Sandtray Therapy

This method was inspired by Jung's construction of stone "villages" during his self-analysis and then was further developed by Dora Kalff, who combined Jung's ideas with Margaret Lowenfeld's World Technique. In Kalff's adaptation, a rectangular box measuring approximately 30 × 20 × 3 inches is filled with sand and becomes a miniature world that a child or adult can shape and form, meanwhile arranging any of the hundreds of figurines the analyst provides. In therapy, the sandtray becomes a world through which complexes, pain, trauma, moods, emotions, and feelings are given expression. Use of the sandtray, like other forms of active imagination, provides a bridge to the unconscious; during the process, the child or adult can also recover undeveloped elements of his or her character (Bradway, Chambers, & Chiaia, 2005). Sand-play studies document the efficacy of the procedure (Bradway & McCoard, 1997). Over the course of therapy, the trays show a progressive change from a primitive and disorganized state, through images representative of vegetation, animals, the shadow and the human, toward more order, peacefulness, and integration. Symbols appearing toward the end of therapy often have a mandala form and tend to evoke a holy feeling.

Sandtray therapy with children is useful as a structured and healing form of free play that promotes the child's ego development and unblocks hidden feelings. In adults, it returns the patient to a world of childhood play where lost parts of the personality can again come alive and contribute to self-healing.

Child Analysis

Children pick up and reflect what is going on in their surroundings. This happens to such a degree that Jung once analyzed a parent through the dreams and nightmares of his son. Training in child analysis is required at a growing number of Jungian Institutes and is based on core work by the Jungian analysts Frances Wickes, Erich Neumann, Dora Kalff, and Edith Sullwold. Treatment is based on the theory that children have within themselves what they need for a natural process of growth and self-healing to occur. The process works by providing a safe environment in which the therapist serves as witness, participant, and ally, who not only treats the child but also intervenes appropriately so that the child's family and life situation can be improved. During therapy, the child slowly learns to integrate and humanize potentially overwhelming archetypal images. Children's therapy is similar to adults' analytical psychotherapy, but it uses a wider variety of tactile and nonverbal modalities. A child finds expression for dreams, fantasies, and fears through sandtray therapy, arts and crafts, clay modeling, musical instruments, and body movement, as well as through stories and myths. The therapist provides boundaries and a safe space so that the child can work out problems, strengthen ego and resilience, and become more self-accepting, independent, and better functioning.

Post-Traumatic Stress

In 1934, in a letter to a Dr. Birnie, Jung wrote of the profound biological (as well as psychological) changes that can follow the experience of an overwhelming trauma. He went on to write about repetitive dreams and the way the unconscious keeps bringing the trauma up as if to search for its healing through repetition. Modern research on post-traumatic stress disorder (PTSD) supports Jung's observations and documents similar physical and psychological changes in survivors of wars, abuse, torture, and other overwhelming situations. Werner Engel (1986) has described his work with Nazi concentration camp survivors and their long-lasting feelings of guilt. He states that the power of Jungian psychotherapy lies in the curative value of patient and therapist listening

together to a patient's horrors, combined with a belief in self-healing and the application of archetypal theory.

Henry Wilmer (1986) studied 103 patients suffering from PTSD subsequent to their Vietnam service, focusing on their repetitive nightmares. He believed that such photographic repetition must have a psychological and/or biological purpose. He shared the pain of one PTSD patient as expressed through his dreams and experience. Accompanying the patient in a receptive, noninterpretive way, Wilmer watched as the patient's nightmares finally began to change. The patient started to wake up, not caught in the frozen repetition of a flashback, but in tears. Healing took place when the patient mourned what had happened, found meaning in his experience, and finally saw his role in the dream shift into one in which he could actively change the outcome.

Donald Kalsched (1996, 2009) found that severe trauma during childhood can produce an internalization of the traumatizer that remains active in the now-adult psyche. He observes that the patients' self-attacking internal figures initially serve to defend the psyche but gradually change, over the course of therapy, until these isolating defenses are no longer needed.

Increasing numbers of individual Jungian analysts are helping traumatized populations around the world (Murray Stein, personal communication). For instance: Heyong Shen, a Chinese analyst, took his students and volunteer analysts from other countries to help set up sandtray centers in schools and orphanages after the 2008 earthquake in China. Eva Pattis and others have done the same in townships of Africa and Ethiopia, while some Zurich analysts are delivering Jungian oriented therapy services to refugees and traumatized people in Afghanistan and the Balkans. This indicates a new and growing urge to widen the response of Jungians to our increasingly troubled world.

