THE WRITTEN PSYCHODYNAMIC FORMULATION IN A JUNGIAN FRAMEWORK

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"Neuroses are still – very unjustly – counted as mild illnesses, mainly because their nature is not tangible and of the body. People do not "die" of a neurosis – as if every bodily illness had a fatal outcome! But it is entirely forgotten that, unlike bodily illnesses, neuroses may be extremely deleterious in their psychic and social consequences, often worse than psychoses, which generally lead to the social isolation of the sufferer and thus render him innocuous. An anchylosed knee, an amputated foot, a long drawn out phthisis, are in every respect preferable to a severe neurosis. When the neurosis is regarded not merely from a clinical but from the psychological and social standpoint, one comes to the conclusion that it really is a severe illness, particularly in view of its effects on the patient's environment and way of life" (Jung, 1935b, para. 37).

"The content of a neurosis can never be established by a single examination, or even by several. It manifests itself only in the course of treatment. Hence the paradox that the true psychological diagnosis becomes apparent only at the end" (Jung, 1945, para. 197).

"[M]ost neuroses are misdevelopments that have built up over many years, and these cannot be remedied by a short and intensive process. Time is therefore an irreplaceable factor in healing" (Jung, 1935b, para. 36).

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ABSTRACT

The present thesis has two main aims. The first of these is to examine the reasons behind the author's finding during his training for the MA (Clinical Psychology) degree that there is a tendency in the Jungian literature for analytical psychology to be presented in a way which is distanced from the practical realities of the clinical situation. This examination is conducted through an appraisal of the Jungian literature and several clear, substantial reasons are revealed. The second aim has two parts to it. The first part is to attempt to justify using Jungian theory in the diagnostic and assessment context of clinical work. This is done by showing that two models, the individuation and medical models, both exist in analytical psychology but that the medical model has been under-emphasized. Following this, the psychodynamic formulation is situated in the context of clinical psychology in order to show its relationship to the diagnostic and assessment context of clinical work. The second part is to attempt to partly fill the gap in the Jungian literature through providing a format for the psychodynamic formulation in a Jungian framework and to show how the Jungian psychodynamic formulation informs management planning, with particular emphasis being placed on the assessment of patients for psychotherapy. This is done through providing provisional guidelines for the construction and use of the psychodynamic formulation in a Jungian framework in the context of a training programme such as the one the author has been in. Finally, a brief comment is included about a contrast which the author sees between the thesis of pluralism and his own views on the theoretical diversity that is employed in the present thesis.

CONTENTS

Quotations

Acknowledgements

Abstract

Contents

		Page
Part 1.	Introduction	1
Part 2.	Reasons for a lacuna of clinically related material in the Jungian literature	5
Part 3.	The medical and individuation models in Jungian theory	12
Part 4.	Clinical psychology and the psychodynamic formulation	18
Part 5.	A comment on pluralism	24
Part 6.	Aspects of Jungian theory necessary for the psychodynamic formulation	27
Part 7.	The written psychodynamic formulation in a Jungian framework	42
Part 8.	A case example	53
Part 9.	Conclusions	65

Bibliography 67

PART 1

INTRODUCTION

The incentive for the present thesis stems from the author's experience during his training for the MA (Clinical Psychology) degree at the University of Cape Town from 1989 to 1991. On the basis of his academic, clinical and personal experience, he had developed a preference for Jungian theory above other personality theories. He found, however, that there was no format available in the Jungian literature for the doing of the psychodynamic formulation. The author also found that there was very little available in the Jungian literature on the subject of the assessment of patients for psychotherapy, a subject which the psychodynamic formulation is very closely related to (Malan, 1979, pp.231-238). Although there was some teaching input on these topics using Jungian theory that was helpful to him, it formed an ongoing source of puzzlement and concern that there were these gaps in the literature.

The situation was clearly different in the psychoanalytic literature and in some of the psychiatric literature, namely where psychoanalytic theory had been drawn on. Relevant topics dealt with by specific sources in this literature that had come to the author's attention are as follows: the aetiology of the neuroses in classical psychoanalytic terms (Fenichel, 1946), how to do an assessment for psychotherapy (Malan, 1979) and the psychodynamic case formulation (MacKinnon & Yudofsky, 1986; Perry, Cooper & Michels, 1987). Characteristics common to all of these are that clear, direct links are made between psychoanalytic theory and the assessment context of clinical work. Fenichel's book is pertinent to this context since it serves as a kind of handbook which can be used as an aid to understanding the patient's presenting problems and dealing with them in psychotherapy.

These differences between on the one hand the Jungian and on the other hand the psychoanalytic and psychoanalytically-oriented literature did not seem to only have to do with the assessment context of clinical work. Referring to Jung's Collected Works, Storr (1973) notes that:

> He writes next to nothing about the effect of analysis upon the patient's life in the world or upon his personal relationships. Obviously, if a person becomes happier, more balanced, more integrated, one expects that his personal relationships will improve. One might also hope that he would become better at his job, or take up a new career. But Jung says nothing about all this. [And] in discussing his patients, he tells us about their dreams and phantasies,

> but next to nothing about the persons to whom these dreams and phantasies occurred. This is why the Collected Works of Jung discourage the average reader. Unless he is exceptionally persistent, he is unlikely to find anything which seems remotely connected with day-to-day problems, neurotic symptoms, sexual difficulties, and all the other matters which may make a person turn to books on psychology and psychotherapy (p.90).

To focus on the secondary sources in the Jungian literature which do cover more closely what actually goes on in the clinical setting, there is actually material available on case studies, on the aetiology and treatment of a particular problem or disorder, or on conducting Jungian analysis or psychotherapy; for example, Fordham, Gordon, Hubback, Lambert & Williams (1973, 1974), Woodman (1980), Fordham (1986), Schwartz-Salant (1982, 1988), Samuals (1989a), Jacoby (1990) and Steinberg (1990). Nevertheless, despite such contributions it still remains generally true that the Jungian literature tends to lack clarity and practical applicability unless one is thoroughly familiar with Jung's point of view. As Hall points out, the "... Jungian literature generally does not clearly demonstrate how to translate the concepts [of Jungian theory] into practice". Hall further believes that "While it is admittedly difficult to do this without the experience of a personal analysis, it is still possible to absorb the true spirit of Jung's work through written material of a more clinically descriptive nature". He also mentions some recent literature which has had this aim, namely certain of the Inner City Books series and the journal *Chiron* (Hall, 1986, p.16). It is the author's view that this tendency for analytical psychology to be presented in a way which is distanced from the practical realities of the clinical situation represents a one-sidedness of the Jungian approach in general. This issue will be explored more fully in Part 2.

This dissertation attempts the following: firstly, to unravel the reasons that may have led to the circumstances regarding the Jungian literature described above; secondly, to justify using Jungian theory in the diagnostic and assessment context of clinical work and then to attempt to partly redress the gap in the literature by providing a format for the psychodynamic formulation in a Jungian framework and to show how the psychodynamic formulation informs management planning, with particular emphasis being placed on the assessment for psychotherapy. He also reasoned that it would be worthwhile to provide provisional guidelines for the construction and use of the psychodynamic formulation in a Jungian framework in the context of a training programme such as the one he has been in.

Some comments on the literature: Research into the psychology and psychiatry literature with a bearing on psychodynamic formulation yielded a substantial amount of information. References will be made to this literature throughout the present thesis; a large proportion of it will be covered separately in Part 4 when the role of the psychodynamic formulation in psychotherapy research is discussed. Two points about this literature must be mentioned here. Firstly, in the preface to their book, MacKinnon & Yudofsky (1986) note that, to "... the best of our knowledge, the chapter on the psychodynamic case formulation, with its three sample formulations, is the only published work of its kind" (p.ix). This is not entirely accurate. Work that dealt with the psychodynamic formulation was published previously: for example Whitehorn, 1944; Weisman, 1959 and Malan referred to in DeWitt, Kaltreider, Weiss & Horowitz, 1983. However, it may be true that MacKinnon's and Yudofsky's format is the most comprehensive and the most suitable for treatment purposes (rather than research purposes) published to that point. Secondly, while the present thesis consists in part of an attempt to extend Jungian theory to the clinical context of case assessment and formulation, drawing on where psychoanalytic theory has been used for this purpose and motivated by the way in which psychoanalytic theory has been presented in the context of clinical reality, it is ironic that Friedman & Lister (1987) note that during their psychiatry residencies they developed "... the suspicion that our instructors had no clear idea or uniform model of formulation in mind to teach us ... In moving on to other training centers, into psychoanalytic training, and into the teacher's role ourselves, we found that the ambiguity surrounding the nature of psychodynamic formulation persisted" (p.126). Hence, it seems that even in psychoanalysis, attempts to clarify the nature of the psychodynamic formulation have only been made fairly recently.

Finally, a paper prepared recently by Levett (1991) for use at the Child Guidance Clinic, University of Cape Town, on the clinical formulation is pertinent here. The format used seems to be derived from the 'Maudsley' format for 'Formulation' which consists of a number of sub-sections, one of which is the psychodynamic formulation. (The format used in the Cape Town hospital service and which is derived from the Maudsley format is reproduced in Gillis, 1986, pp.251-260. Hereafter it will be referred to as the 'Maudsley'.) Since this paper represents Child Guidance Clinic policy on the training of interns on this topic, four important features of it should be mentioned. Firstly, in referring to the drawing up of the psychodynamic formulation Levett points out that "[a]ny psychological theory which throws light on the problems may be used. This may be psychoanalytically based, .. or cognitive behaviourist, family

systems theory, or some other framework . . ." (p.5). Although the use of the term 'psychodynamic' to pertain to psychoanalysis is regarded by English & English (1958) as ". . . unduly restrictive and unnecessary . . .," in the author's impression from the (mainly psychiatric) literature this is its most widely accepted meaning, with regard to both 'psychodynamic' and 'psychodynamic formulation' (for example, see Friedman & Lister, 1987, pp.131-132). However, this may not be the correct meaning of these terms. According to Prof. L.S. Gillis of the Department of Psychiatry, Faculty of Medicine, University of Cape Town (personal communication) the psychodynamic formulation does not refer to psychoanalysis; it refers to an explanation of how the aetiological factors as outlined in the aetiological formulation (see Part 7) *using*, for example, Freud, Rogers, Jung, systems theory, etc. have affected the patient and led to him or her becoming ill. These points are important as they indicate that there seem to be different meanings associated with the terms 'psychodynamic' and 'psychodynamic formulation'. The reader should note that although the term 'psychodynamics' has usually been used in the present thesis to refer to the use of psychoanalytic or Jungian theory, this is not meant to exclude the use of other theoretical perspectives to describe or discuss psychodynamics. In Part 7, some different meanings associated with the term 'psychodynamic formulation' will be apparent from the different formats that have been put forward for the psychodynamic formulation just by psychoanalytically oriented authors alone. Secondly, Levett writes, "Sometimes it is useful to draw on more than one theory (for instance, a psychoanalytic theory may inform your understanding of the case but you may choose or be forced to work in family therapy, behaviour modification, or parental counselling, because of constraints of training, time or client resources)" (ibid). Here Levett is indicating that the clinician may need or want to understand the case from different theoretical perspectives before spelling out management details in the management plan. Apart from again drawing attention to the above comments about the different meanings associated with the term 'psychodynamic formulation', Levett's statement points to the fact that the theoretical orientations that inform one's understanding of the case and those of the treatment modality do not have to be the same. Thirdly, her paper seems to be intended mainly for the kind of cases typically seen at the Child Guidance Clinic, i.e. children and their families. The reader is referred to Part 4 where the question of when and for whom to do a psychodynamic formulation will be dealt with. Finally, Levett makes useful practical suggestions in her paper which will be employed in the present thesis.

PART 2

REASONS FOR A LACUNA OF CLINICALLY RELATED MATERIAL IN THE JUNGIAN LITERATURE

In this section, reasons for the absence of clinically related material in the Jungian literature will be examined.

Freud's and Jung's attitudes towards symptoms: The first reason that will be examined concerns Freud's and Jung's different attitudes towards symptomatology. Despite the shift in emphasis from the identification of an organic to a psychological aetiology for certain 'nervous conditions', it seems true that Freud remained committed to a scientific-causal model; perhaps this reflected his extensive medical and neurological experience. As Frey-Rohn writes, in ". . . explaining the origin of neurosis, Freud retained the basic concept that neurosis *was caused by childhood experiences*" (Frey-Rohn, 1990, p.206; emphasis added). Jung felt that ". . . Freud's most significant achievement . . . lay in investigating the symptomatology and etiology of the disease and, particularly, in analysing the decisive mechanisms, chiefly repression and regression" (ibid, pp.212-213). However, as little as Jung was inclined

> to carry the origin of the neurotic conflict back to childhood, so was he, in general, reluctant to reduce it to personal problems. In 1912 he had already emphasised that problems common to all mankind could manifest themselves in neurosis. In such instances, neurotic disease seemed to represent 'an unsuccessful attempt on the part of the individual to solve the problem in his own person' [Jung in ibid, p. 215]. . . . [Hence,] Jung complemented circumstances relevant to the patient's life with those pertinent to goals and issues common to all [people]. This approach was later much enhanced by Jung's investigations into the problems of the collective unconscious and the archetypes. (ibid)

Elsewhere Frey-Rohn writes that "... the causal explanation of neurosis became less and less interesting to [Jung]. He increasingly recognised the hidden meaning of the symptom – the underlying archetypal process – as the symptom's essential aspect" (ibid, p.216). Apart from pointing to Jung's emphasis on its symbolic content in these extracts, Frey-Rohn is also pointing to Jung's claim that the aetiology of the neurosis also lies in the here-and-now, in the patient's attitude to life at the moment. In Jung's words:

> Freud emphasizes the aetiology of the case, and assumes that once the causes are brought into consciousness [i.e. and the associated libido released] the neurosis will be cured. But mere consciousness of the causes does not help any more than detailed knowledge of the causes of the 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. . . . The regressive tendency only means that the patient is seeking *himself* in his childhood memories, sometimes for better, sometimes for worse. His development was one-sided; it left important items of character and personality behind, and thus it ended in failure. That is why he has to go back (Jung, 1930, paras. 53 & 59).

Jung's attitude towards illness: In addition to the above difference from Freud, Jung emphasised ". . . that sick people exist as well as sickness . . ." (Jung in Frey-Rohn, 1990, p.213), and that the real point of treatment is the whole person " – not just his neurosis which, after all, was only a contrived diagnostic term" (ibid).

These extracts, which demonstrate Jung's different views from Freud on neurosis and his different approach to an individual suffering from neurosis, shed some light on why there is an absence of a Jungian equivalent to a book like Fenichel's (referred to in Part 1). Apart from stating his differences from Freud, however, Jung also stated that the domain of neurosis that began in childhood belonged to Freud and that his theories were correct in many essentials.

Freud's and Jung's different patient populations: Another factor contributing to the differences in the literature concerns Jung's patient population. Spiegelman notes, "Psychoanalysis was founded on work with younger people with hysterical and obsessive- compulsive symptoms, hence the theory" (Spiegelman, 1989, p.62). On the other hand, Jung wrote that most of his cases

> already have some form of psychotherapeutic treatment behind them, with partial or negative results. About a third of my clients are *not suffering from any clinically definable neurosis*, but from the senselessness and aimlessness of their lives. . . . Fully two thirds of my patients are in the second half of life. [And they] are socially well-adapted individuals, often of outstanding ability, to whom normalization means nothing (Jung, 1931, paras.83-84; emphasis added).

