Time Limited Treatment and C. G. Jung's Analytical Psychology

George B. Hogenson

ABSTRACT. The work of C. G. Jung has been largely neglected in recent discussions of time-limited psychotherapy. Notwithstanding this state of affairs, this paper argues that much is to be gained from familiarity with Jung's view on treatment. A brief overview of Jung's general system of psychology is presented, and contrasts are drawn to the work of Freud. Several distinctive characteristics of Jung's view of the clinical process are then identified, and a discussion of the course of treatment is provided with a brief reference to a case of Jung's and to the author's experience working with gay men. *[Article copies available for a fee from The Haworth Document Delivery Service: 1-800-342-9678. E-mail address: <getinfo@haworthpressinc.com> Website: <http://www.haworthpressinc.com>]*

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INTRODUCTION

C. G. Jung's analytical psychology is rarely thought of in the context of brief psychotherapeutic treatment. In their classic work, *Psychotherapy in a New Key*, for example, Strupp and Binder make no reference to Jung's work, and fail to recognize those points at which he might actually contribute to their project. Similarly, Steven Friedman, in his recent *Time Effective Psychotherapy*, makes no mention of Jung. There are many reasons for this state of affairs, not the least

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being a relative lack of familiarity with the fundamentals of Jung's system of psychology. When they occur, discussions of Jung's work often devolve into generalizations about the theory of archetypes or the collective unconscious, or dismiss his work as mystical and lacking in scientific foundation. When some recognition is found regarding Jung's work, it is usually to draw a brief and undeveloped parallel with some other system. For example, in the first volume of their annual compendium on brief treatment, Matthews and Edgette (1997) note that Jung's notion of the transcendent function is used by Milton Erickson, but there is no real explanation of how Jung thought about this concept. Similarly, Ecker and Hulley (1996) make passing reference to Jung's use of what he called active imagination and compare it, again without much explanation, to various forms of gestalt work. While both of these concepts are indeed central to Jung's mature thinking, they must be understood within the context of his overall theory. Merely mentioning them may give the sense of inclusion, but without a larger context, inclusion becomes illusory. Both the notion of the transcendent function, which refers to Jung's recognition of the role of symbols in mediating the relationship between consciousness and the unconscious, and active imagination, which refers to a technique of accessing the unconscious which Jung explicitly contrasted to Freud's use of free association, relate to fully developed aspects of Jung's system, and particularly to his interest in the spiritual side of mental health.

While Jung was unquestionably committed to the idea that the religious or spiritual dimension of human experience was crucial to mental health, this alone did not define his approach to therapy nor did it make him a mystic. Rather, as is increasingly evident in the clinical literature, Jung appears to have been well ahead of his time in this important area of treatment. But in the commentaries on Jung, both by his followers and by his critics, much is lost that is of value to any theory of treatment when the discussion focuses only on these aspects of Jung's work. I therefore want to argue in this paper, that a close examination of a number of other elements in Jung's work casts a light on aspects of treatment that, while often taken for granted, are inadequately understood, or are not adequately understood in relation to other issues in general psychotherapeutic theory. In the end, I believe, Jung's insights into the processes of the psyche, and the therapeutic

enterprise, hold considerable promise for enlarging our clinical horizons in both long-term and short-term treatment.

The lack of familiarity with Jung's theories requires special attention in relation to short-term therapy. Consequently, this paper will present a brief overview of the development of Jung's thought and, necessarily, of certain crucial ways in which his theories differ from Freud's. The relationship to Freud is important because much confusion about Jung originates in a misunderstanding of his relationship to the founder of psychoanalysis. This misunderstanding works itself out in relation to all of the therapeutic points of view that derive from Freud. I will then consider Jung's practical recommendations for treatment which are largely outlined in a series of essays found in volume 16 of his *Collected Works*. I will conclude with a brief discussion of Jung's view of the religious or spiritual dimension of treatment. Thus, this paper will deal with those aspects of Jung's work that are least commonly associated with him in popular or stereotyped discussions. It will remain for a later time to connect the aspects of Jung's work discussed in this paper with concepts such as the transcendent function, active imagination, and the collective unconscious.

