Understanding the Unconscious Mind: Jungian Psychology and Mental Health Nursing

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How might the unconscious part of the mind affect mental health patients’ emotions or behaviour? How might the unconscious motivations of mental health nurses affect their patients? The discovery of “the unconscious” two centuries ago has allowed philosophers and scientists, such as C. G. Jung, to explore the field. Contemporary mental health care subscribes to a dominance of neurobiological approaches, neglecting the unconscious or relegating it to that of a merely biological process. Approaching this subject from the perspective of Jung, we make a case for the inclusion of theoretical concepts about the unconscious in the discourse of mental health nursing. Such awareness may help mental health nurses to better understand the mental disease, disorder, and distress found in patients. It also may help them understand their own conflicts and motivations that, in turn, can have an affect on their patients.

Know thyself —Inscription in the forecourt of the Temple of Apollo at Delphi

What do we know about the unconscious part of the mind? That which, by definition, is “un”-conscious and therefore largely inaccessible to the conscious mind, sometimes referred to as the human soul, spirit, or psyche (Soanes & Stevenson, 2004). The unconscious mind affects our behaviour and emotions. Our relationship to the unconscious is not unlike that of Tennyson’s The Ancient Sage, “the swallow on the lake that sees and stirs the surface shadow there” (Dodsworth, 2013, p. 25) and we know little of the depths below or the contents therein. If we are to believe psychiatrist and depth psychologist C. G. Jung, our conscious mind is but the tip of an iceberg when compared to the vastness of the unconscious (Donohue, 2003).

Although present throughout history in some form, “the unconscious” is a relatively new concept that became popular in the nineteenth century and is now part of the vernacular. It has been suggested that, in recent times, it has largely been absent from mental health nursing and the nursing dialogue (Crowe, 2004). In this article, we show that the absence of the unconscious from the nursing dialogue is to the detriment of mental health nursing. The unconscious, by its very nature, is elusive but its recent disappearance may be due, in part, to a preoccupation with the science of neurobiology, despite support for the reality of the unconscious from contemporary scientists (Claxton, 2005). This article examines the history of the unconscious mind, with particular reference to the work of Jung, and we make a case for its place in the contemporary discourse of mental health nursing.

DEFINITIONS OF THE UNCONSCIOUS

The part of the mind which is inaccessible to the conscious mind but which affects behaviour and emotions. (Soanes & Stevenson, 2004, p. 893)

Theoretically, no limits can be set to the field of consciousness, since it is capable of indefinite extension. Empirically, however, it always finds its limit when it comes up against the unknown. This consists of everything we do not know, which, therefore, is not related to the ego as the centre of the field of consciousness. The unknown falls into two groups of objects: those which are outside and can be experienced by the senses, and those which are inside and are experienced immediately. The first group comprises the unknown in the outer world; the second the unknown in the inner world. We call the latter territory the unconscious. (Jung, 1959, p. 3)

THE MISTS OF TIME: BEFORE THE UNCONSCIOUS WAS DISCOVERED

It is impossible for us to understand the role and expression of the unconscious in our distant ancestors because we are viewing events from our own modern standpoint. However, there seem to be two conflicting contemporary views relating to the myths, religions, spirits, or taboos that governed our ancestors: that these represent early attempts at explaining natural and biological forces or, alternatively, that they represent these ancients’ deepest spiritual impulses (Tacey, 2011). The former alternative is in tune with the contemporary view of the unconscious, which sees it as a product of biological processes (although some have questioned whether it exists at all) (Damasio, 2011). The latter view, however, is seen by some commentators as explaining why the loss of myth and culture by indigenous
cultures is so devastating for them, both physically and mentally (Tacey, 2011).