By normalization Jung meant the Freudian ideals that ". . . social adaptation and normalization are

desirable goals, that they are absolutely necessary, the consummation of human life" (Jung, 1929, para. 152). However, it should not be understood that the type of patients that Jung is referring to do not have neurotic problems or symptoms, but rather that they have managed to get through the 'first half' of life with a good adaptation (Jung, 1935a, para. 11). It was with this sort of patient that Jung developed the classical symbolic-synthetic method of analysis (McCurdy in Stein, 1984, p.48). McCurdy states that Jung

> was concerned mainly with the classical symbolic-synthetic approach. He did not give precise directives about how analysts should structure their work or deal with the numerous details that inevitably confront them, such as the physical setup of the office [Jung did, however, state that he preferred it if he and the patient sat opposite each other] or the beginning of an analysis (ibid., p.50).

As regards Jung's treatment of the patients whom he mostly dealt with, Samuals (1985a) writes that

> Memories of those who worked with Jung often present him as a sort of analytical trickster: master of insights, wisdom, intuition and one who did not demur from admonishing, instructing or suggesting. . . . For those who may be thought of to have had a 'reductive analysis', as Jung hints, such input coming from the analyst seems more appropriate. Jung's analytical input centred on his psychological elucidation of his patients' images using 'the history of religion in its widest sense, mythology, folklore and primitive psychology'. This 'treasure house of archetypal forms' enables the analyst to 'draw helpful parallels and enlightening comparisons. . . . Experience has shown that the best way to do this is by means of comparative mythological material' [Jung, 1944a, para. 38]. It is on this that the [classical symbolic-synthetic] method rests (pp.197-198).

Samuals also points out that

> Jung has left neither classification of neurosis nor a statement about the borderline between neurosis and psychosis. Nor does he link presenting symptoms and aetiology. Post-Jungians, particularly, but not exclusively, of the Developmental School, have had to lean heavily on psychoanalytic expertise in classifying neuroses and upon its skill in delineating the syndromes brought about by childhood experience (ibid, p.177. See also McCurdy in Stein, 1984, pp.55 ff).

The author's impression is that Samuals is referring to, for example, descriptions of the neuroses as in Fenichel (1945) and the work of object-relations analysts on borderline, narcissistic and schizoid characterological defects.

Jung's analytic technique: On the topic of analytic technique, Zinkin notes that

> Analytical psychologists as a group appear to concern themselves less with problems of technique than perhaps any other comparable group of therapists. Most of the published work follows Jung's own writings in concentrating on psychological content rather than on method, and yet this very content, the data on which we depend to enlarge our knowledge, may well depend on the method used to collect it (Zinkin in Fordham et al, 1974, p.45).

It seems that this refers to a correlation between Jung's method, the contents that emerge in analysis where that method is employed and the kind of patient that Jung typically dealt with.

The effect of the Freud-Jung split: Writing on the effect that the parting of ways between Freud and Jung had on the literature, Stein (1988) claims that in the

> classical consensus, an unofficial taboo was placed upon Freud and his writings and even upon the writings of his followers. . . . In its literature there was little reference to authors or works outside of the inner circle. Epigones would quote Jung, and Jung would occasionally refer to one of them. The tradition began to isolate itself and soon became rich enough internally to support a kind of autonomous culture. Methods of treatment, clinical theories, metapsychological viewpoints, cultural commentaries, case reports, interpretations of religion, culture and myth all wove together to create a body of literature with little or no reference to the wider field of psychoanalysis. The only time reference would be made to Freud or to psychoanalytic thinkers would be to use them as contrast points or to rebut their short- sightedness . . . [M]ore and more one had the sense of an autonomous Jungian tradition, which learned from history of religions, from anthropology, from classical studies, from philosophy and literature, but *not* from other clinical schools, psychoanalytic or other. This gave a sort of non-clinical flavor to the literature and turned it into something akin to cultural hermeneutics (p.4).

Stein continues,

> In the last ten years, however, the field has begun to change rapidly, and Freud and psychoanalysts are no longer the taboo contents they once were. As this material has come flooding into our field during these last years, the shadow has come along, creating anxiety about identity, integrity and self-worth. . . . There may have been a period in the heyday of the classical consensus when Jungians felt they had the world by the tail. . . . The other clinical schools were looked upon as hopelessly . . . bogged down in superficial concerns of adjustment, symptom relief, or obsessive analysis of the personal unconscious. I do not believe Jungians would generally speak this way today. . . . The appearance of the repressed shadow of classical Jungianism has made it much more difficult than before to deny history and development. . . . Jung led the field away from developmental issues, transference and countertransference, childhood and infancy, and personal psychodynamics. These issues

> were taken up in Jung's thought, but symbolically, and they thus became relativized by the plethora of archetypal themes discovered in the unconscious. [According to the classical consensus, t]here was no point in investigating infancy, childhood, transference, treatment outcomes, unresolved problems in psychic functioning, etc. These kinds of questions were left to the shadow field, psychoanalysis, which did meanwhile continue developing its own clinical and theoretical tradition precisely along these lines. . . . In opening up the path into this region of shadow, the image of Jung, our hero and father, has become altered. . . . Now instead of quoting only Jung for authority, one quotes Jung and . . . Winnicott, Kohut, Jacobson, Klein and even Freud (ibid, pp.5-7).

The author disagrees with Stein that Jung ". . . led the field away . . ." and prefers to see the break between Freud and Jung in terms of Jung ". . . going deeper and further in his pioneering explorations . . ." (ibid, p.5); hence, the emphasis is on 'going further' rather than 'leading away'. However, the author agrees with Stein that the 'shadow' he discusses did come to exist historically. While this seems true, however, it must not be overlooked that Jung advocated using other theories, namely those of Freud and Adler, whenever they were applicable (Jung, 1931, paras. 74 & 76; 1935a, para. 24). With regard to psychoanalysis, Jung wrote that he ". . . would not call any treatment thorough that did not take into account [the regressive tendency,]" which he saw as the domain of psychoanalysis (Jung, 1930, para 54).

Introversion and extraversion in the theories of Freud and Jung: Finally, it is possible that another factor that has contributed to the differences in the literature concerns the possibility that psychoanalysis and psychoanalytic psychologists reflect Freud's extraversion and that the reverse holds true for Jungian theory and Jungian psychologists. In his autobiography, Jung stated that his book *Psychological Types* which he worked on immediately following his break from Freud,

> sprang originally from my need to define the ways in which my outlook differed from Freud's and Adler's. In attempting to answer this question, I came across the problem of types, for it is one's psychological type which from the outset determines and limits a person's judgement (Jung, 1983, p.233).

In this book, he explained how Freud's view ". . . is essentially extraverted, Adler's introverted" and furthermore states that their standpoints ". . . are equally one-sided and characteristic of one type" (Jung, 1971, paras. 91-92). Jung's reasoning regarding Freud was that the ". . . basic formula with Freud is . . . sexuality, which expresses the strongest relation between subject and object . . ." (ibid, para. 91). Therefore, it seems possible that psychoanalysis, with its emphasis on the transference and

countertransference (particularly post-Freudian psychoanalysis), reflects a more extraverted attitude than is commonly found among Jungians. In addition, this extraverted orientation may also be behind why psychoanalysis has been so successfully applied to the clinical context of assessment since, it may be argued, it is here that the clinician must be highly aware and critical of his or her relationship with the patient and of the external dimensions of the patient's life (e.g. outside influences, job, relationships, and so on). Conversely, it seems true that the Jungian literature reflects more interest in the inner and therefore more introverted imaginal world.

To summarise. It has been hypothesised that Jung's complementary views concerning symptomatology, his more 'holistic' approach to the patient, Jung's and Freud's different patient populations, Jung's symbolic-analytic method and differences in the contents of psychoanalytic and classical Jungian analysis, the acrimony surrounding Jung's parting from Freud and finally, a possible extraverted bias in psychoanalysis and an introverted one in analytical psychology are all factors that have contributed to differences between the psychoanalytic and Jungian literature. (This list of factors may not be exhaustive.)

In what follows in Part 3 an attempt will be made to justify using Jungian theory in the diagnostic and assessment context of clinical work. It seems that this will be necessary because of how long the absence of clinically related material in the Jungian literature has existed and before attempting to partly fill the gap with the practical proposals contained in the present thesis. This will be done by showing that two models, the individuation and medical models, each of which are influenced by archetypal elements, already exist in analytical psychology. It will be shown that the individuation model has traditionally been favoured by analytical psychologists but that the use of the under-emphasised medical model will naturally and comfortably allow for the use of Jungian theory in the manner suggested.

The predominance of the individuation model in analytical psychology as a reason for the differences between the Jungian and psychoanalytic literature has not been used in the preceding argument. Whilst it is fairly clear that the medical model is present in both theories, it is not clear what the psychoanalytic equivalent of the individuation model is. This makes comparison of the two theories on the level of what weighting each gives to each model difficult, if not impossible. It seems true, however, that the

medical model has been favoured more by psychoanalysts than it has been in analytical psychology and hence that this could count as another reason, although this may have been covered implicitly to some extent above already.

PART 3

THE MEDICAL AND INDIVIDUATION MODELS IN JUNGIAN THEORY

The medical model: From a Jungian perspective, the medical model is based on the archetypally generated situation of the projection of the image of the inner healer onto the figure of the doctor or analyst and by the assuming of the identity of this image by the latter. From a psychological perspective, this inner image represents a potential to heal oneself or to be healed, in everyone. This psychologically determined configuration makes the social configuration possible of the healer as an authority who is consulted by the sick patient who needs help. (See Groesbeck, 1975 and Guggenbühl-Craig, 1971.) Within this age-old psychological and social configuration, and with the accumulation and consolidation of practical knowledge, the medical model has developed as a rational, scientific approach to healing (Ziman, 1976, pp.146-165).

The individuation model: The individuation model, on the other hand, is based on different unconscious factors – in this instance, these concern the idea of individuation (Zinkin, 1984, p.119). Within this model, psychological development over the lifespan is taken as a

> spontaneous, natural process in the psyche; it is potentially present in every[body], although most [people] are unaware of it. Unless it is inhibited, obstructed, or distorted by some . . . disturbance, it is a process of maturation and unfolding, the psychic parallel to the physical process of growth and aging (Jacobi, 1968, p.107).

From the point of view of the medical model, the patient is said to have pathological symptoms (i.e. thoughts, feelings or behaviours) that can be generally identified by virtue of their already having been investigated by research, described in textbooks, and so on. Ideally the object of a successful medical treatment would be to remove these symptoms and return the patient to health (Hall, 1986, p.45). From the point of view of the individuation model, the above approach overlooks the *meaning* associated with the problematic thoughts, feelings or behaviours and fails to consider them within the context of the individual's whole life and the psychological world which he or she has constructed for themselves. In the former, the object is to diagnose the problem and prescribe a course of treatment which will remove the symptom(s). In the latter, it is for the individual concerned to deal with the meaning of the symptom and to psychologically outgrow the problem (Jung in Jacobi, 1968, p.134).

It is widely accepted that the individuation model is inherent in Jungian theory. Before showing that the medical model is also present in the Jungian approach, it will be necessary to show that from a non-classical Jungian point of view the use of psychoanalytic theory is also part of using the individuation model. The implications of the latter point are that using the individuation model in assessment from a Jungian perspective will allow the clinician to use either psychoanalytic or Jungian theory or both.

Individuation and psychoanalysis: It has already been said that it is widely accepted that the individuation model is inherent in Jungian theory. This state of affairs seems too restrictive and only occurs because the process of individuation is identified with what Jung called the second half of life. This excludes the first half of life from the individuation process. That this is so is corroborated by Samuals (1983a). (For a description of these different stages, see Jung, 1930-1931). Jung had a separate meaning for "individuation" and he contrasted this with "normalization" (Jung, 1931, paras. 84 & 109) which he saw as the aim of psychotherapy with younger patients. McCurdy has discussed the non-classical trend of treating patients who are in the first half of life (McCurdy in Stein, 1984, p.50 ff). Shifting the perspective one has as a clinician on what constitutes individuation away from the classical Jungian notion allows one to appreciate that the individuation needs of a patient can be served by the use of psychodynamic theories other than analytical psychology where these are appropriate. In this regard, Samuals expresses the view that through the work of analysts from both the Archetypal and Developmental schools, "... the notion of individuation has been brought down to earth, democratized, located throughout life . . , and made available to the psychologically infirm" (Samuals, 1983, p.54).

Objections to the medical model: Samuals (1989a, p.7) and Zinkin (1984, p.124) list objections commonly made against the medical model. Zinkin's list is presented below:

1. It is impersonal – the patient is seen not as a person but in terms of his disease.
2. It aims at relieving symptoms, at best concerning itself with the cause rather than the meaning of symptoms for the patient, and may be content to accomplish this end even if at considerable cost to the integrity of the patient.
3. It sets the doctor up as an expert or, to use Lacan's happy phrase, "the subject who is supposed to know", which he is not.
4. It is based on a naive, optimistic view of health which denies the realities of death and decay.
5. It reduces the patient to an object. This means he is *passive* – plays no part in his own case – *mystified*, and *alienated*.

6. The whole process becomes over-institutionalized and may be used politically – to serve an ideology and to manipulate others.

Zinkin's attitude is that we need to accept all of these objections "... but to see them as dangers resulting from misuse of the model which is particularly great if it is our only model, rather than one ..." (ibid). He adds that analysts cannot manage without the medical model (ibid, p.117). He also points out that Jung never abandoned the medical model completely and that "... he had the rare gift of tolerating opposites in himself throughout his life" (ibid), although he also states elsewhere that the individuation model "... is the one Jungians prefer" (ibid, p.123). However, McCurdy concludes from a reference to Jung that he

> and his followers have emphasized the importance of sorting out the therapeutic needs of patients by giving careful consideration to their present psychological and real-life situations, their stages of development, their intelligence, ... their ego strengths, as well as their ability to be introspective (McCurdy in Stein, 1984, p.48).

McCurdy adds, however, that Jung

> never ceased to counsel against having too sanguine an attitude about knowing a patient's diagnosis precisely and definitively. 'There are only individual cases,' he wrote, 'with the most heterogenous needs and demands ... for which reason it is better for the doctor to abandon all preconceived opinions' [Jung, 1929, para. 163]. Yet at the same time he qualifies this somewhat "liberal" statement by adding: 'This does not mean that he should throw them overboard, but that in any given case he should use them merely as hypotheses for a possible explanation' [ibid]. It is typical of Jung's thought ... that he finds answers in the tension between opposites (ibid).

The medical and individuation models in Jung's writings: Both models can be seen to exist in Jung's own views on case assessment. Speaking on the issue of diagnosis with regard to psychotherapy, it seems that Jung came out strongly in favour of the use of the more individualized individuation model over the medical model. Jung gave the latter only minimum significance except insofar as it is necessary to be "... reasonably sure of the differential diagnosis between organic and psychic, and [to know] what a genuine melancholy is and what it can mean" (Jung, 1945, para. 197). Speaking, it seems, also on behalf of psychoanalysis, he stated that it is

> generally assumed in medical circles that the examination of the patient should lead to the diagnosis of his illness ... and that with the establishment of the diagnosis an important decision has been arrived at as regards prognosis and therapy. Psychotherapy forms a

> startling exception to this rule. . . . In general, it is enough to diagnose a 'psychoneurosis' as distinct from some organic disturbance – the word means no more than that. I have in the course of years accustomed myself wholly to disregard the diagnosing of specific neuroses, and I have sometimes found myself in a quandary when some word addict urged me to hand him a specific diagnosis. . . . The sonorous diagnosis of neuroses *secundum ordinem* ['as a matter of course'] is just a facade; it is not the psychotherapist's real diagnosis. His establishment of certain facts might conceivably be called 'diagnosis', though it is psychological rather than medical in nature. . . . [I]n psychotherapy the recognition of disease rests much less on the clinical picture than on the content of complexes. Psychological diagnosis aims at the diagnosis of complexes and hence at the formulation of facts which are far more likely to be concealed than revealed by the clinical picture (ibid, paras. 195-196).