THE HISTORICAL BACKGROUND OF JUNG'S THEORIES

C. G. Jung was born in 1875 in the small Swiss village of Kesswill, on Lake Constance. Jung's own account of his life–albeit much edited by his assistant, Aniela Jaffé–can be found in his autobiography, *Memories, Dreams, Reflections* (1963). His father was a Protestant minister and his mother was the daughter and granddaughter of Protestant ministers. His mother appears to have suffered from bouts of major depression, and possibly from some form of personality disorder. When Jung was three, his mother was hospitalized for an extended period, probably for depression, and Jung frequently spoke of her as seeming to have two distinct personalities. From the beginning, therefore, Jung was deeply concerned with the problem of how to form and sustain relationships, beginning with a mother who presented a very fragmented personality.

In 1900, Jung received his medical degree from Basel University. His dissertation, ''On the Psychology and Pathology of So-Called Occult Phenomena,'' was based on his observation of a young medium, who was also his first cousin on his mother's side (Jung, 1902).

In her trances, the medium presented a variety of personalities, including recently deceased relatives of the séance participants as well as other personalities unknown to the participants. Despite its subject matter, this dissertation is objective in the presentation of the data of the seances, and closely follows, in style and argument, work then being conducted by the eminent psychologists William James and Theodore Flournoy, among others.

With the completion of his medical training, Jung was invited to join the staff of the Burghölzli psychiatric hospital in Zurich, under the direction of Eugen Bleuler. The Burghölzli was probably the premiere psychiatric institution in Europe at this time, and under the guidance of Bleuler, Jung soon rose to the position of what would now be called chief resident. The hospital was a center of psychiatric research, and Jung quickly made a name for himself by extending work begun by Wundt, Aschaffenburg and others on the word association test. Jung's work on the word association test laid the foundations for his theory of the complex, which is the centerpiece of his theory of psychopathology and hence for any theory of treatment.

In addition to this research, Jung was in constant contact with psychiatric patients. Bleuler ran something akin to what we would now call a milieu institution, and the psychiatric staff was required to live in the hospital itself. Bleuler was also concerned that his subordinates gain a wide exposure to psychiatric theory, so Jung was sent to Paris early in his residency to study the work of Pierre Janet. As with Freud's time in Paris under Charcot, Jung's exposure to Janet was decisive for the development of his views on psychopathology. While Charcot had concentrated on hysteria, however, Janet was primarily concerned with dissociative states. For Jung, Janet's theories, coupled with his own research on mediumship, the complex, and the psychoses, shaped his general theory of psychological processes in ways that Freud's theories were never able to supplant.

Jung was among the 700 or so original readers of Freud's *Interpretation of Dreams*. He immediately recognized the importance of Freud's work and began to refer to Freud in his early papers. Jung viewed Freud as one among many important theoreticians who could contribute to his own understanding, but he never elevated Freud to a position of priority over all others. Nevertheless, in his refinement of the word-association test, Jung had concluded that he was observing experimental evidence that supported Freud's theory of repression.

The association test showed distinct variations in response time and other, more physiological, changes in relation to stimulus words. Jung questioned test subjects about the significance of the stimulus words in a manner that he explicitly identified as deriving from Freud's writings. What he found upon analysis, was that the words most associated with disturbances of response revealed hidden aspects of the person's life which were also disturbing; this seemed to vindicate a version of Freud's notion of repression. Jung sent Freud a copy of a collection of his papers, only to learn by return mail that Freud already had one (Freud & Jung, 1974). Freud was excited to find what he thought would be independent verification of one of his most important, but also most controversial, theoretical constructs. Also, Jung was associated with the great Burghölzli hospital and the eminent Eugen Bleuler, and had an established reputation as an experimental researcher. As John Kerr has remarked in his important study of the relationship, at the beginning Freud needed Jung, and not the other way around (Kerr, 1993).

I have explored elsewhere the systematic problems that arose during the seven years Jung and Freud were directly associated with one another (Hogenson, 1983), and will not outline in this paper the details of the relationship. It is important, however, in making sense of Jung's work, to forgo the notion that he began his career as a follower of Freud and then deviated from the master's set course. Jung came to the relationship with a set of assumptions, based on a broad familiarity with the psychological and psychiatric literature of the time, as well as his own empirical observations, that were markedly at variance with Freud's views. Freud never presented arguments that were sufficient to make Jung give up those assumptions. To the contrary, Jung felt that he was on solid scientific ground in his efforts to enlarge on the work he had already done, certainly with due regard for Freud's insights, but not slavishly committed to accepting Freud's theories when they were contrary to Jung's own experience. This fundamental difference allows us to articulate precisely the elements of Jung's theorizing.

