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The Therapist's Inferior Function

M. Sabini PHD ℹ

As Therapists, we have to be familiar with our own limitations and with the areas of our personalities that might be weak, damaged, or undeveloped. I think that the inferior function qualifies as one of these areas, a place where we are less developed, perhaps touchy, and probably less competent than in other areas of our functioning. This was brought home to me recently by a minor incident in my practice, and it led me to do some thinking about the ways the inferior function can alter professional competence.

What I plan to do in this paper is to sketch out some of the major and minor ways the therapist's inferior function can cause disruptions in handling a clinical practice. I will also review studies of therapists' dreams, with an eye for how dreams may play a compensatory role during times of such disruptions. After laying this groundwork, I will return to the episode in my own practice and tell you that story, as it exemplifies this problem and the role of the objective psyche in restoring the therapist's equilibrium after a disruption or eruption of the inferior function.

But before proceeding, I believe a confession is in order. If typology is to be the topic, then you have a right to know at the outset my own bias: intuition is my primary function, and although I learned to use it extravertedly, its natural inclination is introverted. Because of my family's dislike of intuition (although it was also a natural function for each of my parents), I initially developed my second and third functions, extraverted thinking and introverted feeling. Sensation is definitely the inferior function and seems to be inferior in both directions.

I would like to say a word about determining one's own type. This can be a complicated process, for our typology is enormously affected if not obscured or skewed by family dynamics and personal complexes. Apparently neither self-typing nor any one of the type tests alone can be considered wholly reliable and valid. Each of the tests available has advantages and disadvantages. At times it may be more helpful to ask, ‘What functions do I use in what situations, and with

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what patients?' than 'What type am I?' The relative certainty with which I stated my type took years to reach and emerged only slowly out of considering, with an analyst knowledgeable in typology, an enormous array of data: conflicting results on the MBTI, GW, and SLIP; numerous dreams that named intuition and sensation explicitly; other dreams in which typology was indicated by certain known people and by colours of clothing I wore; and personal impressions based on readings and experience.

Establishing one's inferior function may be a bit easier, for it is the area with which one has regular trouble. Between a sober reading of and reflection on Jung's and von Franz's descriptions of the inferior functions and a sober query of one's family and friends, the likely areas of inferior functioning will probably be discernible. Taking all of the type tests can give hints as to the inferior function, but because of methodological biases in test construction, the results must be matched by a sound assessment from actual experience. As far as I know, the assessment of the inferior function by itself has not received any attention; it needs more careful scrutiny, as does typology as a whole, according to Meier (14).

Caveats

The style of this paper is typical for an intuitive: it meanders at times, offers global generalisations, and generates hypotheses from single experiences. The material will be presented anecdotally, more in the tradition of story-telling than of science. My hope is that readers will be able to identify with the incidents and that more accounts of the difficulty with the inferior function will come forth.

The limitations of this paper is that much of what is presented will pertain primarily to therapists with intuition as a primary or secondary function. According to research, this pattern is prevalent among Jungians (BRADWAY AND DETLOFF 3), but of course it is not universal. Also, I am going to be talking about intuition in general and will not make a distinction between problems related to the directionality—introverted or extraverted. This is not because the distinction is unimportant. As Beebe (1) has shown, the direction of a function can be a crucial dimension between therapist and patient. The pairing of intuition with either feeling or thinking is another distinction that will have to be neglected here.

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As you will see, the focus here is on the way the inferior function disrupts the handling of a clinical practice. It does not go into the ways it can affect one's clinical style or how it colours the types of interventions we make. Papers by Jungian analysts such as Beebe (1), Groesbeck (7), and the Quenck (16) offer thoughtful insights into the

role of the therapist's typology in clinical interactions, and I hope that the ideas offered can be explored further.

The entire topic of typology and clinical practice lies open to investigation. It may turn out that some of my observations are based on personal idiosyncrasies and not on general typological issues. This is only preliminary and relatively personal commentary, but it does contain some tentative hypotheses and so I hope it is of heuristic value.

The Inferior Function: General Background

The term ‘inferior’ is an unfortunate one, since it immediately conjures up an image of incompetence. But Jung was clear that it was not meant to be judgmental or pejorative: ‘These functions may properly be called *inferior* in a psychological but not a psychopathological sense, since they are in no way morbid but merely backward as compared with the favoured function’. (JUNG 10). Thus, we are ‘inferior’ only in relation to the rest of our own more developed selves.

Jung left a succinct description of how the inferior function behaves:

> *An essential criterion is its lack of self-sufficiency and consequent dependence on people and circumstances, its disposing us to moods and crotchetiness, its unreliable use, its suggestability and labile character. The inferior function always puts us at a disadvantage because we cannot direct it, but rather are its victims. (JUNG 10, para. 956.)*

Crotchetiness, unreliability, dependence, lability—the inferior function brings about each of these states, and thus disrupts our basic sense of intactness and competence. Would this not happen in our clinical work just as it happens elsewhere, or do we expect to be immune in that area?