DISCOVERY OF THE UNCONSCIOUS MIND

Can the unconscious mind be said to have been discovered? We use the term “discovered,” maintaining that the unconscious has always been present and also in appreciation of Ellenberger’s (1970) definitive account, The Discovery of the Unconscious: the History and Evolution of Dynamic Psychiatry. Discovery of the unconscious mind can largely be attributed to the age of enlightenment in the seventeenth and eighteenth centuries, when intellectuals used reason and scientific method to challenge traditions and superstitions. The enlightenment and the birth of science meant that it was no longer acceptable for philosophers or theologians to make pronouncements about life and the universe; they were required to offer some proof for their theories (Whyte, 1960). This meant that the days of superstition and absolute church rule were numbered, despite resistance from the clergy. As Aristotle (384–322 BC) observed, “Nature abhors a vacuum,” so it was therefore inevitable that a more scientific solution would be developed to discuss the issue of gods, myths, taboos, and spirits. Thus, the unconscious was revealed. According to Whyte (1960) the idea of unconscious mental processes was conceived around the year 1700, was topical around 1800, and became accepted around 1900.

The writings of depth psychologist and psychiatrist C. G. Jung (1875–1961) have added significantly to the literature about the unconscious. The discovery of the unconscious has often been attributed to Sigmund Freud but, as has been pointed out by Claxton (2005), Freud merely repackaged ideas that were in vogue in the 1860s and 1870s. Before he met Freud, Jung had already reached his own concept of the unconscious through his studies of philosophy, attributing philosophers such as Kant, Schopenhauer, Carus, and von Hartmann as being influential in his developing ideas (Shamdasani, 2003). Jung eventually went beyond Freud’s parameters with his concept of the collective unconscious.

THE UNCONSCIOUS MIND AND MENTAL ILLNESS

Jung was closely involved in the theories of the unconscious as they developed in the late nineteenth century. Jung, unlike Freud, worked with what we now call major mental illnesses: schizophrenia and bipolar disorder (Jung & Jaffe, 1965). Like Freud, however, he was interested in the psychology of mental illness and in using the newly emerging psychotherapeutic techniques to treat mental illness. He developed a word-association test that he used for uncovering repressed contents in the unconscious of his patients (Jung, 1966). He used the term “complex” to describe psychic fragments that may have split off owing to traumatic influences or certain incompatible tendencies. Experiments with the word-association tests (Jung, 1973) supported Freud’s theories of repression. However, Jung differed from Freud as to the causes of these repressions, which Jung believed were not always due to sexual trauma but may have been related to other causes, such as problems of social adaptation or tragic circumstances in life. Jung was also deeply interested in discovering what it was that actually took place inside the mind of the mentally ill. The concept of the unconscious mind therefore provided him with a framework with which to theorise and experiment.

His tentative theories were presented in a 1907 paper that described Dementia Praecox (Jung, 1960) a disorder which later became known schizophrenia. He was still exploring the subject in 1939 when his paper On the Psychogenesis of Schizophrenia was published (Jung, 1960). Although Jung viewed the cause of mental illness (including major mental illness) as being primarily psychogenic, his views were quite modern in that he did not discount the possibility of an organic component. Nevertheless, his primary interest was in the psychology of mental illness and the use of psychotherapeutic techniques to improve his patient’s symptoms.

After 1909, Jung devoted himself to his private practice and to his research interests, which had moved into the areas of mythology, religion, and folklore (Jung & Shamdasani, 2009). Jung, like Freud, used dreams as a method for accessing the unconscious.

In 1912, Jung began to have a series of dreams that he could not understand and that seemed to have no bearing on his personal unconscious. Even before these dreams, he had postulated the possibility of a layer of the unconscious that was common to all mankind and that was the myth-making faculty responsible for primordial images (Jung & Shamdasani, 2009). “Primordial images” was a term borrowed by Jung from Jacob Burckhardt to describe typical myths common to all of mankind. Jung later used the term “archetype” to describe these phenomena (Jung & Shamdasani, 2009). Jung termed the layer of the unconscious that was common to all mankind the “collective unconscious.” He devised a technique of active imagination to try to access the deeper layers of his unconscious and described this experiment in The Red Book: Liber Novus (Jung & Shamdasani, 2009). This was his attempt at representing his exploration of the unconscious in images and in words.