ELEMENTS OF JUNG'S THEORY

At the center of Jung's system is the theory of the complex. Jung's discoveries in his work on the word-association test pointed to considerable variety and variability in any individual's array of complexes.

Indeed, one of the first points of contention between Jung and Freud had to do with whether or not both the variety and the etiology of the complexes Jung was examining could be reduced to a single etiological pattern–infantile sexual fantasy–and, in effect, a single complex–the Oedipus complex. Jung steadfastly resisted Freud's reductionism, precisely because his own research indicated that complexes could have many causes, could originate at any point in the life history of the individual, and could each take its own developmental course.

Jung's view of the complex dovetailed neatly with Janet's notion of personality fragments that derived from his studies of dissociative states. In essence, both Janet and Jung viewed the personality as comprised of fragments or complexes, most of which are independent of the ego complex–itself merely a fragment of the complete person–and hence of consciousness. The result of this point of view is that the clinician is always confronted with personality fragments that are seeking expression and development, and one must take seriously the distinctive needs of each personality fragment. "The complex forms," Jung writes in 1929, "so to speak, a miniature self-contained psyche which, as experience shows, develops a peculiar fantasy-life of its own" (CW 16:125).[1]

This point of view has important implications for our understanding of phenomena such as regression. Lecturing in 1929, Jung remarked regarding regression:

> I have suggested that [regression] is not just a relapse into infantilism, but a genuine attempt to get at something necessary. There is, to be sure, no lack of infantile perversions. But are we so certain that what appears to be, and is interpreted as, an incestuous craving is really only that? When we try, conscientiously and without theoretical bias, to find out what the patient is really seeking in his father or mother, we certainly do not, as a rule, find incest, but rather a genuine horror of it. We find that he is seeking something entirely different, something that Freud only appreciates negatively; the universal feeling of childhood innocence, the sense of security, of protection, of reciprocated love, of trust, of faith–a thing that has many names. (CW 16:55)

Jung is arguing that the psychic fragments or partial personalities that make up the complete personality may display different needs and different levels of development. Put another way, the total personality

consists of a variety of complexes or partial personalities, each of which has its own point of origin in the life history of the individual, and each of which has its own developmental needs and patterns. It is worth noting that this point of view is not too distant from Heinz Kohut's understanding of the role of selfobjects in the entire life history of the individual, and of the need for distinctive therapeutic responses to varied selfobject deficits (Kohut, 1984). I will have more to say about this resemblance below.

This point of view has important implications for a theory of treatment. While analysis in depth is certainly one possibility for treatment, it is by no means the only solution to the problems faced by one's patients. Putting the issue in terms of the debate between Freud and Jung, while Freud believed that he had a (largely) complete understanding of the etiology of the neuroses-essentially the conflict model of development-and that the objective of treatment was the revelation and recognition of that univocal conflict, Jung argued that the etiology of any given neurosis could not be determined a priori. Rather, the first objective of treatment was to determine what specific life problem was associated with the complex. This point of view originated for Jung in his earliest research, that which he conducted for his dissertation on mediumship.

In the dissertation, Jung argued that many of the ''personalities'' generated by the medium in the séances could be interpreted as attempts on the part of a young girl entering adolescence to accommodate, psychologically, to that life transition. Some of the personalities that emerged were flighty and juvenile, while others were grave and mature. Sexual fantasies were present, but they were largely fantasies of fecundity, which Jung interpreted as the adolescent girl's attempt to come to terms with her sexual maturation. This point of view would eventually be framed by Jung in one of the cardinal elements of his theory of psychic activity: the symptoms associated with a given complex, or neurosis, should be viewed as attempting to solve a particular *contemporary* life problem.

It was this point of view that led Jung to the profound impact he had on the origins of Alcoholics Anonymous. In the 1920s, an alcoholic from the United States, Roland H., came to Jung for treatment. After a period of evaluative consultation, Jung advised Roland H. that he could not treat him, that only a spiritual renewal would overcome the grip of the spirits in Roland H's life. This insight became the basis for

the first step in the AA system, and Jung's contribution was acknowledged years later in a famous exchange of letters between Jung and Bill Wilson. Jung's point was that the symptom of alcoholism, ingesting ever-larger quantities of a mood-altering drug, was an attempt to solve the problem of spiritual poverty. The pathological aspect of the behavior resulted more from the fact that the problem was poorly understood and the alcoholic's attempted solution was therefore destructive. The first step, in consequence, was a recognition that the alcoholic could not solve the problem, that only a spiritually meaningful relationship to the ''higher power'' could solve it. Jung's own formulation of this principle was that in treating the alcoholic one needed to enlist the ''spiritus contra spiritum'' the spirit against the spirits (Jung, 1973, pp. 623-25). Indeed, this point of view on the treatment of alcoholism can be taken as virtually paradigmatic of Jungian treatment in general.

