and integrative, but they were also used to hold and cover pathological states that could only be resolved by penetrating to the source of the splitting.

The cases were not clinically psychotic, nor were they like Dunn's case, since they all used imagination creatively in their lives to a considerable extent. In three cases there was no doubt that there were undetected transferences, which were revealed and progressively dissolved only in the second (analytical) part of the treatment.

It will be asked—how could these transferences have been missed? The answer seems to lie in the attitude of the therapist: he and the patient are there to further transpersonal 'work on the unconscious'. This assumes a common task of experiencing the 'truth', which the unconscious will reveal. Consequently a transference which, it may be noticed, also carries the feeling of being objective, is liable to be accepted by the analyst as true about himself; in this he can unwittingly play the game of the patient, and this would have taken place had I agreed with my patient that I was indeed the child because I did not know how to analyse her. This does not follow. It would be wrong to equate incapacity and lack of knowledge with infantilism, though my counter-transference in these cases tended to contain just this illusion. But even if lack of knowledge did indicate infantilism in the analyst, unless the general statement is made quite specific nothing can be decided. When investigated, the analyst's history is always significantly different from that of his patient, and the apparently true statement is shown up in its true colours as a projection by the patient.

Another point I would like to make is that the equal-status attitude can all too easily lead to overlooking the fact that magically endowed archetypal figures are a compensation for dependent situations hidden behind them. The delusional transference is directly related to the omnipotent and idealized images so frequently reported in the literature (cf. particularly Wickes, 1938). Analysis of this situation can only occur when frequent interviews take place and when the analytical attitude is sustained.

Amplification and the effect of knowledge of mythology

According to the constructive method, the imagery produced by patients is to be related to historical parallels only, for example alchemy, yoga, mysticism or folklore, by providing the necessary references or talking directly about them to elucidate meanings or reassure the patient that he is not alone in his experience. This method can also be used to reinforce the objectivity of the data, a procedure not always desirable, as my cases show.

However stimulating, reassuring, inspiring, depressing or persecuting therapy can be to the patient, who is brought to feel himself part of the march of history, or even the tool of it, the intensity of feeling, the assembly of knowledge (amplification) and the resultant meaning that his life acquires, are all vulnerable. It is an illusion which it is agreed to treat as true and whose creative possibilities may or may not be realized. In many cases it cannot be grasped without the analysis of childhood and especially infancy.

The Achilles heel of the historical amplificatory method is this: the patient can never have been present in the historical context. A patient who produces archetypal material with striking alchemical parallels is not practising in the alchemical laboratory, nor is he living in the religious and social setting to which alchemy was relevant. Therefore, it can become unrealistic and anachronistic if this imagination is thought of as alchemical. In relating historical data to the here and now nothing truly fits, even though there are basic archetypal identities, and the patient easily becomes more divorced than before from his setting in contemporary life, and only too easily consoles himself with the belief that one day, though not now, he will be understood and recognized. In short, the main value of the parallels is that they provide him with a new step in consciousness of the phylogenetic matrix from which he sprang.

Infantile roots in active imagination

All the cases showed that it was essential to relate the patient to his personal and individual development from birth onwards. Concurrently with using the historical analogic method went a blind spot about the personal history, a feature to be observed in the literature; there was also to be found an inability to scrutinize the patient's imagery and so the roots of the symbols were ignored; and their personal relevance, as Williams (1963) has emphasized, was easy to overlook. Then the symbol was only too easily used defensively and the concept of the objective psyche gave support to defences against the reconstruction

and integration of those parts of infancy and childhood without which the patient was more or less crippled.

Elsewhere I reported (Fordham, 1976, p. 204) on a child with infantile schizophrenia whose play could be related to alchemical symbolism of water. This is one example amongst others in which the rather clear collective symbols have been observed in children (cf. also Kalff, 1964; Zublin, 1959, not to mention Jung's memories, 1963). It follows that we cannot assume the appearance of these symbols to be a sign of maturity—it may equally well be just the reverse.

It is sometimes felt that to refer the material of active imagination produced by adult people to infancy is to depreciate and devalue their creative life and their personal status. Against this it may be said that the prototype of individuation in later life occurs in the first two years of life. During this comparatively brief period the infant progressively masters all the essential skills necessary for him to realize himself as a viable being, becomes able to tolerate the absence of his mother for short periods and so to be alone on his own for limited periods. To tolerate being alone is an essential condition for active imagination to occur.

It is in these two years (the most astonishing in the whole life of an individual) that we must look for the root processes of the psyche that lead to objectifying deintegrates of the self. Symbolic representations begin during this period and are built into the infant's fantasy life. During this time the introjective-projective mechanisms are active and plastic; they run concurrently with building up the rudiments of the idealizing and persecutory systems which patients using active imagination can also reveal. In addition there is reason to believe that, when the roots of the depressive reaction in infancy occur, this is related to the beginnings of symbol formation (see Segal, 1964) upon which active imagination depends.

But all this does not truly cover the value all my patients felt was contained in the 'synthetic' attitude and method. It was quite evident that as the result of analysis the grander archetypal images featured much less and even disappeared sufficiently for one to reflect: where had they gone? And had they, as some Jungians fear, been done away with by the supposedly destructive analytical method? To me it seems quite evident that their contents had been integrated into the patients' lives and a much more manageable inner world, but even so one wants to know about their roots in childhood, so that, when conducting analyses of infancy and childhood, it may be possible to know and so avoid interfering with a valuable feature of unconscious processes. I believe that the theory of transitional objects and their derivatives as developed by Winnicott (1971) provides a clue to the problem.

Many years back I was struck by a story told me about a small girl. She had acquired a doll to which she became especially attached and which she used for all sorts of purposes for which it had not been designed. It began to smell so much that her mother tried to persuade her to relinquish it, but without success; replacements were offered but were discarded in favour of her special doll. Eventually her mother took the object and threw it in the dustbin, only to find that her daughter retrieved it. Intrigued, her mother then asked her

why she wanted to keep such a revolting thing. She received the reply: 'Though, mummy, you may not like it, it smells lovely to me'.

This is one of a whole class of objects having the characteristic of being treated as a specially valuable possession—they sometimes seem as if the child's whole existence depends upon them. Later such observations were made even more significant and given a place in the child's life by calling them 'transitional objects'. The example I have given is a doll, the possession of a relatively mature child who could speak, and at this age fluffy toys, dolls and animals and hard toys will suffice, but much less complex objects such as bits of fluff, string or a rag can easily be used by infants, who begin to use them in this way by about the age of three months.

The objects, according to Winnicott, neither represent the mother as a real person nor the child's image of her as a 'subjective' object or, as I prefer to call it, a self-object in that she is experienced in archetypal form, but originate between the two in the space created by the infant's discovery of his real mother who no longer fits his archetypal, or self-image, of her. As to the fate of these objects, they are, after a variable period, 'relegated to limbo', as Winnicott graphically puts it, meaning that they are not repressed but depotentiated and replaced by various activities: interest in stories, fairy tales, dreams, imagination, play.

The characteristics of transitional phenomena can be found in children's imaginary companions, examples of which were collected by Frances G. Wickes (1966), who interestingly observes that they can contain the elements of creative imagination. All these activities have 'not-me' characteristics. So transitional objects are the first 'not-me' possessions and are the basis of much significant play and, according to Winnicott, subsequently of cultural and religious life.

The products of active imagination are like this in the following respects. Patients who paint pictures will treasure them and, as Jung found, will often appreciate their being compared with other pictures of a similar kind from the history of civilization or those produced by interesting persons engaged on a religious or mystical quest—thus their value is enhanced but not tampered with. Analysis is usually regarded as destructive tampering and is resisted because they are 'not-me' objects and the patient's possession—at least that is the much cherished classical attitude. Nearly always the pictures are carefully kept by the patient. It is true that sometimes they are handed over to the analyst, but only temporarily. If a more or less permanent transfer takes place, the analyst is usually looked on with grave suspicion by his colleagues, and his act can be deeply resented by patients.

The attitude adopted by the therapist towards them is as follows: the archetypal objects must be treated as not-ego (the subject) and not-real persons; they are in between the two and are valued as such—hence the idea of two people working on the 'material'.

Inasmuch as the transitional object can represent all sorts of past and present experiences combined in an object, it seems likely that it is an important, perhaps essential, self-representation and that it nurtures the infant's or child's

sense of his person as an object because it belongs essentially to himself. In this it is unlike his mother, who he now knows is not his possession any longer—in reality she never was.

Jung's account of how he himself initiated active imagination began with his collecting stones and playing with them, starting from his childhood games from which there developed a sequence of images to which he related as if they were not him, nor were they real objects in the environment. With the images he developed a dialectic, just as children do with their transitional objects and in their subsequent play. All this can be seen as coming within the field of transitional phenomena. Their understanding does not require the intrusion of another and, it will be observed, Jung never thought it necessary to go to an analyst for therapy. On the contrary all his active imagination was conducted on his own in the morning, evening or between patients, and his family was not allowed to intrude. Till later life he never revealed what went on except to his patients and close associates. He kept records of his experiences, however, in a private 'black book' and he developed the experiences set out in a 'red book', both of which still remain unpublished, though some of the pictures have been included in the series of mandalas to be found in *Collected Works* (9, 1). As a further parallel with the transitional phenomena, the understanding of these experiences required a knowledge of the cultural life of our civilization, of religion, of magic, of the heresies and of comparative religion. They thus promoted a study of culture and this led on to looking at the state of civilization and the problem of our times which featured so largely in the interest in analytical psychology in the course of its development.

So much for the cultural aspect of Jung's work. There was another aspect to it which was, however, equally important: the sequence of images, if well related to, leads to a development; they themselves seemed to evolve at first fragmentary and then increasingly coherent patterns, which are the basis for individuation and realization of the self conceived as a cultural task—what, early in his career, he formulated as the aim of achieving moral autonomy.

Can there be any evidence for relating this to transitional objects? Jung's own memories of his childhood contain interesting matter (Jung, 1963). He was in many respects a secretive child and much of his time was occupied with playing and thinking on his own, but there was one object that took on particular importance: the manikin. This small figure was carved in wood '... about two inches long, with frock coat, top hat, and shiny black boots'. It was put in a pencil case together with a stone, which was 'his' stone. Jung then secreted the object in the attic where he was forbidden to go, so nobody would ever find it. Having placed the manikin there he says: 'I felt safe, and the tormenting sense of being at odds with myself was gone'. He would steal up to the attic and look at the figure when he was in a difficult situation and it comforted him. 'The episode with the carved manikin formed the climax and the conclusion of my childhood. It lasted about a year. Thereafter I completely forgot the whole affair until I was thirty-five' (1963, p. 35). When he was working on *The Psychology of the Unconscious* (1912) he came across a group of parallels

with his childhood transitional objects and in later life he included such figures amongst the manifestations of the self in his essay on 'The Child Archetype' (1951).