In spite of Jung sounding so against the medical model, *both* models *can* be discerned in his approach to case assessment, albeit that they are inseparably entwined. He exhibits a distinct diagnostic orientation, which indicates the presence of the medical model in his approach. On the other hand, the individuation model is reflected by the 'psychological diagnosis' (with the emphasis on *psychological*), which he appears to see as separate from the 'medical diagnosis'. Also, despite Jung's bias towards the use of the individuation model in assessment and treatment, one does nevertheless find references to various diagnostic categories throughout his work, e.g. hysteria, obsessional neurosis, phobias and psychoses. What Jung called the 'psychological diagnosis' can be construed as the psychodynamic formulation. Note that Jung said of this 'diagnosis' that it is "[not] meant to be communicated; for reasons of discretion, and also on account of the subsequent therapy, [the therapist] usually keeps it to himself" and finally, that

> The content of a neurosis can never be established by a single examination, or even by several. It manifests itself only in the course of treatment. Hence the paradox that the true psychological diagnosis becomes apparent only at the end (ibid, paras. 196-197).

Other authors and the mixing of the medical and individuation models: It can be argued that various other authors, Jungian and psychoanalytic, also prescribe a mixing of the medical and individuation (or its psychoanalytic equivalent) models in case assessment. Frances & Cooper (1981) write that ". . . a sharp polarization of descriptive and psychodynamic observations [as the APA tried to do through the advent of the DSM-III] is artificial and misleading . . ." (p.1198). They claim that

> a modern psychiatrist must be expert in the techniques of both descriptive and dynamic interviewing and able to apply flexibly each type of data gathering to the particular needs of

> a given situation. . . . A clinician fixed on descriptive interviewing may learn a good deal about the patient's symptoms and course but evaluates incompletely the patient's conflicts, inter-personal relationships, likely transferences and resistences, and he or she may even miss clues to descriptive data that the patient is reluctant to reveal. On the other hand, clinicians who are excessively passive and attempt to gather data solely through the patient's associations may fail to ask the specific questions that lead to the appropriate DSM-III [or DSM-III-R] diagnosis. In the clinical situation, the descriptive and dynamic approaches are obviously overlapping and complementary, not opposed, and each is incomplete without the other (ibid, pp.1199-1200).

Malan (1979) suggests that the interviewer doing an assessment for psychotherapy must think and behave on several levels simultaneously: psychiatrically, psychodynamically, psychotherapeutically, practically, in terms of creating enough rapport in the interview and in terms of taking care of the patient's feelings in and about the interview (pp.210-211). It could be claimed that the combination of the medical and individuation models can also be discerned in Malan's approach.

More ways in which the medical and individuation models mix in the assessment context: There are other ways in which the medical and individuation models can be said to mix in the context of case assessment apart from the simple combinations of approaches that Frances & Cooper and Malan advocate. It could be argued that providing a psychodynamic formulation for a case is also a medical, diagnostic procedure in the sense that a 'psychodynamic diagnosis' is identified on the basis of an assessment. It seems as if Jung's position (see above) would fall into this category. This category could also be extended to include those occasions when looser psychodynamic diagnoses, which are not always accompanied by complete formulations, of, for example, borderline or narcissistic character pathology are made that do not necessarily coincide with descriptive psychiatric (and therefore medical) diagnoses of, correspondingly, borderline or narcissistic personality disorder (Frances & Cooper, 1981, p.1201). On a similar note, Zinkin writes that "In practice the division of patients into neurotic and psychotic, so important in psychiatric diagnosis, becomes a deceptive over-simplification in the analytic situation, where psychotic mechanisms can always be seen" (Zinkin in Fordham et al, 1974, p.60). In such instances, the clinician is diagnosing a condition using the medical model but at the same time is leaning heavily on developmental depth theory and therefore the individuation model and is hereby not being merely descriptive.

Zinkin also describes the models as mixed in practice. He writes that the

> medical model might be regarded by some as a sub-system of the individuation model, but I would be equally happy to regard it the other way round. We could regard dementia, for example, as an incurable obstacle to individuation . . . in our present state of knowledge – but a fever would be a curable one. On the other hand we could, as Jung was inclined to do, consider which of our patients might be suitable to undergo an individuation process and which might be more suitable for other methods, e.g. hypnotic suggestion, a Freudian reductive analysis, drugs, ECT, behaviour therapy, or no treatment at all. Even to enter into such a discussion is to use the medical model, and individuation could be just one available treatment [Note that Zinkin uses the term "individuation" in its classical sense discussed above.] (Zinkin, 1984, pp.123-124).

To summarize the essential points made so far: in Part 2 reasons were given for a lacuna of clinically relevant material in the Jungian literature; in what followed in Part 3 the medical and individuation models were presented and it was demonstrated that, although the individuation model was favoured, they were both present in Jung's approach to case assessment and that they are present in several other authors' approaches too; it was also shown that the use of psychoanalytic theory can be included in the use of the Jungian individuation model; the point of demonstrating that both models are present in Jung's approach to case assessment was to show that a foothold exists for the use of Jungian theory in the diagnostic and assessment context of clinical work.

Next, an attempt will be made to situate the psychodynamic formulation in the context of clinical psychology in order to show its relationship to the diagnostic and assessment context of clinical work.

PART 4

CLINICAL PSYCHOLOGY AND THE PSYCHODYNAMIC FORMULATION

Broadly speaking, the clinical psychologist's expertise falls into the following categories: psychological assessment and psychodiagnosis; psychometric assessment; treatment planning; the use of various therapeutic/intervention modalities as well as behaviour modification techniques; and finally, the keeping of case records and report making (from the University of Cape Town, MA Clinical Psychology programme, general information booklet, 1990-1991; Rodnick in Kaplan & Sadock, 1984, pp.1929-1935). In addition, the clinical context encompasses a wide variety of potential problem situations in which the clinical psychologist is trained to intervene; for example from children to the elderly, from organic to functional illnesses, from the individual to groups, etc. In the U.S.A, training programs in clinical psychology also include a substantial research training component. In this regard, the clinical psychologist's role as researcher "... cannot be considered as independent of the other roles of assessing the person, diagnosing and treating the clinical condition, and evaluating the outcome ... if appropriate research questions are to be asked..." (Rodnick in ibid, p.1932). Regarding psychological testing, the role and importance of psychological tests in clinical practice has been reviewed extensively and there has been a "... movement away from the general use of tests for diagnostic decisions ... to the use of a variety of assessment procedures, some of which may be standardized tests, for the development and testing of hypotheses regarding the patient's problem and of strategies for alleviating it" (ibid, p.1933. See also Maloney & Ward, 1976).

This brief review of the clinical psychologist's different areas of expertise demonstrates the scientific-professional role that the clinical psychologist is expected to fulfil. It also contextualizes the role of the psychodynamic formulation. As an aspect of the assessment process, the psychodynamic formulation facilitates the transition from clinical facts to useful hypotheses (Weisman, 1959, p.288) about the patient's symptoms, development, personality and treatment. Other definitions are as follows. The Chambers Twentieth Century Dictionary (1979) defines 'formulate' as 'to state or express in a clear or definite form'. Perry et al (1987) note that the purpose of the clinical diagnosis and the psychodynamic formulation taken together is to "... provide a succinct conceptualization of the case and thereby guide

a treatment plan" (p.543). Similarly, Shapiro (1989) notes that the purpose of the psychodynamic formulation is to complement diagnosis and guide management (from the abstract). Rosenberg, Silberschatz, Curtis, Sampson & Weiss (1986) note an additional purpose to these, stating that psychodynamic case formulations are "... widely used in clinical practice to understand the meaning of a patient's problems, to guide therapeutic interventions, and to *evaluate response to treatment*" (p.1454; emphasis added). From a review of the literature, Friedman & Lister (1987) extracted four uses of the psychodynamic formulation. These are:

> (1) *Organization.* A formulation organizes the clinical data and the theoretical understanding of that data. In so doing, it allows succinct summary and communication of the data and ensures that gaps in the data or in understanding it are recognized . . . (2) *Empathy.* A formulation aids in the induction of therapeutic attitudes. What one can understand or explain seems less foreign: understanding fosters empathy . . . (3) *Treatment.* A formulation allows one to design treatment: to choose a modality, to predict problems and progress, to time interventions, and to evaluate progress in treatment . . . (4) *Research.* A formulation is a heuristic device that generates hypotheses that may subsequently be tested. Such testable hypotheses are essential to process and outcome studies.

Next, it will be considered when and for whom the psychodynamic formulation should be done.

When should a formal, written psychodynamic formulation be done?: MacKinnon & Yudofsky (1986) write that the formulation

> is useful whether the patient is to be treated with analytically oriented psychotherapy or supportive psychotherapy. Even decisions about whether to medicate or to hospitalize a patient can benefit from a thorough understanding of the balance of factors that caused the patient's illness at this time (p.219).

These authors have even given case examples where there was an organic aetiology but where a psychodynamic formulation was prepared and where, for various reasons, the patient was given psychotherapy. Similarly, Perry et al (1987) note that

> One common misconception is that a psychodynamic formulation is indicated only for those patients in a long-term, expressive psychotherapy. This belief ignores the fact that the success of any treatment may involve supporting, managing, or even modifying aspects of the patient's personality. Therapeutic effectiveness or failure often hinges on how well or poorly the therapist understands the patient's dynamics, predicts what resistances the patient will present, and designs an approach that will circumvent, undermine, or surmount these obstacles. A second common misconception is that the construction of a psychodynamic

formulation is primarily a training experience (p.543).

With regard to children and adolescents, Shapiro (1989) has leaned heavily on Perry et al's (1987) paper "... in order to make the child psychiatric process symmetrical with the adult process" (p.677). From these authors' point of view then, a psychodynamic formulation should be drawn up for each patient who presents for treatment.

It would seem that acceptable exceptions to doing formal, written psychodynamic formulations might be as follows. The first is in emergency psychiatry, where there is usually insufficient time or information and when other factors bear on the interventions that are made. Secondly, a psychodynamic formulation is not called for when a couple or a family are assessed for conjoint or family therapy; usually, however, an index patient or more than one member of the family will have been individually assessed and a psychodynamic formulation(s) drawn up. For there to be a third exception would depend on the reader's view about what a psychodynamic formulation is. (The possibility of different meanings in this regard was raised in Part 1 during discussion of Levett's paper.) If one took the view that 'psychodynamic' referred to depth theory then the corollary of this would be that the use of any other kind of theory would mean that the formulation that resulted should be called by that name. For example, Turkat has edited an excellent book on behavioural case formulation (Turkat, 1985).

A formal aetiological formulation was required in every case during the author's training at the University's Child Guidance Clinic. In the Cape Town hospital service, both an aetiological formulation and psychodynamic formulation was required in at least one therapeutic placement and in another a psychodynamic formulation was all that was required provided that it demonstrated an adequate understanding of the case's aetiology. However, both types of formulation were seldom requested nor seemingly of any great relevance on many wards. This was the case with, for example, cases of organic aetiology and repeat admissions. Although many clinicians in the hospital service may be of the opinion that a diagnosis and treatment plan suffice in many cases, the author's view is that a brief psychodynamic formulation may be of additional interest and even of use. Often, psychodynamic formulations enter the mind of the clinician during the assessment or treatment, or emerge in ward rounds anyway, but are not formally recorded. For purposes such as these, a brief format such as the one proposed by Karasu & Skodol (1980) as a sixth axis in DSM-III diagnosis (which would also apply to DSM-III-R) may be

suitable. The author is not in favour of the formats proposed by Perry et al (1987) and Shapiro (1989) since they include discussion of management issues as a sub-section; their sub-sections on the 'psychodynamic explanation' are, however, excellent. (The distinctions between the aetiological formulation, the psychodynamic formulation and management planning will be made clear in Part 7.) Perhaps new admissions should at least receive some form of formal, written psychodynamic formulation along with the diagnosis that is ascribed, regardless of the treatment prescribed.

The psychodynamic formulation and psychotherapy research: With regard to the use of the psychodynamic case formulation for research purposes, a significant amount of research has been started in the past decade to develop guided methods for doing the formulation that are sufficiently reliable for such purposes. Curtis, Silberschatz, Sampson, Weiss & Rosenberg (1988) note that a "... central problem in developing reliable case formulations is that they are usually complex narratives that vary in topics covered or styles employed. If judges are given free rein to develop formulations, the latitude of their descriptions and judgements is so broad as to defy comparison" (p.256).

In psychotherapy research, it is necessary for the researcher to have a reliable statement about the patient's psychodynamics because later assessment of the patient assesses the efficacy of the therapy that has been undergone. Curtis et al (ibid) appear to describe another aspect to having a reliable formulation, namely that "... we are testing the validity of our theoretical orientation by measuring the degree to which formulations based on it can predict the process and outcome of therapy" (p.265). In the studies cited below, each of the methods was based on a specially developed 'sub-theory' directly derived from psychoanalytic theory; for example, goals to be met, central relationship patterns or principal conflicts. However, as Curtis et al also note, "As reliable formulations are developed from other theoretical perspectives, the relative contributions to therapy of variables deemed insignificant by different theories can be studied and compared" (ibid).

So far, the "... most fundamental stage of research has been the determination of the reliability of the method[s]" (Perry, 1989, p.248). Perry notes that "As science moves on from generating propositions to testing them, it needs advances in its instruments and techniques. These methods represent potential advances in psychodynamic science" (ibid, p.246). For further information on this body of research the

reader is referred to De Witt et al, 1983; Rosenberg et al, 1986; Curtis et al, 1988; Crits-Cristoph, Luborsky, Dahe, Popp, Mellon & Mark, 1988; Perry, 1989; Luborsky & Crits-Cristoph, 1989; Horowitz, 1989; Johnson, Popp, Schacht, Mellon & Strupp, 1989; Perry, Augusto & Cooper, 1989; and finally, Perry, Luborsky & Silberschatz, 1989.

It is necessary to consider the relevance of the latter body of research to the present thesis. Perry et al (1987) argue that the psychodynamic formulation should be "Like a psychiatric diagnosis [i.e.] specific, brief, focused, and therefore limited in its intent, scope and wisdom . . ., concisely and incisively clarif[ying] the central issues and conflicts, differentiating what the therapist sees as essential from what is secondary" (p.543). Similarly, Levett (1991) states that ". . . succinct language, without meandering or repetition . . ." is desirable and that "Fancy terminology sometimes turns out to be a way of obscuring a lack of understanding" (p.5). Hence, it would seem to make sense to make use of one of the above methods, developed in order to reliably guide the making of clear, low-level inferences from patients' data, to develop the format for the psychodynamic formulation presented in the present thesis. However, on the whole these methods are too closely tied to psychoanalysis and too time consuming and have only been used with recordings of sessions or transcripts of them, to provide a basis for the doing of the formulation in the present thesis. In addition, the methods limit the production of hypotheses to low-level inferences of recurrent patterns which in some cases are actually compatible with a cognitive psychological framework. Although these are desirable features for research designs, they may be too limiting if they were only to be used in clinical practice.