The Treatment of Psychosis

Jung as a psychiatrist treated a full range of severe mental problems. He discerned a pattern and internal logic in the psychotic utterances and fantasies of patients he treated and concluded that the personality of the patient in a psychosis is dominated by a complex split from reality and/or is overwhelmed by (and identifies with) archetypal images that belong to the collective unconscious. Jung believed that the psychotic's upheaval led to distinct psychosomatic changes as well as to chemical changes in the brain. He also speculated that some bodily toxin might produce the psychosis. Today, analytical treatment of psychosis includes listening for the meaning or metaphor behind the symptom so that psychotics' mental worlds and imagery can be used in their healing. Group work, a safe living environment, and art therapy are valuable adjuncts to psychotherapy, as is medication. All help build an environment in which patients can emerge from their chaotic and mythic worlds and prepare for a more regular life. A minority of analytical therapists believe that medication blunts the regression of a psychotic person and prevents the individual from working through the psychosis. Some therapists have run types of home-based therapy, where patients and therapists interact in a homelike setting throughout the day. They report the successful treatment of a schizophrenic episode without the use of drugs and with no relapse; however, no long-range study of this form of therapy has been done.

Evidence

Evaluation of the Therapist

Training and supervisory assessment: A Jungian analyst undergoes a rigorous training program during which he or she is assessed and evaluated in classes, in case seminars, in individual supervision, and through appearances before various committees that closely monitor the quality of candidates' patient care as well as their self-knowledge.

A combination of clinical and theoretical exams and a written case study and/or thesis round out training based on the depth of the candidate's own analysis. Participation in peer supervision, in monthly meetings of individual analytic societies, regional yearly meetings, and international meetings is combined with reading or writing articles in various Jungian clinical journals. Each society of Jungian analysts has education and ethics committees that monitor and review the quality of care that therapists deliver.

Evaluation of Therapy

The most convincing and conclusive studies evaluating particular forms of psychodynamic psychotherapy conclude that therapy is more beneficial than no therapy, but that the type of therapy is less important than the quality of the person who delivers it and the match, and/or empathic bond, between patient and therapist. Thus, followers of a specific modality can make only modest claims for their theory's value, even though therapists' and patients' belief in that theory enhances positive outcomes.

The evaluation of the success of analytical psychotherapy comes from clinical observation, mainly through single case studies. In them, as well as in patients' reports, the patient's quality of life usually improves slowly over the course of the therapy. Dreams can be evaluated in terms of the evolution of the types of images and in terms of changes in their affective content over the course of the analysis. For example, nightmares usually cease, and their terrifying images or threatening figures slowly change into more benign or friendly ones. A specific dream may indicate that the time for the termination of therapy has arrived; this could be as graphic as a dream in which the patient bids good-bye to the therapist before a positive move or journey, or as subtle as one in which the patient not only acquires a piece of beautiful fabric she once dreamed her therapist owned but is now weaving her own material as well.

Subjective assessment is also meaningful: The improving patient reports symptom relief, looks more alive, has more energy, and often can release and experience blocked or untapped channels of creativity. Relationships with other people improve markedly. The process of growth becomes independent of the therapist when patients start to do their own work between sessions, master new and enriching habits of introspection and self-examination, pay attention to their dreams and fantasies, and deal with themselves and others with integrity. An analytical psychotherapist would agree with Freud that learning to love and to work is the key to measuring the outcome of a successful analysis. Jungians would also want to see their patients develop a more intimate knowledge of, a relationship with, and responsibility for all aspects of their psyche. This development often leads patients to grapple with philosophical and religious questions about the meaning of existence, including their personal responsibility to the world in which they find themselves and which they will pass on to others.

Evaluation of Theory

Both qualitative and quantitative studies have examined Jung's theories (Kast, 2009), most especially of typology. These types, or personality dimensions, consist of the two basic attitudes of introversion and extraversion and the four functions of thinking, feeling, intuition, and sensation. We all have these qualities to different degrees, but we often prefer one mode to the others. The *Myers-Briggs* and the *Grey-Wheelwright* typology tests ascertain a person's predominant attitude and function, as well as the relative amounts of each attitude and function in an individual's personality (Beebe, 2006). Both tests are questionnaires that follow Jung's original formulations, determining a person's degree of introversion and extraversion, as well as his or her relative preference for the thinking, feeling, sensing, and intuitive modes of experiencing reality. The tests give a more rounded view of character than simply looking at a single

function or attitude. The Myers-Briggs adds questions to determine whether one perceives things first (as Jung wrote of sensates and intuitives) or judges them first (as both feelers and thinkers do). It yields 16 different personality types. Many analysts find these typology tests especially beneficial when working with couples. By indicating differences in the ways in which people of differing types tend to interpret their environment, they provide an objective explanation for many problems in communication. The theory is now undergoing major assessment and review (Beebe, 2006).