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In the 1959 BBC interview ‘Face to Face’, Jung gave a hint about his own inferior function when John Freeman asked him, ‘Have you concluded what psychological type you are yourself?’ Jung replied:

> *Well, you see, the type is nothing static. It changes in the course of life, but I most certainly was characterised by thinking. I always thought, from early childhood on, and I had a great deal of intuition too. And I had a definite difficulty with feeling, and my relation to reality was not particularly brilliant. I was often at variance with the reality of things. Now that gives you all the necessary data for a diagnosis!*

How could Jung say he was not good ‘with reality’? That is a rather shocking admission. But the tone of the interview here is playful, and I believe Jung is simply stating what it is like for an introverted intuitive in relation not to reality in general but to outer, factual reality in

particular. He is telling us about his inferior sensation function. In the one basic writing on this subject, ‘The inferior function’, von Franz speaks about this very problem with reality: ‘The introverted intuitive suffers, as the extraverted intuitive does also, from a tremendous vagueness where facts are concerned.’(VON FRANZ 4).

Both Jung and von Franz had highly developed intuition, and their writings on these types are excellent; I will not attempt to summarise here what they have to say. We need only a basic working definition of intuition: it is a function related to the immaterial world of possibilities, a mode of perception via the unconscious. Sensation, on the other hand, is related to the material world of actualities, a perception of the visible or tangible world.

Both Jung and von Franz made some general statements about the kinds of trouble an inferior sensation function could cause. Von Franz warned that ‘The introverted intuitive is often so completely unaware of outer facts that their reports have to be treated with the greatest care’. Jung stated that when an inferior sensation function is activated, the extraverted intuitive may be prone to ‘sexual suspicions, financial hazards and forebodings of illness’. For both the introvert and extravert, there may be neurotic symptoms, according to Jung, involving hypochondriacal ideas, hypersensitivity of the sense organs, compulsive ties to particular persons or places, and ‘every imaginable kind of absurd bodily sensation’. (JUNG 10, p. 370) Von Franz stated that there can be ‘a

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particular problem in approaching sex' because it involves the inferior sensation function.

So it isn't hard to imagine the sort of troubles intuitive therapists may run into: not noticing they need to take time off to rest; not finding out about physical or sexual symptoms of patients; confusing the children of one patient with those of another; giving two patients the same appointment time; and so forth. My own predilections are forgetting to get addresses of new patients and making appointments in two different locations without taking the travel time between them into account.

Our analytic attitude will lead us to search for unconscious motivation behind these errors, and from what von Franz says about the inferior function, we are right to do so: 'The inferior function is so close to the unconscious and remains so barbaric and undeveloped that it is naturally the weak spot through which ... the unconscious can break in'. She calls it 'the fourth door of your room, where angels can come in, but devils also!' Last week, as a patient was leaving, I said goodbye to her using the name of another patient. Both their names begin with the same letter, have five letters, and a similar phonetic sound, so the primary process association between them makes sense. But I had never considered any link between the two patients; and

without doing some psychological homework I could not know whether it was the devil prompting me to act out by depriving this patient of her identity or an angel showing me an unnoticed and important similarity between them. (It turned out to be the latter.)

I wonder whether there can be a danger of over-analysing such slips that emanate from the inferior function. Intuition is so fond of 'meaning' that it looks for it everywhere and it tends to link up events that may not necessarily be linked. For instance, during times of personal upheaval I tend to make more scheduling errors in my practice, but the errors are not necessarily personally related to the *patients* who are affected. The secondary function of thinking or feeling must be called upon to sort this out.

Von Franz, in her essay, stated that 'One of the great troubles of the inferior function is its slowness'. Intuition, on the other hand, tends to be a 'fast' function, able to imagine possibilities and changes with facility. (MANN, *et al.,* 13). Thus there can be a clash of speeds, with intuition and sensation keeping pace unevenly. Examples of this problem, and the transference and countertransference implications of it, will be mentioned in the next section.

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Consciousness prefers to remain consolidated, but disruptions caused by the inferior function can destabilise our equilibrium. When the disruption is minor, the equilibrium can be restored with modest effort. But when the disruption is a major one, some serious self-examination may be required. In the following sections I will give examples of the types of disruption to clinical practice that the inferior sensation function can cause.

Disruptions to Clinical Practice: The Office Environment, Paperwork, Clothing

If we took a walk through the consulting rooms of intuitive therapists, what foibles related to the inferior sensation function might we find? Come into my office and I will show you a few, and then we will visit others.

There is a spare key hidden away so that if I ever forget mine or am locked out, I can still get in and work. But sometimes I cannot recall where the key is—is it still in such and such a place, or did I move it? The same thing happens with my hidden house and car keys: although I have never had to use them, and assume they do not change places of their own accord, my memory for where they are fails, like a lack of object constancy.

There is also a lampshade in my office that pulls away from the wall occasionally and hangs half off. Fortunately this happens only at the end of the day when I close the shades, so patients are spared the

pathetic sight; you would not see it on a superficial inspection of this intuitive's office. The prospect of fixing the shade or having it fixed so that it remains securely fastened is so overwhelming that it has stayed in this state for two years now. When I imagine fixing it, my phantasy is that I would have to go to the hardware store and spend hours looking among the hundreds of types of nuts and bolts there, and then I would probably buy the wrong size and have to go back and do it all over again. I have enough reality experience to know that sensation problems are not necessarily so hard to remedy, but the *phantasy* accompanying them is always an initial one of feeling overwhelmed and incompetent.

A colleague of mine has another sort of problem with sensation, and a visit to his office reveals the story, in one corner is an enormous pile of mail and magazines; not just a pile but a veritable mountain about waist high and three foot in diameter at the floor! It seems appalling that the pile is left there for

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patients to see; but it is an honest statement of his difficulty with sensation: he can neither disregard the collective and throw the publications away nor can he digest the onslaught.