In reading through Jung's account of his childhood one cannot fail to be struck by the predominance of cultural interests, in religion especially, and this percolated into his dream and fantasy life where his creative imagination produced interest, original thought and intense fears.

From this it seems clear, especially as patients who easily start on active imagination in later life often give a history of a rich imagination in childhood, that investigation of a patient's childhood may be necessary sooner or later, and can be fundamental. Having in mind that the transitional phenomena reach back to preverbal times, and that the transitional object and its derivations cannot be violated or impinged upon without risk, it is important to include non-interpretative methods because these refer to periods in which the infant or child is taking steps in separation from his real mother and, just as his mother allows this to take place without unnecessary intervention, so the analyst needs to play a similar role for quite long periods of the therapy.

But that does not mean that active imagination, as a transitional phenomenon, is only fulfilling the function of furthering individuation as it is supposed to do. On the contrary it can be, and often is, both in adults and children put to nefarious purposes and promotes psychopathology. This probably takes place when the mother's impingements have distorted the 'cultural' elements in maturation and therefore it becomes necessary to analyse childhood and infancy if the distortion is to be shown up.

Note

1. This chapter is developed from two previous papers published, with the titles 'Active Imagination: Deintegration or Disintegration', in *The Journal of Analytical Psychology*, 12, 1, and 'A Possible Origin of Active Imagination in Childhood' (*ibid.*, 22, 4) (1977a).

CHAPTER 15

*Terminating Analysis*¹

An account of how Jung looked at the end of an analysis has already been recorded in Chapter 2. There he stated that an archetypal transference seemed to resolve itself through the operation of a 'control point', which gathered to itself the energies of the patient so that the personal tie could be resolved. Jung had created conditions in which this could take place. The internal changes that interested him were accompanied by deepening of the patient's relation to a friend and so 'when the time came for leaving me, it was no catastrophe, but a perfectly reasonable parting' (*C.W.*7, p. 131).

This condensed account contains essential ingredients of ending. First of all, it is a process; secondly, there is the resolution of the transference; thirdly, the patient develops relationships in her daily life and a deepening of her inner life concurrently.

Of these three aspects to ending, the most difficult and the most discussed is the resolution of the transference: it has gradually become more and more problematic. In the early years of analytical therapy it was thought that transference could be resolved by making the tie conscious and appealing to reason and good sense. Then it was realized that that simple solution did not hold and that educational methods were needed so that the analyst could help in constructing a bridge to reality which the patient needed. But Jung concluded by saying that even that may not work and the patient may still hang on; many of these patients move on to the stage of transformation: 'It is just this hanging on which leads to the union of opposites and so of wholeness'.

But there still remains the awkward truth that often a transference does not resolve and this applies not only to the archetypal aspects but also to its infantile characteristics as well. Perhaps this is best illustrated in the analytical societies, which formed initially around one man and whose subgroups are usually designated by the name of an innovating analyst or therapist (for instance, Freudian, Jungian, Adlerian, Kleinian), who sometimes quarrel amongst each other so that scientific discussion becomes impossible for quite long periods. But even outside the groups, with patients who have undertaken a thorough analysis, transference indications can be observed quite frequently. For such

reasons the resolution of the transference must nowadays be taken as an ideal that is probably never realized. The position thus appears not much different from that of antiquity and the analogy that Meier draws with the cults of the therapeutae (see p. 17ff.) is quite relevant. Experiences such as that of Timarchus, the young philosopher, would, no doubt, mark him out as an initiate, a member of the cult, and this applies to the other members of the mystery religions such as those of the great mother at Eleusis, another Greek mystery cult. Many other examples will no doubt occur to the reader.

It would, however, be mistaken to believe that analytical therapy leads inevitably to cult-formation, for its aims and ideals are different. The goal of individuation, and the moral autonomy that goes with it, would not be the aim of the mystery cults, for they made no attempt at resolving the patient's, or initiate's, affiliation to the cult, which would have been the equivalent of resolving the transference.

The idea of resolving the transference must be considered along with that of separating from childhood, often interpreted to mean that this period in life can be done away with, much as it is thought about the transference. This is an error because no period in life that has taken place can be eradicated—we can only modify its influence, change attitudes towards it or withdraw libido from it. And since it is the infantile nature of transference to which I have paid particular attention, it will follow that transference content and intensity can only be modified but not done away with. At the best it may be hoped that the patient will be able to take responsibility for it.

With these background reflections in mind I will approach the subject of how analysis ends. In selecting for this analytical therapy from the other therapies that have been distinguished, I do so because it gives the best opportunities for understanding what takes place; this is ensured by maintaining the analytical attitude.

My intention is to give an account that includes my own personal experience so that it cannot be taken as only objective, and no doubt another analyst would give a different account. Indeed, reading papers on ending one finds that they can best be understood as ideal endings, such as the analyst would wish for. Prominent amongst these are those maintaining that if the individuation process has not been completed, at least its essentials have been arrived at and indicated by the painting of mandala images. Another one is that the end is arrived at by reaching the depressive position. To my mind both of these formulations are relevant but it is much more important for the analyst to understand the patient's potential and individual capacities. Therefore he needs to take into account his patient's whole analysis, the way it has developed and the knowledge especially of the patient's history and the traumatic events that have occurred during it.

Stopping analysis

Before embarking on the subject of ending I would like to consider a number of ways in which analysis may not end so much as stop. There are five common

ways and, though each of them may be decisive, they may combine in varying amounts:

- (1) financial stringency—in this situation the patient will not or cannot continue to pay money for what he receives. For the analyst's part he may not, in reality, be in a position to go on treating his patient without financial return. I would like to remark here that analysis can be conducted without the patient being able to pay for it but an analyst cannot live on air alone;
- (2) change of work essential to the patient's career involving moving to a place from which the analyst cannot be reached;
- (3) overt or latent delusional transference;
- (4) overt or latent delusional counter-transference;
- (5) termination by analyst or patient because further analysis is deemed to be fruitless.

Ending analysis

In contrast to stopping analysis, ending it is a separation to which both analyst and patient agree as to its desirability. The nature of the agreement will emerge as the discussion proceeds but, to start with, here is a very much oversimplified version of an end, to illustrate how it could take place:

The patient's contributions to the analysis become thinner than heretofore and not very much new material is brought to the interviews. The intensity of the transference becomes progressively less and the patient's recognition of the analyst as a real person increases. The patient is able to manage what comes into his mind without much help and concurrently his life outside the analysis becomes richer and more satisfying—difficulties and conflicts can be managed and, if not mastered, tolerated and worked on.

Both analyst and patient start to think of and reflect about ending and one or other begins a communication with the other about the question of doing so. It seems sad that such a long partnership should end just as the patient becomes truly viable, but both participants may come to recognize that to go on with analysis would be less fruitful than ending it. After a variable period, separation occurs with regrets on both sides—for ever? I leave that as an open question for the time being.

Afterwards the memory of the analyst and what he has done persists in the patient, and so an ongoing internal analytical process continues, not so much consciously as unconsciously; and what the analyst has learnt from his patient becomes gradually assimilated into his work with others. Both events are a manifestation of a mourning process which both need to work on, not only before but also after the analytical contract has ended.

The ending phase

This brief statement about ending contains two points that need to be taken up further. One is the idea that ending does not take place at once when it is thought of, indeed it may need working on for some considerable time.

It is not infrequent for a patient to broach it long before the analyst conceives it to be desirable; nor is it the patient's intention to implement the idea. There are a great variety of reasons for this idea in the patient's mind: anything from belief that an effective treatment should be short and analysts prolong it unnecessarily, to hostility and anger at the analyst for an unwelcome interpretation. The end may, indeed, be said to be in the patient's mind from the moment that an analysis starts: most patients ask when the question of analysis is broached, how long will it take? All these thoughts are either not very strongly cathected or they are ones that analysis will reveal as symptomatic rather than truly meant.

The ending period begins when the thought of ending is not one needing analysis but is serious and not related to resistance phenomena. It will be made within the context defined above: the condition of the patient is such as to confirm that the idea of ending is firmly based. How is this firm intention to be implemented?

The following data will be available for both parties but they are likely to be in the analyst's mind more than his patient's. It will be known

- (1) how the patient begins and ends interviews and whether the style of each is regular or variable;
- (2) how the patient tolerates and manages weekend breaks;
- (3) how much the patient enjoys holidays and how much the analyst is missed;
- (4) how much jealousy and envy the patient exhibits at his analyst's weekends and holidays;
- (5) about the patient's experience of previous separations such as birth, weaning, birth of a sibling, loss of one or both parents and other separations or disruptions of his life with significance.

Upon assessment of this information the course of ending will depend. At first the patient may not be able to make a judgement but the analyst needs to do so and it will be his aim to bring the meaning of the information home to his patient. In addition, if it is agreed that ending is in sight, particular attention will be paid to dreams, fantasies and associations bearing upon the future event.

It frequently happens, once the idea of ending has been firmly established, that the patient starts showing clear evidence of resistance to it, and indeed he may almost ostentatiously drop the matter altogether. But it is more usual for there to be subtle changes in the analysis, a new urgency may be detected and apparently increased efforts to interest the analyst will begin to appear as an attempt to make out that only the analyst has a wish to end. This signals a regression, which may go very deep and reach into childhood and infancy once again.

Example 1

A patient who had come with a depression had revealed a long history of traumatic separations, starting from a depression in her mother after her birth,

inability to make a relation with her father, who abandoned her mother at the time of the patient's birth. Ever afterwards her love-relationships were, with one exception, ended by the lover, so that she felt abandoned as her mother had been. Yet her depression had become manageable and there were a number of good reasons for ending, financial amongst them. Her analysis had become thin in the extreme, but working on her wishes to end was almost, but not quite impossible, because they were at once converted into my intention to get rid of her, a repetition of her early experiences. In this case, ending became a long-term project which took over a year, and even then it was only possible to reduce interview-frequency. This case is regularly repeated with less intensity in others.