Jung used statistics in his Word Association Tests to display evidence of his theory of complexes. Some analysts make use of these association tests to uncover material in patients who have difficulties with self-exploration. Projective tests such as the Rorschach test and the Thematic Apperception Test (TAT), which are based on Jung's theories of complex and projection, are also used. Contemporary studies of the validity of projective tests have been less persuasive, but the tests themselves still prove clinically useful. *The Journal of Analytical Psychology* has a research section, as well as a directory of research in analytical psychology, and sponsors a yearly conference.

A major contribution to the science of Analytical Psychology has come about through recent discoveries in neuroscience. Infant research and infant observation have mapped the development of self-awareness and the crucial importance of relational dynamics, whereas trauma and its healing are being measured in analysis of brain MRIs (Wilkinson, 2006). Daniel Shore (2006), in his foreword to Wilkinson's book, states that these more accurate models of development have generated "a deeper understanding of change processes within the unconscious mind that potentially occur over all later stages of the lifespan, including models of change within the psychotherapeutic context" (p. vii).

Hester Solomon (2000) goes so far as to conclude that these discoveries are synthesizing "archetypal theory, the ethological basis of attachment theory, psychoanalytic object relations theory, and Jungian development theory, all of which can be hard-grounded in the skin-to-skin, brain-to-brain neurobiological interconnectedness between the infant and its primary caregiver" (p. 136). Therapy is being measured for the best ways to accomplish repair (Wilkinson, 2003; 2006).

Psychotherapy in a Multicultural World

Multiculturalism can be seen through the growing number of South American, Asian, and Eastern European Institutes and Jungian societies; the small but growing number of Asian, African-American, Hispanic, gay, lesbian, and feminist analysts in the United States; and a newly active attention in training and in journals to multicultural, gender, and aging issues. Samuels, for example, in *Politics on the Couch* (2001) calls for psychotherapists to develop a sense of sociocultural reality and responsibility with clients and in the community at large, while Singer and Kimbles (2004), in *The Cultural Complex,* examine the source and nature of group conflict from a Jungian perspective. An important new book, *Jungian Psychoanalysis* (Stein, in press), has chapters on cultural complexes in the process of analysis or psychotherapy, on the influence of gender and sexuality on therapy, on the influence of culture (in this case Japanese culture), and a study of therapy with a person with a congenital physical disability.

Along with this important and growing emphasis, there is also a backlash among more conservative Jungians who argue that Jung's original words—even when considered socioculturally suspect by today's standards—should not be reinterpreted or "watered down" by contemporary standards or cross-fertilization but, rather, should be accepted and taught as he first presented them. Some Jungian institutes are experiencing a paradigm shift, accompanied by fruitful ferment and discussion (see Casement, 2009, Douglas, 2008, and Withers, 2003 for a discussion of these issues); other institutes have split into two or more groups because of this disagreement.

CASE EXAMPLE

Rochelle, a divorced white woman in her mid-thirties, taught at a community college. Her self-consciousness and anxiety brought her into analysis, as did the nightmares that had plagued her since childhood. She was drawn to Jungian psychotherapy because of a lifelong interest in dreams and a love of myths and fairy tales. She had been in therapy before (it had started off well but ended in disappointment), and she wondered if working with a female analyst this time would make a difference.

During the initial stages of therapy, Rochelle settled into twice-weekly sessions. The following facts emerged during the first months of treatment, often in association with dream material. She remembered little about her childhood except having had an active fantasy and dream life and having been happiest alone, outdoors, or daydreaming. Her family life had been chaotic. For several years while she was in grade school, partly because of her father's illness, Rochelle was sent by her mother to live with a series of relatives. Later she was dispatched to a girls' boarding school, where she did well. She was a good student who was active in student government. Rochelle had earned her own living since she was 18, putting herself through college with a scholarship and a series of part-time jobs.

She reported being close to neither parent but having more negative feelings toward her mother, blaming her for neglect. Rochelle had a form of negative mother complex expressed in her determination to do everything in a way opposite to the way her mother did things. Rochelle kept clear of her mother psychically through the development of her thinking function, especially in academic work, in which she excelled. She typified Jung's further description of this type of unmothered daughter as being awkward, lacking body awareness, and suffering from a variety of uterine problems; in Rochelle's case, a hysterectomy had been suggested.

