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The Clinical Implications of Jung's Concept of Sensitiveness

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Abstract

The first portion of this paper reviews the concept of innate sensitiveness (present in about twenty percent of the population) as employed by Jung and in the empirical research conducted by the author and others. Both veins of scholarship suggest that being born highly sensitive interacts with experiences of trauma in childhood to produce more neurotic symptoms—depression, anxiety, shyness—than are found in nonsensitive persons with a similar history. Thus, given the baseline number of persons with this trait and their vulnerability, they surely represent a large percentage of patients in Jungian treatment—indeed, the history of the development of Jungian psychology is tightly intertwined with them, beginning with Jung himself. After this review of the evidence for the basic concept, we turn to its clinical application, the second and third portions of the paper. The second focuses on the initial understanding of a patient with the trait, such as distinguishing normal effects of being innately sensitive from the puer complex and from difficulties more related to trauma. The third portion considers adapting treatment to the highly sensitive patient—in particular maintaining an optimal level of arousal and the development of the patient's perception of the analyst's affect attunement.

Keywords

Affect regulation, depression, introversion, persona, puer, sensitiveness, sensitivity, temperament, trauma.

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> (Jung, 1913, para. 398)

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> [Psychoanalysis] is, and should be, only a means for giving the individual trends breathing-space, for developing them and bringing them into harmony with the rest of the personality. . . . The best result . . . is that he shall become in the end what he really is, in harmony with himself. . . . We yield too much to the ridiculous fear that we are at bottom quite impossible beings.
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> (Jung, 1913, para. 441-442)

Introduction

This paper examines the validity of the concept of innate sensitiveness as employed by Jung and begins with the theory and evidence behind the idea. I will be brief here because the material is covered elsewhere (particularly Aron & Aron, 1997; Aron, 2004b; Aron, Aron, & Davies, 2005). In particular Aron (2004), "Revisiting Jung's Concept of Sensitivity" (*Journal of Analytical Psychology*) discusses the concept from a Jungian perspective, but could only treat the clinical implications cursorily. Hence the purpose of this paper is entirely clinical, to offer suggestions for identifying and treating sensitive patients, after first providing enough theory and research to support this clinical application.

Both Jung (1913, for example) and Jungians frequently describe patients as "sensitive" (see, for example, Kalsched [1996, pp. 11-12]: "in most cases these patients were extremely bright, sensitive individuals who had suffered on account of this very sensitivity some acute or cumulative trauma in early life"; and Perera [1986, p. 34]: "Individuals . . . who are especially sensitive may perceive both pain and pleasure intensely"). But what has been meant by the term and why has is it been chosen over, for example, "vulnerable" or "introverted" or even intuitive or feeling type? To answer that, I turn to Jung's discussion of "sensitiveness" and then my own research.

The Research

A Review of Jung

In Jung's (1913) seventh and eighth Fordham lectures, given in 1912, he took on the problem of the origin of neuroses, responding to Freud's (1897) changed position, from the cause being actual intrusive sexual experiences in childhood to innate sexual perversity. In these lectures Jung unveiled his own view of the origin of neuroses as the result of an interaction between childhood trauma and a constitutional sensitiveness. This sensitiveness, he argued, predisposes some individuals to be particularly affected by any type of negative childhood experiences, so that later, when under pressure to adapt to a current challenge, they retreat into infantile fantasies. (In more current terms, Knox [2003] has discussed these "infantile fantasies" as the mental representations of insecure attachment with the caregiver.) Jung (1913) saw these fantasies as normal, but a definite sign that "*an act of adaptation has failed*" (para. 574, Jung's italics). That is, sensitive individuals have trouble adapting because as children they were more affected by early traumas. If these were sexual experiences or innuendoes, the current fantasies would have a

sexual flavor. But to him the "primary" point, in answer to a paragraph heading "Is Sensitiveness Primary?", was that some people are innately more sensitive. Indeed, he seemed to find it obvious as well as primary: "An attentive observer of small children can detect, even in early infancy, any unusual sensitiveness" (para. 397).