Example 2

A middle-aged married woman had been in and out of analysis ever since her adolescence. On each occasion, her analyst had stopped the work onesidedly, either because he thought that further treatment was not indicated or because he went to another country, leaving the patient stranded. Therefore it might be said that she returned for analytical therapy so as to find out how to end analysis once and for all. When ending came under review, she persistently enquired what I thought about it, and it was only by not answering but interpreting why she asked this question, in relation to her previous experiences, that she could eventually be brought to arrive at her own ending.

These examples illustrate features of ending and the need to work on how it comes about. But the constellation takes on many forms, of which the following lies almost at the other extreme.

Example 3

After considering ending, a patient who had worked hard and systematically at his analysis for many years dreamed that everything was going to pieces and he was hanging on to something and so precariously holding himself together. This led on to reassessment of his omnipotent feelings in relation to his dependence on myself as an ideal mother. When he had worked through this he could reach ending in a rich way.

These examples indicate the wide spectrum of endings: they vary from patient to patient. The most interesting recurrent feature, however, is a tendency to repeat in condensed form the whole analytical process. There is a feature of this event which has been implied: the patient tests the analyst and in particular ways which make separation difficult if they are not worked on. I refer to manifest faults of the analyst, which may or may not be known about by the patient but which are known of by the analyst.

In the course of almost any analysis, the analyst will make mistakes, which are optimally spotted at the time, acknowledged by the analyst and their effect worked on with the patient. But this may not have taken place and the faults may, as it were, have dropped under the table. This is particularly liable

to happen when the analysis is moving into a field with which the analyst is not familiar.

Example 4

When I was working on the delusional transference and gradually finding out about it, I could not discover how to deal with a patient who said things about my interventions that I thought were true but that had left me with the feeling there was something wrong with this conclusion. The patient kept bringing up my faults with a view to establishing that I was the patient not she—and I got into a masochistic counter-transference which made me passive and unable to do anything about the situation other than remain passive. Therefore a sort of nexus accumulated consisting of bits of the patient combined with bits of myself. It was only when I came to realize that the faults were true only on the surface that I saw that, if their latent content was examined, their delusional nature could be grasped. Then I had room to move about. First, I reduced the growth of a gradually accumulating pile, and then I started to communicate to the patient what had happened.

This pathological nexus is present in almost any analysis; sometimes it does not need to be gone into but sometimes it does, for it can be a reason why ending cannot take place and then some measures need taking to deal with it. It would be surprising if some pathological nexus failed to form, because the traumatic situations of our childhood are always there, ready to be awakened when regression takes place. It is apparent that analysis of a patient in regression will evoke regression by the analyst, indeed it is required of him, and so the projective-introjective mechanisms may lead to the nexus just described.

Considered as a whole, the nexus may be thought of as part and parcel of the patient getting to know his analyst as a real presence. The realistic relationship has been known about before, especially in the therapeutic alliance which is the basis on which the analysis has been built. The good parts of the analyst are required but so also his bad parts, and it is these that need to be allowed by a patient before parting takes place. In a long analysis the nexus will be known about often well enough by the patient, but it needs to be communicated as well.

The post-analytical phase

Example 5

A patient who had finished coming for regular interviews communicates with me from time to time and occasionally comes to see me. She writes to tell me how she is getting on and indicates a crisis of anxiety. Each time she arrives it is easy to get to the core of her situation and interpret it; she seldom needs a second interview and soon after ending went abroad on a two-year work assignment. She could never have done this when she ended regular interviews (four times a week, tailing off to once a week and then every so often).

Symptomatically the result was moderate but she had been regretful about ending and so the way was open for her to return.

This example illustrates the importance of working at how ending takes place. It also indicates that ending does not necessarily happen because a complete therapeutic result has been achieved; indeed, symptoms may finally go after and not during analysis. In my example perhaps the most important achievement of the analysis had been that she had acquired a method whereby she could usually deal with symptoms when they came back.

I believe it is a matter for satisfaction if a patient behaves like this one, and that in her case it was more favourable than if she had broken off contact altogether. She came with severe compulsions and showed a number of phobias and near-hallucinations, alternating with periodic depressions in which she was suicidal.

It may seem that such a post-analytical phase could go on indefinitely and indeed there are some patients who need periodic contact with a therapist over long periods—it was these patients who, as Jung put it, ‘hang on’, who interested him particularly on the grounds that they are the ones who ‘enlist the energies of the whole man’ (*C.W.12*, p. 6). Some, it is true, are of this kind, others have taken ‘analysis’ as a ‘way of life’ and nothing seems to deter them from so doing, however unrealistic they may know it to be.

The needs of some patients should not, however, deter us from sustaining the much more usual aim of arriving at a satisfactory ending with therapy completed, with the patient truly viable and no longer in need of analytical assistance. With the majority of patients this aim is achievable and it is with these in mind that analysts express anxiety lest the post-analytical phase be converted into a blurring of ending or worse still the beginning of a new and fruitless extension of it. This is not usual, however, and the post-analytical phase then looks much like a convalescent period which terminates itself. Perhaps its existence can be understood by taking into account the pieces of unresolved damage to defences that need to be given time to heal without much intervention. Comparing analysis to an operation sheds light on my meaning: the final healing of the wound inflicted on the patient by the surgeon is a part of the recovery, which takes time and needs no further intervention.

Further reflections

In the literature, the end point of analytical therapy varies according to the views of the analyst. At one time, Jung gave a list of nine reasons for ending (*C.W.12*, p. 4), and if the stoppings are extracted then the remainder can be seen to correspond to his views on the stages of therapy. The same applies to my own position. It makes a great deal of difference whether the self is conceived as a system that only integrates the personality or whether it is conceived as one that deintegrates as well. In the light of this I would not think it adequate to end when it appears that the patient is capable of managing his inner and outer worlds, and I would look rather for evidence that he can work through periods

when he (that is, the self-integrate) is not in charge. This gives a rationale for not ending simply because everything is going well, and suggests the importance of using the ending period to test the patient's capacity to work through an especially stressful situation that can reach the level at which it seems to be a matter of life and death.

Such a situation is illustrated by example 3 above, which seemed like a dangerous disintegration. Having in mind the theory of deintegration in a person with obsessional character-structure it provided material for a final piece of analysis so that the deintegration processes could be allowed space beside the patient's organized thought-processes.

The ending period gives room for mourning to be reached even if it is incomplete and requires a post-analytical phase to complete it, so that the valuable parts of the analysis and the good parts of the analyst may be sufficiently introjected and identified with. When this has taken place the patient will have developed a firm core to the self and a method of continuing his analysis internally when necessary. The counterpart of this in the analyst is the learning, which also involves introjection of his patient, that has gone on in the analysis. It will hopefully lead to enrichment of his life and increase in knowledge and so to better exercise of his therapeutic endeavours.

The importance and severity of the stress that ending involves vary within wide limits. The variation depends upon the psychopathology of the patient or the degree of regression necessary for the patient to reach the traumatic situations in his early life. If the ongoing individuating processes have been distorted from the start, a different ending may be expected from that which happens when the traumata have taken place later on, that is after the self has achieved firm representation in the ego. Then sadness and grief will be available and the ending period will be shorter. In both cases, however, a recapitulation of the analysis, implicit or explicit, is usual and the analyst may expect attacks on the way his analysis has failed. They represent the patient's final disillusionment about what analysis can do and the recognition of the failings of the analyst. Ending is also a period in which any pathological nexus that remains can be made conscious.

Note

1. Apart from Jung's references and my own reflections, there are two articles of moment written by analytical psychologists on the subject of ending an analysis: Henderson (1955) and Strauss (1964).

CHAPTER 16

*Training*¹

All through this book emphasis has been laid on the affective engagement of the therapist with his patient and his need to understand the importance and nature of his counter-transference as a source both of error and of information. The training of any therapist must therefore take engagement fully into account. So far there is agreement amongst all analytical psychologists.

It is also agreed that efforts must be made to facilitate the candidate in developing his own individual style of therapy. It is on how to implement these principles that the divergences in training practice arise. On the one hand, it is held that the most important feature of the training analysis is the fostering and investigation of the transference neurosis and that for this to be accomplished one analyst is best. On the other hand, it is held that the future therapist's individuality is best served by insisting on the candidate going to two or more therapists, of whom two must be of opposite sexes.

These divergent approaches to training each attempt to deal with the tendency of candidates to identify themselves with their analysts when treating patients. This occurrence can be turned to advantage if the transference neurosis be well handled, for then identification becomes the basis for skills to be acquired. But it has raised great anxiety in some who think of it as the acquisition of a false self-organization, by which is meant that the candidate appears as a good one by compliance when it comes to treating patients. Indoctrination can, it is true, be built on this and so, far from the analyst being engaged with his patient, the patient is presented not with a person so much as with a doctrine. This argument has fed the notion of multiple analysts (see p. 51), for if the candidate goes to many analysts then these false self-identifications may hopefully be counter-acted or neutralized.

A further matter occupying training analysts is that of the interaction of the therapist and patient. If this is to be made the central feature of therapy, can it be taught or does teaching endanger the individual character of the open-system approach? On this subject there have been differences of opinion centring on the supervision of cases taken by a candidate whilst he is in training. On the one

hand, supervision is thought of as a teaching situation, which must be separate from the analysis; on the other, it is believed that analysis of the candidate and his supervision should be combined. A similar difference arises over the subject matter to be taught: how important is it to discuss clinical material and how important is it to provide the candidate with knowledge of basic psychic structures and processes through the detailed study of myths? To elucidate these differences it may be of value to look for a moment at how they developed.

When it was started as a discipline separate from psychoanalysis, analytical psychology depended upon the investigations of one man: C. G. Jung. He was not entirely isolated but scientific work was, to all intents and purposes, carried out solely by him. Therefore when it came to training therapists he had to do it all. So, quite apart from his broad view of therapy, which has been dealt with in detail above, the spectrum of therapies had to be included in one man. As we have seen, Jung analysed and taught as well, expanding his educational aspect of therapy to giving seminars and for many years he remained the hub of all training, though he accumulated assistants and a group of his patients made up the Analytical Psychology Club. This body was non-professional and took no part in training, restricting its activities to studying Jung's work and to social gatherings in which Jung participated.