Even though Rochelle most often appeared to be dryly rationalistic, there was also a charged emotional component in her personality that revealed itself in the outbursts of tears that accompanied early therapy sessions. Her therapist gave Rochelle typology tests. Rochelle was found to be markedly introverted, with thinking as her primary function followed by intuition; sensation and feeling were conspicuously low. Rochelle gained comfort from reading about these types and learning that she behaved fairly typically for a person with an undeveloped and primitive feeling function.

In the initial stages of therapy, Rochelle exhibited a strong idealizing transference and worked hard during the hour, although it felt to her therapist as if she were encased in ice. (The therapist was primarily an introverted sensation type and so tended to experience things first as inner images or sensations rather than as ideas or emotions.) However, Rochelle took great pleasure in having someone listen to the story of her life and take her dreams seriously. Her therapist kept interpretations to a minimum and directed attention as much as possible to Rochelle's daily life. Rochelle could not accept anything that seemed like criticism from her analyst but flourished under the analyst's empathic reflection of her feelings; gradually she started to look more relaxed and attractive as she felt herself valued and nurtured.

Rochelle had one or two women friends but had trouble relating to men. She tended to fall in love rapidly, idealizing the man and often negating her own interests to meet his and to help him with his career. Overidealization and a romantic belief in living happily ever after, however, soon turned into hypercriticism and rejection, withdrawal, and flight. Some of these dynamics in her personal life started to appear in the consulting room. Compliance and admiration marked Rochelle's conscious relationship to her therapist, but she seemed to be always on guard. The therapist's countertransference was a strong bodily feeling of distance, at times as if her patient were miles away across the room or vanishing. There was something almost desperate behind the exaggeratedly "Jungian" quality and quantity of the material Rochelle brought to her therapy hour.

It was as if Rochelle were trying very hard to produce what she thought her therapist would want, without noticing her therapist's efforts to focus on Rochelle's anxiety symptoms and her outer life. The therapist used the dream material sparingly, primarily as a doorway into the reality of Rochelle's experience. Rochelle concealed from herself her contempt for her analyst's continued emphasis on the here and now and her focus on Rochelle's physical and psychological condition. When this was brought to Rochelle's attention, she responded with a fierce burst of anger that brought the pain of her negative mother complex to the surface. There ensued a number of months of transference in which Rochelle attacked the analyst as the negative mother while the analyst subjectively felt the misery Rochelle had experienced under her mother's care.

Despite the negative transference, however, Rochelle kept turning up for sessions. In response to the therapist's support of Rochelle's sensation function and her need for autonomy, she sought out a second opinion concerning her hysterectomy and found that it was not indicated. Rochelle also started to pay attention to her body. About nine months after her decision not to undergo the operation, she enrolled in a dance class upon learning from an acquaintance that her analyst liked to dance.

The analyst did not interpret her behavior but held it in the back of her mind. She continued to pay a hovering, almost free-floating attention to Rochelle's behavior and words, as well as to the images and sensations they brought up in her own mind. She noticed that the feeling quality in the room was growing warmer but still contained chilling voids that seemed to parallel Rochelle's own recollection of her past. The therapist felt a sense of foreboding building up with each visit, as though Rochelle were accompanied by some chaotic and unspecific feeling of violence.

Rochelle attended a weekend dance/movement seminar at the local Jungian Institute; at the following session, as she started to describe a nightmare, her nose started to bleed. A look of horror came over Rochelle's face as she experienced the first of a series of flashbacks accompanied by recurrent nightmares. They concerned the sexual attacks she had endured as a child after she had been sent to live with a relative who was an elder in their church. He had coerced her into secrecy under the threat of God's wrath, and he had explained the blood on the child's bedclothes to the housekeeper as the result of a nosebleed.

Initially in therapy, Rochelle had professed herself untouched by this molestation, but now its full emotional impact flooded her. The slow recall of discrete images and memories marked a critical point in therapy. Rochelle fell into a depression and entered a needy and fearful regression during which her sessions were increased to four times a week. At this time, Rochelle made considerable use of the clay, art materials, and sandtray that her analyst kept in her office. Most of the emotional history of her trauma came first through her hands; only later could it be put into words. It took many more months before the splits in Rochelle's feeling recall were slowly filled in and the story of her early life emerged in a more or less linear way. Rochelle now looked to her therapist as a positive mother figure and felt entirely safe only in the therapy room and its boundaries, although she lashed out at her therapist for causing her to feel the reality of her memories and for taking away the lovely dreams into which she had escaped.