Views concerning the feasibility of doing a psychodynamic formulation at the beginning of treatment:

Friedman & Lister (1987) note that, "Some teachers expected us to make a formulation based on the first encounter with the patient. Others insisted that only after treating the patient over many months or even years could one make a proper formulation of the case" (p.126). Samuals, Shorter & Plaut (1986) make a related point that ". . . so far as psychoneurosis is concerned, a full history is well nigh impossible to compile, since the contributing factors to the situation are initially unconscious for the patient and often hidden from the therapist" (pp.106-107). This extract echoes Jung's statement when he was contrasting diagnosis in medicine and psychotherapy, namely that, "The content of a neurosis can never be established by a single examination, or even by several. . . . Hence the paradox that the

true psychological diagnosis becomes apparent only at the end" (Jung, 1945, para. 197). Nevertheless, it is standard clinical practice in psychiatry and clinical psychology to do an initial assessment. However, it should be stressed that assessment ". . . is not simply an activity occurring in the initial interview. Rather, we continually gather information and hypothesize about the client's . . . difficulties . . . throughout the initial and subsequent interviews" (Brammer, Shostrom & Abrego, 1989, pp.148-149).

The psychodynamic formulation and management planning: Because of how intimately related the psychodynamic formulation and management planning often are, it will be pertinent in the present thesis to describe this relationship. Particular emphasis will be placed on how the psychodynamic formulation informs the assessment for psychotherapy. This will be done in Parts 7 and 8.

PART 5

A COMMENT ON PLURALISM

Before presenting aspects of Jungian theory which are necessary for the psychodynamic formulation in Part 6, some brief discussion about theoretical diversity is called for.

Contemporary depth psychology presents the psychoanalytic- or Jungian-oriented therapist or analyst with many points of view which seem to have clinical validity. In psychoanalysis, the Middle Group in London (a sub-section of the A Group) accepts theoretical diversity, in opposition to the A Group (Kleinian) and the B Group (Anna Freudian) (Fuller in Introduction to Rycroft, 1985). Samuals has written a great deal about the state of post-Jungian analytical psychology (Samuals, 1981, 1983a; 1983b; 1985a; 1985b; 1985c, p.48; 1989a; 1989b; 1989c; 1989d). Independently, Singer has commented on the 'neo-Jungian' era of Jungian analysis in America (Foreword to Stein, 1985).

Spelling out the contemporary situation in Jungian psychology, Samuals (1983b) writes:

> That analytical psychology, as a discipline, is now functioning in schools [namely, Classical, Developmental and Archetypal] is no longer a contentious proposition. Although it is often the emphasis given to Jung's various theses that distinguishes the schools, an influx of ideas from a variety of external sources (e.g. comparative religion or object relations) and a plethora of personal vicissitudes mean that the schools are here to stay (p.43).

Stein (1988) writes that

> most individual analysts in our field today carry the tensions of each of these schools within themselves. There are relatively few analysts who practise in a 'pure' way in any one of these three schools. All of us have been influenced, I imagine, to at least a small degree, by the schools to which we do *not* subscribe (p.3).

Samuals has put forward his idea of pluralism as a methodology for nurturing the tension between points of view in depth psychology (Samuals, 1989a, 1989b, 1989c, 1989d). He writes that "Pluralism is an attitude to conflict which tries to reconcile differences.... However, I am not trying merely to advance pluralism as a desirable state or goal for depth psychology. My suggestion is that we begin to *use* the idea of pluralism as a tool or instrument to make sure that diversity need not be a basis for schismatic conflict" (1989b, p.1). A very tenable aspect of Samual's thesis is that ". . . when analysts argue, the

plural psyche is speaking. Differing points of view reflect the multiplicity of the psyche itself . . . and for an individual to become truly himself [i.e. individuated or whole], *all* . . . potentials would have to be realized" (ibid, pp.5-6).

There were the following exchanges in recent articles of the *Journal of Analytical Psychology*. While being committed in the first instance to ". . . the spirit of pluralism . . .," McCurdy (1990), however, sees ". . . the shadow of an inappropriate tolerance [following] along silently in the wake of the pluralistic approach and spirit" (p.82). Clark (1990) responded to this, saying that it ". . . is the passion and aggression of plural argument that we avoid and suppress and which, therefore, get hidden in our professional shadow" (p.344). In other words, it seems that it is schism that Samuals is trying to avoid, not conflict.

Pluralism cannot be faulted for the way it attempts to hold the tension between different points of view among depth psychology theories and ways of practising. Nevertheless, Samuals appears to have overlooked the fact that from an intrapsychic point of view, the idea of pluralism fits into a 'Jungian mould'. Hence, the Jungian attitude appears to enable one to accept other points of view where these are apt or fit the phenomenology of a case or some aspect of it more so than any other depth theory can. Expressing this relationship, Jung wrote that by 'analytical psychology' he meant ". . . something like a general concept embracing both psychoanalysis and individual psychology as well as other endeavours in the field of 'complex psychology'" (Jung, 1929, para. 115). Hence, there seems to be a non-reciprocal relationship between analytical psychology and psychoanalysis. It does not seem possible, therefore, to hold this view and at the same time to simply do as Samuals in a pluralistic spirit suggests, namely ". . . to extend the field and call it depth psychology (or dynamic psychology) [in which] analytical psychology takes its place as one strand of the diversity [and in which] analytical psychology and psychoanalysis . . . are complementary, sibling disciplines" (Samuals, 1989a, p.3). This argument would seem to point up a problem that Samuals does not seem to address. Hence, although Jungian and other theoretical points of view (in particular, classical psychoanalysis and object-relations theories) are seen as having clinical validity, the theoretical approach adopted in the present thesis should not be seen in quite the same light as pluralism. With regard to using more than one depth theory in the psychodynamic formulation, Perry et al (1987) make a useful suggestion: ". . . in clinical practice

therapists tend to use one primary model, introducing secondary models to explain features of the patient that do not easily fit into the primary model" (p.548).

PART 6

ASPECTS OF JUNGIAN THEORY NECESSARY FOR THE PSYCHODYNAMIC FORMULATION

Due to the focus of this section on the assessment (and not psychotherapy) context and to space constraints, it has been necessary to be selective with regard to the body of Jungian theory and to be very brief; the emphasis in general is to describe concepts in the context of their relevance to the assessment process and the distinction between health and pathology rather than to attempt full descriptions. The choice of concepts is meant to be provisional.

Jung referred to several *indicia* which he would use as pointers to orient himself in the treatment of patients. These are: the patient's age and if they are in ". . . the youthful phase of life" whether the Freudian or Adlerian point should be applied; their typology; whether they are materialistic or spiritual in nature, including the possibility of an ". . . outspoken materialism [having] its source in a denial of religious temperament [or the] reverse", and finally; ". . . whether an attitude or so called *habitus* is authentic, or whether it may not be just a compensation for its opposite [although he admitted that he had] so often been deceived in this matter . . ." (Jung, 1931, paras. 75-81). The author has used these points as guidelines to structure this section.

The theory that has been presented is meant to serve as a backbone to which additional theory or theoretical elements can be added according to the needs of the case (i.e. Jungian or psychoanalytic theory). Adlerian theory, which Jung was inclined to use at times, may also be added according to this principle. It will be clear from Parts 4 and 5 that psychoanalytic theory may also be used to formulate cases from a Jungian perspective; however, mainly (although not exclusively) Jungian theory has been presented below since the emphasis in the present thesis is on the application of Jungian theory. Note that the concepts have not always been presented with regard to the backgrounds or order in which they were originally developed.

The complex: It was alluded to in Part 2 that Jung did not leave behind a comprehensive theory of psychopathology i.e. he did not overly concern himself with the definition and aetiology of pathological

states. However, as Samuals et al (1986) point out, albeit only with regard to neurosis, ". . . the idea of the complex may be used descriptively to make clear the make-up of a neurosis" (p.99). They also state that complexes ". . . are particularly useful in the analysis of neurotic symptoms" (ibid, p.34). For these reasons, it will be appropriate to begin with the concept of the complex as well as for the reason that the discovery of complexes was of seminal significance in the development of Jung's theories. It is easy to see how this concept, which Jung developed from his use of the word-association method, was prefigured in his doctoral dissertation for the medical degree on so-called occult phenomena in a 15 year-old girl with a marked tendency for dissociation. The complex is a group of associated ideas with a common feeling tone. Jung realized that the long discredited concept of possession used as a primitive explanation for mental disease can be applied to the behaviour of complexes (Sandner & Beebe in Stein, 1984, p.311). He also noted ". . . the phenomena of assimilation caused by them" (Jung, 1934, para. 197). Sandner & Beebe note that with regard to psychopathology, "Possession is the hallmark of serious personality disorders and psychotic states. Substitution of sectors of the ego by complexes and their archetypal cores results in drastic alteration in normal ego-attributes, such as ethical behaviour, reliable reality testing, and a stable level of mood" (ibid). These authors appear to make a distinction between the "splitting off" of complexes which they say occurs in neurotic conditions and "possession". Jung noted that ". . . complexes behave like independent beings" (Jung, 1937, para.253). However, Quenk & Quenk state that ". . . unconscious complexes become autonomous and may gain energic amplitude" only with psychic imbalance (Quenk & Quenk in Stein, 1984, p.158). In the case of possession, the autonomy of the complex amounts to the ego being

> the subject of a *coup d'état*. Because of the strength and obstinacy of the neurotic or psychotic symptom, a person is deprived of choice and is powerless to dispose of his will. A restraining effect is placed on consciousness proportional to the strength of the invading autonomous psychic content . . . This imperils not only conscious freedom but also psychic equilibrium. Individual aims are falsified in favour of the possessing psychic agent whether it be a mother-complex or an identification with the persona or anima/animus principle, for example. (Samuals et al, 1986, p.110).

According to Jacobi (1959), possession happens because the complex is "swollen" and ". . . proves even more powerful than the ego complex" (pp.13 & 15). Note that Samuals et al speak of possession as being common to both neurosis and psychosis. A feature of possession involving archetypal contents is that these can become *rationalized* by the psyche (Sandner & Beebe in Stein, 1984, p.311). A concept

related to those of the complex and possession is inflation, which refers

> to a greater or lesser degree to an identification with the collective psyche caused by an invasion of unconscious archetypal contents or as a result of extended consciousness. . . . There is disorientation accompanied either by a feeling of immense power and uniqueness or a sense of non-worth and being of no account. . . . Jung wrote that 'inflation is a regression of consciousness into unconsciousness. This always happens when consciousness takes too many unconscious contents upon itself and loses the faculty of discrimination' [Jung, 1944b, para.563] . . . He added that it is always dangerous when the ego becomes inflated to the point when it is identified with the self. This is a form of hybris and individuation is not possible since there is no longer any differentiation between person and God-image (Samuals et al, 1986, pp.81-82).

Another instance where individuation may be blocked is when the contents of the complex are "lived out" (i.e. "acted out"); here, integration of the complex into conscious ego functioning is not likely to occur (Sandner & Beebe in Stein, 1984, p.310).

It is necessary to describe how complexes develop. Complexes are usually described as psychic contents which have developed as a result of personal experience and that they make up the contents of the personal unconscious. Regarding this personal experience, however, archetypal structures and archetypal activity too play major roles in the development of complexes; for example, the mother-complex is constructed from the interaction of the mother archetype and experience of the actual mother. According to Stevens, "When an archetype is . . . activated, it accrues to itself ideas, percepts and emotional experiences associated with the situation or person responsible for its activation, and these are built into a complex which then becomes functional in the personal unconscious" (Stevens, 1990, p.32). Regarding this functional aspect, it is important to realize that the tendency of the psyche to split and the formation and autonomous activity of complexes are entirely normal phenomena; however, they are most clearly observable in psychopathology (Jung, 1937, para. 253). Jung also observed that the

> behaviour of *new* contents that have been constellated in the unconscious but are not yet assimilated to consciousness is similar to that of complexes. These contents may be based on subliminal perceptions, or they may be creative in character. Like complexes, they lead a life of their own so long as they are not made conscious and integrated (ibid., para.254).

In the author's view, an example of the constellation of such new contents can be seen at the onset of the so-called 'midlife crisis'.

The distinguishing criterion between psychological health and illness, it seems, is the viability of the connection between the ego-complex and any other given complex (Samuals et al, 1986, p.34). Looked at differently, health depends on the amount of libido associated with a given complex, the form of the complex and the extent of dissociation from or integration of that complex with the ego-complex. The concept of the complex has profound implications which extend beyond its heuristic value in the sense that complexes must in some sense exist as neurophysiological entities by virtue of their archetypal core and because they consist of associated ideas which behave like fragmentary personalities. This idea is supported by Samuals et al (1986, p.34). They also note that the idea of the complex "... was so important to Jung that, at one point, he considered labelling his ideas 'Complex Psychology' ... Jung referred to the complex as the '*via regia* to the unconscious' and as 'the architect of dreams'. This would suggest that dreams and other symbolic manifestations are closely related to complexes" (ibid.). However, although complexes would be involved in the "... incessant *symbol-forming activity* of the psyche ...," (Jacobi, 1959, p.116) it should be noted that insofar as complexes are concerned, symbols produced would have a more personal, individualized meaning for the subject than symbols produced by the deeper layers of the psyche.

Several authors have emphasized the bipolar nature of how complexes structure object-relations (e.g. Hall, 1986, p.37; Sandner & Beebe in Stein, 1984, p.298). According to Hall, the ego

> always experiences itself as identified with one pole [the ego-aligned pole]. It then experiences *from* that pole of identification *to* other parts of the [complex structure, the ego-projected pole]. For example, a person with an authoritarian complex usually has an identifiable bipolar structure of complexes: one pole is the 'victim', the other the 'victimizer'. ... True freedom from such an authoritarian complex releases the person from the danger of compulsively falling into *either* the role of the victim or the role of the victimizer [, depending on the situation] (ibid, p.38).

The author has found this aspect of the nature of complexes to be of particular use in their detection for clinical purposes.

Relating Jung's definition of neurosis to the concept of the complex, Samuals et al (1986) note that

> Inasmuch as he defined neurosis, Jung's reference was to one-sided or unbalanced development. Sometimes, the imbalance is between the ego and one or more complexes. Sometimes, Jung [refers] to the ego's difficulties in relation to the other psychic agencies

> such as the anima or animus and the shadow . . . Neurosis is therefore a (temporary) failure of the . . . self-regulatory function of the psyche (p.99).

Stevens (1990) notes that "The treatment lies in confronting the complex, freeing the archetype and permitting the formation of healthier associations with the outside world" (p.35); essentially, this is a process not only of breaking down pathological associations but of constellating new complexes. "In analysis, use may [also] be made of personifications arising from complexes; the patient may 'name' the various parts of himself" (Samuals et al, 1986, p.35). Various syndromes of psychotic possession in analysis are described by Sandner & Beebe in Stein (1984) pp.319-331.