At the same time Jung was adamant about the interaction of nature and nurture:

> In reality, it is not a question of either one or the other [constitution or experience]. A certain innate sensitiveness produces a special prehistory, a special way of experiencing infantile events, which in their turn are not without influence on the development of the child's view of the world. Events bound up with powerful impressions can never pass off without leaving some trace on sensitive people. Some of them remain effective throughout life, and such events can have a determining influence on a person's whole mental development. Dirty and disillusioning experiences in the realm of sexuality are especially apt to frighten off a sensitive person for years afterwards, so that the mere thought of sex arouses the greatest resistances. (Jung, 1913, para. 399)

Jung (1913) illustrates his point with a description of two sisters faced with the same difficulties, but the older, more sensitive, "gloomy, ill-tempered, full of bitterness and malice, unwilling to make any effort to lead a reasonable life, egotistical, quarrelsome, and a nuisance to all around her. . . . Originally the conditions were exactly the same for both sisters. It was the greater sensitiveness of the elder that made all the difference" (para. 390).

Clearly Jung (1913) had strong feelings about those born with this trait, which he saw as characteristic of most if not all neurotics: "The ultimate and deepest root of neurosis appears to be innate sensitiveness, which causes difficulties even to the infant at the mother's breast, in the form of unnecessary excitement and resistance" (para. 409). Further, in this discussion he almost seems to hold these individuals responsible for their difficulties:

> We must never forget that the world is, in the first place, a subjective phenomenon. *The impressions we receive from these accidental happenings are also our own doing*. It is not true that the impressions are forced on us unconditionally; our predisposition conditions the impression. (para. 400)

On the other hand, at other points in this lecture he reveals a different bias. For example, of the two sisters he describes, he personally prefers the elder, who was "the darling of her parents . . . due to the special kind of sensitiveness . . . which, because of their contradictory and slightly unbalanced character, make a person specially charming" (para. 384)

In the following comment Jung also offers his estimate of the percentage of those with the trait, which is very close to what has now been found empirically (see Kagan, 1994):

> This excessive sensitiveness very often brings an enrichment of the personality and contributes more to its charm than to the undoing of a person's character. Only, when unusual situations arise, the advantage frequently turns into a very great disadvantage, since calm consideration is then disturbed by untimely affects. Nothing could be more mistaken, though, than to regard this excessive sensitiveness as in itself a pathological character component. If that were really so, we should have to rate about one quarter of humanity as pathological. Yet if this sensitiveness has such destructive consequences for the individual, we must admit that it can no longer be considered quite normal. (Jung, 1913, para. 398)

Finally, in bracketed material at the end of the seventh lecture, added later, he elaborates on the teleological side of the trait, in that their "apparently pathological fantasies . . . are . . . the first beginnings of spiritualization . . . the possibility of discovering a new life" (para. 406). In a similar vein, in the next lecture he states that neurosis has "a meaning and a purpose" (para. 415), so that once the meaning of the unconscious fantasies are revealed, the sensitive person is able to return to his or her duties—not social duties now, but duties to the self, the achievement of a "harmony with himself, neither good nor bad, just as he is in his natural state" (para. 442).

Prelude to Research

In 1991, when I became interested in what we clinicians mean by "sensitive," I was not aware of Jung's discussions of it, which I have been citing from *CW 4*. Rather, I thought the term overlapped with his concept of introversion, which led me to review the hundreds of research studies on the physiological differences between introverts and extraverts. The overlap was certainly there, in that introverts have been found to be more sensitive to stimuli and stimulants (for reviews, see Geen, 1986; Stelmack, 1990; Stelmack & Geen, 1992), more vigilant during discrimination tasks (for a review, see Koelega, 1992), more influenced by implicit learning paradigms (Deo & Singh, 1973), more reflective when given feedback (Patterson & Newman, 1993), and slower to acquire and forget information due to their depth of processing input into memory (Howarth & Eysenck, 1968). In the words of Stelmack (1997), "There is a substantial body of evidence . . . that converges on one general effect, namely the greater sensitivity (or reactivity) of introverts than extraverts to punctate, physical stimulation" (p. 1239). Researchers Patterson and Newman (1993), like Brebner (1980), concluded that introverts are best described as more reflective and stringent in their criteria for responses. And this greater sensitivity and its physiological correlates are found at all levels of the nervous system, from measures of skin conductance, reaction times, and evoked potential (Stelmack, 1990), to subcortical areas of the brain (Fischer, Wik, & Fredrikson, 1997), to differences in cortical processing (generally more right hemisphere activity; see Berenbaum & Williams, 1994).