In her regression, Rochelle found weekends and holidays intolerable but got through them by borrowing a small figure from the sandtray. Her analyst felt great tenderness for her patient as she witnessed Rochelle's experience and shared her pain. She allied herself with her patient's efforts to recall secrets that had long been repressed. She let them unfold in their own order and time, without questioning or probing. Sometimes the therapist felt drained by the quantity of pain that was now flooding the room and struggled with herself to neither block it nor silence Rochelle. For both analyst and patient, these were difficult times in the analysis, as both experienced the surfacing of the agony that Rochelle had not been able to permit herself to feel before. The therapist found herself increasingly inclined to comfort Rochelle and was tempted to break

her own boundary rules by extending the hour or letting Rochelle stay on for a cup of tea. She considered how much of her response was countertransference and how much represented something she needed to process further in herself. The analyst knew how crucial it was for her to symbolically hold the transference in this charged arena and not act it out; she also knew that part of the force field generated by Rochelle's initial trauma came from the dangerous pull toward repetition that Rochelle and many trauma survivors experience. In order to check that she completely understood her own countertransference issues, the analyst went into supervision with a senior analyst. Through weeks of self-confrontive work, the analyst gained a deeper understanding of the powerfully destructive pull to reenactment that makes trauma survivors all too often fall victim to reinjury. Both Rochelle and her therapist succeeded in maintaining their boundaries without cutting off the current between them. [See Douglas (1997a, 2006), Kalsched (1996, 2009), and Rutter (1997) for a further discussion of this important subject from a Jungian standpoint.]

Shortly after her therapist had completed her own self-examination, Rochelle emerged from her depression and started intensive work on the transference on a different level. This was accompanied by Rochelle's reading about goddesses and images of powerful female archetypes. At this point, work on the archetypal image of incest started to accompany the personal work. Rochelle came into the session one day with an Irish myth that she said both terrified and fascinated her. For a time, its analogies with her own trauma became the focus of much of Rochelle's interest, as she and the therapist began to use the myth as a common metaphor. This caused renewed work on Rochelle's childhood abuse at a deeper but also more universal level.

The myth was about a girl named Saeve, whose relative, a Druid named Dark, pursued her. Unable to escape his advances, she turned herself into a deer and vanished into the woods. Three years later a hero, Fionn, found her and led her to his castle, where she turned back into a beautiful young woman. They lived completely enraptured with each other until Fionn had to leave for battle. Soon after Fionn's departure, Saeve thought she saw him returning; she raced out of the castle to meet him but realized too late that it was the Druid disguised as Fionn. He tapped her with his hazel rod and turned her back into a deer, and they vanished.

Rochelle used this fairy tale to picture her own neurotic patterns of behavior. Through the story, she could start to view them objectively, without shame. The myth gave form and an image to the damage she had experienced from too potent and too early experience of an invasive other. Rochelle gained a feeling for her own horrors through her feelings for Saeve; she also began to understand her defense of splitting off from reality (becoming a deer) when scared and vanishing into daydreams. The story also helped Rochelle comprehend why she seemed incapable of maintaining a relationship, turning every lover from a Fionn into a Druid. Eventually she even recognized that she had internalized the church elder into an inner negative animus who kept judgmentally assaulting her.

As Rochelle's therapy progressed, she stopped turning against the childlike parts of herself that needed to idealize someone as all-good, and she started to forgive herself for what had happened to her. She also started to understand the protective value of splitting off from an intolerable reality and assuming a deerlike disguise. As she did this, that particular defense started to drop away. Rochelle also grew to understand her desire for a savior: What she had experienced was so vile (the touch of the Druid) that what she longed for became impossibly pure (Fionn). She also better understood her self-consciousness and fear of people, as well as her feelings of loneliness; she felt she had lived much of her life alone as a deer in the woods hiding in disguise, flight, and illusion instead of being able to maintain relationships.

Her therapist's accompanying Rochelle on this voyage of discovery allowed her the time to look at the world in terms of the separation and division of opposites: the blackest

of villains versus the noblest of heroes. Rochelle realized that she was repeatedly searching for Fionn, the hero, protector, and savior, whom she inevitably scanned for the slightest defect. And just as inevitably, when he showed a failing or two, she looked upon him as an all-evil Druid. She then escaped in deer disguise and in a split-off little-girl vulnerability, yet behind her meltingly doelike softness lay a self-destructive, self-hating, abusive, rapist animus tearing at her sad child's soul. On the other side, her inner hero tended to become icily rational or heady; he drove Rochelle into unmercifully heroic activity and disdained the dark, sensual, unmaidenly feminine inside her. The Druid animus brutalized her inner child-maiden and the deer, while the virtuous animus punished her for the very brutalization she experienced.