Jung's practice was international and so, though some therapists remained in Zurich, others, perhaps more numerous, who had been to Zurich, started to make use of what they had learned when they returned to their own country. They soon trained others, once again on this essentially personal basis. But, up to the Second World War, anyone who wanted to call himself a Jungian therapist, and who had been trained in his own country was expected to go out to Zurich to work with Jung or his assistants for an unspecified period of time. Thus Jung remained at the centre of developments in other countries as well as in Switzerland.

As time went on the growth in the number of therapists, as well as Jung's ageing, made it increasingly difficult to implement this uncoded requirement. When the London Society started its training programme, the first in the field, no requirement was laid down for candidates to go out to Zurich after training had been completed and, when consulted, Jung never mentioned the possibility or indeed the desirability of their doing so.

In these early days, the 'prehistoric period' as it is sometimes called, there was no training in the sense that it is known today. If somebody wanted to become a Jungian therapist there was no essential difference in the way he was treated from that meted out to others who came to see Jung for treatment. Thus it came about that training was thought of as the same as 'analysis', though we have seen that much else was included in that term, and whether a person became a therapist or not depended upon whether it was indicated as a result of therapy. To put it another way, becoming a therapist was conceived as vocational. It was a procedure that produced a number of devoted and dedicated followers of Jung.

The influence of this prehistoric period can be seen in all the training groups, be it in diffidence in teaching theoretical systems, in dissociating supervision from analysis, in refraining from instituting examinations of diplomas, or in the more general anxiety about introducing an undesirable degree of professionalism at the expense of vocation.

It was, however, the increasing number of persons with a 'vocation', combined with the increasingly organized nature of society, especially the Health Service in Great Britain, that gave rise to the need for a change in the direction of more professionalism: persons with a gift for therapy tended to start up in practice without sufficient training, often with peculiar and sometimes disastrous results.

When the C. G. Jung Institute opened in Zurich the changes were surprising. For instance, when it came to the question of whether to introduce an examination system and a diploma or not, it was Jung himself who insisted on the importance of both. This is only understandable if he recognized the importance of meeting the collectivist trends in society, and of putting a brake on the undesirable effects of 'vocation'. The seminar and lecturing practices of Jung were greatly developed for all the 'students' who came to Zurich, and a cultural centre grew up for teaching large numbers; only some were selected as suitable for becoming therapists after about one year of attending lectures and seminars. When this stage was reached seminars on psychopathology and case material were added and the candidate started to practise therapy with patients under supervision. The features discussed previously, as characteristic of Jungian practice, have been continued: multiple analysts and the secrecy of proceedings in analysis have been preserved, to the extent that a training analyst must not reveal details of the candidate's therapy to the training committee, but only send in a statement as to whether the candidate is ready to be accepted for training, or to be recognized as a fully qualified analyst. Thus, it is claimed, the status, influence and power of the training 'analyst' is sustained. Probably as a result of these practices very little information has come from Zurich of the kind that will now be detailed, based on experience gained from training at the Society of Analytical Psychology in London. The basic framework is similar in both Institutes; in other words, analysis is the fulcrum of training but combined with seminars and analysing patients under supervision.

The Society in London departed, however, from Jung's practice by separating supervision from training analysis, which came about mainly because of experience gained by some of its members who had participated in other trainings in psychotherapy. Another change, but rather in the nature of a development, was that analysis of the candidate became progressively more intense: four interviews a week and at least two years before the candidate could attend seminars and take cases under supervision.

Besides the previous experience in training of some members, both changes may be attributed to the clinical orientation that developed, leading to the study of transference and counter-transference. Inevitably the investigation of childhood and infancy, indispensable for modifying the transference, whether neurotic or 'psychotic', became necessary.

A further modification took place within the training body that was revolutionary for the status of the training analyst: he was required to report fully on his candidate's analysis to the training committee within the criteria laid down for publication of clinical material (p. 71f.) and sometimes outside it. Thus, much information was made available about the analyst's training and especially the effects of his counter-transference.

Training analysis

It is often asked whether training analysis is different from any other. That question is not easy to answer briefly. It must, however, be the aim of any society or institute to create conditions that make it as nearly the same as possible. Modifications, quantitative rather than qualitative are, however, inevitable; they arise out of the training situation and the candidate's aim of becoming an analyst. Both slant the analysis and exert pressures on both analyst and candidate to behave differently.

(1) A trainee is required to spend a period in analysis before he applies for acceptance to the next stage in training. He is thus obliged by an external authority to attend his analysis. Therefore the analyst will have less anxiety than in other cases about losing a patient and consequently he may be less on the alert to detect features suggesting a negative transference. For his part the patient will have more reason to conceal them.

(2) Then there comes the time when the trainee applies for admission to the next stage in training. Then the analyst must attend the committee, report on his trainee and make a judgement upon him that will possibly affect his future. This is not required in any other analysis and must affect the analyst's relation to his patient even if it only makes the patient wish to create a good impression. When the candidate is accepted all may seem to go well, but if the candidate be rejected it can provoke a crisis in the negative transference, and its resolution is made more difficult if the analyst agrees with the decision of the committee when his candidate does not; then there arises a transference/counter-transference situation which has more reality loading than in an ordinary analysis.

In working out these complications much depends upon how much the training analyst has influenced the candidate's application.

During his two years of analysis, time has been given for the trainee to become aware of his motives for wanting to become an analyst even if the implications of so doing cannot be fully understood. He will also form an impression of when he is ready to take the next step and so will be in a position to arrive at his own decision about when to apply—which will be when he wants to test his judgement of himself. Assuming that the analyst has successfully analysed his patient/candidate, then he can present the case for acceptance virtually in the candidate's own terms and register his agreement with them. This is the position the training analyst wishes to achieve, but it is not always possible. The analyst may believe he has done so and then, when meeting the committee and discussing the applicant, he may start to realize that his view

has faults in it and occasionally he will become an advocate for his candidate on patently unsound grounds, due to injury to his narcissism. Actually, it was these phenomena that confirmed members of the London Society in the view that a training analyst's judgement could be at fault, sometimes considerably so.

Yet the tendency of a training analyst to support his candidate is hardly surprising. In accepting him for analysis at all he will have decided, provisionally, that his patient is capable of being analysed and that the outlook for his becoming an analyst is reasonably good; in these judgements he may be correct. But as the analysis proceeds and his counter-transference develops, his judgement may become faulty. The analysis may be going well enough and it is only when he is faced with the committee that the fault appears, and the committee will then have an educative function to perform.

Probably the most significant inflationary pressure exerted on the training analyst is his narcissistic wish to have his analysands accepted by the Society because he hopes they will enhance his status within the Society. In addition, thinking his work good, he will feel that it will benefit the Society to have one of his trainees as a member.

These pressures feed into his counter-transference and, combined with his established prestige as a recognized training analyst, make him especially vulnerable to any omnipotent tendencies that he may harbour. Partly to check these pressures, two interviews of the trainee are arranged when the trainee makes his application. Each interviewer can thus gain an impression sufficient to ask the analyst pertinent questions so that a sound judgement may be arrived at by the committee. Apart from its critical aspect the arrangement has a positive function: it reduces the weight of responsibility that rests upon the training analyst and helps him to continue his analytical function with his patient, since he is freed from making an irreversible judgement.

Dilution of the transference

When a candidate is accepted as suitable to attend the seminars and start analysing cases under supervision, a dilution of the transference takes place. This means that some of its infantile components are channelled into the trainee's group and analytical activities. The dilution is part of the trainee cathecting the training process; it is inevitable and mostly desirable but it evokes a shift in the transference/counter-transference situation.

In the seminars the training analyst may give seminars, thus displaying his teaching capacities and making him more of a real person than may be desirable. Further than this, in the seminars discussion of the training analyst's views and personal characteristics may result in praise or criticisms which the candidate may have difficulty in assimilating and find hard to report to his analyst. In this class of experience there is a tendency for the training analyst to overlook the transference component in the trainee's communications because they evoke a counter-transference displacement: the analyst projects or displaces his counter-transference affects into the Society or particular members of it.

A further aspect of dilution takes place when the trainee takes his cases. The supervisor may tend to turn into a second analyst—a situation that will be considered later from the supervisor's point of view. For the training analyst difficulties arise when the trainee brings evidence to suggest that his supervisor is not as satisfactory as he estimates his own analyst would be. In ordinary analysis all this would easily be treated within the transference and the patient's relationships gone into; indeed this is what will take place in a training analysis also, but it is more difficult because the analyst may feel rivalry with the supervisor and be tempted to agree with the trainee, especially if he knows that the supervisor is, in fact, less competent than he in some particular area of analysis. It seems unrealistic to do nothing and so he may be tempted to introduce supervision to the detriment of analysis.

The end of training analysis

It is unusual for a training analysis to end when the trainee has been accepted as a member of the Society. It has even been jokingly said that, because of the insoluble conflicts arising through the training situation, no analysis takes place till training is over! This is unfair and inaccurate but it is usual that, after training has ended, conflicts remain that have not been sufficiently gone into and need further elucidation.

Besides this there is a manifest difference between the ending of an ordinary analysis and of a training analysis. In the former, analyst and patient only occasionally develop an ongoing personal relationship after analysis has ended; on the contrary, after training analysis has finished and the trainee becomes a member of the Society, meetings between the two will continue indefinitely and parting will be incomplete. Consequently, residual aspects of the transference and counter-transference will be carried over into the Society to be hopefully worked out there.

Supervision

The introduction of another person—the supervisor—into the candidate's training means that somebody besides his analyst will from time to time come into relation with his affective life. One can, as I have done before in considering the training analyst's function, profitably construct an ideal of how supervision should operate as a learning situation.

When he starts supervision it can be assumed that the trainee has been sufficiently long in analysis for him, together with his analyst, to confront, elucidate, interpret and work through any conflicting situations which will be stimulated by analysis of his patient and brought to his notice during supervision. The trainee has already started and continues to attend seminars on the theory and techniques of analytical psychology, which will increase his knowledge and refine the use of his mind in generalized analytical thought. It is therefore the function of the supervisor to help the trainee to apply what he has

discovered in his analysis and his seminars to the detailed processes of analysing a patient. In doing this he should be at pains not to interfere with the trainee as he develops his own style of analysis.

In principle the supervisor's place in the training is thus easy to define but it takes skill and experience before he can fulfil the exacting job he has undertaken.