Given this point of view, we can specify one of several principles of Jung's thought as follows:

1. Many psychological phenomena that might be classified as neurotic or otherwise pathological are in fact attempts on the part of the unconscious to solve a contemporary life problem

Implicit in this formulation is a view of the unconscious that requires some illustration if we are to gain a sufficient understanding of Jung's point to view to allow us to specify what is possible for treatment. If we begin with Freud, we find that for him the unconscious comes into being in order to hold knowledge of unacceptable materials and keep them outside the range of consciousness. In *Totem and Taboo*, and elsewhere, Freud proposes a theory of the origins of the unconscious within the story line of libidinal conflict and wish fulfillment (Freud, 1953-1964). The corollary to this view of the unconscious is that when material does emerge from the unconscious, in the form of dreams, myths, or parapraxes, it is distorted by the censorship and therefore a misrepresentation of its true nature. The task of the analyst is to decipher the true meaning of the material and to reveal its origins in libidinal conflict.

Jung did not accept Freud's univocal account of the nature of the unconscious, and proposed an alternative view of how the unconscious was structured. Jung certainly agreed that some contents of what he called the personal unconscious were unconscious for precise-

ly the reasons Freud proposed, that is, they were unacceptable to consciousness and therefore repressed. But this was not the end of the story for him. Jung's view of the unconscious begins with the notion that the term itself is its own definition: the unconscious consists of all those psychic activities of which we are not conscious at any given moment. These may range from automatic processes of perception and memory to complex cultural assumptions shared through time and space. Indeed, this view of the unconscious leads directly to Jung's most famous addition to the theory of the unconscious, the hypothesis of the collective unconscious.

At the beginning of this paper, I remarked that it was a mistake to reduce Jung's views to a caricature of his ideas about the collective unconscious and the archetypes. Both concepts are complicated in their details and controversial even in Jungian circles. I believe, however, that if Jung is simply allowed to speak for himself, these concepts are not as daunting as they are often made out to be. Simply put, the collective unconscious, in Jung's own formulation of the concept, is nothing more than the common, biologically evolved structure of the human mind or psyche. To the extent that human beings share certain common and innate modes of perception and behavior, which are not under the control of the conscious ego, Jung argues, one can legitimately speak of a ''collective unconscious.'' And the archetypes are the specifiable units of perception and behavior within the general notion of the collective unconscious. The notion is no more peculiar than the fact that human beings everywhere, and at all times for which we have any record, have spoken syntactically complex languages, or that there are normative limits to the range of light frequencies perceived by the human eye.

This last analogy, however, points us towards a deeper understanding of Jung's view of psychopathology. The collective unconscious is largely responsible for the formation of cultural patterns and norms. To that degree, there is room to compare the notion of the collective unconscious with Freud's second topology, in particular his ideas regarding the superego. For Jung, however, the collective unconscious is much more the result of straightforward evolutionary forces at work on the species, rather than more volitional cultural forces of repression as is the case with Freud. Nevertheless, they share an appreciation for the difficulties that the individual faces when out of step with the collective. For Jung, this means that the individual constantly feels a

tension between the objectives of individuality and the pull of collective activities and perceptions. The psyche seeks balance between the two poles, but it is the inherent tension associated with the quest for balance that can lead to dysfunction.