Typology and character: According to Mattoon (1981), the system of typology developed by Jung to describe different modes of conscious functioning and to account for individual differences in people's conscious attitudes towards themselves and the world is ". . . outstanding among his theories in its heuristic value [and] of great clinical value . . ." (p.81). Quenk & Quenk write that,

> The importance of the theory of psychological types in the practice of Jungian analysis can best be introduced with two statements by Jung himself: 'When one begins as a young doctor, one's head is still full of clinical pictures and diagnoses. In the course of the years, impressions of quite another kind accumulate. One is struck by the enormous diversity of human individuals, by the chaotic profusion of individual cases, the special circumstances of whose lives and whose special characters produce clinical pictures that, even supposing one still felt any desire to do so, can be squeezed into the straitjacket of a diagnosis only by force. . . . The pathological problem upon which everything turns has virtually nothing to do with the clinical picture, but is essentially an expression of character. Even the complexes, the "nuclear elements" of a neurosis, are beside the point, being mere concomitants of a certain characterological disposition.' (Jung, 1936, p.548). 'The opposition between types is not merely an external conflict between men, it is the source of endless inner conflicts; the cause, not only of external disputes and dislikes, but of nervous ills and psychic suffering.' (Jung, 1923, p.523). (Quenk & Quenk in Stein, 1984, pp.157-158).

It seems that what Jung means is that ultimately, it is a question of typology and character why a certain psychological illness has developed and what its structure is. However, a caveat must be pointed out here, namely that typology ". . . is especially important in the *second* half of life, when the striving for wholeness and balance becomes a major task" (ibid., p.171; emphasis added). Hall has even claimed that, "Because the four functions and the two attitudinal types represent one model of the totality of psychic functioning, the goal of individuation can be phrased in terms of typology [as] individuation is

furthered by the development of the inferior function [and] the opposite attitudinal type . . ." (Hall, 1986, p.54. See also Quenk & Quenk in Stein, 1984, p.171); similarly, Meier has claimed that, "Individuation begins and ends with typology. . . . [Jung said that in his typology he had intended] to give nothing less than the clearest pattern for simply all the *dynamics* of the human soul" (Meier in Mattoon, 1981, p.82). Despite the significance of typology for analysis in the second half of life, however, a knowledge of the patient's typology will also be of use in the psychotherapy of younger individuals.

There is uncertainty about what determines the predominance of one of the two attitudes (i.e. introversion and extraversion) over the other and even more uncertainty about what determines the arrangement of the four functions (i.e. thinking, feeling, sensation and intuition) in terms of their being 'arranged' as dominant, auxiliary, tertiary and inferior (Mattoon, 1981, pp.58-70). There is evidence for innate influence, as children develop different dominant attitudes and functions than those that are favoured by their family and/or culture; on the other hand, a child's typology also develops in response to the environment (ibid). Naturally, the culture may include sex-role stereotypes. See Mattoon (1981) p.69 for a description of how Western trends in this regard have changed. During the life-cycle, it is generally true that the tasks of the first half of life demand the use of extraverted skills and the second half introverted skills, despite the basic (innate) characterological trends that a person may have. With regard to the functions, note that

> The feeling function is not the same as emotion . . . The fourth function, and sometimes the third, however, are likely to be highly emotional. An . . . example is the thinking function of a person with primary feeling; when his or her ideas (products of thinking) are questioned by another person, the effect can be emotionally devastating (Mattoon, 1981, p.69).

Results of research have also shown that with increasing emotion there is an increasing influence of the inferior functions (ibid).

The following factors regarding type must be determined during assessment: (1) the patient's response to his or her environment and inner world and the locus of the failures at adaptation; (2) the strength and differentiation of the patient's conscious or dominant attitude and functions; (3) the type mix of the family, including strengths and failures at adaptation; and (4) the inferior function that 'possesses' the patient during times of stress. Furthermore, the psychotherapist must have an ". . . exact knowledge

..." of his or her typology in order to avoid "... many serious blunders in dealing with his [or her] patients (Jung, 1936, p.555)." (Quenk & Quenk in Stein, 1984, pp.161ff).

Psychometric tests are available for assessing type, namely the Grey-Wheelright Test, the Myers-Briggs Type Indicator and the Singer-Loomis Inventory of Personality. In psychotherapy, however, type is usually inferred from the initial interviews.

Regarding typology and psychopathology, Jung discussed the characterological parallels of mainly two groups of psychopathology, namely hysteria and schizophrenia, equating them with the maladaptive sides of extraversion and introversion respectively (Ekstrom, 1988, p.330). Quenk & Quenk also note that

> Typological theory not only accounts for individual differences, but also indicates the source of what in modern terminology can be called character disorders. . . . Failure to appreciate a child's type as different from his or her parents' can interfere with or disrupt the self-regulating aspect of the child's psyche as it strives for balance, wholeness or individuation. Hypothetically, individuation could occur if a child were completely accepted and were not the target of parental expectations that might impede or block the child's innate striving for wholeness. It is the task of analysis . . . to enable the patient to become aware of and remove such impediments (Quenk & Quenk in Stein, 1984, pp.158-159).

Note that this formulation applies to the psychogenesis of psychopathology in general and not only to character disorder. Ekstrom has written on the characterological parallels of the DSM III categories of personality disorder and has pointed out that Jung's typology and the DSM III's description of the personality disorders have in common the distinction made between symptomatology and deep-seated structures that have a long-term effect on a person's functioning, in that both refer to the latter (Ekstrom, 1988). In the author's experience, a knowledge of typology is particularly useful when dealing with relationship problems between spouses.

Finally, Jung wrote that one of several *indicia* that he used to orient himself with was whether the patient was materialistic or spiritual in nature, including the possibility of one of these attitudes being expressed one-sidedly (Jung, 1931, para. 79). Although the opposites of materialism and spiritualism can feature in the psychological problems of younger patients, they are probably usually of more pertinence in the

analysis of older patients.

The life-cycle: Another facet of Jung's theories that is necessary for assessing cases is his hypothesis of the psychological changes and development that occur throughout the lifespan. According to Jung, psychic development is orchestrated by archetypal activity and is teleological or purposive. It may, however "... be distorted and even partially or temporarily arrested, [resulting in] psychopathology ..." (Faber, 1989, pp.11-12) due to the specific way in which complexes are constellated and the ego develops. Archetypal activity

> is most readily discernible during species-specific *typical* experiences which occur during the course of the life-cycle. Such experiences constitute some form of developmental transformation of the subject [which] must, according to Jung, be conceptualized as a biological ('material') and a psychical ('spiritual') process (ibid, p.11).

Jung stated that psychic development parallels the bodily developmental and aging process. This apparent dualism actually originates from the psychoid aspect of the archetype which, to use Jung's analogy, emits a spectrum, the infra-red end of which appears to us as instinctual, physiological processes while the ultra-violet end appears to us as mythological, imaginal processes (Samuals et al, 1986, p.122).

Regarding the psychodynamic formulation and the life-cycle, it should be noted here that a given patient's psychodynamics will be described with a different emphasis each time a different depth theory is used; from a Jungian perspective, a patient's psychodynamics should be described with reference to how the individuation process is manifesting in his or her particular instance.

Despite the fact that Jung's interests ". . . lay in the growth process of later adulthood – after age thirty-five or forty ..." (Mattoon, 1981, p.165), it seems possible to talk about the psychological process of the entire life-cycle from a Jungian perspective. Regarding early ego development, the work of Fordham and other members of the Developmental School and the work of Neumann are of importance (Samuals, 1985a, p.154). From a psychoanalytic perspective, it is an important aspect of the assessment process to attempt to identify the developmental phase or position which the patient has had difficulty negotiating in order to understand the patient's current functioning. From the point of view of analytical psychology the clinician is in addition able to assess the patient's functioning relative to the ego tasks

which one could expect to already have been completed or which should be of *current* concern. These are broadly described below.

There are a number of depth theories which can contribute to an understanding of normal and pathological development during infancy and childhood. It is interesting to note as Friedman (1975) does that there

> has been a marked shift in the kind of patients seeking analysis in recent years. Many reports refer to an increasing number, perhaps a preponderance, of patients with disorders of character rather than with symptom neurosis.... With [this] shift in the patient population towards increasing proportions of people with character problems or personality disorders, i.e. with major aspects of the pattern of their lives in relation to other people and themselves in need of change, there has been an increasing theoretical interest in object relations in psychoanalysis (pp.137-138).

One wonders about the role played by theoretical developments and refinements in diagnostic skills in this trend, although naturally a real trend could influence theoretical developments too; nevertheless it is interesting to note this relationship between theory and its usefulness for particular types of clinical phenomena and their developmental origins.

Apart from theory, some clinicians may also use collective material (e.g. mythology) to shed light on a particular clinical problem during the assessment phase. The common ground between these two ways of understanding psychodynamics is that theories in psychology and mythology both elucidate archetypal processes. In the format proposed in Part 7, provision will be made for recording relevant collective material.

The brief description of the life-cycle which follows relies mainly on Neumann, Freud, Klein and Jung.

Neumann called the period from birth to approximately the end of the first year the Uroboric or post-uterine embryonic stage. This stage roughly coincides with Freud's oral stage, which is said to extend for approximately the first eighteen months. In this phase the ego exists only in nucleic form as a potential and there is no distinction between inside and outside. "When the mother is 'good enough', early infancy is only marginally less secure and tension-free from the intra-uterine phase [and] because

this earliest phase . . . is [or should be] a period of well-being and security, it is commonly symbolized as 'paradise' " (Stevens, 1982, p.94). Here, the mother needs to function in her archetypally conditioned role as caregiver; one also would hope that illness or other unforeseen discomforts do not predominate. According to Cirlot (1962), among the various meanings of the Uroborus symbol are: union with one's self, self-fecundation, self-sufficiency, time and the merging of beginning and end, the continuity of life, undifferentiation and hermaphroditism (pp.246-247). During this period, the narcissistic defences of denial, distortion and projection predominate with the coalescence of the primitive ego. It is possible to list the defences used by the ego according to a variety of classifications. For example, they can be listed developmentally, on the basis of particular forms of psychopathology, or as to whether they are simple mechanisms or complex; i.e. combinations or composites of simple mechanisms (Meissner in Kaplan & Sadock, 1985, p.388). Tables of the defence mechanisms most thoroughly investigated by psychoanalysis and of the libidinal phases of psycho-sexual development are given in ibid., pp.389ff and pp.360ff respectively. According to Klein, the ego maintains the paranoid-schizoid position during the first three to four months during which time the infant copes with paranoid anxieties provoked by frustrations and its oral destructiveness with the defences of radical splitting of experience, projection, denial, and idealization of good experience (Couve, 1982, p.91b). In the second phase the ego moves into the depressive position where the capacities for ambivalence, recognition of the other as a separate person, guilt, remorse and reparitive feelings develop, leading to proper object-relations as opposed to the 'psychotic' and part-object relations of the initial phase (ibid.). There seems to be a parallel between Neumann and Klein as the former saw the child's ". . . true birth . . ." as occuring at the end of the first year, when it enters the Matriarchal stage. It is roundabout this point that it first forms ". . . an integral ego [from] a situation of identity with the Good Mother and has the power to assimilate negative experience . . . or to abreact it" (Neumann, 1990, pp.56-57). As Stevens (1982) puts it, "Provided his mother succeeds in constellating the Good Mother, rather than her Terrible alternative, the child will be able to cope with even distressing and frightening experiences through repeated maternal assistance in dealing with them" (p.101).

In the Matriarchal Stage there is ". . . a gradual development of a two-person relationship . . ." (Samuals, 1985a, p.158). According to Stevens (although not referring directly to Neumann), "The tentative emergence of [the child's] positive self-concept then facilitates the dissolution of the child's original

identity with mother and enables him to begin his first hesitant explorations of the . . . enticing world beyond the mother's body. . . . [Through] the healthy mother-child bond . . ., the child learns to trust in the continuity of existence . . ." (Stevens, 1982, p.101).

In Freud's description the oral phase is succeeded by the anal and urethral phases. During the anal phase, development centres on a striving for independence and separation from dependence on and control by the parent. It seems that the objectives of urethral functioning are similar to those of the anal period.

According to Freud, the focusing of libidinal activity in the genital regions marks the beginning of the phallic stage, which extends from ages three to six. Castration fears are experienced because of how experiences are aggrandized with respect to threats of punishment for masturbating and the fantasy of sexual involvement with the opposite-sex parent. However, there is an asymmetry to the boy's and girl's experience in this phase. Both children begin from the phallic orientation but the castration complex is meant to end the boy's Oedipus complex, whereas it introduces the girl to her's; the castration complex for the boy centres on the development of the superego, for the little girl it is said to centre on her loss of the phallus; the girl must undergo a more radical development, in terms of both her genital orientation and choice of love-object, the mother being the primary love-object in both cases. This period influences the relation of the ego of the boy and girl to their anima and animus complexes respectively. Following Freud, there will be opportunity in adolescence for reresolution of conflicts regarding the opposite sex. In Jungian terms, the personal father (or some substitute) provides the occasion for the constellation of the archetypal masculine principle. This must happen for the development of a viable ego-consciousness, a development that can be symbolized as the escape from the embrace of the mother. This is an essential development for further development of the ego and also provides the psyche with the prototypical experience of the opposites, which are always symbolically sexed as male and female. Neumann called this the Patriarchal stage.

Following the widely-accepted Freudian schema, development now proceeds into the latency stage, which is a period of relative quiescence of the sexual drive and further maturation of ego functions. The genital or adolescent phase follows, extending from the onset of puberty until young adulthood is reached. Here physiological maturation leads to an intensification of drives which reopens conflicts of

previous stages of psychosexual development. The opportunity is provided for a ". . . reresolution of these conflicts in the context of achieving a mature sexual and adult identity" (Meissner in Kaplan & Sadock, 1985, p.361). Jungians are of the view that adolescence would be easier for teenagers and their parents if our culture ". . . provided an adequate initiation, comparable to the rituals of many preliterate societies. [In such societies, young people are considered] to be closer to adulthood than they are in Western culture" (Mattoon, 1981, p.171).

Jungians conceptualize the period from early adulthood to approximately thirty-five or forty as entailing a necessary ego-self estrangement as the ego fulfils biological imperatives and cultural norms. As Samuals et al (1986) state, ". . . the acquisition of an adult identity [suggests] the achievement of a social position, relationship or marriage, parenthood or employment" (p.142). The accent here should be on the interpersonal and external dimensions of one's life (ibid.) and consequently this area is predominantly the focus of attention in therapy with younger patients (Jung, 1931, para. 75). Although lengthy, the following extracts give an excellent description of issues at stake during this phase:

> Interpretation and therapeutic work, when they occur during this phase, proceed primarily in terms of interpretation and direction on the object level, through uncovering faulty adaptations to external reality. Of particular concern are the effects upon external adaptation of insufficient separation from the parental world and of the disruptive complexes which were conditioned through parental influences. This, therefore, is the phase in which the usual reductive psychoanalytic interpretation – which interprets personality problems in terms of childhood difficulties – is viable (Whitmont, 1969, p.281).

> The danger of this phase is the assimilation of the ego by the Self; an insufficient separation, in which the ego is fascinated by the collective unconscious, gives itself up to day dreams, lives in fantasies and confuses fantasy with reality. Or one's aspirations are so great and uncompromising that in actual reality nothing or only very little can be achieved. For realization in the here and now requires a renunciation of the infiniteness of the many possibilities of the intuitive Great Vision for the sake of its finite and few limited aspects which, through concentration and work, can be made concrete. . . . If the ego fails to give its energies to the seemingly small and limited tasks at hand because it wants only to deal with big ideas, then it cannot move on, it misses the bus and the personality is not ready for the next phase, that of ego-Self reintegration (ibid, pp.281-282).