In the first place, he is in a good position to embark on a course that will seek to indoctrinate the trainee with his own conception of how analysis should be conducted. He must not do this, but he may have considerable difficulty because of it in refraining from intrusion upon the development of the analysis, as conducted by his supervisee. As his objective is to teach, this may seem to justify what he is doing. But what should his teaching do? It should help the candidate to apply what he has already learnt. This largely means creating a situation in which he and his candidate can work out in particular situations how to implement the analytical procedures defined in Chapter 6. He will help the trainee to find out how to listen, when to intervene by confronting a patient with his situation and when and how to interpret.

Within the area of closed systems all this will present relatively little difficulty, but since there is always unconscious interaction between analyst and patient, the supervisors will have this in mind and will need to indicate when there is interference in these ordinarily smoothly working processes. It is at this point that special skills are required of the supervisor. In bringing difficulties and conflicts, affective in nature, the trainee may well start behaving something like a patient and it is at this point that the question arises as to whether the supervisor should start to behave like an analyst and so set up a two-analyst situation. There are those who will contend that he should, and supervision and analysis should not be separated.

It is inevitable that the supervisor may, after listening, draw the trainee's attention to what is happening. There may be advantages sometimes in making an interpretation in the here and now, but it must be remembered that he is at an enormous disadvantage *vis-à-vis* the training analyst, who has detailed information about his trainee within the transference situation. I do not hesitate to say that if he is not very careful he will end up looking foolish and inadequate in the eyes of the trainee when his interpretation proves much less adequate than that of the analyst.

It is from time to time inevitable that, listening to the trainee making what are evidently recurrent blunders, or departing from analytical standards, or behaving with recurrent inadequacy, the supervisor will wonder what the training analyst is up to, and so will develop a critical attitude towards him. This may very well get through to the trainee at a time when he is working on a bit of negative transference to his analyst of which he is only half aware and about which he has considerable anxiety. Then the supervisor may, in extreme cases, become 'the devil's advocate' and the trainee may become defensive or guarded and find it difficult or impossible to communicate the events taking place in the analysis of his training case.

It may after all be that, in reality, the training analyst is well aware of the situation and is working hard on the very conflicts that are causing what seems to the supervisor to be the result of bad analysis. If the supervisor has sufficient trust in the analyst then he can wait until a solution is found so that supervision can then go forward again.

Suppose, however, a scientific conflict has arisen within the society in which the training analyst and the supervisor have taken opposite positions, a very difficult situation then arises, of which the following is an example.

Example 1

A trainee was coming for supervision at a time when there was an acute conflict within the Society over the importance of transference. The trainee was going to an analyst who did not, in my view, understand its relevance. The supervision went on quite well until the trainee's homosexual patient began to show signs of a transference. At this point he started to paint pictures containing anima figures. I tried to show the trainee that the painting of pictures might be related to the patient's behaviour and that they were images of his female parts, which wanted to seduce the analyst-trainee. This was water off a duck's back—the trainee would have nothing to do with it. Instead, he wanted to study the pictures because they contained quite rich archetypal material. Reporting on the interviews ceased altogether and shortly afterwards the trainee's patient left his analysis with many protests about the great benefit he had received from his treatment. This was regarded by the trainee as a satisfactory ending; but to me his result with the patient, if correctly communicated (which I doubted), was superficial and almost certainly unstable. Some years later the trainee, who had become a therapist, grew through experience to recognize the sense of my ideas and was very angry with me for not starting an analysis with him. He came to realize that what I had said was not so terrible and destructive to the archetypal images: he belonged to the more-than-one-analyst school, so why not? For my part I would have regarded my so doing as a seduction of the kind that his patient was trying to initiate and outside the analytical ethic I thought of as essential to any analysis. If I had tried to initiate an analysis it would have started off on the wrong foot and so would have been bound to fail.

These reflections indicate the importance of the relation between the supervisor, the training analyst and the scientific conflicts within the Society. There are evidently two elements to this: firstly, the degree of trust between the analyst and the supervisor and, secondly, the degree of agreement on scientific matters. I could trust the trainee's analyst in the above example, but could not agree sufficiently with him. Consequently supervision broke down.

I have given an extreme example, which exaggerates a state of affairs to be found in any supervision. It shows how a supervisor can be frustrated in his work by the kind of analysis that his trainee is receiving, the state of the analysis at any particular time as well as the personal gifts and capacities of the trainee.

Defects of the supervision

So far the supervisor has been considered as adequate for practical purposes. What of his defects? It may be that through his analysis and personal and clinical experience a trainee may find that his supervisor does not contribute to the problem presented by his patient in a way that he finds helpful, his comments may even be off the mark altogether. He then has two ways of proceeding; he may find an opportunity to present the problem in the seminars, or to his co-trainees if they are on sufficiently good terms, but more likely than either of these is that he will present it to his analyst. If the analyst sticks to his analytical stance he will review the trainee's relation to the supervisor, listen to the material about the training case and analyse the situation as a whole in relation to what he knows of his patient. He will resist encroaching on the supervisor's position as far as possible. In doing so, however, it may be necessary or desirable to clarify the case material and this will involve what is in effect a bit of supervision. His justification for this must, however, be that it is necessary to do so because the trainee can only in this way gain access to the projection that he is making and which is distorting the analytical relation to the training patient.

Serious distortions of this analytical stance may arise from the considerations given above: the analyst may know that the supervisor is not fully effective in the field in which the trainee is asking for assistance, he may be in conflict with the supervisor on scientific matters or his capacity to trust the supervisor may be precarious.

I have gone with some care into the subject of supervision, which for most of the time works well, if it is separated from analysis. I have highlighted some of the situations where a strict application of the separation may be at risk or break down. It is useful to be on the watch for deviations and to evaluate them, but they also bear on the question brought forward in the first part of this chapter: should supervision and analysis be separated at all?

It has been noted that bits of supervision will usually include bits of analysis of the trainee, and bits of the training analysis may include bits of supervision, so why not just apply analysis and supervision without restriction?

The answer to this can, I think, be given by considering the regulations of the Society. Because of these, the analyst is in a much better position to analyse his trainee, through his greater knowledge of him, and the supervisor is in a much better position to supervise the training case because of his much greater knowledge of the case that he and the trainee are studying together.

All this applies if the training analysis is rigorous and there are analytical interviews regularly four or five times a week. It does not apply if interviews are once or twice a week and the transference is frequently overlooked. As this is the rule in some schools of analytical psychology, the distinction between analysis and supervision loses meaning and the trainee is almost required to get therapy wherever he can, though within the prescribed limits that training analysts only must be used.

Note

1. Volumes 6, 2 (1961) and 7, 1 of *The Journal of Analytical Psychology* contain a symposium on training in which Fordham, Newton and Plaut present conclusions arrived at in London; Hillman writes from the C. G. Jung Institute in Zurich.

Two ex-students, Marshak and Stone, describe experiences of being a trainee in volume 9, 1 (1964) of the same journal.

CHAPTER 17

Some Applications of Therapeutic Method

Considering the wide field covered by current usage of the term psychotherapy, one is confronted by a number of disciplines deriving their inspiration from dynamic psychology as a whole. By this I mean the disciplines inaugurated by Freud and developed or altered in various ways by his followers and others. It would be no place here to enter into all of these, so I shall only indicate the ways in which Jung's work and those that have been inspired by it have contributed to this field.

It will be evident from the discussion in Chapter 4 that various methods can be used with different patients and that the theory of types was an attempt to orientate therapists as to what approach to use in their work; it has been noted that besides the analytical method Jung laid emphasis on education, personal interaction and non-verbal communication. It might therefore have been thought that such psychotherapeutic procedures as confrontation therapy, art therapy, psychodrama (which might be related to active imagination) Gestalt therapy and so forth might all have engaged the interest of analytical therapists. This does not appear to have been the case. Indeed, if the literature is reviewed, there are only two fields of therapeutic endeavour to which 'Jungians' have made significant contributions: group therapy and child analytical therapy.

Group therapy

The concept of archetypes and the collective unconscious would seem to be admirably suited to the study of group processes and, indeed, Jung had made investigations into large groups and especially national movements. He studied individuals in his international practice with relation to their cultural background and thus he succeeded in identifying Germany as the focus for movements in the collective unconscious applying in different ways to other national groups. In addition he developed an interest in archetypal dreams and visions with significance for groups. Examples of this are to be found in the utterances

of Old Testament prophets and the communication of 'big dreams', with archetypal contents to groups in primitive communities.

Nevertheless, Jung himself was critical of group therapy on the grounds that the tendency in any group was to lower the level of consciousness and thus act against the individuation process on which he laid so much stress.¹ Therapy, Jung maintained logically, was essentially individual in its very nature.

In his lifetime, however, he used group methods concurrently with individual therapy but largely to further education (seminars of his own and lectures in the Analytical Psychology Club, membership of which required a previous analytical experience) and since his death the 'emotional climate' of the trainee group has been given importance at the C. G. Jung Institute in Zurich. None of these exercises could, however, be considered as group therapy in its more sophisticated sense.

No balanced account of the therapeutic influence of groups was made till Hobson (1959) suggested that groups tended to structure themselves as if they had a self. This could be inferred from the tendency of different members of the group to become the exponents of archetypal forms. Hobson's paper was followed by Whitmont (1964) who applied dream analysis to group study. These two contributions have been followed by others, including a study of the use of groups as a research method to study transference and counter-transference data—a method used by Plaut many years earlier in 1955.

Jung's stand, though it deterred analytical psychologists, has not in the long run prevented them from applying their methods to group practice.² Fiumara (1976) has even considered the possibility that it may complement individual therapy by acting as a 'testing ground for individuation'. As such it may act as a counterbalance to centrifugal introverting tendencies which classical Jungian therapy undoubtedly fostered. Thus group therapy is seen as a complement to rather than an opponent of individual therapy.³

As to techniques, there do not appear to have been significant innovations in principle. The members of the group form an archetypal matrix in which analytical and educational methods can be employed. Reference to this matrix can be made, just as it is made in individual therapy, though without the forcefulness engendered by the presence of a number of people rather than two. The difference may lie here: the members of a group tend to personify archetypal forms more personally, and in addition they may exhibit different cultural backgrounds and so different archetypal configurations, fertilizing fruitful interchanges.

Child analytical therapy⁴

Just as the methods investigated in this book can be applied to group therapy so also can they be used to benefit children. The wide range of educational or analytical methods that are currently used in child therapy have been contributed to by analytical psychologists.