Obliviousness of the sensation world can come out in other ways. Lighting seems to be a problem area for many intuitives. I have sat for meetings in offices and homes of intuitives where the lights were either so dim to begin with that people could barely see each other, or they became dim during the meeting and the dimness went unnoticed until someone other than the host asked gingerly if a light might be turned on!

Keeping up with paperwork seems to be a regular albatross around the neck of many intuitives. Von Franz referred specifically to this when she said, 'If an intuitive fills out a tax form he needs a week where other people would take a day'. For myself and many intuitives I know, a week would be fast! Perhaps if thinking is the auxiliary function, it can be called upon to provide the logic and organising that intuition cannot do to get the forms filled out. But if feeling is the auxiliary, forms may never get filled out, for one may never *feel* like doing it; there is no value placed on business matters and the form falls to the bottom of the pile over and over as those matters with value rise to the top.

Early in my practice, I registered in order to be able to take Medicare patients, fees being paid by a state insurance fund. A patient came, I did an initial evaluation, and then tried to fill out the proper forms to be compensated. Knowing how difficult this was for me, I was especially careful to check and recheck my work to be sure I used the correct code numbers for the diagnosis, procedure, and so forth. A few weeks later the response came: claim denied because the form was

incorrectly filled out. With enough experiences like this, intuitives usually come to realise they have to take some other course of action to handle paperwork. One solution is of course to hire a secretary or bookkeeper to do the work. Another approach some therapists take is to ask clients to keep track of their hours and pay accordingly.

The therapist may have trouble doing the bookkeeping, which can then show up as a countertransference issue; or the patient may present bookkeeping or 'housekeeping' matters to the therapist, the transference implications of which go unnoticed. I have the impression that when intuitive therapists are confronted by what appear to be 'plain' sensation matters, they neglect to think about them psychologically, as they would do naturally when confronted with

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other types of analytic material. For example, a patient handed me a tax form that listed the amount he paid in fees for the previous year; he stated that his accountant told him it was required. No one had ever given me such a form, and, on checking with my accountant, I learned it was not necessary. I returned the form at the next appointment. Later in the session, an explosion of unconscious material came forth, stemming from this incident but having deeper roots. The patient told a painful story about repeated incidents in his boyhood of trying to do what he was told, but no one ever appreciated his efforts. Although there was no particular 'mistake' in my handling of the incident, it reminded me of how I take sensation matters at face value and forget to think about the underlying meaning behind them. If the man had told me a dream about trying to give me a tax form and worrying over whether or not I would accept it, then I would have immediately thought of the transference issues; but with the 'plain' sensation episode, I was not able to think that way at first.

Scheduling is another area that can be affected by the conflict between intuition and sensation. Intuitives can picture a change in schedule or a new work plan with great rapidity, but the sensation reality of whether the plan is feasible may lag far behind. Changing hours for patients on short notice is a situation that often leads me to make mistakes. Recently, a patient asked for an extra hour one week in order to compensate for missing her appointment during a business trip the next week. I agreed and gave her an hour; two days later the sensation reality caught up and I realised that the hour would put her adjacent to another client whom she peripherally knew (but did not know was also coming to see me).

Difficulty with sensation can also show up in the therapist's mode of dress. In supervising interns, I had occasion to mention such a problem to two students. Each of them had a good clinical ability, but one woman wore blouses that were a size too small for her ample bosom and the other woman was oblivious of the placement of her

skirts, so that each time she sat down, the back of her skirt caught on the chair and exposed her upper legs, giving clients much to see. From talking with them, I could see that the difficulty regarding clothing fell within the penumbra of an inferior sensation function, in the shadows where they could not see the problem but others could all too well. Both were introverted intuitives.

The last category to mention is the least specific: *action.* Patients' actions usually consist of entering and leaving the office, sitting or lying down, and perhaps

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gesturing. Recently, a new patient had trouble in the area of action, and it made me aware of how alien it felt to deal with that dimension. She had trouble getting into the office: for her first visit, she waited about five minutes in the public lobby, rather than come up to my waiting room; on the second visit, as if to make up for that initial delay, she walked into my office without knocking during my break between patients. She asked if I were ready for her; taken aback by this intrusion, I said no, that I would come out for her at the hour. I was not especially cordial and she had grounds for feeling rebuffed. Later, I felt at a loss as to what to make of these two faulty approaches; no client had ever done either of these things, so I knew they meant something about her, but what? It took the distance of several weeks for my psychological imagination to click in. Had the two attempts to enter my office appeared in a dream, I easily would have perceived her difficulty with approaches; but with the message communicated via bodily action, I was hit in my inferior function and at a standstill. The immediacy of the sensate world created such an impact that I felt stunned.