At midlife, the ego is confronted by its mortality and the individual usually begins to question the

ultimate meaning of his or her achievements and present concerns. Turning to Whitmont again:

> The demands of the unconscious no longer press towards external adaptation – unless of course the needs of the preceding phase have not been adequately fulfilled. If we have been lagging on the journey we still have to make up for tasks undone. But when ego development and external adaptation have been adequate, the developmental needs will change at this point (ibid., p.283).

About aging, Jung wrote that,

> A human being would certainly not grow to be seventy or eighty years old if this longevity had no meaning for the species. The afternoon of life must also have a significance of its own and cannot be merely a pitiful appendage to life's morning. . . . Whoever carries over into the afternoon the law of the morning . . . must pay for it with damage to his soul, just as surely as a growing youth who tries to carry over his childish egoism into adult life must pay for his mistake with social failure (Jung, 1930-1931, para.787).

Finally, an essential difference between ego-tasks in the two phases of life is that in the first they are on the object level while in the second a more symbolic attitude is needed to deal with ". . . whatever was left behind, indeed had to be left behind . . ." (Whitmont, 1969, p.283) and to achieve a synthesis of the personality. It must be emphasized that the classical symbolic-synthetic approach should only be adopted provided that ". . . ego development and external adaptation have been adequate . . ." (ibid.), otherwise the treatment may only assist the patient to avoid life tasks that have not been attended to and the ego will not have the strength for the task of further individuation. Note that treatment of patients in the second half of life is not identical with the treatment of patients in geriatric psychiatry.

The structural components of the psyche: Having dealt with some of the dynamics of individuation, it will now be in order to present the main structural components or complexes of the psyche. Some assessment of the structural components of the patient's psyche in terms of such aspects as their nature, their effects on the rest of the personality and intrapsychic dynamics is necessary as part of initial hypothesis formation with any patient. This is the last area of Jungian theory that will be presented.

The ego: Jung distinguished his description of the ego from Freud's. Although he perceived it to be the centre of consciousness, he also stressed it as being less than the whole personality. In particular, he described the relation of the ego to the self and pointed out the second half of life as the period when

confrontation between the two characteristically occurred (Samuals et al, 1986, p.50). Ego functions include a sense of personal identity and of the history of one's consciousness, maintenance of the personality and mediation between conscious and unconscious realms, cognition and reality testing (ibid.). Samuals et al point out that Jung's tendency to equate the ego with consciousness makes it difficult to conceptualize unconscious aspects of ego structure, e.g. defences. They also point out that the ego's task in relation to the shadow is to recognise and integrate it rather than splitting it off via projection (ibid., p.51). Regarding psychotherapy and the ego, the following possibilities exist: (1) that the ego will not emerge from its primary identity with the self and so is unable to meet the demands of reality; (2) that the ego will become equated with self, leading to inflation; (3) that the ego may take up a rigid and extreme attitude, forsaking reference to the self; (4) that the ego is unable to relate to a particular complex, leading to the splitting off of the complex and its dominating the life of the individual; (5) that the ego may be overwhelmed by a content arising out of the unconscious; and (6) that the inferior function may remain unintegrated and unavailable to the ego, leading to grossly unconscious behaviour and an impoverishment of the personality (ibid, pp.51-52).

The shadow: It seems that there are different ways in which a definition of the shadow can be approached. From one perspective one could say that it is simply synonymous with that part of the psyche that is not conscious. However, Samuals et al point out Jung's

> most direct and clear-cut definition of the shadow: 'the thing a person has no wish to be' [Jung, 1946, para.470]. In this . . . statement is subsumed the many-sided and repeated references to shadow as the negative side of the personality, the sum of all the unpleasant qualities one wants to hide, the inferior, worthless and primitive side of man's nature, the 'other person' in one, one's own dark side. . . . Jung spoke of Freud's method as the most detailed and profound analysis of the shadow ever achieved. [T]he contents of the personal unconscious are inextricably merged with the contents of the collective unconscious, themselves containing their own dark side. [I]t is impossible to eradicate shadow; the term most frequently employed . . . for the process of shadow confrontation in analysis is 'coming to terms with the shadow'. [Because of its archetypal aspects,] its contents are powerful, marked by affect, obsessional, possessive, autonomous – in short, capable of startling and overwhelming the well-ordered ego. Like all contents capable of entering consciousness, initially they appear in projection [particularly when the ego] is in a threatened or doubtful condition (ibid., pp.138-139).

Although in dreams, "... the shadow figure is always of the same sex of the dreamer" (Jaffe, 1979, p.229)

there can be contamination between the shadow and contrasexual aspects of the personality particularly when unconscious contents are denied and repressed (Samuals et al, 1986, p.24).

The anima and animus: These concepts were devised empirically by Jung (ibid). According to Samuals et al (ibid)

> Possession by [the] anima or animus transforms the personality in such a way as to give prominence to those traits that are seen as *psychologically* characteristic of the opposite sex. Either way, a person loses individuality, first of all, and then in either case, both charm and values. In a man, he becomes dominated by anima and by the Eros principle with connotations of restlessness, promiscuity, moodiness, sentimentality – whatever could be described as unconstrained emotionality. A woman subject to the authority of animus and Logos is managerial, obstinate, ruthless, domineering. Both become one-sided. He is seduced by inferior people and forms meaningless attachments; she, being taken in by second-rate thinking, marches forward under the banner of unrelated convictions.

Naturally, the mother and father, although not to the exclusion of other experiences, have large influences on the form taken by these complexes; this includes the animus and anima of the mother and father respectively.

The self: Jung stressed that this was an empirical concept and not a philosophical or theological formulation (ibid., p.135). At times he spoke of it as initiating all psychic life, at other times he refers to its realization as the goal (ibid). "In life, the self demands to be recognised, integrated, realized. . . . Following Jung conceptually, the self can be defined as an archetypal urge to coordinate, relativise and mediate the tension of the opposites" (ibid., p.136). The relationship of ego to self is "... a never-ending process. The process carries with it the danger of inflation unless the ego is both flexible and capable of setting individual and conscious . . . boundaries" (ibid., p.135). "Jung . . . found an empirically demonstrable compensatory function operative in psychological processes. This corresponded to the self-regulatory (homeostatic) functions of the organism observable in the physiological sphere" (ibid., p.32). This compensatory activity of the psyche is an aspect of the self's functioning. It is operative in both health and disturbance. In the author's view, it would be useful if it were possible to assess how the patient's psyche is trying to compensate for conditions that pertain to their psychological difficulties, for example the unyielding, outwardly tough patriarch who is capable of breaking down and becoming sentimental under stress.

PART 7

THE WRITTEN PSYCHODYNAMIC FORMULATION IN A JUNGIAN FRAMEWORK

It should be emphasized that the proposals that are set out below are provisional.

It is assumed for the purposes of the present thesis that unlike the guided methods referred to in Part 4 which rely on recordings of sessions or transcripts of them, the history taken and the clinician's impressions from initial contact with the patient serve as the database for writing the psychodynamic formulation. The 'Maudsley' format has been adopted for the purposes of the present thesis. According to Perry, a feature which would increase the chance of one of the guided methods surviving in the future is that it will be applicable to different types of data: live interviews, therapy transcripts, historical data, projective data and dreams (Perry, 1989, p.248).

The psychodynamic formulation must be distinguished from the larger type of formulation that follows the completion of the history and mental state examination. This formulation is known as 'The Psychiatric Report', 'Clinical Formulation', 'Case Formulation' or just 'Formulation' and includes the following kinds of sub-sections: identification data, referral details, highlights of the history and positive findings of the mental state and physical examinations, differential diagnosis, further diagnostic studies or further investigations, discussion of aetiological factors including a psychodynamic formulation where relevant, treatment or management plan and comment on prognosis (taken from Kaplan & Sadock in Kaplan & Sadock, 1985, pp.494ff; Levett, 1991 and Gillis, 1986, pp.258ff). Levett does not include data from the personal and family histories in the synthesis of findings from the history and she includes further investigations under management. She also suggests practical steps to follow to prepare the aetiological and psychodynamic formulations, which include listing the salient features and organizing them in terms of predisposing, precipitating and perpetuating factors and constructing a genogram(s) and time-line(s).

There are a great number of methods and suggestions for doing the psychodynamic formulation. The format proposed by MacKinnon & Yudofsky tends towards being a clinical formulation with a

psychoanalytic orientation, replacing the kind of clinical formulation referred to above. Perry et al (1987) and Shapiro (1989) include a summary paragraph, a description of nondynamic factors, the psychodynamic formulation itself and a prediction of the patient's responses to treatment based on their psychodynamics, in their format for the psychodynamic formulation. Most authors, however, focus more narrowly only on the patient's psychodynamics when talking about a psychodynamic formulation. Nevertheless, even when authors only concentrate on the patient's psychodynamics, each of their methods uses different factors or a different arrangement of factors to arrive at a comprehensive, systematic formulation. Examples of different formats for the psychodynamic formulation are as follows: Karasu & Skodol (1980) recommend the following dimensions: (1) conscious and/or unconscious conflicts, (2) defence mechanisms and coping styles and (3) ego functions; Cleghorn, Bellisimo & Will (1983) propose a framework with three categories of experience that the therapist should describe: (1) key relationships, their history and representation in memory, (2) conflict, including anxiety, defence and solution and (3) the experience of the self; Johnson et al (1989) describe the Cyclical Maladaptive Pattern method as consisting of the following categories: (1) interpersonal acts by the patient and perceived of others, (2) introjective acts by the patient and perceived of others and (3) expectancies (predictions, wishes and fears). Friedman & Lister (1987) grouped the literature on psychodynamic formulation available at the time that their paper was written into several conceptual categories based on the authors' approach: systematic ego psychological models, focal psychodynamic approaches, idiosyncratic psychodynamic approaches and biopsychosocial models.

It should be noted that the guided methods referred to in Part 4 do not include genetic explanations of the patients' current psychodynamics, presumably because they ". . . limit the observer to low-level inference, eschewing deeper, theoretically driven inferences" (Perry, 1989, p.246).

The lack of consensus about the exact nature of the psychodynamic formulation in the literature reviewed for the present thesis can be summarized as follows. The first factor concerns whether psychoanalytic (or, for that matter, any depth) theory should be used or whether any theory can be used. Secondly: some models only make provision for a description of the patient's *current* psychodynamics while others also make provision for a *genetic* explanation of current psychodynamics; some make provision for links to be made between on the one hand psychopathology and clinical problems and on

the other hand the patient's psychodynamics while others do not; and finally, some make provision for making predictions about treatment based on the patient's psychodynamics while others do not. Thirdly, there is a lack of consensus among all the psychoanalytically-based models about which psychoanalytic constructs to use. Finally, there is also a lack of consensus about the relationship between the clinical formulation and the psychodynamic formulation i.e. should the psychodynamic formulation be the case formulation or just a part of it?

However, there is also some overlapping of models and the format proposed in the present thesis includes characteristics common to several of them. In what follows, a format will be proposed for doing the psychodynamic formulation in a Jungian framework that forms a sub-section of the clinical formulation. It can be seen that discussion of the patient's psychodynamic issues and treatment issues have been kept separate. The format proposed allows for the provision of a genetic explanation of the patient's psychodynamics in Jungian terms as well as for links to be made between the latter and psychopathology and clinical problems. Finally, the proposed format relies on the four theoretical areas outlined in Part 6.

Recommendations in the literature concerning length vary: Levett (1991, p.5) recommends one to two pages for the entire case formulation; MacKinnon & Yudofsky (1986, p.240) recommend two pages and Perry et al (1987, p.544) 500-700 words for the discussion of the patient's psychodynamics alone. The present author recommends the fairly arbitrary but seemingly reasonable guideline of one-and-a-half to two typed pages for the psychodynamic formulation alone.

Clinical Formulation

The **clinical formulation** should begin with a descriptive, journalese-style statement of the patient and his or her illness under the following headings, which may simply be embroidered into a narrative: **Identifying data, referral details** and **main complaints/problems.** It is useful to pause here for the following practical preparation.

Practical preparation: This section contributes to the construction of the **highlights of the history** as well as the **aetiological** and **psychodynamic formulations**; there should be internal consistency between the pieces of information contained in these different sections. The clinician must select and list in chronological order all the salient features which he or she deems to have had an effect on the patient. Include genetic, constitutional, familial, social, environmental, medical and neurophysiological factors (MacKinnon & Yudofsky, 1986, p.222). This selection will reflect the clinician's range of familiarity with empirical and theoretical psychology (Levett, 1991). Producing a genogram is useful. A good description of the genogram is given in Brammer et al (1989, pp.161-162). Time-line diagrams are also useful aids for arranging salient features. In the author's experience, it is useful to complete the genogram while taking the family history. This section is not meant for inclusion in case notes, although the genogram and time-line are useful to retain, especially for presentation purposes (Levett, 1991).

After this practical preparation the section started above can be completed continuing with **highlights from the history, positive findings of the MSE and physical examination** and **differential diagnosis** using DSM-III-R (American Psychiatric Association, 1987). Following Levett (ibid.), **further investigations** (usually included in this section) have been included under **management** below.

Aetiological formulation: The salient features singled out above must be arranged so that they constitute the predisposing, precipitating and maintaining factors that have led to the patient presenting or being referred for treatment, according to the information available so far. Up to this point only facts must be recorded; hypothesis generation only begins in the section below. These factors should constitute important threads of the fabric of the **psychodynamic formulation**.

Psychodynamic formulation:

Psychopathology: MacKinnon & Yudofsky (1986) recommend using this section to give a full, phenomenological description of the patient's symptom clusters which will assist diagnosis and which the psychodynamic formulation will attempt to explain. They emphasize that psychodynamic constructs should not be confused with the patient's psychopathology and that the psychopathology must also not be confused with the patient's total life development because it seems that that is where their psychopathology began. They emphasize that, "Psychopathology is phenomenologic (i.e. simple

descriptive psychiatry)" (p.221) and give examples of how to describe how symptoms manifest in patient's lives and are experienced by them. Where these have been described in the presenting problem they may simply be cross-referenced here. Information which emerges which the clinician deems psychopathological but about which "... the patient is unaware or does not wish to change ..." (p.222) must be presented as such and presented towards the end of this section; an obvious exception is denial related to an organic brain syndrome. Symptoms should be grouped in order following these principles: (1) importance to the patient and (2) chronology of presentation.

In principle this seems an excellent idea although the exercise of completing this section appears to be more of a learning device (p.219) than it is suitable for routine clinical practice. Moreover, the principle with which the present author is familiar and which is followed in the present thesis is to describe all symptoms and symptom clusters belonging to the case in the presenting illness, history and mental state examination and to base the differential diagnosis and/or further investigations on these. However, it is recommended that the psychodynamic formulation is opened with a statement of the psychopathology that it will attempt to explain. In addition to this, however, it must be remembered that the object of the 'diagnosis' for psychotherapy purposes is to understand the "... content of [the] complexes" and not only to be concerned with the psychiatric diagnosis (Jung, 1945, para. 196). It may also be useful not to attempt explanations that are too atomistic; for example, it may be better to attempt a psychodynamic explanation of a patient's depressive syndrome rather than to try and formulate a reason for every one of their symptoms that led to that diagnosis.