It goes without saying that the setting in which these techniques are applied

must be modified and made suitable for children. Therefore before adolescence a playroom and toys need to be provided. It is striking that the number of toys varies considerably from therapist to therapist. The possibility of using them to study archetypal fantasies has led to Kalff (1964) adopting Lowenfeld's sandtray technique in which a great variety of toys are presented to the child so as to facilitate fantasy activity which is conceived to be therapeutic in itself.

By and large the number of toys relates inversely to the therapist's belief that transference and counter-transference are the important therapeutic influences. Those who pursue analytical therapy with children will create a setting in which these affective interchanges will be fostered—fewer toys are required under this condition.

As with group therapy, Jung's views have been influential. He not so much opposed child therapy as believed that since parents are the most powerful influence in a child's life the most effective way of benefiting a child was to apply therapy to parents, thus freeing the way for the health-potential to exert itself in the child. There were, however, a number of indications in his work that have been taken up especially by Neumann in Israel and myself in England. They have led to establishing child therapy and analysis as a discipline in its own right.

I have commented before that the position taken up in this book has been fertilized by the analytical study of small children and so it may be of interest if I say just how. The comparative investigations by Jung led to developing a technique of handling essentially complex symbolic structures. These symbolic forms can be found in children but their root in infancy is concealed and a much simpler and more direct means of communication, which reaches bodily interactions, is required. The simple 'instinctual' patterns are referred to in myths but only indirectly. A myth is a mediator between instinct and spiritual (in the sense of mental) life but it does not express directly enough the often non-verbal language of infancy. Tempting as it may be to develop the equivalent of a myth of childhood expressed as a model (or its abstract counterpart, a theory) and much as these may be required, especially when real knowledge is lacking, I set as much limit to it as possible: premature theorizing or model-building does not further knowledge but rather puts a theory or construction (myth) in its place.

Adults need a means of talking to children that is neither an imposition nor an abstraction. What they say must therefore grow out of experience of children and the therapist's knowledge about his own childhood and the childhood of others than himself. For this reason in child analytical therapy the counter-transference takes a more prominent part than in the therapy of adults. This can easily be observed in the tendency of child therapists, and indeed all those engaged in the care of children, to identify themselves with a child's distress and imagine that it can be alleviated by a change in his parent's management of him. From this derives much of the enthusiasm for the treatment of parents and that rather odd agglomerate of treatments called 'family therapy'.

The counter-transference in analytical child therapy is a specific danger and

at the same time, more than in adult therapy, a source of interpretative interventions. The principles involved in this state of affairs have already been discussed (p. 89ff.): it is more significant and urgent in the analytical treatment of children since the pressures to act as a parent are greater.

It is increased because, in treating a child, the therapist evokes a transference from his parents, which needs handling so that treatment is not disrupted. All manner of jealousies and envies are evoked which it is hard for the parents to control; the child therapist needs to be aware of them and at the same time sustain a therapeutic alliance over the effort to heal their child. It was the complexities of this situation which contributed largely to, but not only to, the investigation of therapeutic method of which this book is the outcome.

Note

1. Hobson (1964) provided a good discussion of Jung's views and those of analytical psychologists up to that year.
2. For a clear and concise account of later work cf. Fiumara (1976). He was influenced by Foulkes whose theory of the group matrix he relates to that of the collective unconscious.
3. For an experiment in running a therapeutic community along Jungian lines cf. Champernowne and Lewis (1966).
4. For details on the subject of child analytic therapy cf. Fordham (1969a and 1976) from which access to the literature may be gained.

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Index

- Abreaction therapy, 3, 90
Abstract model, 3
Acting out, 71
Activation of drivers, 9
Active imagination, 13, 14, 25, 29, 38–42,
62, 138
 and transference, 68
 dream, 16
 in self-analysis, 40
 individuation, 143
 infantile roots in, 145–9
 initiating, 36
 origins of, 138–49
 products of, 147
 symbolic attitude, 39
Addictions, 109
Adolescence, 44
Affective psychosis, 139
Affective responses, 131
Aggression, oedipal roots of, 61
Albedo, 88
Alchemy, 19, 38, 46, 85, 88, 136
Amalgam of analyst–patient, 135
Ambivalence, 81
Ambivalent nexus, 91
Ambivalent patient, 77
Amplification, 26–7, 35–8, 48, 84, 140,
145
Anal fantasies and impulses, 9
Analysis, 57–64
 and psychotherapy, 62–4
 as ‘way of life’, 156
 destructiveness of, 60–1
 ending, 152–3
 full, 58, 77
 genetic aspect of, 130
 historical nature of, 59–61
 limits of, 63
 multiple, 51
 setting of, 65–72, 80
 starting, 73–9
 stopping, 151–2
 style of, 90
 terminating, 150–7
 unnaturalness of, 67
 use of term, 57
Analyst
 and holding function, 89
 as projection screen, 81, 90
 as real person, 152
 as screen, 106, 125
 bad, 123
 crude but specific feeling of, 110
 ego of, 96
 engagement with patient, 91
 faults of, 100
 idealized, 82
 introjection and identification with, 64
 mistakes of, 154
 multiple, 51
 part in generating resistances, 100
 passivity, 82
 position of, 65
 resistance to making interpretations, 103
 responsibility of, 108–9
 substitute, 134
 total response (‘R’), 109–10, 131
 see also Therapist
Analyst–patient amalgam, 135
Analytical attitude, 30, 62, 71, 84, 99, 151
Analytical frame, 70–1
Analytical method, vi

- Analytical procedures, 164
- Analytical process, 62
- Analytical psychology, v
- Analytical psychotherapy, v
- Analytical-reductive method, 58
- Analytical stance, 166
- Analytical stereotypes, 121
- Analytical therapist, 3
- Analytical therapy, 62, 64, 140
 - aims and ideals, 151
- Analytical work, defences against, 121
- Anima, 5, 31, 32, 37, 57, 86, 87
- Animus, 5, 37, 57, 86, 87, 101
- Anthropology, vi
- Anxiety, 62, 73, 129
- Applications of therapeutic method, 168–71
- Archaic primordial idea, 13
- Archetypal configurations, 169
- Archetypal forms, 4–5
- Archetypal framework, 89
- Archetypal images, 165
- Archetypal impersonal layers, 4
- Archetypal level, 24
- Archetypal matrix, 169
- Archetypal processes, 16
- Archetypal transference, 81, 83–8, 150
- Archetypes, 57, 58
 - central, 144
 - concept of, 168
 - inherited, 9
 - theory of, v, 14, 20
- Art therapy, 168
- Assessing motivation, 74
 - interpretations as means of, 77
- Association experiments, 3, 14
- Associations, 22, 97, 140
- Attitude concept, 7
 - see also* Analytical attitude
- Auto-analysis of dreams, 34
- Bisexuality, 87
- Body feelings, 68
- Borderline cases, 41, 43, 73, 89, 109
- Breast feeding, 126, 128
- Castration, 102, 103
- Catharsis, 44
- Centralizing process, 22, 40
- Chair versus couch, 65–70
- Chaos, 136
- Character disorders, 57, 73, 89
- Child
 - ego nuclei, 8
 - symbol of self, 40
- Childhood, 24, 27, 29, 117, 124–37
 - imagination in, 149
 - individuation processes, 89
 - memories of, 116
- Children
 - analytical therapy with, 169–71
 - symbolic forms in, 170
- Claustrophobic case, 41
- Closed system, 11, 15, 16, 50, 66, 69, 100, 107, 118, 164
- Collective unconscious, v, 48, 168
- Compensation, theory of, 25
- Compensatory relation between conscious and unconscious, 25
- Complementary counter-transference, 94
- Compulsions, 105–6
- Concern, rudiments of, 128
- Concordant counter-transference, 94
- Confession, 44, 86
- Confrontation, 59
 - with unconscious, 45
- Confrontation therapy, 168
- Conjunctio*, 87
- Conjunction, 39
- Construction, historical, 38
- Constructive therapy, 139
 - transferences during, 142–3
- Containing frame, 112
- Continued existence, 111
- Controlling functions, 96
- Conversion of good into bad objects, 133
- Couch
 - advantages of, 68
 - use of, 66
 - versus chair, 65–70
- Counter-projection, 92
- Counter-resistance, 100–4
 - containing passivity, 103
- Counter-transference, 32, 89–94, 106, 108, 134–6, 158–61
 - analyst's, 27, 46
 - as only source of information, 137
 - complementary, 94
 - concordant, 94
 - delusional, 152
 - illusion, 144
 - in child therapy, 170
 - masochistic, 155
 - studies of, 52
 - syntonic, 92
 - malignant form of, 135
 - technique in relation to, 95
- Counter-transference neurosis, 66, 69, 91

- Creative archetypal processes leading to individuation, 29
- Creative attitude, 29
- Creative imagination, 42, 147
- Cult formation, 64
- Cult practices, 136
 - and psychotherapy, 18
 - and regression, 17
- Cultural education of psychotherapists, 19
- Cultural elements, 149
- Culture pattern, 4, 84
 - and personal history, 59
- Defence, regression as, 134
- Defence system, 117
- Defence theory, 4
- Defences, 4, 32
 - against analytical work, 121
 - idealizing, 61
- Defensive ingredients, 99
- Deintegrate–integrative sequences, 144
- Deintegration, 137, 157
- Delinquency, 109
- Delusional counter-transference, 152
- Delusional transference, 67, 110, 119, 145, 152, 155
- Delusions, 15, 80
- Demand feeding, 127
- Denial, 99
- Denigration of patients, 133
- Dependence
 - and frustration, 10
 - on analyst, 22
- Dependent situations, 145
- Depersonalizing tendencies, 107
- Depression, 41, 71, 92
- Depressive anxiety, 129
- Depressive pathology, 92
- Depressive position, 151
- Deprivation, 58
- Destruction of interpretations, 122–3
- Destructive impulses, 80
- Destructive processes, 133
- Destructive wishes, 61
- Destructiveness
 - of analysis, 60–1
 - of interpretations, 117
- Dialectic, 13, 90
- Dialectical procedure, 32, 58, 107
- Dialectical relationship, 127
- Disintegration, 157
- Disorientation, 136
- Displacement, 82
- Dream analysis, 14, 21–5, 30–2, 62
 - and group study, 169
 - royal road to the unconscious, 34
 - see also* Dreams
- Dream context, 22
- Dream images, objective, 29
- Dream series, 22, 97
- Dream work, 21
- Dreamers, environmental influences on, 27
- Dreaming and reporting, 33
- Dreams, 12–13, 21–34, 111, 139, 140
 - active imagination, 16
 - as creative storytelling process, 28
 - as dreamed and its memory, 33
 - as resistance, 33
 - as ritual, 33
 - attitudes towards, 29–32
 - auto-analysis of, 34
 - big, 169
 - facade of, 21
 - general theory of, 21
 - ‘good or bad’ notion, 30
 - guardian of sleep, 21
 - in childhood and adolescence, 28
 - latent content, 21
 - therapist’s influence, 27–9
 - to foster self-analysis, 32
 - with significance for groups, 168
 - see also* Dream analysis
- Drives, activation of, 9
- Education, 84, 168
 - in social adaptation, 44
- Educational methods, 150
- Educative method of storytelling, 48
- Ego, 40, 58, 114
 - analyst’s, 86
 - attitude or function of, 7
 - centre of consciousness, 3–4
 - interpretation of, 11
 - of analyst, 96
 - of patient, 86
 - psychic death of, 87
 - unconscious complex by, 17
 - undoing of defences in, 16
- Ego formation and self, 9
- Ego nuclei, 9
- Ego-psychology, 136
- Ego-strength, 144
- Ego-weakness, 144
- Elucidation, 44, 57, 59
- Emotional climate, 51, 169
- Emotional trauma, 57
- Empathy, 91