IMPACT OF THE COLLECTIVE UNCONSCIOUS IN MENTAL ILLNESS

Jung’s experience of the collective unconscious (see Table 1) contributed to his understanding of the psychology of major mental illness, in particular, of schizophrenia. Perhaps quoting Kant, he described patients with schizophrenia as “dreamers in a world awake” (Jung & Jaffe, 1965) and saw them as being invaded psychologically by the contents from the collective unconscious. Jung’s view of the unconscious was that whilst it could produce pathology from repressed contents, it also had the ability to heal and could be responsible for great artistic achievements. On the other hand, Freud tended to see the unconscious as a cesspit of repressed personal material that caused
mentall illness and needed draining from time to time if the individual was to maintain mental health (Tacey, 2011). Jung felt that modern man had lost touch with his spiritual roots in the collective unconscious, and that accounted for the malaise of modern man and the epidemic of mental illness. His solution was a reconnection to myth and the archetypes of the collective unconscious (Tacey, 2011). Contact with the archetypes can produce feelings of attraction and awe that are characteristic of religious experiences for which Jung used the term numinosity. Jung was keen to point out that this did not mean a return to institutional religion and he saw the dangers inherent in a return to the old Gods, for example as was experienced by the German nation before and during the second World War (Jung & Jaffe, 1965). Jung’s view was that depth psychology underpinned all of life and that it could be the basis of a scientific philosophy that linked mind and body (the psyche with matter) (Shamdasani, 2003).

KEY CONCEPTS FROM JUNG

Jung always emphasised that he did not use any particular method when helping his patients, using the terms depth psychology or complex psychology to differentiate his psychology from psychoanalysis. He stated:

I am unsystematic very much by intention. To my mind, in dealing with individuals, only individual understanding will do. We need a different language for every patient. (Jung & Jaffe, 1965)

Jung was an original thinker and, although some of his ideas can be traced to the cultural environment he was living in and influenced by (Shamdasani, 2003, many of his concepts were, nevertheless, a result of his own psychological explorations (Jung & Shamdasani, 2009). Jung’s methods of psychotherapy and analysis (Jungian analysis) are now seen as being ahead of his time and are reflective of modern practice (Samuels, 2008).

WHY WE SHOULD CONSIDER JUNG’S VIEWS OF THE UNCONSCIOUS

Although Jung’s standing in academic circles and his contribution to psychotherapy has recently been re-evaluated and supported (Samuels, 2008), in mainstream psychiatry his influence is non-existent. For mental health nurses, however, as for other mental health workers, his views on the unconscious, even if not providing direct clinical application, can frame and give us a philosophy of the unconscious. This may help us to better understand the mental disease, disorder, and distress we find in our patients and also promote greater understanding of ourselves and our role as mental health nurses. His views are all-encompassing and can be the bridge that connects the body with the mind, the separation of which has been a constant dilemma of psychiatry. Jung had definite views about the unconscious but he always considered them tentative and, in keeping with the scientific spirit, was prepared to change them if new information came along. It was the same way with his therapeutic style, which did not rely on a method, as such, but sought to treat the patient as an individual with an individual story (Jung & Jaffe, 1965). In this post-modern world, where the gods of the past have now become diseases (Jung, 1929, cited in Tacey, 2011) and our cultural and spiritual connections have been lost or severed, Jung offers a link back to this ancient world using modern day language, that is, the language of the unconscious, which he charted and described.

Jung was instrumental in bringing psychology into psychiatry and believed that even major mental illness could be improved by such an approach (Jung, 1960). Cognitive Behavioural Therapy (CBT) is used in the treatment of major mental illness, but a more psychodynamic approach is suggested by Jung’s pioneering work. Combining CBT and psychodynamic therapy may not be easy, but it is also not impossible (Owen-Pugh, 2010).