I have listed the office environment, clothing, bookkeeping and scheduling under the heading of minor disruptions, and yet this may not be correct, for any of these can become major issues in treatment. The distinction between what is a minor disruption and what is a major one depends as much upon the client and the state of the transference as on the actual nature of the disruption. On an initial visit, one client seeing a dimly lit office, a huge pile of correspondence, or an ill-dressed therapist may be upset and not return; but another may see the dimness as cosy, the disarray as a comfortable antidote to an obsessive family background, or the ill-dressed therapist as a welcome relief from an excessive persona. I do not intend these stories to imply that one mode is better clinically than another, but rather to highlight that there can be areas of 'practical matters' to which we as intuitives forget to give psychological thought. It is not uncommon for clients to assess how they can expect to be treated by the way the plants, the furniture, and the office in general are treated and by how the therapist appears to care for him or herself. What are the implications of having clients do the book-keeping? What piles of

journals, falling shades, dim lighting, unwatered plants or soiled carpets are there in our offices that we pay little attention to, but which stand out to others like a sore thumb? New clients can be deterred, unfortunately, from seeing therapists whose clinical abilities are not accurately reflected in these outer ways.

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Now I would like to turn to the types of problems which have potentially more serious repercussions.

Major Disruptions to Clinical Practice: Assessing Physical Symptoms, Suicidality, Child Abuse, and the Need for Hospitalisation

The difficulty with the body that both Jung and von Franz mentioned can come up in a number of ways. One is a tendency to omit questions regarding physical, psychosomatic and sexual symptoms and practices in the initial hours with new clients. Such omission can give the client the impression that these areas are not within the bounds of psychotherapy, and patients may then follow this lead and not bring up matters pertaining to the body in their subsequent treatment. Another way this can come up is in an overly psychological attitude toward somatic issues. Just as physicians tend to be primarily oriented toward the body and hence neglect the psyche, so therapists tend to be primarily oriented toward the psyche and neglect the body. Symptoms may be 'psychologised' and thus not receive the balanced treatment they need. I had a colleague who was bothered for years by allergies but assumed they were 'all in his head'. Friends finally convinced him to get an allergy work-up done; he returned from the doctor's office elated because the allergies were 'really there' and could be treated. Another example was the story told by an established therapist who had been stung by poison oak after walking through a field of the stuff; she then 'wondered what it meant'. I resisted the temptation to tell her it meant she'd been dumb enough to walk through poison oak. Her query was for a more lofty, intuitive 'message from the universe'. I tell these stories to illustrate how careful intuitives have to be regarding their own shadow, which will fall into the realm of the soma.

Another area where an inferior sensation function can seriously hamper a clinician is in making assessments and decisions having to do with medication, hospitalisation, suicide, homicide and child abuse. In some states, the law has entered the consulting room and insisted, under threat of serious penalty, that licensed therapists break confidentiality and report or take certain actions if one of these conditions appears to exist. How this is handled clinically is a topic of its own;

what I want to mention here are the ways the inferior sensation function can affect this process for the clinician.

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Whereas intuitives live comfortably in the *immaterial* world, these situations require a transit over into the material or objective world. The assessments of child abuse, suicide, hospitalisation need and so forth, are based on both qualitative or clinical and immaterial considerations as well as on quantitative or material ones. In each of these circumstances, an impulse in the patient has left the psychic realm of imagination and phantasy and gone over into the realm of material action, or is imminently about to do so. The phantasies of hitting one's child, gunning down an unrequited love, or driving one's car off the road have shifted into a grey area where they are no longer safely contained in the psyche but may break out into the realm of actuality. In order to assess this likelihood, the therapist has to inquire skilfully about the magnitude and power of the phantasies, about the history of previous actions, about the appeal of action in the present. Fortunately collective psychiatry is fairly well developed in this domain and there are useful guidelines one can follow to make these assessments. But I do think that when intuitive therapists are required to make judgments pertaining to the realm of *actual,* present possibilities, there can be a unique and special difficulty, for this is the realm of the inferior function, the ‘tremendous vagueness where facts are concerned’.

I assiduously avoided this whole clinical area during my training; only after I was established and had some experience under my belt did I return for additional training to make up for the deficit. I spent a year working at the psychiatric emergency facility of a major urban hospital, where assessments and decisions regarding medication, hospitalisation, and holding suicidal and homicidal patients against their will was a daily and a nightly occurrence. The work was profoundly upsetting, for with intuition I easily perceived the unconscious situation and felt the immensity of their suffering. Breathing in too much of that atmosphere, I became ill with a lung condition for the first three months; the lungs are associated with the breath or pneuma, and are often the site of symptoms for intuitives. But after six months, the work finally became easier and even seemed routine. It probably grew easier because I had learned how to leave aside the pull to attend to the patients' unconscious emotional states and to the ‘transformative field’ activated between the patient and myself; I no longer had to make that transit out of the immaterial world of intuition each time I came on duty, for I learned to leave it behind and function primarily in the material world: asking if the patients have been eating, have they ever tried to kill themselves before, do they have a therapist, and so forth. The phrase from Jack Webb's television detective show ‘Dragnet’ came to mind: when interviewing people he used to say,

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‘Just the facts, ma'am’. What he meant was, ‘Leave aside your own hysteria for a moment and tell me exactly what actually happened’. In crisis work, the emotional aspect needs to be tended for a short time, with the goal of sewing up the ruptures in the psychic vessel well enough for the patient to be referred for on-going treatment. The natural tendency of intuition to be open-ended, by which we reach into the future and help patients keep the material flowing, was contra-indicated.

Using as a basis the preparatory training given at the hospital, I drew up a list of questions that I then would take into the interview room each time. The list itself constituted ‘sensation’, and carrying it with me seemed to serve as a ritual way of binding the anxiety that having to work out from the inferior function always stirs up; it seemed to protect me from being swept along by my own emotional reactions to patients or by intuitive perceptions of their suffering, so that I could attend to the matters at hand.