- Ending
 - of analysis, *see* Analysis
 - resistance to, 153
- Energy, theory of, 6
- Engagement between patient and analyst, 87, 103
- Environmental influences on dreamers, 27
- Envy, 61
- Equal status, attitude of, 141, 145
- Erotic impulses, infantile, 121
- Evolution, 58
- Extravert, 7, 139

- Family therapy, 170
- Fantasies, 124, 140
 - containing defensive ingredients, 99
 - genital, 9
 - retreat into, 144
- Feeding
 - difficulties, 128
 - in infancy, 126
- Feeling, 7, 120
- Feeling type, 106, 139
- Fees, 78
- Feminine identifications, 101
- First half of life, 8
- Forbidden wishes, 21
- Framework, 65, 80
- Framing of interpretations, 108
- Free association, 90, 94, 107
- Free floating attention, 90
- Freud, S., self-analysis, 22
- Frustration, 10, 108, 135
- Function concept, 7
- Function types, 7
- Fusion, 87

- Genetic aspect of analysis, 130
- Genital cathexis, 132
- Genital excitement, 83
- Genital fantasies and impulses, 9
- Genital feelings, 68
- German school, 53
- Gestalt therapy, 168
- Gratitude, 61
- Grief, 157
- Group therapy, 168–9
- Guilt, 31, 92, 98, 99, 111, 114, 132, 135

- Hallucinations, 15, 80
- Hate, 61
- 'Here and now', 115, 139, 142
- History of religion, vi
- History taking, 77

- Holding frame, 111
- Holding function and analyst, 89
- Holding person, therapist as, 124
- Hostility to analytical process, 99
- Human relationship, 67
- Hunger, 68
- Hysteria, 73, 99, 139

- Id, 58
- Idealization, 99, 106, 134
- Idealized image, 145
- Idealizing defences, 61
- Identifications
 - between parents and children, 9
 - introjective, 91
 - projective, 91, 137
- Identity, 44, 137
- Illusion, 80, 82, 145
 - counter-transference, 144
- Imagination in childhood, 149
- Impingements, 136
- Impulses, 68, 120, 124
 - genital fantasies, 9
 - infantile erotic, 121
 - infantile sexual, 57
 - instinctual, 80
 - primitive, 130–2
 - uncontrollable, 128
- Incestuous union, 87
- Individual psychology, 11
- Individuality of patient, 63
- Individuating processes in infancy and childhood, 89
- Individuation, 7, 8, 16, 40, 81, 138, 143, 151
 - archetypal transference in, 85–8
 - creative archetypal processes leading to, 29
 - prototype of, 146
 - purposive trend towards, 21
 - transference in, 88
- Indoctrination, 64, 158
- Infancy, 89
 - feeding in, 126
 - individuation processes, 89
 - regression to, 130
- Infantile contents active in present, 116
- Infantile erotic impulses, 121
- Infantile experience in relation to analyst, 80
- Infantile memories, 125–9
- Infantile nature of transference, 151
- Infantile roots in active imagination, 145–9
- Infantile sexual fantasies and impulses, 57

- Infantile sexuality, 9
- Inferior feeling, 24, 25
- Inheritance, theory of, 58
- Initiant, 18
- Inner world, 65
- Insight, 59, 124
- Instinctual energy, transformers of, 6
- Instinctual impulses, 80
- Instinctual patterns, 170
- Interpretation(s), 59, 62, 76, 95, 113–23
 - abundant and beautiful, 119
 - analyst's resistance to making, 103
 - analytical-reductive, 117
 - as means of assessing motivation, 77
 - classification, 114
 - correct and incorrect, 122
 - destruction of, 117, 122–3
 - form of, 119
 - framing of, 108
 - general propositions, 113–14
 - intellectual act, 113
 - muddled or chopped up, 121
 - 'mutative', 115
 - on objective plane, 12, 82, 116
 - on subjective plane, 13, 116, 143
 - part and whole, 117
 - spontaneity in, 114
 - store of, 108, 109
 - structure, 114
 - synthetic, 117
 - technique of, 113
 - timing, 117–19
 - transference, 115
 - nullification, 132
 - premature and wrong, 115
 - validity of, 114
 - what happens to, 119
- Interpretative method, 45, 52
- Interview
 - first, 74
 - frequency, 79
 - good, 108
- Introjected analyst, 40
- Introjection, 69, 86, 92–5, 99, 134, 137, 157
- Introjective identification, 91
- Introjective–projective mechanisms, 146
- Introvert, 7, 139
- Intuitive types, 139
- Irrational functions sensation and intuition, 7
- Isolation, 4
- Jealousy, 61
- Jung, C. G.,
 - active imagination, 138–49
 - conception of psychotherapy, 43–53
 - development of thesis, 11–20
 - dream analysis, 21
 - exposition of thesis, 16
 - historical thesis, 42
 - idea of educative method by storytelling, 48
 - multi-faceted as therapist, 50
 - personal development, 13–15
 - personal style, 46–50
 - self analysis, 3
 - study of Western civilization, 37
- 'Knowing beforehand' attitude, 93
- Latency, 125
- Latent psychosis, 75, 97
- Libido, 58, 116, 132
- London school, 52, 55
- Love, 61
- Lowenfeld's sandtray technique, 170
- Magical thinking, 5
- Mandala figures, 36
- Mandala images, 151
- Mandala symbols, 143
- Marriage conflicts, 53
- Masculine identifications, 101
- Masculine protest, 58
- Masochistic counter-transference, 155
- Masochistic transference, 141
- Maturation, 52, 95
- Meaning, 43
- Memory(ies), 83
 - childhood, 116
 - fixity of, 133–4
 - infantile, 125–9
 - repressed, 67
 - screen, 134
 - truth of, 83
- Model, 63
- Moral autonomy, 148, 151
- Moral standards, predisposition replacement by, 57
- Mother
 - impingements of, 149
 - real, 147
- Mother complex, 25
- Motivation, 73, 76
 - assessing, 74, 77
- Mourning process, 152, 157
- Multiple analysis, 51

Multiple analysts, 158
 Mutative transference interpretation, 115
 Myth and dream, 12–13
 Mythology, 24, 145

Narcissism, 162
 Narcissistic neuroses, 43, 89, 109
 Negative nexus, 91
 Negative therapeutic reaction, 123, 135
 'Neurosis of our times', 44
Nigredo, 88
 Non-ego, 16
 structures and processes, 4
 Non-verbal communications, 93, 168
 Non-verbal language of infancy, 170
 'Not-me' characteristics, 147
 'Not-me' possessions, 147
 Nuclei, child's ego, 8
 Numinosity, 4

Objective and subjective worlds, 143
 Objective myth, 13
 Objective plane, interpretations on, 12
 Objective psyche, 145
 Objective world, 143
 Objects, good and bad, 137
 Obsessional disorders, 73
 Obsessional neuroses, 99
 Obsessional patient, 105
 Obsessional state, 98
 Obsessive compulsive disorder, 139
 Oedipal conflicts, 125, 132
 archetypal, 9
 Oedipal roots of aggression, 61
 Oedipal situation, three-body, 10
 Oedipal wishes, 83
 Omnipotent feelings, 154
 Omnipotent image, 145
 Omnipotent thought, 24
 Openmindedness, cultivated, 118
 Open-system, 14, 15, 50, 66, 69, 107, 118, 158
 Opposites, union of, 87, 139
 Oral cannibalistic impulses, 128
 Oral nutritive phase, 9
 Oral sadism, 126
 Organic disease, 73
 Parapsychology, 5, 15
 Parental images, 57, 84
 Parents, 37
 therapy to, 170
 transference from, 171
 treatment of, 170

Passive imagination, 39
 Passivity, 58
 counter-resistance containing, 103
 Pathological nexus, 155, 157
 Patient
 denigration of, 133
 interfering with individuality of, 95
 Penis-envy, 58, 102
 Penis-lack, 102
 Persecution, 134, 135
 Persona, 85
 Personal history and culture pattern, 59
 Personal interaction, 168
 Personal reactions, 111
 Personal unconscious, 4, 86
 Phobia, 61, 73, 122, 139
 Physical contacts with therapist, 129
 Pioneering analysts, 64
 Playroom, 170
 Post-analytical phase, 41, 155
 Predictive element, 114
 Predisposition, 57
 replacement by moral standards, 57
 Prehistoric period, 159, 160
 Premature transference interpretations, 115
 Pre-oedipal states, 125
 Presexual fantasies and impulses, 9
 Preverbal communications, 124
 Primary entities, 57, 58, 84, 136
 Primary identity, 9
 Primitive impulses, 130–2
 'Problem of our time', 84–5
 Process theory, 8
 Professional confidence, 71–2
 Projection, 4, 26, 69, 86, 92–5, 99, 134, 137
 transference as, 81
 Projection screen, analyst as, 81, 90
 Projective identification, 91, 137
 Psyche, 3
 archetypal, 14
 autonomous, 14
 conscious parts, 3
 geography of, 36, 42
 healing splits in, 144
 map of, 37
 model of, 25
 objective, 14, 41, 42, 145
 reality of, 42
 Psychiatry, vi
 Psychic death of ego, 87
 Psychic reality, theory of, 13
 Psychoanalysis, vi 3, 44
 classical, 107