Mindfulness has more recently been used as a therapeutic tool in mental health settings (Hirst, 2003). One of the origins of this technique is found in Buddhism; Jung’s appreciation of Buddhism and its therapeutic potential (Daniel, 2007) predicted this modern movement. Jung’s commentaries on the therapeutic potential of Buddhism and other world religions also created a bridge between psychiatry and spirituality. In his explorations of the psyche, he saw the healing potential in religion and spirituality, whereas many others, including Freud, could only see the pathological side of these things. Spirituality is one of the missing pieces in modern mental health nursing (Jackson & O’Brien, 2005) and Jung’s empirical approach can help steer a course for mental health nurses in this minefield (or mindfield) of misunderstandings. Jung’s concept of the shadow and its projection has implications for mental health nurses and their therapeutic use of self. The shadow, whereby we repress aspects of ourselves we refuse to acknowledge, is vitally important as our shadow side can easily be projected onto others, including patients, to the detriment of the therapeutic relationship. A true understanding of the concept of the shadow can also help mental health nurses realise that their patients may have repressed healing qualities, which, if expressed, can provide the patient with meaning and purpose.

THE CURRENT SITUATION: WHERE IS THE UNCONSCIOUS NOW?

Although the term “the unconscious” is part of our language and its existence is accepted even by neurobiologists (Van Gaal, Lamme, Fahrenfort, & Richard-Ridderinkhof, 2010), its elusive qualities (un-conscious) mean that the original use and meaning of the word have changed and become more circumscribed. This is partly in response to the findings of neurobiology and partly in response to the demand for evidence-based practice (Gallop & O’Brien, 2003). This has led to some confusion in mental health nursing, with some commentators celebrating the clarity they feel neurobiology has provided (Mohr & Mohr, 2001) and others feeling the need to re-establish psychodynamic theory and principles (Gallop & O’Brien, 2003).
The Unconscious

Theoretically, no limits can be set to the field of consciousness, since it is capable of indefinite extension. Empirically, however, it always finds its limit when it comes up against the unknown. This consists of everything we do not know, which, therefore, is not related to the ego as the centre of the field of consciousness. The unknown falls into two groups of objects: those which are outside and can be experienced by the senses, and those which are inside and are experienced immediately. The first group comprises the unknown in the outer world; the second the unknown in the inner world. We call this latter territory the unconscious.

Active Imagination

You choose a dream, or some other fantasy-image, and concentrate on it by simply catching hold of it and looking at it. You can also use a bad mood as a starting point, and then try to find out what sort of fantasy-image it will produce, or what image expresses this mood. You then fix this image in the mind by concentrating your attention. Usually it will alter, as the mere fact of contemplating it animates it. The alterations must be carefully noted down all the time, for they reflect the psychic processes in the unconscious background, which appear in the form of images consisting of conscious memory material. In this way conscious and unconscious are united, just as a waterfall connects above and below. (The conjunction: C. W. vol. 14, para. 706)

Jungian Analysis

Analysis is only a means for removing the stones from the path of development, and not a method . . . of putting things into the patient that were not there before. It is better to renounce any attempt to give direction, and simply try to throw into relief everything that the analysis brings to light, so that the patient can see it clearly and be able to draw suitable conclusions. Anything he has not acquired himself he will not believe in the long run, and what he takes over from authority merely keeps him infantile. He should rather be put in a position to take his own life in hand. The art of analysis lies in following the patient on all his erring ways and so gathering his strayed sheep together. (Crucial points in psychoanalysis. C. W. vol. 4, para. 643)

Collective Unconscious

The collective unconscious contains the whole spiritual heritage of mankind’s evolution, born anew in the brain structure of every individual. (The Structure of the Psyche. C. W. vol. 8, para. 342). The collective unconscious—so far as we can say anything about it at all—appears to consist of mythological motifs or primordial images, for which reason the myths of all nations are its real exponents. In fact, the whole of mythology could be taken as a sort of projection of the collective unconscious. . . . We can therefore study the collective unconscious in two ways, either in mythology or in the analysis of the individual. (The structure of the psyche. C. W. vol. 8, para. 325)

Complex

The image of a certain psychic situation which is strongly accentuated emotionally and is, moreover, incompatible with the habitual attitude of consciousness. (A review of the complex theory. C. W. vol. 8, para. 201)

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Everything of which I know, but of which I am not at the moment thinking; everything of which I was once conscious but have now forgotten; everything perceived by my senses, but not noted by my conscious mind; everything which, involuntarily and without paying attention to it, I feel, think, remember, want, and do; all the future things that are taking shape in me and will sometime come to consciousness: all this is the content of the unconscious. (The structure and dynamics of the psyche. C. W. vol. 8)