At this point Rochelle became kinder to herself. She stopped ricocheting from one opposite to the other and stopped mistaking the dark for the light or turning someone she had thought good into bad as soon as he made a mistake. Her impaired relations with others slowly started to heal as she allowed her therapist to be neither all-light nor all-dark but intermingled. Through confronting and fighting with her analyst, Rochelle started to regain some of her own darkly potent female energy. Now she also started to be able to claim her own needs in a relationship, rather than disguising herself as an all-giving woman.

Assimilation of her shadow, not identification with it, grounded Rochelle. Her nightmares lessened in intensity after a watchful and self-contained black cat, whom Rochelle associated with her therapist, started to appear in her dreams sitting on a round rug and silently witnessing the dream's turmoil. Rochelle felt that the female cat figure symbolized something old and complex, as if it held attributes of both a Wise Woman and a Terrible Mother in its centered witnessing. From this center and with the continued empathic witnessing support of her therapist, Rochelle's inner and outer lives gradually changed as she mulled over her life history and her powerfully archetypal myth and dream material. It was not enough for her to experience something of this intensity in the consulting room; she needed to see what the images meant in her own life. As Rochelle slowly reclaimed and integrated the cat, the animus figures, and finally the good-enough mother analyst in herself, the black cat figure in her dreams assumed a human form. Rochelle decided to leave an analysis that had taken three and a half years; there followed a newly creative turn in her work, and she also risked loving a quiet and fallible man. Over the next few years, Rochelle returned to her therapy for brief periods in times of crisis or as her complexes reappeared, but she generally could rely on her inner therapist for recentering herself.

SUMMARY

Jung pioneered an approach to the psyche that attracts a growing number of people through its breadth of vision and its deep respect for the individual. Rather than pathologizing, Jung looked for the meaning behind symptoms, believing that symptoms held the key to their own cure. Jung discovered methods and techniques for tapping into the self-healing potential in human beings and taught a process that engages therapist and patient alike in a profound and growth-promoting experience. Jung's purpose was to assist psychological development and healing by involving all aspects of the personality.

Analytical personality theory provides a map of the psyche that values the unconscious as much as consciousness, seeing each as complementing the other. In the personal realm, the personal conscious (the ego or I) and persona (the social mask) are matched with the personal unconscious. The personal unconscious contains things repressed, forgotten, or at the verge of consciousness, as well as the personal shadow (what the ego does not accept in itself) and the animus and anima (ego-alien contrasexual elements). The impersonal or collective unconscious can never be known, but it can

be pictured as a vast deposit that flows into the personal unconscious and consciousness by means of archetypal images: propensities, motifs, and forms common to all humanity. The interface between the collective and personal unconscious may represent the most archaic and least-mapped layer of the psyche. Complexes grow in this interface. Complexes are energy-filled constellations of psychic elements that have an archetypal core and erupt into consciousness, often in an autonomous way. They are both personal and impersonal. The personal unconscious is created by the individual and ultimately is his or her personal responsibility. Since the collective unconscious is innate and impersonal, it would be an error for the individual to claim its powers or in any way identify with its contents. The unconscious itself is completely neutral and becomes dangerous only to the degree that the ego has a wrong relationship to it or represses it. The impersonal realm is home also to the collective consciousness, the giant matrix of the outer world in which an individual lives his or her life.

The archetype of the Self encompasses the personal unconscious and conscious and a bit of the other realms as they impinge on or seep into the personal. A newborn infant is immersed in the self; it soon splits (or deintegrates) into fragments of ego, consciousness, and unconscious. The task of psychotherapy is to consolidate the ego and let the psyche heal and responsibly enlarge itself so that all the parts of the self can develop, reintegrate, and maintain a more balanced and less egocentric relationship with each other. In analytical psychotherapy, it is not enough to understand these concepts and their activity; they must be felt experientially by the individual in relation to the past and as they come into play in the therapy room through transference and countertransference. The new understanding then needs to be lived so that the individual can participate in life with integrity. To this end, experiential methods of analytical psychotherapy are especially valuable, as is the therapist's inclusion of the feminine dimension of receptive empathy, groundedness, nurturing, and ability to hold the personality as it develops. This generative approach allows growth and healing to take place alongside what can be gained from insight and interpretation.