The following should be added to MacKinnon's & Yudofsky's points. Firstly, it is useful to describe psychopathology here which is detectable from a psychoanalytic point of view but which may not warrant a psychiatric diagnosis, e.g. narcissistic issues. Secondly, personality deterioration or regression occurring during an episode of another mental disorder must be distinguished from more longstanding personality problems which do warrant being labelled as psychopathology (American Psychiatric Association, 1987, p.335). Finally, Hall (1986, p.46) writes that "Some clinical syndromes frequently seen by Jungians are not easily described in terms of DSM-III [or DSM-III-R, for example the] syndrome of the puer [or puella]"; how such syndromes manifest in the life of the patient should also be described in this section.

Nondynamic factors: This section

> mentions the nondynamic factors that may have contributed to the psychiatric disorder, such as genetic predisposition, mental retardation, social deprivation, overwhelming trauma, and drugs or any physical illness affecting the brain. Noting [such] etiological factors [here] underscores that even if nondynamic factors have played a major role in causing the disorder, the psychodynamics of the patient cannot be ignored in the choice and implementation of the treatment. [It also] serves as a reminder that certain experiences of the patient may have psychodynamic meaning even though they do not stem from psychodynamic causes (Perry et al, 1987, pp.544 -545).

Psychodynamics: The following are important guidelines for this section. MacKinnon & Yudofsky (ibid, pp.239-240) point out that

> the beginner [typically] prepares a formulation that suffers from one of two excesses. The first excess is a repetition of the history with little or no attempt to apply psychodynamics to these data. . . . The second excess is an entirely theoretical discussion with little indication of how it applies to the special historical data of this patient. A formulation of this type appears as if it were copied from a textbook in that it lacks specificity for the individual. The task is a formidable one. . . . Of necessity, even the best formulation will be a compromise that focuses on a central theme that is the patient's dominant conflict at the present time.

Similarly, Perry et al (1987, p.546) note that the psychodynamic formulation "... is most useful clinically if it does not attempt to explain too much in too many ways [. If this is not done] the formulation (and consequently perhaps the treatment itself) will lack an integrative coherence."

The aim here is to use the predisposing, precipitating and maintaining factors selected above and then to, from the perspective of the life-cycle model, develop hypotheses about the nature and development of complexes and the other components of the psyche in the patient. The development of psychopathology must be explained with reference to the points in the life-cycle at which it develops. The role of typology in the patient's psychopathology must also be distinguished.

The following are practical suggestions: (1) the clinician may again find it useful to organise his or her thoughts by means of rough notes; (2) the clinician must get it clear in his or her mind what the psychiatric diagnosis/es is or are, what other syndromes exist and what the clinical problems are. These are what the clinician is going to attempt to explain. Obviously, one would not attempt to explain a psychiatric

diagnosis of multi-infarct dementia. Such a diagnosis would be included under the nondynamic factors above; (3) next, the clinician must try to identify a stage/s in the patient's life-cycle where it seems that there were developmental problems which would account for the manifest clinical problems. The following simple example illustrates the combining of (2) and (3): an anxious patient with a persistent pattern of heterosexual relationship problems may be manifesting oedipal pathology. This is only a simple illustration. The case example in Part 8 has more of the kind of detail that is needed. Often psychopathology may appear to originate from the patient's total life development. However, where possible the clinician must try to identify a developmental phase which carries the greatest weight explanation-wise; (4) bearing all of the above factors in mind, the clinician must now think about the different components of the psyche: their nature, how they have formed or malformed (it will also be important to make a note of notable strengths) and how they interact; (5) it is necessary to think about the patient's typology: its nature and relationship to the components in (4).

After each of these steps has been completed it will be possible to begin a written, narrative description by going through the patient's life-cycle development, bearing in mind (2) and (3). In the course of this narrative, (4) must be woven in and an opportunity must be found to bring in (5).

A useful conceptual aid to bear in mind when developing psychodynamic hypotheses concerns the identification of the life problem (Malan, 1979, p.234): part of the ideal situation for making a psychodynamic formulation, according to Malan, is when a recent precipitating event can be identified that led to the patient's symptoms; if previous precipitating factors can also be identified and there is an obvious parallel between the two instances *and* an antecedent event can be identified, then hidden feelings can be inferred. These hidden feelings will be expressed in the patient's symptoms and in their human relations.

Finally, it will be of additional clinical benefit if collective material can be identified which depicts an aspect of the patient's life-cycle, problems, etc. Such material must be linked up with the particular circumstances and phenomenology of the patient's inner and outer life.

Management: This must be described under the following headings: medical, psychiatric, psychological

and social. Levett (1991, p.6) notes that, "Not infrequently the *first* step in management plans is to indicate the data which is still needed . . ." (emphasis added).

In Part 4 it was said that a psychodynamic formulation of the patient's problems impinges on the management even when psychotherapy is not an option. Transference and countertransference reactions, potential resistances and other possible implications of the patient's psychodynamics for treatment must be predicted even when the treatment does not consist of or contain psychotherapy (MacKinnon & Yudofsky, 1986; Perry et al, 1987; Shapiro, 1989).

It was also said in Part 4 that an emphasis will be placed in the present thesis on how the psychodynamic formulation informs the assessment for psychotherapy. In practice, the clinician may go over many of the points below without recording the whole decision-making process and how his or her thoughts were organised. However, the steps described below have been set out in detail to indicate how the psychodynamic formulation informs the process; they have been included in this section because of their relevance to management planning. They have been drawn from Malan (1979) and from a Jungian perspective would appear to be most ideally suited for adult patients with varying degrees of neurotic and characterological disturbance which impairs their adaptation in the world. Naturally, the criteria that are considered when assessing the type of patient that Jung referred to who is ". . . not suffering from any clinically definable neurosis, but from the senselessness and aimlessness of their lives" (Jung, 1931, para.83) would be different. Other sources which describe procedures for the assessment for psychotherapy are as follows. The assessment of patients for individual 'adult' dynamic psychotherapy in terms of criteria that have been associated with the most favourable outcome is dealt with by Bloch (1979). Selection criteria for brief psychotherapies are given by Malan (1979), Clarkin & Frances (1982) and Sifneos (1984). Contraindications and dangers of psychotherapy are discussed by Crown (1983) and no treatment as the prescription of choice is dealt with by Frances & Clarkin (1981). Contraindications to, specifically, uncovering psychotherapy are dealt with by Malan (1979). Jackson (1985) has presented criteria for the suitability of psychotherapy with psychotic patients. Fordham (1986) has presented some criteria for the suitability of patients for analytical therapy. Levy (1991) has written on the assessment of children for play therapy.

Once the clinician feels sure that an organic disorder is not behind the patient's presenting for treatment and it seems that psychotherapy may be the or one treatment option, he or she should then be assessed for psychotherapy. It seems that the assessment for psychotherapy has three purposes: (1) to exclude for or include patients for psychotherapy, (2) to make suitable treatment plans and (3) to make predictions about the course of psychotherapy. According to Malan

> The truth is that the assessment of a patient for psychotherapy is probably the most complex, subtle and highly skilled procedure in the whole field [of psychotherapy.] The complexity arises because of the many different layers at which the interviewer has to operate, sometimes in sequence, sometimes simultaneously, and all of them overlapping with one another. A large part of the skill arises from the way in which he has to 'think on his feet', constantly switching roles and modifying his approach according to his changing view of the patient and the possible disposals that seem appropriate. Moreover . . . there is often no truly satisfactory order in which the various operations can be carried out (Malan, 1979, p.210).

The different steps may be presented as follows:

(1) The psychiatric diagnosis must be weighed up. How different diagnoses bear on management decision-making is dealt with by Malan (ibid., pp.217ff) and Fordham (1986, p.73).

(2) A psychodynamic formulation must be made. Obviously, this will point to the main themes that psychotherapy will be concerned with.

(3) There must be a forecasting of the themes and the probable course of events if the patient is taken into psychotherapy. Also, Perry et al (1987, p.547) emphasize the identification of potential forms of resistance. From a Jungian point of view, however, resistance may also have a positive aspect to it (Frey-Rohn, 1990, pp.218-219).

At this point it may be noted that

> Psychiatric, psychodynamic and psychotherapeutic thinking come together in estimating the balance between the patient's *strength* on the one hand, and the *severity of his disturbance* on the other. With this balance in mind, the interviewer tries to forecast whether the patient will be able to interact with a therapist and face his hidden feelings without serious threats to himself . . ., to others . . ., or to his therapy (Malan, 1979, p.211).

Here the following kinds of criteria must be considered: extent of early positive and/or negative experience, impulse control, tendency towards breakdown and quality of relationships (ibid., p.235). Similarly, Sandner & Beebe (in Stein, 1984, p.332) have emphasized the importance of estimating ego

strengths before embarking on analytic work. Malan further emphasizes the importance of the law of increased disturbance (namely, that "... a therapist always runs the risk of making a patient as disturbed as [he or she] has ever been in the past, or more so"), of assessing depressive psychopathology and the question of suicide thoroughly and patients who contain psychotic features with regard to the possibility of the patient actually becoming psychotic (Malan, 1979, pp.220-223). Malan also relates the issue of differential diagnosis to Hildebrand's 'excluding factors' (ibid., p.225). Fordham relates these points, which seem pertinent to add here: "In making his assessment [the clinician] will take into account his patient's intelligence, his likely capacity for growth and change and the degree of regression needed" (Fordham, 1986, p.73).

Finally,

(4) The clinician must think practically. The distinction must be made between the ideal disposal and what is actually available. Points for consideration here are: how much support the patient has at present and how much may be needed (e.g. in-patient treatment or temporary in-patient containment); whether or not there are other people in the patient's life who need to be seen either for diagnostic or therapeutic purposes; the therapist's age, sex and experience and the frequency of sessions.

Regarding the obtaining of information, Malan notes that interpretations are an essential part of most initial assessment interviews for the following reasons: they are the best way of deepening rapport, of removing resistances, of obtaining evidence about whether the patient can work in interpretive psychotherapy and their motivation for insight and one of the best ways of gathering information and obtaining direct evidence about psychopathology (ibid., pp.211-215). However, Malan adds these two seemingly irreconcilable statements: "You must not make interpretations until you have found out what kind of patient it is that you are talking to. [And] you may not be able to find out what kind of patient you are talking to without making interpretations" (ibid., p.212). The possibility of increased disturbance has already been noted; there are two other types of effect that the interviewer must be aware of concerned with making contact with the patient, namely increased hope and increased attachment (ibid., pp.212-213).

For assessment purposes, the clinician must perform the dual task of taking a history and giving due consideration to all of the steps concerned with clinical formulation that have been indicated. The author has not intended to give the impression that the development of a psychodynamic formulation is at the centre, as it were, of management planning in general or the assessment for psychotherapy, nor the impression that the assessment for psychotherapy always enters management planning. He has wanted to convey the significance of the role played by the psychodynamic formulation in management planning, particularly with regard to the assessment for psychotherapy and potentially with regard to other treatment modalities.

The procedure of taking an initial history, constructing a clinical formulation and giving the patient feedback in a subsequent interview naturally makes the clinician's task easier because then there is time for him or her to order their thoughts; naturally the task becomes easier with practice and experience to the point where decisions can be reached *in situ,* followed by the making of notes.

PART 8

A CASE EXAMPLE

The presenting problem, history, mental state examination and salient collateral information belonging to a case managed by the author during his internship have been presented below. All names and places have been changed to protect the patient's confidentiality. A full clinical formulation has not been prepared because this would contain superfluous information for the purposes of the present thesis; a differential diagnosis, aetiological formulation, psychodynamic formulation and management plans have been presented.

Case History

Identifying Data:

Joey, an 18 year old female student living in women's residence, studying first year BSc (Eng.) at a predominantly Afrikaans-speaking university in the Cape Province.

Admitted voluntarily.

Referred By:

Dr. Louw (Clinical Psychologist, Psychology Department at above university) and Dr. Roos (Psychiatrist, nearby town).

Reason for Referral:

Major Depression, bulimic tendencies, suicidal behaviour, not coping, abuse of medication.

PRESENTING PROBLEM:

Apart from longstanding psychological problems which extend back to early childhood, Joey's present admission was precipitated by problems which began at the beginning of the year. Firstly, she found

herself unhappy with her course and she was unable to concentrate properly in class. Then, she found she also could not relate to university social life and a week before admission turned down a request from a male peer to go steady with him, because the prospect "freaked her out". Also in that last week (which was also the last week of the term) she changed to a BA degree, and then had to catch up with all the assignments she had missed. As she was not eating because of how disgusted she felt with herself and her body or sleeping enough and was generally not coping in that last week, her psychologist had her admitted to a nearby hospital. After the vacation started she was discharged and then began binging on junk food. As she felt everything getting on top of her, she took all 28 sleeping tablets she had to "switch off" and slept on and off for two days. She carried on binge-eating after this. Subsequently, she was again admitted to the above hospital and from there came straight to a local psychiatric hospital after her psychologist first tried to get her into a therapeutic milieu treatment unit at a local general hospital.

Recent stressful events: Joey did not complete her matric finals as she dropped out of school because she was not coping; last year while on a Kibbutz (the year after Matric) she was physically assaulted by a man.

Highest level of functioning in the past year: She functioned relatively well on the Kibbutz.

FAMILY HISTORY

Joey has a lower middle class background and her parents live in the Transvaal.

Her father is about 45 years old. He is a Major in the SAP. He is of Afrikaans background. He is described as very nervous, although he does not like to admit it. He is very hard-working. He is also very aggressive, and very religious.

Relationship to father: She says that one cannot argue with him or he feels attacked as a person. She says they rub each other up the wrong way. She says that she loves him a lot, but he says she does not respect him. She says she has never felt good enough for him. Of note is that he has assaulted her a few times after arguments between them, which have resulted in a number of blue eyes and once a broken

nose which required hospital treatment.

Mother is about 40 years old. She works as a clerk at a university in Joey's home-town. Joey says that she is very neurotic, and she will do anything for the children. She has always been very easily upset by things, and if upset, she does not eat or go to work and will often just stay in bed. Of note is that her mother is very concerned about keeping thin and is often "sick" because she does not eat enough.

Relationship to mother: She feels that she is always upsetting her mother. Of note is that her mother has always encouraged her not to eat and get fat. She has a brother three years younger than her with whom she gets on very well.

Early home atmosphere: During this part of the history what stuck out for her were the early sports practices. Because her brother went to crèche at three months and her mother returned to work, she thinks it was the same with her. She says she always saw very little of her parents as they both worked.

Medical history: Nil of note.

Psychiatric history: Paternal uncle and grandfather had histories of alcoholism.

PERSONAL HISTORY

Early development and health during childhood: She had good health except that in Sub A she used to get very thin and then people would worry about her. She was always over-anxious about making it onto sports teams or about getting full marks in an exam. In Junior School she stopped eating prior to a ballet exam in the belief that ballet dancers must be thin, and in the end had to be hospitalised and could not do the exam.

In her education she began school one year early as she could already read and write. She always got more than 90% and she got seven A's in Matric. She was the headgirl at a prestigious girls' high school in her home-town. During Matric, she was very stressed by her responsibility to extra-mural activities as headgirl, and as a result stopped eating and slept very poorly. After her mock exams she had a fainting

spell and ended up being hospitalised and never returned to school. At university she enrolled for a BSc (Eng.) degree.

In her psychosexual history, she received no information from her parents and denied masturbation or any sexual fantasies. She began her menses only in matric after her mother took her to the doctor and she had to be started on hormone treatment. She hates her periods. She says she is heterosexual, but has had no sexual experiences. She feels unable to relate to males.