(Continued on next page)
### TABLE 1
Jungian Psychoanalysis Terminology and Related Concepts (Continued)

<table>
<thead>
<tr>
<th>Concept</th>
<th>Jung’s Description</th>
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<tr>
<td>Individuation</td>
<td>The process by which individual beings are formed and differentiated; in particular, it is the development of the psychological individual as a being distinct from the general, collective psychology. (Definitions. C. W. vol. 6, para. 756) The aim of individuation is nothing less than to divest the self of the false wrappings of the persona on the one hand, and of the suggestive power of primordial images on the other. (The function of the unconscious. C. W. vol. 7, para. 269)</td>
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<td>Myth</td>
<td>The primitive mentality does not invent myths, it experiences them. Myths are original revelations of the preconscious psyche. . . Many of these unconscious processes may be indirectly occasioned by consciousness, but never by conscious choice. Others appear to arise spontaneously, that is to say, from no discernible or demonstrable conscious cause. (The psychology of the child archetype. C. W. vol. 1, para. 261)</td>
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<tr>
<td>Numinous</td>
<td>Jung used this term coined by Rudolf Otto to describe the mysterious and inexpressible experience that sometimes comes to individuals and has a psychologically healing effect.</td>
</tr>
<tr>
<td>Psyche</td>
<td>Psyche is the term Jung used to describe the totality of the conscious and the unconscious processes.</td>
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<tr>
<td>Repression</td>
<td>Repression is a process that begins in early childhood under the moral influence of the environment and continues through life. (The personal and the collective unconscious. C. W. vol. 7, para. 202) Repression causes what is called a systematic amnesia, where only specific memories or groups of ideas are withdrawn from recollection. In such cases, a certain attitude or tendency can be detected on the part of the conscious mind, a deliberate intention to avoid even the bare possibility of recollection, for the very good reason that it would be painful or disagreeable. (Analytical psychology and education. C. W. vol 17, para. 199)</td>
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<tr>
<td>Shadow</td>
<td>Jung emphasised that the shadow, although very often expressing negative tendencies, can also express positive ones which have been repressed. The shadow personifies everything that the subject refuses to acknowledge about himself and yet is always thrusting itself upon him directly or indirectly—for instance, inferior traits of character and other incompatible tendencies. (The archetypes of the collective unconscious, C. W. vol. 9, para. 284)</td>
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<tr>
<td>Wholeness</td>
<td>A state in which the conscious and unconscious are working together in harmony and closely associated with the concept of individuation. Although “wholeness” seems at first sight to be nothing but an abstract idea (like anima and animus), it is nevertheless empirical in so far as it is anticipated by the psyche in the form of spontaneous or autonomous symbols. These are the quaternity or mandala symbols, which occur not only in the dreams of modern people who have never heard of them, but are widely disseminated in the historical records of many peoples and many epochs. Their significance as symbols of unity and totality is amply confirmed by history as well as by empirical psychology. (The self. C. W. vol. 9 (2), para. 59)</td>
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*Note: C. W. refers to volumes of Jung’s Collective Works.
Sources: Jung & Jaffe, 1965; Sharp, 1991.*

If Jung’s view of the unconscious as underpinning all of life (Shamdasani, 2003) is correct, the unconscious cannot ever disappear or be quantified; it will always have an expression in some manner or other. Tacey (2011) pointed out the dangers inherent in a society, and the implications for mental health, in circumstances where religious rites and symbols no longer have any meaning. His hypothesis is that a number of mental illnesses and disorders can be traced back to the loss of such symbols and rites as can the breakdown of society if it no longer has a “myth” that governs it. The unconscious will always seek expression whether by the “front door” or the “back door.” Tacey’s view was that if the front door is closed (by loss of myth, etc.) the unconscious will seek expression by the back door, that is to say, in a pathological way. In the individual this can lead to mental illness and anti-social behaviour whilst, collectively, it can lead to horror on a greater scale, such as ethnic cleansing (Tacey, 2011).