I still use a modification of this list regularly when seeing new private patients, for I have learned that this is a constant area of non-competence: to ask about the basic facts of a person's life, what is their address, do they have children, are there physical symptoms, the ‘simple’ things that go into a standard history taking. I feel reluctant to disclose this because the problem seems so embarrassingly basic; how could a doctor forget to get a patient's address? Von Franz's essay on the inferior function is very comforting in this regard, especially one story she tells about herself. She says that being a thinking intuitive type, she has feeling as the inferior function, and so she does not have ready access to expressions of feeling when it comes, for example, to writing letters of condolence. To compensate, she has saved up over the years ‘certain phrases that have struck me as being very nice and touching’, and she puts together a ‘cocktail of these conventional phrases’ when writing such a letter. She emphasises that our efforts to deal with our inferior function are always going to be quite low grade in comparison to the level of development we achieve in our other functions. And my list of questions comes in for another criticism, which von Franz describes as follows:

> *The same applies to intuitives with their inferior sensation: they simply have the habitual, technical ways of dealing with it, borrowing help from the collective … You can always observe these adaptive reactions by the fact that they are impersonal and banal and very collective. They have no convincing personal quality about them.*

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My questions are indeed very banal, and I feel like a stereotypical doctor when I ask them. The banality of having to use a collective device in order to do the most elementary history-taking grates

against the flare of my intuition, which would like a more creative solution; but *it* has never remembered to get the patient's address.

Intuition is excellent at picking up possibilities that exist in the psyche, but it is not good at deciding where a possibility belongs temporally: to the present, the near future, or the distant future. Nor is intuition alone able to ascertain whether an image belongs to the psychic world or the material world. A new patient came recently, and in the first hour I had a very strong intuition that she needed to go through a breakdown, could be seriously suicidal, and might have to go to the hospital. The strength of my affect alerted me to the imminence of these images, but a bit of checking with the patient ruled out their present immediacy. Determining whether an image belongs to the psychic or material world and how imminent it is involves a type of differential diagnosis and requires another function by which we learn more about a patient's psychology, so that the image can be filled out and shaped.

Implications for Transference and Countertransference

I imagine that the implications of our typology on how we handle transference and countertransference are tremendous. Intuition is very good at perceiving and holding for clients their undeveloped potentials, and so the atmosphere is probably accepting and open. But we are less good at meeting clients at exactly where they are, less comfortable staying with them at one place for a long time. Intuition is so good at moving towards the future that the present does not have the impact that it might, or should. An intuitive may have clear sight for the growth potential for a client and less clear sight for the pathologies that block that growth. I suspect that this shows up on both the microscopic level of minute to minute interactions and on the macroscopic level of the long-term goals we hold for clients. Because intuition counts on a new possibility just around the corner, it can be blind to actual limitations. How and when does an intuitive therapist come to the conclusion that a particular patient is not getting anywhere and that something else should be considered, or treatment discontinued? How long does the therapist listen to stories of physical symptoms or marital discord before suggesting a referral for additional

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treatment? Is the therapist overestimating the self and underestimating the ego?

These issues may also have implications for dealing with transference. I wonder if it is more difficult for intuitive therapists to invite clients to explore their experiences of negative transference that take place right in the room if there is a tendency to deflect this immediacy

by talking about people in the outer world or about the historical determinants? Are intuitives more likely to ignore the transference implications of a client's being late, not paying the bill, changing hours, and so forth?

And what sort of reactions will our inferior function provoke in clients? When confronted with the therapist's area of weakness, I imagine that clients will respond along the lines of their main transference complex: one client may feel frightened or distressed when the therapist appears to be an unreliable parent; another may feel outraged at being let down. A third may find a way to take advantage of the therapist, knowing about the vulnerable spots; and a fourth may begin to carry the inferior function for the therapist. Since the inferior function creates an area where the therapist is in fact at times a less than good enough parent, an area where we do fail our clients, I imagine we can expect a range of reactions and should be prepared to own up to the difficulties we have caused. The therapist thus provides a model of how to relate to the inferior function so that clients can feel free to discuss and experience the areas of their own psyches that feel less than satisfactory.

I would now like to turn to the clinical episode that involved the inferior function.

Clinical Vignette

This incident took place when I was doing vacation coverage for another therapist, Mrs Thomas. About a week before the vacation, I stopped by her office. It was six o'clock in the evening and the end of my work day; I was tired and my mind was already shifting out of its daytime alertness, with the cognitive ego functions filing into their nocturnal resting places in the back rooms of the psyche. After we had talked for a few minutes, she said to me, ‘A patient might be calling you’. My attention was then half-turned outward, listening to Mrs Thomas describe this patient, and half-turned inward, trying to figure out why she was telling me this. It seemed to take several minutes before

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I hit upon the memory that the vacation period was only a week away and that this was a patient of hers who might need to contact me in her absence. Probably an intuitive herself, Mrs Thomas jumped right into the clinical presentation; she did not rescue my poor sensation by providing a bridge with either thinking or feeling, and so there had been neither logic nor emotional meaning to that opening sentence, 'A patient might be calling you'. I felt at a loss, left swimming around trying to find some framework to put around those 'bare facts'. By the time I did get oriented, Mrs Thomas had finished her description of the patient. Embarrassed over my initial 'stupidity',

I did not ask her to repeat anything I had missed during the moments of trying to get oriented.