Meanwhile I was curious enough about sensitivity to begin some research, interviewing at length 40 persons ranging in age from 18 to 80 and representing many occupations, but all self-described as highly sensitive (Aron & Aron, 1997, Study 1). Many common characteristics emerged from these interviews and my

subsequent surveys, all of which seemed to be consequences of depth of processing (many of these items are included in the scale described in the next section): for example, in most cases they report being very aware of their environment; more sensitive than others to caffeine, pain, hunger, and medications; easily startled; prone to allergies (a depth of processing of the immune system); and easily overwhelmed by highly stimulating or unfamiliar situations—crowds, noise, deadlines, sudden changes in their life, rough textures, strange odors, visual clutter, and so forth (if one processes everything thoroughly, it seems it is easy for there to be too much to process). Their tendency to reflect before acting also results in their being more motivated than nonsensitive persons to avoid unnecessary risks, stressful or high-pressure situations, exposure to violent media, and making errors. They also report performing worse when observed, generally not liking competition, and thoroughly processing negative feedback, so that they are often told, "Don't take things so personally."

This sensitivity seems to bestow substantial benefits—the highly sensitive generally feel they are more aware than others of beauty and pleasure; better able to sense other's moods and what needs to be done to improve a physical environment; able to take great delight in the arts and music; and most find it natural to be conscientious, ethical, and concerned about social justice (reflecting on the consequences of actions generally leads to thoughts such as "What will happen if I do not act?" or "What if everybody did this?"). They are often seen by others as highly creative and intuitive, yet also detail-oriented. They are good with plants, animals, bodies, or in any other situation requiring use of nonverbal cues. They have stronger emotional reactions than others—for example, they almost all report crying very easily (what I have come to call "emotional leadership")—and as children were usually seen as shy or sensitive. Finally, they generally report being spiritually oriented and possessed of a rich, complex inner life and having vivid dreams.

Introversion and Sensitivity

Much of the above certainly fits within Jung's concept of introversion. The only difficulty with calling my interviewees introverts was that 30% were clearly social extraverts, in that they liked meeting strangers, being in groups, and having a large circle of friends. These socially extraverted sensitive individuals became a special focus of my interviews, and I found that most had grown up in highly social environments, so that group life and meeting strangers were familiar and therefore calming rather than novel and overarousing, although they did need substantial time alone, unlike typical nonsensitive social extraverts.

Thus what seemed confused in the research literature was the *measuring* of introversion. Research subjects were being compared and assigned to conditions on the basis of questions mainly about sociability, even though an equally or more important characteristic of introverts is their greater physical sensitivity and cognitive depth of processing. It seemed that any description or measurement of introversion should focus on this more fundamental biological and possibly genetic sensitivity rather than on sociability, which could be influenced as much by relationship history or current state of mind as by DNA.

Hence Jung was right to describe innate introversion not in terms of sociability but as a preference to process information from the external world in a thor-

oughly subjective way. But his original meaning of introversion seemed lost. So I was gradually beginning to see that "sensitive," what I now knew was Jung's original term, might be necessary after all.[1]

Evidence for Innateness

Turning from these findings regarding introversion and sensitivity, I also became aware of the breadth of literature on infant temperaments and their persistence into adulthood, in particular the work of Kagan (1994) on inhibitedness being an innate dichotomous trait found in 20% of children, as well as other sensitivity-like descriptors in the work of Thomas and Chess (1977), Rothbart (1989), Strelau (1983), Buss (1989), Daniels and Plomin (1985), and many others (much of this research is accessible through edited books such as Kohnstamm, Bates, & Rothbart, 1989; and Bates & Wachs, 1994). Whatever their term for it, all of these researchers view this trait as innate, and some have collected twin and genetic data as well. (For a review of the most recent work on behavioral genetics, see Reif & Lesch, 2003; Canli, 2006.)