A popular neurobiological explanation, “chemical imbalance,” for major mental illness, despite the lack of evidence for this theory (Barker & Buchanan-Barker, 2011), has led to the alienation of some patients. Medical and pharmacological dominance of the diagnosis and treatment of major mental illnesses can leave patients with little control over their illness except to keep taking the pills. Evidence of this alienation, that affects not only service users but also clinicians, can be seen in the growth of networks such as the Hearing Voices Movement.
(Hearing Voices Network Australia [HVNA], 2013) and the Campaign for the Elimination of the Schizophrenic Label (British Broadcasting Corporation [BBC], 2006). The recovery model of care is postulated as allowing mentally ill patients to gain control over their illness and treatment, but this model does not take into account unconscious conflicts, which may be a dominant factor.

The excessive use of recreational drugs and alcohol, according to Tacey (2011), can be an unconscious attempt to transcend the ego and recover the spiritual ecstasy that was previously accessed in a culture’s symbols, but is now lost in a secular society. Whilst the ego may be transcended, the invasion of unconscious contents in a disorderly manner can, and frequently does, cause mental illness (Tacey, 2011). Jung likened the use of such substances to prodding a sleeping demon and then being surprised when it woke up (Jung & Jaffe, 1965).

In the general nursing literature there has been a growing interest in spirituality as a key component of healing (Royal College of Nursing, 2011). This has not been reflected in the mental health nursing literature—this is understandable given that mental illness can often overlap with religious or spiritual states. Despite this, spirituality seems to be a contemporary means of expression of the unconscious (Tacey, 2011), perhaps replacing and surpassing some of the expressions that were found in psychotherapy. Sooner or, perhaps, later, mental health nurses will need to tackle this difficult area. Jung’s view was that the ultimate healing factor in mental illness was experience of the numinous and he expressed this quite clearly (whilst saying it had nothing to do with a particular creed or membership of a church):

> Among all my patients in the second half of life—that is to say, over thirty-five—there has not been one whose problem in the last resort was not that of finding a religious outlook on life. It is safe to say that every one of them fell ill because he had lost what the living religions of every age have given to their followers, and none of them has been really healed who did not regain his religious outlook. (Jung, 1932, p. 59)

**THE UNCONSCIOUS AND MENTAL HEALTH NURSING PRACTICE**

It could be that mental health nurses have given up trying to understand mental illness. This, to some extent, is reasonable given that mental health nursing is a practical business and, therefore, an empirical approach is of first importance. Barker and Buchanan-Barker (2011), however, argue that using the term “mental health” nurse, as opposed to “psychiatric” nurse, implies moving beyond offering technical support and implementation of medical management plans and toward more of a recovery approach to care. Without an overriding curiosity about what actually takes place inside the mentally ill and an understanding of the unconscious mind, there is a danger that mental health nurses will not be able to achieve the competency that the term “mental health nurse” aspires to.

If Jung’s views of the unconscious are correct (and we believe that, substantially, they are), in order for mental health nurses to work effectively with their patients, the nurses must be whole individuals, aware of their strengths and weaknesses and their shadow sides. Jung was the first psychotherapist to insist the psychoanalyst-in-training also undergo analysis under the guidance of a trained psychoanalyst.

The patient’s treatment begins with the doctor, so to speak. Only if the doctor knows how to cope with himself and his own problems will he be able to teach the patient to do the same. ... The doctor must learn to know his own psyche and to take it seriously. If he cannot do that, the patient will not learn either. He will lose a portion of his psyche, just as the doctor has lost that portion of his psyche, which he has not learned to understand. It is not enough, therefore, for the training analysis to consist in acquiring a set of concepts. The analysand must realise that it concerns himself; that the training analysis is a bit of real life and not a method which can be learned by rote. (Jung & Jaffe 1965 p154)

**MENTAL HEALTH NURSES AS THERAPISTS**

In an era when many post-graduate mental health nursing courses are delivered digitally (Australian College of Mental Health Nurses [ACMHN], 2011), Jung’s views seem potent. Ideally, clinical supervision should provide reflective time in which some of these unconscious conflicts (as well as conscious ones) can be dealt with. Are nurses offered sufficient opportunity for this, and is there sufficient expertise available? The concerns raised in the 1990s about the threat to mental health nursing posed by biological determinism (Barker, Reynolds, & Stevenson, 1998) seem to have largely come true, and little emphasis is placed on the nurse-patient relationship, despite many nurses wishing it were otherwise (Awty, Welsh, & Kuhn, 2010). The need for nurses to be whole and individuated human beings has thus received little attention.