What I recalled later was that the patient was borderline, had been in therapy for three years, tended to be dependent, and 'felt suicidal every week'. Mrs Thomas characterised the nature of their interaction as one in which the patient, whom I will call Ruth, used her support; and so if Ruth called me, it would be because she needed to feel assured someone was there and could be called upon. These are the 'facts' that I recalled; what was more important to me was the *tone* Mrs Thomas used: I had the intuitive impression that when she said Ruth tended to be 'suicidal every week', this meant Ruth used the expression 'feeling suicidal' to convey the seriousness and regularity of her psychic distress; not that it was a set of potential actions she contemplated.

This picture might seem descriptive enough, but for what developed the following week, it did not feel adequate. The vacation came, and with it a call from Ruth on the second day. She left a message with my service Monday evening, asking that I telephone her. I picked up the message the next morning, and placed the first call to her at 9.30. Her line was busy until 10.00, when I had to see my first client. The phone being busy for so long was a factor of importance later.

When I tried to reach her at my 10.50 break, the phone did answer. Ruth told me she was concerned about getting through the week, as she had so much to do to prepare for a trip with her husband that was coming up: she was worried about packing for a different climate, about leaving her children, about medicine for health problems. I could feel her need for support, and since there seemed to be more than we could talk over during the ten-minute break, I offered to call her that evening; I also made it clear that I could see her in the office if she wanted an appointment during the week. She seemed surprised, relieved, and grateful for the containing effort of this initial contact; and we

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agreed that I would call her back between seven and nine that evening. From this brief contact, I was able to learn that she would be leaving for her own trip before Mrs Thomas returned, and thus her underlying anxiety had probably to do with an experience of leaving the mother without being able to count on the mother ‘to watch her go’, an early rapprochement issue.

I telephoned her at seven that evening and found her phone busy. It continued to be busy until 7.30, when I had to meet someone for dinner. I thought little about the busy signal, since the phone had been busy that morning. When I telephoned again at 8.45, it was again busy. I called intermittently until 9.30, when it first occurred to me that something might be wrong with the line. The operator checked the line and reported back that indeed the phone was out of order and

would not be repaired until the end of the next day. I asked if the party with the phone trouble, Ruth, would be aware of it; the operator said no, it was possible she could make out-going calls but not receive incoming ones, and thus might not suspect any trouble. This meant that I knew about Ruth's phone trouble but she herself might not know, and thus not know why I had not called back as planned. If she knew about the trouble, she would have a way of attributing my failure to call, that is, my failure of empathy. If she did not, she might feel abandoned not only by her regular therapist but by me as well.

The sequence of events thus far is ordinary. It was my own reaction to them that threw a pall over the situation; and these reactions were largely induced by the presence of the inferior function. I grew worried and felt helpless, increasingly anxious about what to do next. It felt painfully clear that if I had been listening better to Mrs Thomas, and knew exactly what Ruth's supposed suicidality meant, none of this would have arisen to the proportions of a crisis. An annoying inner assault of ‘if onlys’ haunted me: if only I had called Ruth back sooner, if only I had asked more questions, if only I had paid attention to Mrs Thomas.

The telephone being out of service and my being unable to get through to Ruth crystallised this into what I would like to call a ‘crisis of the inferior function’. Not only had my sensation function been unreliable that day in Mrs Thomas's office, it was now totally incapacitated by the failure of that sensation device, the telephone. And of course I liked to think that the telephone was wholly to blame.

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As I paced around my house that night, mulling over the situation, in through the doors opened by the inferior function came the complexes. One aspect had to do with wanting to do a good job as substitute therapist and not fail in my duty and be criticised by Mrs Thomas; the other had to do with feeling impotent and unable to complete a desired transaction. I sat with these feelings for some time and let the phantasies wander about the room. In the face of feeling helpless, heroic phantasies began to emerge. I wondered if I should prevail upon the phone company to go out to Ruth's house and tell her about the problem; I wondered if I should tell them she was a suicidal patient to mobilise them into action. Should I call Mrs Thomas and get her advice? I was unable to soothe myself into feeling that the patient would be all right without that return phone call; it was of course *I* who was not all right, and I who was unable to imagine being all right. Fortunately it was clear enough at the time that this crisis belonged not to Ruth, or to the therapeutic situation, but to me.

What eventually came to me was a recognition that I *had* in fact failed at my job: I had to acknowledge that I had been inattentive

when Mrs Thomas first told me about Ruth and that I had failed to ask the practical questions which would now give me the information I felt I needed, in order to know how to proceed. This sense of failure was a pretty bitter pill to swallow, for I am usually conscientious and prefer to think of myself as such. But the failure was there, and I think it was accepting it that allowed a solution to surface.

The way I came to a decision was through realising it was this paired helpless/heroic part of me that was dominating, and I knew I did not want to act out of that complex. A ‘good enough’ phantasy then emerged: it was simply that I would call my service and leave a standing message with them for Ruth, saying that I had tried to call her but her phone was out of order, and she could leave me a message. That good enough solution gave me some relief, and I retired for the night. This brings to a close the events in waking life that led up to the crisis; during the night, the unconscious took up the matter and presented me with the following dream.