Next I was led to the work on behavioral genetics in animals and the consistent findings of a dichotomous (not continuous) intraspecies "personality" typology (for a brief review, see Aron & Aron, 1997, p. 345) thought to be the result of the evolution of two strategies for survival (Wilson, Coleman, Clark, & Biederman, 1993). Just as males and females represent two strategies, mainly for reproduction, there is another pair of traits influencing many more behaviors. One side of the pair is to take fewer risks by observing longer before acting—a strategy that we might give the motto, "Do it once and do it right." The other is to depend on motor activity, to act quickly, range widely. The motto here would be, "Go for it." When one strategy is successful, the other usually is not. For example, when food and predators are abundant, an innate strategy of higher vigilance and lower risk-taking is more successful for prey animals such as deer, but when food is scarce, bolder deer will consume more forage because it is usually in the open (for references, see Aron & Aron, 1997; Aron, 2004).

This dichotomy, often with roughly the same 20-80% split, is found in fish, rodents, ungulates, canines, felines, primates, and quite probably in all species. In the case of fruit flies, there is an allele (variant of a single gene) that determines the two types, "sitters" and "rovers," during foraging. Sitters evidence greater neuron excitability, synaptic transmission, and nerve connectivity, all consistent with a strategy of more processing, less motor activity (Renger, Yao, Sokolowski, & Wu, 1999). It seems probable that high sensitivity in humans could be an expression of this wait-and-observe strategy seen in so many species.

Given these three veins of research—the greater sensitivity of introverts, the innate reactivity of a large minority of infants, and biologists' descriptions of a similar trait as a strategy in numerous animal species—I was encouraged to try to develop a measure to identify and study those with this trait, whatever its final name.

Developing a Measure and Uncovering Correlates

Using the characteristics identified in my interviews of sensitive persons described above, we developed a preliminary 60-item questionnaire and administered it to several large samples. This permitted us to carry out statistical analyses

to reduce it to a final 27-item version in the Appendix (Aron & Aron, 1997). In extensive testing, this questionnaire proved highly internally consistent (i.e., these seemingly diverse items appeared to tap a single construct) and showed strong external validity (e.g., appropriate associations with related measures such as Mehrabian's [1976] scale for assessing low sensory screening). Next, we conducted systematic statistical comparisons with standard measures of social introversion and "neuroticism" (chronic anxiety or depression) in several large survey studies (Aron & Aron, 1997, Studies 2-7). We found that sensitivity was moderately related to, but was not the same as, either social introversion or neuroticism (or their combination). In addition, when the effects of being low on sociability or high on neuroticism were statistically removed, what was being measured as sensitivity clearly remained. Using these and other methods, these studies demonstrated unambiguously that sensitivity was an important variable in its own right, not merely social introversion or neuroticism under a different name.

It is also worth noting that the more widely accepted Five-Factor Model of personality (McRae & Costa, 2003) defines introversion as a lack of positive affect. Yet an item meant to measure sensitivity but not on the final version of the HSP scale—"when you are feeling happy, is the feeling sometimes really strong?"—was one of those most highly correlated with the final measure. Further, the correlation between the HSP scale and a Five-Factor measure of extraversion-introversion was not significant (Aron & Aron, 1997, p. 359), suggesting that Jung's definition of introversion, so close to that of sensitivity, cannot be reduced to lack of positive affect.