- methods of, 46
- Psychoanalysts, x
- Psychoanalytical attitude, 107
- Psychodrama, 168
- Psychological types, 6–8
- Psychology of religion, 11
- Psychopathology, 8, 15
 - categories of, 43
 - implied in training analysis, 15
- Psychoses, 73
 - character traits, 15
 - latent, 75
- Psychosomatic disorders, 73
- Psychosomatic symptoms, 111
- Psychotherapeutic schools, 46
- Psychotherapist, ix
 - cultural education of, 19
 - disease of, 15
- Psychotherapy, ix, x, 43, 57
 - and analysis, 62–4
 - and cultic practices, 18
 - and religion, 18
 - four stages in, 44
 - methods of, 44
 - usage of, 168
- Publication, question of, 72
- ‘R’ (analyst’s total response), 109–10, 131
- Rage, 61
- Rational thought, 5
- Rationalistic defence, 48
- Reaction-formation, 53
- Realistic relationship, 155
- Reality perception, 9
- Reassurance, 45
- Rebirth, 136
- Reconstruction, 60, 83, 125–7
- Reductionism, 60
- Regression, 5, 87, 99, 121–2, 129–32
 - and cult practices, 17
 - as defence, 134
 - freedom for, 68
 - ontogenetic, 138
 - phylogenetic, 138
 - severe, 129
 - syndrome of, 129
 - theoretical reflections on, 136–7
 - to infancy, 130
- Religion
 - and psychotherapy, 18
 - history of, x
 - psychology of, 11
- Religious convictions, 106
- Religious life, objective psyche in, 42
- Repetition, 82
- Repressed memories, 67
- Repressed unconscious, 4, 124–5
- Repression, 4, 114
 - indications of, 124
 - theory of, 97
- Reprojections, 93
- Research, 110–12
 - group therapy, 169
- Reserve, 106
- Reserved analyst, 90, 93
- Resistance(s), 4, 14, 67, 76, 97–104
 - analyst’s part in generating, 100
 - at thought of ending, 153
 - dreams as, 33
 - internal, 98
 - management of, 100
 - projection, 99
 - transference, 121
 - types of, 97–9
 - working on, 32
 - see also* Counter-resistance
- Response, total (‘R’), 109–10, 131
- Responsibility
 - of analyst, 108–9
 - shared, 109
- Restitutive syndrome, 144
- Ritual, 18
- Sadness, 157
- Sadomasochistic transference, 140
- San Francisco school, 53
- Schizoid character disorders, 43
- Schizoid personalities, 139
- Schizophrenia, 15, 41, 43
- Schools of therapy, 50–3
- Scientific conflict, 165
- Screen memory, 134
- Second half of life, 18, 44
- Self, 6, 57, 136, 144, 156, 169
 - and ego-formation, 9
 - and not-self, 137
 - deintegration of, 9
 - emergence, 89
 - false, 123
 - parts of, 60
 - real, 85
 - symbols of, 37, 40
- Self-analysis, 32, 89
 - active imagination in, 40
 - continuing method of, 42
 - dreams to foster, 32
 - Freud, 22
 - Jung, 3

- Self-analysis (contd.)
 - of therapist, 108
- Self-feeling, 85, 89
- Self-images, 136
- Self-knowledge, 42
- Self-model, 58
- Self-organization, false, 158
- Self-realization conceived as cultural task, 148
- Self-representation, 99, 124
- Seminars, 51, 162
- Sensation, 139
- Separation, 129, 134, 136
- Setting of analysis, 65–72, 80
- Sex instinct, 58
- Sexual differences, 101, 102
- Sexual fantasies and impulses, 57, 68, 131
- Sexual interpretation, 11
- Sexual perversions, 73
- Sexual wishes, 83
- Sexuality, infantile, 9
- Shadow, 5, 37, 57
- Shame, 31, 98, 99
- Slapping, compulsive symptom, 105–6
- Sleep, 33
- Social adaptation, education in, 44
- Splitting, 76, 94, 134, 144
- Starting analysis, 73–9
- States of unity, 131
- 'Stirring up', 129
- Stopping analysis, 151–2
- Storytelling, educative method of, 48
- Subjective factor, 14
- Subjective plane, 13, 137
- Subjective world, 143
- Substitute analyst, 134
- Suicidal threats, 71
- Superego, 58
- Supervision, 159, 160, 163, 166
- Supervisor
 - and training analyst, 165
 - as 'devil's advocate', 164
 - as second analyst, 163
- Symbolic forms in children, 170
- Symbolic meaning of transference, 84
- Symbolic representations, 146
- Symbolic solution, 39, 141
- Symbolic union of opposites, 139
- Symbols, 6, 39, 124
 - defensive content of, 6
 - defensive use of, 25
 - of self, 37, 40
 - personal implication of, 40
 - synthetic, 40
 - theory of, 25
- Symptoms, 25
- Synchronicity, 5–6
- Synthetic methods, 139
- Syntonic counter-transference, 92
- Systematic non-method, 46
- Technical faults, 135
- Technique, 94–6, 108
 - in relation to counter-transference, 95
- Theoretical concepts, 3
- Theoretical models, 45, 63
- Theory
 - defence, 4
 - of archetypes, ix, 14, 20
 - of collective unconscious, 48
 - of compensation, 25
 - of deintegration, 157
 - of energy, 6
 - of inheritance, 58
 - of psychic reality, 13
 - of repression, 97
 - of symbols, 25
 - of types, 6, 12, 25, 49, 53, 168
 - process, 8
- Therapeutic alliance, 59, 67, 76, 86, 91, 114, 118, 126, 155, 171
- Therapeutic method, applications of, 168–71
- Therapeutic reaction, negative, 123, 135
- Therapeutic results, 8
- Therapist
 - as holding person, 124
 - attitude adopted by, 147
 - basic requirements, 106–7
 - behaviour of, 53
 - influence on dreams, 27–9
 - limit of tolerance, 108
 - physical contacts with, 129
 - self-analysis of, 108
 - separation from, 129
 - sound of voice, 129
 - synthetic aim of, 61
 - see also* Analyst
- Therapy
 - individual style of, 158
 - nature of, 17–19
 - stages of, 156
- Thinking, 7
- Thinking type, 25, 139
- Three-body oedipal situation, 10
- Time disturbances, 133
- Time flexibility in regression, 129
- Tokens, 130–2

- Tolerance, 108
- Tone of voice, 121
- Total reaction, 46
- Total response ('R'), 109–10, 131
- Toys, 170
- Trainee analyst, 118
- Training, 158–67
 - inflationary pressure, 162
- Training analysis, 45, 160, 161, 163
- Training analyst and supervisor, 165
- Transference, 32, 44, 48–50, 68, 80–9, 144–5, 160, 161
 - and active imagination, 68
 - archetypal, 81, 83–8, 150
 - as essentially infantile manifestation, 116
 - as main therapeutic agent, 115
 - as ongoing process, 48
 - as projection, 81
 - delusional, 67, 110, 119, 145, 152, 155
 - development in, 12
 - dilution of, 162
 - during constructive therapy, 142–3
 - from parents, 171
 - heterosexual, 86
 - idea of resolving, 151
 - importance of, 11, 26, 27, 99
 - in individuation, 88
 - infantile nature of, 151
 - Jung's thesis, 16
 - masochistic, 141
 - mutative, 115
 - negative, 76, 82, 118
 - positive, 76, 122
 - resolution of, 150, 151
 - sadomasochistic, 140
 - significance of, 19
 - studies of, 52
 - symbolic meaning of, 84
- Transference-analysis, 62
- Transference anxiety, shame and guilt and, 31
- Transference illusion, 83
- Transference impulses, 120
- Transference indicators, 81
- Transference interpretation, 31, 83, 115
 - mutative, 115
 - nullification, 132
 - premature, 115
- Transference neurosis, 65, 81, 86, 88, 115, 119, 132, 158
- Transference projections, 65
- Transference psychosis, 87, 88, 99, 132–4
- Transference resistance, 121
- Transformation, 44–50, 61, 89, 150
- Transitional objects, 146
- Transitional phenomena, 147, 148
- Transpersonal myth, 13
- Trust, 144
- Two-analyst situation, 164
- Types, theory of, 6, 12, 25, 49, 53, 168
- Typology, static aspect of, 7
- Uncertainty
 - principle of, 63
 - repressed, 124–5
- Unconscious, storehouse of history, 19
- Unconscious complex, 4, 97
- Unconscious interaction, 164
- Unconscious processes, evolving nature of, 6
- Union of opposites, 150
- Unit status, 10, 85
- Unsystematic by intention, 118
- Unsystematic attitude, 95
- Violence, 131
- Visions with significance for groups, 168
- Vocation, 159, 160
- Waking and wakefulness, 33
- Whole-making effect, 17
- Wholeness, idea of, 38
- Words
 - alterations in the meaning of, 132
 - inadequacy in regression, 129
- Working through, 59, 125
- Wounded healer, 15, 17, 90
- Zurich school, 51

In his preface to *Jungian Psychotherapy: A Study in Analytical Psychology*, Dr Michael Fordham writes:—

'This book contains an exposition of therapeutic methods used by analytical psychologists. It is based on Jung's own investigations and includes developments in his ideas and practices that others have initiated.

Jung held that his work was scientific in that he had discovered an objective field of enquiry. When applying this assertion to analytical psychotherapy one must make it quite clear that, unlike what happens in other sciences, the personality of the therapist enters into the procedures adopted in a way uncharacteristic of experimental method. In the natural sciences study is different in kind and the investigator's personality is significant only in his capacity to be a scientist. By contrast, in analytical therapy the personal influence of the analyst pervades his work and furthermore extends to generations of psychotherapists; the way I conduct psychotherapy is inevitably influenced by my having known Jung, having developed a personal loyalty to him and by being treated by three therapists who came under his influence. This maintains however differently from Jung and my own therapists I conduct myself when treating patients, or whatever conceptions, models or theories of my own I have developed.

It is with these reflections in mind that I have called this volume *Jungian Psychotherapy* with the subtitle: *A Study in Analytical Psychology*. Thus my debt to Jung is acknowledged but it is also indicated that analytical psychology is a discipline in its own right.'

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