Compensatory Dream

> *I watch Mrs. Thomas and myself walking along. I can see our backs. Then I am with her, walking at a leisurely pace; we amble along in a friendly and peaceful manner. It is as if the work week is over and I am*

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filling her in on what transpired in her absence. I say, 'Oh, and then there was that funny incident about Ruth's phone being out...' My remark has a 'by the way' quality, as if the incident were minor, just an amusing incident and nothing more.

Then Mrs Thomas tells me about another patient, one not seen by me. She says that 'he got away' while she was gone. He was a young man about 25 and she had tied him up, as if in a crib. The dream states that 'he carried her creativity.' I tell her, in a voice of quiet authority, that one should not do things for patients; it isn't right and they will rebel. I say to her, 'You have tended to do things for patients, but I try not to do things for them.' The voice with which I spoke was one of wisdom, knowing something that was 'just so'. Mrs Thomas was not offended, for the tone was neutral; she accepted the advice.

I awakened after the dream and could see immediately that it put this incident into a new perspective: it said it was a minor matter, a passing event that could be recounted to Mrs Thomas like an amusing story. There was nothing to be heroic over; the patient survived and I survived to tell the story without shame. My initial understanding of the dream was that it supported my not being heroic and compensated my worry by showing a safe outcome. There is more to be said about the dream, but I would like to weave it into some general comments on how the inferior function arises in clinical practice and how the unconscious may have to play a compensatory role via dreams when the natural connection between the ego and the self is disrupted by the inferior function and related complexes.

Dreams and the Inferior Function

It is easy to hypothesise that whatever a therapist's inferior function, it will cause difficulties somewhere in the practice, and compensatory dreams may occur in relation to these. Although countertransference is a very popular topic now and papers on it abound, therapists' dreams have not been brought into that arena. I went to the literature to see what had been written about therapists' dreams or countertransference dreams, and found very little. In the seven decades that psychiatric literature has been catalogued, there are only four papers in which dreams of therapists are the explicit subject of study (see Spero; Tauber; Whitman; Zweibel). Considering that the book which introduced dreams into clinical practice, Freud's *The Interpretation of Dreams,* begins with

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an analysis of his own about a patient (the famous ‘Irma's injection dream’), this dearth seems especially surprising. Jungian analyst Groesbeck (7) in his paper, ‘Psychological types in the analysis of the transference’ in this Journal, draws upon his own dreams in order to understand the interaction of his typology with the countertransference issues; the paper serves as a good model for how therapists could identify and work with their own typological components as shown in dreams.

The four psychoanalytically oriented papers take a fairly reductive approach, suggesting that dreams about patients usually arise when the therapist's competence is somehow at issue. The inferior function fits nicely into this hypothesis, for there is no question that we are less than usually competent when it comes into play. The dream I had was essentially a dialogue between two parts of the personality, a wiser figure who ‘knows’ and another part that ‘does not know’. This was the dialogue I tried to carry on during the evening before the dream, when I sat with the distress; but at that point, the dialogue went only so far because my ego was dominated by the part that ‘did not know’. In the dream, the dialogue goes farther and the identity shifts so that the knowing part comes into the foreground. I think this shift illustrates the subtle functioning of compensation, whereby a psychic content potentially accessible to consciousness is thrust over the border from the unconscious.

This dream compensated for my state of mind but it did not compensate for an actual lack of knowledge about the patient. It is useful when evaluating dreams to consider other possibilities that could have been portrayed, for this can put the actual dream into a meaningful perspective. What is *not* in a dream is as important as what is in it. Thus, I did dream that the incident was minor; I did not dream that Ruth had killed herself, that Mrs Thomas was suing me for malpractice, that I had seriously overlooked something, and so forth. I

do think it is possible for a therapist to learn objective information about a patient via a dream, information that is not known but needs to be; though these dreams might be labelled telepathic, they are simply the perception of a something that exists psychically or materially, perceived by the objective psychic function of the unconscious.

I believe that the figure in the dream called ‘me’ is not my conscious self but is a representation of the personal aspect of the self, for this part carries the wisdom and advises the alienated part. And the figure called Mrs Thomas must also be taken as an aspect of my own psyche, whether or not I have borrowed any characteristics from the actual person. When I thought about the dream, I

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felt sure this figure represented the aspect of myself that was not connected to the self during the crisis, inasmuch as I felt adrift and unsure of what to do; I could not get connected to the guiding capacity in the psyche. The dream Mrs Thomas would also stand for my own countertransference tendency to 'do things for patients' and thus infantalise them in cribs. In the dream I tell her that she made the clinical error that in reality I had been tempted to make by becoming heroic and doing too much to remedy a natural human situation of blocked communication. The inferior function disrupted my capacity to evaluate realistically what had to be done, and so I overestimated my role and underestimated the patient's.

The dream figures called Mrs Thomas and myself make sense, but who is this 25-year-old man tethered to a crib, who 'carries Mrs. Thomas's creativity'? Let us consider this figure as representing the inferior function itself.* With this interpretation, we then have a satisfactory gestalt, an X-ray view of the whole psychic constellation related to the inferior function: There is one complex, called Mrs. Thomas, that tethered the potential creativity of the inferior function by obsessively ruminating about the phone problem; there is another complex, called myself but informed by the self, that corrects the 'Mrs Thomas' attitude. It was through this self-connection that the young man was set free finally, so that the inferior function could produce the creative solution: to leave a standing message for Ruth with my service. This was not a solution from intuition or feeling or thinking, but arose spontaneously and whole from underground, and it did solve the dilemma with the sensation/telephone.