Currently research on high sensitivity is being conducted in several laboratories using magnetic resonance imaging. Although most of this is too preliminary to report, there are definitely clear differences between the sensitive and nonsensitive in the amount of grey matter in various areas. A functional study comparing brain activation in Asians recently arrived in the United States to European-Americans found that in the nonsensitive, different areas were activated according to culture during a difficult discrimination task known to be affected by culture, but culture had no impact on the activated areas for highly sensitive subjects, as if they were able to view the stimuli without cultural influence (Ketay et al., 2007). Another functional study found that on tasks not requiring subtle discrimination, the nonsensitive and highly sensitive evidenced similar activation, but when subtle discrimination was required, the highly sensitive evidenced activation while the nonsensitive did not (as if the latter were either not detecting differences or not trying to; Jagiellowicz et al., 2007).

Interaction of Trait and Environment

I was particularly eager to study the interaction Jung described between sensitiveness and stressful life experiences, a task made more urgent in my mind as similar traits were being given increasingly negative definitions (inhibitedness) or being redefined (introversion as lack of positive affect). In particular, Gray (1981) is widely respected for identifying systems in the brain associated with behavioral activation and inhibition, and he had suggested that those with a strong behavioral activation system, involving reward and motor areas, are reward sensitive and high sensation seekers; and those with a more active behavioral inhibition system,

involving a temporary inhibition of behavior in order to compare current experience with information in memory before acting, would seem to have the trait which is the topic of this paper. But Gray termed the trait "anxiety," because medications that reduce fear act on this behavioral inhibition system. However, he also pointed out that its comparison process occurs with all stimuli, not just threatening ones. Anxiety would only arise when there was danger, and chronic or trait anxiety would only arise when an individual has had many previous threatening experiences, so that a comparison of almost any current situation would provoke anxiety. In this, Gray was pointing to high trait anxiety being the product of an interaction between a highly active behavioral inhibition system and stressful life events. Meanwhile, we had found (Aron & Aron, 1997, study 5) that some sensitive persons were highly troubled and some not at all, and those who were troubled had reported more troubled childhoods, again implying an interaction.

Our new studies (Aron et al., 2005, Studies 1-3) corroborated this interaction. In three different large samples, those sensitive individuals who reported relatively objective, specific negative circumstances in childhood (e.g., parents absent or mentally ill, alcoholism in the family, etc.) or had poorer scores on a measure of parental bonding in childhood were more depressed and anxious than were nonsensitive persons reporting similar levels of the same childhood stressors. (The methodological issues involved in using retrospective self-reports of this kind are dealt with at length in the Aron et al., 2005, article.) Sensitive persons with few negative circumstances in childhood were no more depressed or anxious than nonsensitive persons. In addition, a structural equation modeling path analysis uncovered an apparently causal pattern in which, again, the combination of childhood problems with sensitivity led to depression and anxiety, and these negative affects led in turn to shyness, or low sociability that is anxiety related.

Recognizing the need to begin to identify how or why the above interaction occurs, we followed up these three survey studies with an experiment using standard methods adapted from social psychology (Aron et al., 2005, Study 4). In this experiment, students who had earlier taken the sensitivity measure, as part of a supposed separate study, took a test of "practical reasoning ability." Unknown to the participants, some of them had been randomly assigned to receive a very difficult test, so that they would feel they had done very poorly, and others had been randomly assigned to a very easy test, on which they would feel they had done very well. Shortly after this test they were given some additional questions, among which were some key items about their mood at the moment. (Of course, all participants were thoroughly debriefed about all aspects of the study afterwards.) The results, as predicted, were that the sensitive students were much more affected by their performance than the nonsensitive students, who at that point in time were hardly affected at all. That is, among those who had taken the easy test, the sensitive students felt much more positively than the nonsensitive students; and among those who had taken the hard test, the sensitive students felt much more negatively than the nonsensitive students. Our prediction was based on the idea that sensitive individuals process all experience more thoroughly, and thus have stronger emotional responses, positive or negative, to the same emotionally-relevant events. The larger point of this study, of course, was that what happens acutely during a particular experience parallels what happens chronically for those with good ver-

sus problematic childhoods. (Imagine, for example, that the feeling of having done well or poorly had come from a parent's response to their behavior.)