Analytical psychotherapy stresses the patient-therapist encounter as one that involves empathy, trust, openness, and risk. Through the interaction of the two personalities and the quality of this relationship, the self-regulating and healing potential of the personality can come into play, repairing old wounds while allowing the individual to grow in self-knowledge. This is why analytical psychotherapy stresses the quality, training, analysis, and continuing self-analysis of therapists.

Depth psychotherapy, as it is understood today, is less than a century old. Jung often wrote of psychology being in its infancy, and he believed no one map of its realm could be complete. Depth-oriented psychotherapeutic systems of all types contain more similarities than differences. The systems reflect the language and style of their creator and attract those of like mind. It is as if all the founders of the varied schools have drawn slightly different maps of the same terrain—the human psyche. Although the particular style of these maps varies, those that are still useful have more and more in common as original rivalries are forgotten and each is freer to borrow what it needs from the others. At the same time, a specifically Jungian map may be best for one person, whereas someone else may need an Adlerian, a Rogerian, a neo-Freudian, or some other map.

Jungian psychology is especially inclusive, because its four stages of therapy cover essential elements of the others' theories while adding a particular emphasis on wholeness, completion, and individuation. Analytical psychotherapy allows room for the depths of the collective unconscious and the width of humanity's collective history, art, and culture, while grounding itself solidly in the particular individual at a particular time and place. It is a rich and diverse system that rests on a theory whose practice undergoes constant transformation as the experience and needs of the individual and society both change.

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A clear, succinct portrayal of the basic concepts of analytical psychology, this book also gives a good account of the early history of depth psychology. Part One sets out Jung's ideas on the psychology of the unconscious, clearly differentiating the personal from the impersonal unconscious. Part Two deals with the ego and its relationship to the personal and collective unconscious and to the task of integration and individuation.

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Reflecting Jungian theory in its development and in practice, this book presents and reclaims the importance of a feminine as well as a masculine way of doing therapy and being in the world. Chapter Three traces the development of a Jungian body-aware, nurturing, and receptively attuned way of doing therapy that values nonverbal and early-attachment states. Chapter Four includes a long case study of the analysis of a middle-aged man integrating his masculine and feminine sides.

Kalsched, D. (1998). Archetypal affect, anxiety and defense in patients who have suffered early trauma. In A. Casement (Ed.), *Post-Jungians today: Key papers in contemporary analytical psychology* (pp. 83–102). New York: Routledge.
Kalsched discusses the ways in which the psyche internalizes trauma and demonstrates the self's role in defending the psyche. He describes the way a self-care system often keeps the trauma victim at the mercy of sadistic, self-attacking internal figures and dreams. Kalsched considers dreams and dream images about these terrifying "dark forces," as well as a dream that demonstrated a core positive side to a patient's psyche and an opening toward healing. After a historical overview of depth psychologists' work on primitive anxiety and defense, he ends with a discussion of the transformation possible in therapy.

Papadopolous, R. K. (2006). *The handbook of Jungian psychology: Theory, practice, applications.* New York: Routledge.
This clear and concise delineation of the basic tenets of analytical psychology and its current developments is authored by many (often British) authorities. Part One sets out Jung's basic theory in seven chapters covering Jung's epistemology, the unconscious, archetypes, shadow, anima/animus, psychological types, and the self. Part Two concerns therapy, Part Three applications to other fields. Each chapter discusses Jung's position, his major innovations, and the relevance of his theories; developments since Jung's time; and the current status of analytical psychology and trends for future development.

Rosen, D. (2002). *Transforming depression: Healing the soul through creativity.* York Beach, ME: Nicholas-Hays.
A practical book on treating depression and suicide that offers a creative way for therapists to help their clients turn away from self-destruction and hopelessness and toward a more meaningful life. The book is a good overview of crisis points and suicidality—as well as of current diagnosis and treatment—from biological, sociological, psychological, and spiritual perspectives. Part Three of the book is particularly useful to the clinician; it follows in detail the treatment of four patients and illustrates Rosen's theory put into practice.

Sedgwick, D. (2001). *Introduction to Jungian psychotherapy: The therapeutic relationship.* Philadelphia: Taylor and Francis.
This is a detailed account of analytical psychotherapy that focuses on the unique relationship between patient and therapist. Sedgwick's well-argued thesis is that this relationship constitutes the main healing factor in psychotherapy. He demonstrates this belief using both traditional Jungian theory and such post-Freudians as Bion, Klein, Kohut, and Winnicott. A clear, concise, and grounded basic teaching text on clinical issues, it is especially thorough on transference and countertransference in therapy and on ways to set up and maintain the practical components of a good therapeutic relationship. Clinical examples are particularly well chosen.