*I would like to thank San Francisco analyst John Beebe for suggesting this interpretation.

Reactions to the Inferior Function: Heroism, Rage, Depression

From this story it is evident how the inferior function can constellate helplessness in the ego. As Jung said, it is 'inaccessible to our will ... (and) appears now as a teasing and distracting imp, now as a *deus ex machina.* But always it comes and goes of its own volition' (JUNG 12). He made it clear that 'the essence of the inferior function is autonomy: it is independent, it attacks, it fascinates and so spins us about so that we are no longer masters of ourselves ...' (JUNG 9). In the face of its autonomy, which has so easily replaced our sense of ego mastery, there can be reactions of heroism and depression and rage. The heroic reaction strives to overcome the failing; in phantasies I had skipped

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a lot of steps and reached out to an imagined superior force that would rectify the situation: one moment the phone did not work and next I was calling out the militia to rescue the patient.

With a depressive reaction, the ego succumbs to the helplessness, feeling that nothing can possibly rectify such an impossible situation, so one might as well accept being an utter incompetent. And with rage against the helplessness, telephones are smashed, operators insulted, car doors slammed and the world of objects generally cursed because ‘they’ don't work right.

With practice, the kinds of trouble the inferior function causes can be kept track of to some extent and then identified when they recur. In the midst of a dilemma, one may feel lost; but with the distance of a day or a week, one may remember, ‘Oh, yes, this is that same territory’. And this objectification can help to reduce the rage of frustration, the heroism, and the succumbing.

Dealing with the Inferior Function

The choices for dealing with the inferior function run the same gamut that we have with regard to any complex: we can deny it, farm it out intentionally to someone else, split it off unconsciously, over-compensate for it, or accept it. Presumably accepting it is the goal we share. I think that one of the main blocks to accepting the inferior function is having unrealistic expectations for it: wishing that one could be more capable in that area than one actually can be.

One image of how to relate to the inferior function is to think of it as a retarded child. It needs extra and continuous care, and will always need it. Its limits are not going to be overcome by heroism, and there will be times of aggravation, but hopefully love and commitment will prevail.

The application of this image of retardation to psychotherapy practice might be illustrated by the example of my forgetting to

obtain the addresses of new clients. For the first so many years of practising, I chastised myself for such stupidity and vowed to ‘do better next time’. With each failure, I argued even more harshly that I must try harder, and was full of recriminations over such ineptness. The animus got into the act with its overcompensatory planning.

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Eventually, this whole attitude gave way to a more accepting one: perhaps I would *always* forget to get patients' addresses in the first hour, and perhaps I could live with that. Like embracing a retarded child who has just spilled finger paint on the carpet for the third time, I felt as if I were embracing this enfeebled aspect of myself. Then some creative ideas arose spontaneously: that I could put a crutch, so to speak, on this lameness, such as tying a red string to my engagement book on days new patients came, a playful idea with colour and verve, but not heavy-handed planning. And when the string blew off on the way to the office, I would smile and wave it goodbye. With development, the main function of intuition is less dominant, and the slow sensation has more space to emerge, and then addresses are asked for.

In the early stages, when one hates the inferior function, there is no relationship of engagement; one simply pushes it away, curses it, and wishes it gone. But if one can accept that the inferior function is going to be around for a while, one may be able to make peace with it and allow the energy tied up with it to operate more freely and creatively. Turning a more accepting face toward the inferior function seems to be rewarded by finding a more positive aspect of the inferior function turned toward the ego. This is where the analogy with the retarded child breaks down, for the inferior function is Janus-faced and its other side is boundlessly creative and powerful, being connected as it is with the self and carrying with it the compensatory function of bringing our opposite side into life.

Active imagination offers a way of relating to the inferior function that can allow this creative side to emerge. According to von Franz, ‘Jung found that active imagination was practically the only means for dealing with the fourth function’. In an earlier section, I mentioned several incidents which I would have understood if they had been told to me as dreams. By converting an actual incident into a dream, one is practising a form of active imagination. This reduces the press of the sensate action and allows breathing space so that intuitives can exercise their natural imaginative capacity.

I was first introduced to this method years ago, when I was considering taking a car trip alone and was worried about what to do if something went wrong. My therapist asked if I knew someone who was good with cars. I came up with a friend's name. The therapist suggested that if trouble arose, I could try imagining this friend in the

car with me and ask him what he would do in the circumstances. This type of solution seems a wise one, for it begins in the creative imagination and it gives

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the unconscious, and hence the inferior function, room to express itself. Asking this sensation figure its opinion, and listening to its answer, is the active imagination. The ego must mediate the process, deciding if the suggestion is to be followed or not.

Von Franz cautioned against becoming concretistic when dealing with an inferior sensation function, by going toward solutions that are overly practical, overly functional. An example of this approach might be the intuitive who decides to 'settle things once and for all' by studying auto mechanics, or some such subject that had heretofore been a *bête noire.*

There may be recurrent dream figures that can be identified, by who they are in fact or what colours they wear, as standing for the inferior function. Once they are known, their movement can be followed, as a way of keeping track of the inferior function. When faced with decisions involving sensation or when problems with it arise, one can call upon these figures in imagination and discuss the matter. Considering the devilish and angelic proclivities of the inferior function, such discussions may be lifelong affairs.

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