Having developed this view of the structure of the psyche, and the relationships among its parts, Jung argued that the conscious expression of unconscious material is frequently the *best possible representation* of the state of affairs the individual is attempting to solve. The form that the initially proposed solution takes may be ''pathological'' but not because it is distorted by the censorship or any other intrapsychic mechanism. This means that the problem has been identified, but under the circumstances prevailing in the individual's life, the understanding of the problem is inadequate to finding a healthy solution. This is often the case because important elements of the problem are collective in nature; they reflect deeply imbedded instinctual patterns of behavior, or they represent a truce between the workings of the ego complex and some other complex at work in the personal unconscious. Nevertheless, the workings of the unconscious are, in some sense, to be trusted as guides to a more satisfactory solution to the problem faced by the individual. Those circumstances include the personal disposition or attitude type of the individual, as well as the presuppositions about the world that developmental experiences may have established in the individual's overall psychological pattern of functioning. This point of view leads to another basic assumption of Jungian clinical theory:

2. An individual's perception of a state of affairs is dependent on character structure, level of education, family history, and other idiosyncratic features unique to that person

Fundamental to this point of view was Jung's development of his own theory of personality which began in 1911 and 1912, while he was still closely associated with Freud, but came to fruition in 1921 with the publication of his monumental *Psychological Types* (CW 6). Much has since been made of Jung's typology, and in the form of the Myers-Briggs Type Index, it has become one of the most commonly used psychological tests. Jung's work on the typology, however, had originated in his efforts to understand why it was that Freud, Alfred Adler, and himself should look at the same psychological material and yet come to such different theoretical positions. It was, for example, the case of Freud and Adler that

gave rise to Jung's proposing the distinction between extraversion and introversion. Freud's emphasis on object relations was a paradigmatic example of extraversion while Adler's emphasis on the will to power and related constructs was a characteristically introverted theory in which the perception of interior states predominated.

Jung's interest in the diversity of individual psychological functioning was not limited to the theory of types. Freud's psychology, with its elaborate system of distortion and censorship relied on a rigorously reductive method to arrive at the primitive source of distress. This meant that any human expression, from a dream to a work of art to a religious inspiration, could be analytically reduced to an infantile wish or libidinal conflict. Furthermore, all of these alternative expressions, particularly if they entailed the use of visual or motor representation, were considered deceptions, perpetrated on the censorship by the unconscious, in order to communicate an otherwise unacceptable unconscious content to consciousness. Consequently, the only veridical forms of representation that would actually confront the conscious mind with the materials of the unconscious were those verbal accounts given in the process of free association. Images in particular had to be reduced to language.

Jung considered Freud thoroughly mistaken on this point. His position was that the means of representing psychological states of affairs could be as varied and distinct as the means of acquiring material. To the degree that an extraordinary amount of information is gained by way of sight, visual representation was an equally powerful and legitimate means of representing the contents of the psyche, including unconscious contents. Similarly, the importance of kinesthetic learning, particularly in childhood, opened the possibility that body movements, including formalized rituals and dance had to be considered as equally legitimate with speech as a means of presenting a veridical account of the unconscious processes of the individual. This argument can be stated in a third axiom of Jungian clinical thinking as:

3. The complexity of our perceptual apparatus, and of the brain's processing patterns, is such that no single system of representation is capable of fully describing the state of the individual's psychological processes. Thus, speech should be viewed as only one among many possible systems of representation available to the therapist

In practice, this means that the therapist has available a considerable range of modalities for accessing unconscious material. While a ma-

jority of therapists oriented to Jung's theories still probably rely on talk as the primary form of therapeutic activity, the option remains open to use alternatives such as painting, drawing, sand tray, clay, music, dream interpretation, and even kinesthetic methods such as dance, to gain insight into the concerns of the individual.

THE COURSE OF TREATMENT

Given this overview of Jung's theories, let us turn to the course of treatment envisioned by his system, and ask what implications the theory holds for brief treatment. Jung was skeptical about the possibility of shortening the course of treatment because he viewed the neurosis as ''misdevelopments that have been built up over many years'' (CW 16:36). Jung's point of view on treatment was deeply pragmatic, however, and he was therefore open to innovation at any reasonable point. The focal point of the therapeutic enterprise was always the individual, and this required that the therapist stress the ''individualization of the method of treatment'' (CW 16:42), and find the best possible means of dealing with the particularities of the individual who comes to the clinician with a complaint. As is evident from his remarks regarding the search for incestuous impulses, cited above, Jung rejected the notion that a reductive move towards a single etiological theory was the appropriate guide to treatment. Rather, the first questions on the mind of the therapist should concern what exactly is it that this person is confronting in life, and why have the attempted solutions thus far failed.