In her activities she enjoys reading and in her habits does not use drugs, alcohol or cigarettes. In her eating she prefers salads and fruits and says that dieting was always associated with sports achievement. She weighs herself regularly and is in the "50's" at present [62kg is normal for her age, height and build]. She admitted that she has dieted and exercised when it had nothing to do with sport. She abused laxatives in Israel. Binging only began this year and she admits to having made herself vomit to purge herself after feeling that she has eaten too much.

Medical history: She had a breast reduction operation last year when she came back from Israel after her mother's urging.

Psychiatric history:

- She saw the school psychologist briefly in Std 4 when it became apparent that she was not getting enough sleep and for staying away from school.
- In matric, she went to a psychiatric hospital for adolescents in her home-town. Of note here is that when things started to go awry in matric, she cut her wrists and climbed into the bath where she was discovered by her mother. It seems that it was this that precipitated her going to hospital, rather than the fainting.
- When she came back from Israel last year, she went back to see the psychologist she had seen in Matric.

In her **PERSONALITY** she had to be prompted after first saying that she did not really know. She only has a few friends and those she does have she says like her "in spite of herself". She always feels that people are not going to like her. She has always enjoyed reading but lately cannot do this because of

how poor her concentration has become. She says that her moods change a lot in one day, e.g. she can get all "hyper" and excited but then can also feel very down. She says that she always gets elected for things but then cannot live up to it.

MENTAL STATE EXAMINATION:

Joey presented as a tall girl with a big frame and with blonde hair which was cut short. She was often tearful and her eyes were mostly downcast. She had long thin scars on her arms and legs from cutting herself with a razor blade at university. Rapport and her cooperation improved after she was initially doubtful that staying at hospital or coming for the interview could help. Her affect was dysphoric and anxious and she said that she felt down. There were no disorders in her thinking. In perception, she reported familiarity with the feeling of depersonalisation. She also reported a hypnogogic hallucination of a child screaming in her head, particularly after a day of keeping her "persona" up. Cognitive functioning was intact and it was clear that she had high standards for herself. Regarding her insight and judgement, she responded to the interpretation that doing well academically was obviously something that was always important to her, but that she had come to a point when her feelings were obviously catching up with her, e.g. she had this child screaming in her head. She was asked what that meant to her. She replied that she supposes that it means that she has to grow in other ways. This was supported; but she also thought that her problems were because she was too slack and "spineless". She said that she felt motivated if treatment was going to help.

SALIENT POINTS FROM SOME OF THE COLLATERAL SOURCES:

Dr. Louw:

- She was in the limelight because of all her distinctions and having one of the biggest bursaries on offer.
- That her father had high expectations of her.
- She was seeing Joey everyday towards the end of the term and said that she just was not coping; she was crying, skipping classes, sitting on the residence roof.

Mother:

- She was a colicky baby and difficult "all her life".
- She never played and was "off my hands" as soon as she could read.

- She was "demanding of attention", wanting mother to play with her. She said that "quite frankly, she finished me off."

Clinical Formulation

Provisional diagnosis:

Axis 1: Major depression, recurrent episodes, mild symptoms.

- depressed mood and tearfulness
- insomnia
- feelings of excessive guilt
- impaired concentration
- suicidal ideation

Bulimia Nervosa.

Joey does not have all the criteria for a full diagnosis; these symptoms are not considered part of her Axis II diagnosis.

- episodes of binge eating
- lack of control during binges
- engages in measures to prevent weight gain
- overconcern with body shape and weight

Axis II: Borderline features

- impulsive
- affective instability
- self-mutilation
- identity disturbance

Axis III: Anaemia

Axis IV: Moderate stressors – university life, away from home, heterosexual advance by a fellow student, change in courses

Axis V: Present – serious impairment

Past year – some mild symptoms

Aetiological formulation:

Predisposing:

- possible eating disorder and alcoholism in family, possibly predisposing Joey to eating disorder and depression; genetic mechanisms or role-modelling possible (American Psychiatric Association, 1987, pp.22, 66, 174 & 229)
- colic as a baby
- anxious mother
- minimal care received in early home environment
- -father's instilling of guilt, does not allow confrontation and can be aggressive and violent, sets high standards for himself and Joey

Precipitating:

- away from home in a stressful environment
- inability to relate socially
- heterosexual advance by fellow student
- attempting to do a course she did not want to do and her change in courses

Maintaining:

- poor coping skills and personality problems
- high expectations of her by others
- the way she pushes herself
- unfulfilled course demands after change
- her depression

Psychodynamic formulation:

Psychopathology: This formulation will attempt to account for Joey's depression, bulimia and borderline personality traits.

Nondynamic factors: Possible nondynamic factors are a possible history of eating disorder in her mother and of alcoholism on her father's side, predisposing Joey to eating disorder and depression (American Psychiatric Association, 1987, pp.22, 66, 174 & 229).

Psychodynamics: Joey was a colicky baby and her mother found her difficult. In addition, it seems that her mother was an over-anxious mother and that she could not cope with Joey's demands. There is thus evidence that during the primal relationship (Neumann, 1990) with the mother, painful feelings of discomfort, of needs not met, displeasure and distress were not adequately ameliorated by Joey's mother. This situation is sure to have awakened a "distress ego" (Meier-Seethaler, 1982, p.364) accompanied by feelings of oneself being forsaken, unloved, insecure and guilty over being 'unlovable'. The central symbol of this state is hunger (Neumann, 1990, p.74).

Internally, this situation constellated the archetypally mediated image of the Terrible Mother who is experienced as persecutory, depriving and abandoning. As a response to this state of affairs Joey seems to have attempted to gain a premature independence from her link to the "Negative Mother" and her own disturbing baby feelings. As Neumann states, this is the result of an ego 'reduced to its own resources' as a matter of survival.

Certain shadow problems inevitably ensued. Firstly, there was a schizoid withdrawal, or renouncement of object relations because the 'other' (first experienced via the relationship with the mother) has proven inadequate, frustrating and bad. This results in an inner, unconscious sense of painful craving and a state in which the shadow is always going after the 'nourishing mother' but then withdrawing lest she devour and destroy the mother in her intense need to gain total possession of her. There is thus a constant oscillation between hungry eating and refusal to eat, longing for people and rejecting and refusing them. Secondly, it is noteworthy that aggression appears to be absent from her personality and this is probably because this emotion assumes very intense proportions in her unconscious.

Joey's early experience has also had profound implications for the development of the ego-self axis. The child's first encounter with the self is via the mother's role as the container and bearer of its experience and by her ordering of its world. If the primary relationship with the mother is disturbed as seems to be the case with Joey, there is a corresponding disturbance in the development of the ego-self axis with consequences for all future development because ego-consciousness is deprived of its foundations.

Her unsatisfied dependency needs can be seen by the fact that she was very demanding of attention and "finished her mother off". However, she is also capable of apparent autonomy and independence, which can be seen from the fact that she was "off her mother's hands" as soon as she could read. In Joey, the matriarchal stage was probably prematurely precipitated by the development of the distress-ego and during this stage she probably relied more on herself than a healthier development would have demanded.

With regard to her typology, it seems that she relied on thinking as her primary function from an early age as a way of managing her world but also as an intellectual defence to cut herself off from her internal and external worlds. It may be fruitful in future contact with her to try and identify whether one of the other functions has a natural tendency to be dominant but that instead she has had to develop thinking as her dominant function due to her need for precocious ego development and because of the academic expectations that have been placed on her. Her attempts at an engineering degree *may* indicate that her auxiliary function is sensation. With regard to her attitude type it seems almost certain that she is predominantly introverted, as attested by her social difficulties and a solitary pursuit like reading. One can expect that if she is taken into psychotherapy, the integration of her shadow will include the need to develop her inferior function and attitude type. When extraverted feeling is the inferior function, such people are plagued ". . . with bizarre and inappropriate emotional reactions and with naive misjudgements of people" (Whitmont, 1969, p.151). It seems that this might fit Joey's case.

It is noteworthy that the natural urge to play was somehow absent in Joey's childhood. This points to an inability to give free rein to the imaginal activity of the unconscious. Instead she moved straight into a narrow form of intellectual independence. Opportunity for play, because it is pregnant with symbolic meaning, probably aroused intense anxieties that she felt the need to cut herself off from.

Several of Joey's symptoms have already been included in the formulation. At this point some points can be drawn together to present a more coherent picture of her psychopathology. The seeds of Joey's depression were sown in these early phases because of the feelings of guilt and low self-esteem that resulted from her feeling unloved. She has also received the diagnosis of borderline features. Machtiger (1984, p.120) has noted that the borderline syndrome has been called a deficiency illness; in Joey this

manifests in her lack of stable ego identity and in the phenomenon of *abaissement du niveau mental,* a ". . . reduced intensity of consciousness characterised by absence of concentration and attention [and] a state in which unexpected contents may emerge from the unconscious" (Samuals et al, 1986, p.7). Examples of this phenomenon can be seen in Joey's labile emotional life, binges and her hypnogogic hallucination. Her bulimia attests to both her ego's dissociation from her feelings and the power of her 'hunger' which breaks through into her consciousness: she is capable of dieting on the one hand and of uncontrollable binge eating episodes on the other. Her purging herself after intakes attests to the likelihood of an internal conviction that she has introjected something essentially poisonous to her internal psychological system.

During the patriarchal phase, the girl's identification with father affords an opportunity for disidentification and disentanglement from mother. His loving affirmation leads to a positive sense of her femininity with respect to future partners. And he presides over the differentiation of her animus. From the family history, the clinician gained the impression of a closer bond to father than mother, but his aggressiveness and conditional love exacerbated her tendency for depressive feelings, through the internalisation of a negative, critical, demanding animus. The hold this complex has on her ego can be seen in the extreme demands or expectations she places on herself.

During adolescence she was unable to attenuate the internalised links to her parents through peer-group affiliation and experimentation in heterosexual love relationships. At 18, she came to university and began a repeat of what happened in matric, possibly on a worse scale. She tried here to live up to the dictates of the animus by tackling a BSc (Eng.) degree using her most well-developed function, thinking, and operating through a persona of achieving, coping and independence from home. What strength she had was quickly eroded by social and academic stresses and a change of course midstream, and she began frantically binging as her way of coping. Her distress became too great to endure and she tried to achieve some form of regressive extinction of her distressed state by overdosing on sleeping pills.

No collective material appears to be pertinent to the case from the information that has emerged from initial contact.

Management:

Further information is needed about the suicide "attempt" in matric so that there can be more clarity about the risks that would go along with treating her.

Medical: Iron supplement

Psychiatric: Rather than Joey going onto anti-depressant medication, it will probably be more effective to tackle her personality problems; in the short-term, relief from her stressors may promote some recovery in her mood.

Psychological: In terms of selection for psychotherapy and her strengths, she is intelligent, she has shown some motivation and insight that she is in need of personality growth. However, she was initially antagonistic and it is not clear whether her motivation is for symptom relief or real personality change. Although none of Hildebrand's excluding factors appear relevant, she does not seem to have much internalised positive experience from early on. This raises the question of her capacity to cope in the face of difficulty and her history in this regard is not encouraging. She also has the tendency to act her feelings out through self-mutilation. In addition, there was a suicide "attempt" in matric although more information is needed about how serious it really was. A contract with the condition that the hospital will have no option but to send for her parents to fetch her may be necessary to help contain her if acting out becomes a problem by persisting; she should be encouraged to talk about her feelings to staff or her therapist rather than act them out.

Anticipating transference and countertransference, it may be speculated that the therapist will be felt as unable or unwilling to contain her and therefore that she would be reluctant to talk about her feelings. She would probably also see him as critical, demanding and withholding. She may also become anxious that her 'hunger' will drive him away. From initial contact the clinician anticipates that countertransference reactions would be anxiety over the inability to contain her distress and the desire at other times to give her a completely facilitating environment without any demands; care must be taken not to be too protective. The therapist may also experience her 'hunger' as depleting and he should be prepared for this when it happens and not respond unconsciously by holding back. There

does seem to be a realistic need to provide a holding, maternal environment as well as a need to provide a positive, guiding paternal function. From initial contact, responding to these needs appears to have had a positive effect on her. Termination would have to be dealt with carefully because the bond is likely to be markedly dependent unconsciously once contact is made.

Goals of the therapy relevant to such a short stay as is the norm on this ward would be to help her recover from her "failure" at university and to work through what happened, to create an atmosphere which will promote some self-acceptance, and last but very importantly, to prepare her for long-term therapy follow up, one role of which would be to achieve a healthier separation from the parental images. Finally, there needs to be some caution about interpretation. This should not be done from a distance and to provoke anxiety as with some neurotics, but with a view to establishing a strong alliance and to help Joey feel contained and accepted.

Social: This axis does present a management difficulty. The parents should receive some information about her condition and course in hospital without Joey feeling betrayed. At present, it seems acceptable for her to stay in hospital here because she needs some work on her own. At a later stage she should probably return to her home-town and the family should be referred for family therapy; Joey will also need ongoing individual therapy. She should not consider returning to university this year and her parents should be informed of this opinion so that they can make the necessary arrangements.

Note that theoretical constructs not included in Part 6 have been referred to in the above psychodynamic formulation, for example the distress ego. This illustrates the principle that the theory presented there is meant only to serve as a backbone to which additional theory or theoretical elements can be added according to the needs of the case (i.e. Jungian or psychoanalytic theory).

PART 9

CONCLUSIONS

It was stated in the Introduction that the present thesis would have two goals. The first of these has been to unravel the reasons that may have lain behind a one-sidedness of the Jungian literature; the second has been to show that Jungian theory can be applied to the diagnostic and assessment context of clinical work and to attempt to partly fill the gap in the Jungian literature by providing a format for the psychodynamic formulation in a Jungian framework and showing how it informs management planning.

With regard to the first goal, an analysis of the literature revealed a number of clear, substantial reasons why there are the differences which the author found between the psychoanalytic- and Jungian-oriented literature.

The second goal was more difficult to meet. To begin with, it was possible to show that the use of the individuation model and the under-emphasized medical model in Jungian theory facilitates the use of Jungian theory in the diagnostic and assessment context of clinical work. However, with respect to making proposals for a format for the psychodynamic formulation in a Jungian framework, the following difficulties were encountered. Firstly, there is very little consensus about what a psychodynamic formulation is; i.e. what its relation to theory is and what the topics are that it should cover. Also, there was some lack of consensus about the relation between it and the clinical formulation: should it be the clinical formulation or should it be part of the clinical formulation?

Secondly, the author had to be the most inventive with regard to the second goal and thirdly, this inventiveness had to be complemented with the provision of procedural suggestions that are in accord with standard clinical practice (although what is standard was complicated by the lack of consensus). Levett's (1991) paper was an essential aid here.

A further issue which the author chose to deal with is how closely related the psychodynamic formulation and management planning are, with particular emphasis being placed on the assessment for

psychotherapy. This also provided an opportunity for extending the application of Jungian theory just that much further.

On the whole, the present thesis could be said to have a one-sidedness if looked at from a Jungian perspective. This is because very little has been said about the symbolic content of psychological transformation and of psychopathology, usually regarded as the Jungian psychologist's specialised area of knowledge. However, this one-sidedness seems to have been a necessary part of the author's attempt to constantly bear in mind the many practical demands of clinical work.

The author's main hope is that he has provided a format which would be acceptable to the clinical psychology profession, but at the same time does justice to the richness of Jungian theory; he hopes to have achieved this aim.

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