Jung had little time for an intellectual approach to the psyche and indeed found intellectuals the most difficult to help (Jung & Jaffe 1965). What he called for in therapists was wholeness. He did not tackle the unconscious if issues could be dealt with in a conscious manner:

> Consistent support of the conscious attitude has in itself a high therapeutic value and not infrequently serves to bring about satisfactory results. It would be a dangerous prejudice to imagine that analysis of the unconscious is the one and only panacea which should therefore be employed in every case. It is rather like a surgical operation and we should only resort to the knife when other methods have failed. So long as it does not obtrude itself, the unconscious is best left alone. (Jung, 1954, p. 186)

Mental health nurses are not called upon to be analysts. But we believe they are, at least, therapists, in as much as the nurse-patient relationship should be a therapeutic one. It therefore behooves them to have an awareness of unconscious processes as they affect the individual nurse and his or her relations with the patient. It also is necessary for mental health nurses to have an understanding of the unconscious processes and conflicts...
that may be affecting their patients. We have previously recom-
mended Jung’s work to mental health nurses (Moore & Cross, 2010) and believe that Jung’s psychology of the unconscious offers mental health nurses a theoretical and practical means of approaching the unconscious. In this way, nurses might better fulfil their role.

By re-emphasising the importance of the unconscious in mental health nursing there is the danger of further crowding the already full battleground of theoretical assumptions about the causes and treatments of mental illness. Given that there is little common ground between the biological and psychological approaches to mental illness (Heriot-Maitland, 2011), an artificial attempt to draw them together can be destructive for those we are seeking to help, as well as being confusing for the helpers themselves. Re-introducing the unconscious into the dialogue could create further confusion but, as we have sought to demonstrate, the unconscious is a reality. Ignoring it will not make it go away but rather permits surreptitious entry, bringing with it its potentially destructive shadow. Mental health nurses, therefore, cannot afford to ignore the unconscious.

CONCLUSION

We have briefly reviewed the history of the unconscious and its reflection through the ages, particularly since its revelation in the nineteenth century. We have noted that by definition “the un-conscious” is enigmatic and that theoretic assumptions about it have gone through changes of meaning and emphasis. Despite this, we consider that the concept of the unconscious is a valid one and, like Jung, we believe that it will always find expression: Vocatus atque non vocatus, Deus aderit (Called or uncalled, God is present; an ancient Latin phrase used by Jung). With the shift to the dominance of a neurobiological approach to the unconscious, the view of it has become too circumscribed. The rise in spirituality and other meditative practices has been a significant response to this.

The implication for the elimination of the unconscious from mental health nurses’ discourse is that it precipitates them returning to a narrower, more constrained, role. It also leaves them ill-prepared to develop their own therapeutic role and deal with the unconscious conflicts of their patients. Furthermore, it ignores the issue of spirituality, something that has been largely neglected in mental health nursing in recent times. Jung’s psychology addresses many of these neglected areas. His emphasis on the importance of individual understanding, of a different language for each patient, is very much in keeping with the recovery model of care. His understanding of the numinous experience and its role in the recovery of meaning and, therefore, in healing, restores religion and spirituality to a rightful role in mental health. Jung’s commitment to the concept of therapists (nurses) being whole individuals capable of taking seriously their own psyche and having a capacity for self-understanding, promotes the therapeutic relationship and the therapeutic use of self. Finally Jung’s psychology also implies that therapists (nurses) have the skills and capacity to work with their patients’ conscious goals, which are often of the greatest therapeutic value. These factors have implications for the clinical practice of mental health nursing in every setting and provide a very positive argument for the inclusion of a psychodynamic theory base and an understanding of Jungian psychology in mental health nursing.

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