This point of view is not an invitation to wild or unstructured therapy, or simple counseling. To the contrary, he consistently recommended that the clinician be guided by well-specified principles. But those principles derived, for Jung, from the more general, theoretical constructs outlined above. First among these principles is Jung's insistence on addressing the issues presented in the here and now. Lecturing on psychotherapy to the Congress of the Society of Public Health in 1929, Jung insisted on differentiating his position from Freud when he argued that, ''a neurosis or any other mental conflict depends much more on the personal attitude of the patient than on his infantile history.'' One almost begins to hear an appeal for cognitive or systems-based therapy in this point of view, and, indeed, Jung goes on:

> No matter what the influences are that disturbed his youth, he still has to put up with them and he does so by means of a certain attitude. The attitude is all important. Freud emphasizes the aetiology of the case, and assumes that once the causes are brought into consciousness the neurosis will be cured. But mere consciousness of the causes does not help any more than detailed knowledge of the causes of war helps to raise the value of the French franc. The task of psychotherapy is to correct the conscious attitude and not to go chasing after infantile memories. Naturally, you cannot do the one without paying attention to the other, but the main emphasis should be upon the attitude of the patient. (CW 16:53)

If it is attitude that is at the heart of the patient's discomfort, what course of treatment is suited to correcting the problem? As I noted above, Jung was given to a very pragmatic view of treatment which can at times border on something closer to what we would now call cognitive therapy rather than traditional psychoanalysis. This point of view is evident in a stage view of the course of treatment that Jung proposed in one of the important papers on treatment that he presented in 1929. Writing in the *Schweizerisches Medizinisches Jahrbuch*, Jung identified four stages of treatment: Confession, elucidation, education, and transformation. How are we to understand these stages, and what do they have to tell us about brief treatment?

At this point, it is important to recall the brief discussion of the collective unconscious presented above. Recall that I argued that Jung's theory of the collective unconscious led to the problem of how the individual related to the collective, and that material from the unconscious could be viewed as an attempt to resolve that relationship. Lecturing in 1935, Jung challenged a purely medical model of the neurosis, remarking:

> The clinical standpoint by itself is not and cannot be fair to the nature of a neurosis, because a neurosis is more a psychosocial phenomenon than an illness in the strict sense. It forces us to extend the term ''illness'' beyond the idea of an individual body whose functions are disturbed, and to look upon the neurotic person as a sick system of social relationships. (CW 16:37)

When looking at treatment, then, we can view each level of treat-

ment as an attempt to strike a new balance between the individual and the collective, or between conscious and unconscious parts of the individual. The goal of treatment, Jung emphasized, is first of all and most of the time maintenance of one's individuality in conjunction with adaptation to one's environment, and accommodation among the psychic fragments or complexes that make up the total personality.

In the case of confession, Jung places the first step in treatment squarely in the role of allowing the individual to form a relationship to a collective, even if only in the form of the therapeutic dyad established between patient and therapist, in which the patient is able to share both conscious and unconscious secrets. In the case of a conscious secret, simple confession may be possible and the individual will again feel connected to the larger community. In the case of unconscious secrets, the therapist may have to discern what is actually being held in confidence.

A case of Jung's illustrates this point, and provides a working example of Jung conducting a brief treatment (Jung, 1963, p. 115f). We should also note the ''here and now'' quality of the interpretation, a characteristic of Jung's approach. A woman came to Jung suffering from depression. The depression had commenced after one of her children had died of typhoid fever. In the course of interviewing the woman, Jung learned that she had married and had children after the failure of a love affair with a man she still thought fondly of. Shortly before her son's death, she had learned from a mutual acquaintance that the former lover still thought of her as well. This constellated, in Jung's interpretation, a complex with a fantasy content in which she was able to resume the long-past affair. While bathing her children one day, she allowed both of them to drink tainted water, and one died from the ensuing infection. Jung's interpretation, with which he confronted the woman, was that within the fantasy of re-establishing the affair with the former lover, the children would be an impediment. In consequence, she had acted unconsciously to remove them. She was, in effect, a murderer.

By contemporary standards Jung's approach is unusually blunt. He nevertheless judged that the patient would benefit more from knowing what the secret was that her depression hid, and the need for treatment revealed, than she would be if the secret had remained hidden, by removing it from the here and now through reductive analysis. In this

case, according to Jung, the depression was converted to simple sadness, and the woman required no further treatment.