Singer, T., and Kimbles, S. (Eds.). (2004). *The cultural complex: Contemporary Jungian perspectives on psyche and society.* New York: Brunner-Routledge.
This is a key book written by academics and analysts from many countries and cultures. It examines the psychological nature of conflict from a Jungian perspective and presents a clear picture of its source in both personal and cultural complexes. It looks at cultural complexes historically as played out in Jung, Freud, and their followers' quarrel. It examines racism with an excellent case history. Its strongest chapters focus on the way collective and personal trauma fuel cultural complexes.

Withers, R. (2003). *Controversies in analytical psychology.* New York: Brunner-Routledge.

Eleven mostly clinical differences of approach in current analytical practice are discussed by 24 Jungian analysts or psychotherapists. Some of the issues debated are the prospects for a Jung/Klein synthesis; the status of developmental theory; working with the transference; the role of interpretation; frequency of sessions and keeping the analytic frame; integrating the body/mind split; and political, religious, and gender issues, as well as a rare discussion of the heterosexual framing of most theory and how this might affect homosexual analysts and patients.

Young-Eisendrath, P., and Dawson, T. (Eds.). (2008). *The Cambridge companion to Jung.* 2nd ed. Cambridge, Eng. and New York: Cambridge University Press.

A critical introduction to Jung's theory and work and their importance to current psychotherapy, this book is divided into three parts. Part One discusses Jung's ideas and their context. Part Two examines Jungian psychology in practice, with chapters on archetypal, developmental, and classical approaches to psychotherapy and a case study discussed from these three vantage points. Part Three addresses analytical psychology in contemporary society, literature, gender studies, politics, and religion.

CASE READINGS

Abramovich, H. (2002). Temenos regained: Reflections on the absence of the analyst. *Journal of Analytical Psychology, 47*(4), 583–598.

Two cases are used to illustrate boundary and containment issues. The first and lengthier discussion is of a woman who needed to preserve the analytic container while her therapist was away for several months. The case is explored in much detail, and a novel and healing way to provide a holding space is found. Abramovich's discussion of maternal reverie and maternal holding in therapy is of special interest. In the second case, the patient has a chance extra-analytical encounter with his therapist, who exits quickly. The patient perceives Abramovich's sacrifice of his self-interest as an effort to preserve the patient's space; he contrasts it with the way someone in his household took advantage of him over many years. For the first time, the patient could experience a safe place both within and outside of the therapy.

Beebe, J., McNeely, D., and Gordon, G. (2008). The case of Joan: Classical archetypal, and developmental approaches. In Young-Eisendrath and Dawson (Eds.), *Cambridge companion to Jung* (pp. 185–219). Cambridge, UK: Cambridge University Press.

Three analysts focus on the study of a 40-year-old woman suffering from an eating disorder, each with an emphasis on a different style of Jungian therapy.

Douglas, C. (2006). The case of Bruce. In C. Douglas, *The old woman's daughter.* College Station, Texas A&M University Press.

This case study demonstrates the way a Jungian therapist uses dream and analytical work to help a client overcome a midlife crisis through the reintegration of cut-off aspects of himself, especially his feminine side. The case highlights issues of transference and countertransference. [Reprinted in D. Wedding and R. J. Corsini (Eds.). (2011). *Case studies in psychotherapy.* Belmont, CA: Brooks/Cole.]

Jung, C. G. (1968). An analysis of a patient's dream. *Analytical psychology: Its theory and practice.* New York: Pantheon.

This analysis of a patient's dream is taken from one of Jung's speeches. It demonstrates the ways in which dreams can be used to support clinical inferences.

Kalsched, D. (1996). The inner world of trauma in a diabolical form, and further clinical illustrations of the self care system. In *The inner world of trauma: Archetypal defenses of the personal spirit,* Chapters One and Two (pp. 11–67). London and New York: Routledge.

Important case reading on trauma and post-traumatic stress, the two chapters present a series of nine cases, discussed and interpreted, in which early childhood trauma has produced similar defenses, repetition compulsions, and self-care systems that further isolate and attack each of the patients. Healing is shown as occurring in a similar manner across all cases.

Kimbles, S. L. (2004). A cultural complex operating in the overlap of clinical and cultural space. In T. Singer, and S. Kimbles, (Eds.), *The Cultural Complex: Contemporary Jungian perspectives on psyche and society* (pp. 199–211). New York: Brunner-Routledge.

The relationship between personal complexes and a cultural complex is explored in the analysis of a patient and analyst of different races and genders. The material is clearly portrayed through the dreams and fantasies of the patient and through the dynamics of transference/countertransference as experienced by the analyst.