Confession, however, may not be sufficient to solve the issue confronting the patient. A second step, that of elucidation, may be necessary. Jung's interest here is largely with the transference and the countertransference. Seen in terms of the relationship to the collective, the transference and its elucidation provide the means to examine how the individual relates to the collective. Again, the dyadic or triadic relationship to the parents may be the foundation for the transference, and Jung would certainly want to examine the nature of those relationships but, in terms of treatment, he would also want to examine how the transference is actually working in the individual's current relationships.

Understanding how one relates to others, and to the contents of one's own psyche, may be sufficient to relieve the distress one is experiencing. However, it may not be sufficient, and in those cases, it may be necessary to engage in some form of social education. While Jung is appreciative of Freud's approach to the interpretation of the transference-albeit with some reservations-he views Alfred Adler as an appropriate guide to social education for those individuals who are not able to bring their own resources to bear on the information provided by the analysis of transference. Adler, of course, would actually work with his patients in social settings, even taking them to restaurants and dances to facilitate their sense of how to operate in the social world. Comparing the two schools of thought, Jung writes:

> Adler's method begins essentially at the stage of elucidation; he explains the symptoms in the sense just indicated, and to that extent appeals to the patient's understanding. Yet it is characteristic of Adler that he does not expect too much of understanding, but, going beyond that, has clearly recognized the need for social education. Whereas Freud is the investigator and interpreter, Adler is primarily the educator. He thus takes up the negative legacy which Freud bequeathed him, and, refusing to leave the patient a mere child, helpless despite his valuable understanding, tries by every device of education to make him a normal and adapted person . . . . From this fundamental attitude comes the widespread social activity of the Adlerian school, but also its depreci-

> ation of the unconscious, which, it seems, occasionally amounts to its complete denial. (CW16:152)

We must pause for a moment here because the last stage of treatment, transformation, arguably falls outside the range of brief treatment. While I will return to it in a moment, I want to review briefly the characteristics of treatment that Jung views as essential to a more focused and constrained treatment. I have been using the term collective throughout this discussion, but it should be obvious to the reader that one could as easily refer to the relational nature of Jung's theories. And, indeed, Jung was particularly concerned with the relational nature of the psyche, with the formation of a relationship to the therapist being of central importance. In all three of the above stages of treatment, the emphasis is on the establishment and the maintenance of a relationship to the therapist, and through the therapist to the larger community. Emphasis is also placed on what is happening in the here and now, how the fantasies associated with autonomous complexes are functioning in the here and now to try and resolve a conflict, and what alteration of the conscious attitude is necessary to accommodate the forces associated with the complexes. These characteristics of Jung's system, originating as they do in his earliest work, allow for quite focused and constructive interventions in the life of the individual.

In contemporary clinical practice, the Jungian therapist begins with the question, why is this set of symptoms appearing now? What is it about the current circumstances that elicit the particular complex with which this client presents? How does that complex not only represent the problem faced but also point the way to a possible solution? Although these questions may be applied to virtually any clinical material, some of the considerations associated with this point of view may be illustrated by reference to working with gay men, a population that comprises a substantial portion of my own practice.

Specific circumstances of the beginning of therapy define much of the subsequent process. As a straight analyst (my referral base usually identifies me as straight in the process of making the referral), I am almost always asked, by my newly arrived gay client, whether I am comfortable working with gay men. This question already defines at least part of the presenting problem–the relationship of the gay man to the straight world–and the complex that encompasses that situation. Developmentally, this complex usually originates in the relationship

of the male child to the father, as a mutual failure of what Heinz Kohut called mirroring. However, by the time the adult man reaches the therapist's office, the complex has typically ramified far beyond the father's failed mirroring, and may include the mother, siblings, other children with whom the gay man grew up, coworkers, and, frequently, other gay men. Thus, the question of my willingness to work with a gay man marks the continuing difficulty of establishing trusting relationships. Usually, gay men can recount a succession of more or less traumatic experiences in childhood and adolescence that have resulted, even in the openly gay man, in remnant patterns of deception designed to deflect the suspicions of others and keep them from identifying the gay child. These efforts to deflect suspicion can run the gamut from engaging in promiscuous heterosexual sex to casting oneself as the school ''nerd'' who is essentially asexual. Regardless of the pattern, however, these strategies also frequently result in deep resentment at the failure of parents or others to care for the child who knows by the age of eight or nine that he is ''different.''

This understanding of the gay man's situation provides ample grist for a classical analytic mill, and would, as Jung comments, draw the therapy into an ever more detailed examination of the early development of the child. But would it address the issue at hand? While efforts to reconstructively mirror or otherwise provide a holding environment for the affects associated with the child's developmental traumas is unquestionably an important aspect of any therapeutic intervention, the actual problem that emerges from an examination of the life history of the individual is not so much childhood trauma as the now-failing strategies intended to compensate for the trauma. Put another way, the problem throughout has been the need of the individual to strike Faustian bargains with the larger community in order to enjoy any relationships at all. This constitutes a failure to genuinely represent oneself to the outside world. This pattern of adaptation rests on a kind of willed dissociation or alienation from oneself wherein the complex achieves the autonomy Jung characteristically attributes to it. But the complex is no longer a father complex (failed mirroring), nor is it the result of infantile sexual desire gone astray (Freud). Rather, the defining characteristic of the complex is one of trust in the other and in one's ability to form relationships. The precipitating event, that brings the gay man into treatment is some failure of the bargain with the collective that has sustained the gay man's life to that point. And it is

this failure that is in fact being ''confessed,'' even in the first question of whether or not the therapist feels able to establish a relationship.

The problem in the here and now is how to establish an adult human relationship that is not predicated on the compromises struck earlier in one's life. As Jung remarked, writing in the *British Journal of Psychology* in 1921:

> The painstaking pursuit of all the ramifications of infantile fantasy is relatively unimportant in itself; the therapeutic effect comes from the doctor's efforts to enter into the psyche of his patient, thus establishing a psychologically adapted relationship. For the patient is suffering from the absence of such a relationship. (CW 16:276)

For Jung, then, the question of whether or not the therapist is comfortable working with gay men is the first step in solving the problem of relationship, for it calls upon the therapist to respond out of the integrity of his or her own person in the here and now in order to begin the process of establishing a trusting relationship that recognizes the wholeness and integrity of the other. As Jung continues in his paper, ''The Therapeutic Value of Abreaction'':

> Somehow [the patient] must relate himself to an object existing in the immediate present if he is to meet the demands of adaptation with any degree of adequacy. Irrespective of the reductive analysis, he will turn to the doctor not as an object of sexual desire, but as an object of purely human relationship in which each individual is guaranteed his proper place. (CW 16:286)

Transformation, the last stage in Jung's taxonomy of therapeutic treatment is also relational, but it entails the transformation of the therapist as much as of the patient. As such, it becomes a matter of a deeper treatment, and transcends the objectives of this paper. A few things should be said about this stage, however. If confession, elucidation, and social education have failed to reconcile the individual to the demands of the collective, have failed to allow the patient to function as a whole person, have undermined the patient's integrity, Jung hypothesizes that the problem is more in the relationship to the transpersonal materials of the collective unconscious. These materials have traditionally found expression in the great collective systems of repre-

sentation such as myths or religious systems. Work at this level, Jung maintains, requires all the resources of the therapist, and it was Jung's appreciation of the need for grounding the therapist that made him insist, while still working with Freud, on the need for a training analysis.

The nature of the psyche, as it is experienced at this level, brings us back to our starting point, where the question of spiritual work was first mentioned. What exactly was Jung's view of religion? Speaking in his role as a psychiatrist, Jung consistently refused to make what he termed "metaphysical" judgments about the reality of any religious doctrine. However, speaking from his distinctly biological and evolutionary view of the development of the psyche, he insisted that no pattern of behavior could be so universal, in both time and space, if it were not performing some important adaptive function. In this, Jung's views were diametrically opposed to those of Freud, but closely followed those of William James and Theodore Flournoy (for brief reviews of Jung's view of religion in relation to analysis see Storr, 1999, Shamdasani, 1999, and Segal, 1999). For Jung, the great religions, far from being collective neuroses as Freud viewed them, were, despite their many historical and social problems, in fact the great systems of mental health. As Jung had argued in regard to the case of Roland H. and the founding of Alcoholics Anonymous, connection to the spiritual dimension of life was essential for the establishment and maintenance of mental health.

A great deal more remains to be said about Jung's system of psychology and its application to both short-term and long-term treatment. My objective in this paper has been to provide a first overview of Jung's thinking, both about the nature of the psyche and the course of treatment. In future, it may be possible to elaborate further on this important, but frequently misunderstood pioneer in psychotherapy.

NOTE

1. References to Jung's *Collected Works* cite the volume number followed by the paragraph number.

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