Previous Studies Finding Interactions

Other researchers studying something like this innate trait (under other names) have also found that it leads to being more strongly affected by negative life experiences. In a longitudinal study, Hagekill (1996) reported that the most variance in children's neuroticism was accounted for by an interaction of "low sociability" as an infant temperament trait (probably what she calls "sociability" in an infant is something more basic, what I would call sensitivity) and negative life events, such that children evidencing initial low sociability and having more negative life events were more fearful at later ages than either those with low sociability alone or those with more negative life events alone.

Fox (1996) found that infants evidencing more of a temperament trait of "negative affectivity" (perhaps a reaction of sensitive infants to the levels of test stimulation that are tolerated by nonsensitive infants) and right hemisphere activity (a possible correlate of sensitivity in infants [Kagan, 1994]) had more variable outcomes at 4 years. Also, children who were "inhibited" at 2 and not "shy" at 7 attributed their own changes to helpful parents (Fox, Sobel, Calkins, & Cole, 1996). Engfer (1993, p. 77) reported similar results regarding shyness, indicating that "children who as infants were already somewhat more sensitive and vulnerable showed a marked increase in shyness under the cumulative impact of deteriorating family relationships and an abrupt change in the peer-group environment" (i.e., changing schools or school classrooms).

Studying the interaction of parenting and temperament in conscience formation, Kochanska and Thompson (1998) found that at 2 and 3 years of age, sensitive children—those more inhibited in novel environments and more aware of flaws in a toy—were also more upset if the situation was contrived to make it seem to them that they had caused the flaw. At 4 years they were less likely to cheat, break rules, or be selfish when they had no fear of being caught and gave more prosocial responses in moral dilemmas. However, this difference remained at 5 years only if their mothers had used gentle discipline, deemphasizing power, a variable which did not affect nonsensitive children. Mutual cooperation and attachment security had similar interaction effects with temperament.

Medical researchers Boyce et al. (1995) studied what they called high and low reactive children, measured as change from baseline of heart rate and immune reactivity when individuals were placed in a challenge situation. High reactive children living and going to school under stressful conditions were more prone to illness and injury (presumably related to negative affect) than nonreactive children under the same stressful conditions. However, when living and going to school in normal-stress environments, high reactive children were actually less prone to illness and injury than nonreactive children under the same conditions. Gannon, Banks, and Shelton (1989) found a similar pattern of results for adolescents. That reactive children fared better in a good-enough environment may be explained by the fact that "children with a heightened sensitivity to psychosocial processes" might also be better able to notice when "social cues denote encouragement and acceptance" (p. 420). Both good and bad parenting affects

sensitive children more. This also suggests that sensitive patients may be in a position to notice and gain more from a good analytic relationship.

Finally, in the sort of controlled experiment only possible with primates, Suomi (1987) placed innately reactive infants with either anxious or calm mothers. Those raised by anxious mothers became distressed adults; those raised by calm parents became troop leaders. Gunnar, Nachmias, and their colleagues (Gunnar, 1994; Nachmias, Gunnar, Mangelsdorf, Hornik, Parritz, & Buss, 1996) have used experiments to demonstrate more explicitly the conditions under which sensitive children do or do not become neurotic, and again found that the same conditions have far less effect, positive or negative, on nonsensitive children. In one experiment, toddlers were brought into a room full of highly stimulating, unusual toys while their adrenaline and cortisol levels were being monitored. The sensitive ("inhibited") children all had an immediate rise in adrenaline levels not seen in the nonsensitive children. That is, all sensitive children were initially startled. But sensitive children with a secure attachment to their mothers, as previously observed, were soon able to enjoy themselves and play, apparently finding nothing threatening in the situation once they had inspected it, as was also indicated by their normal cortisol levels. But sensitive children with insecure attachments to their mothers evidenced both increased adrenaline and then increased cortisol, suggesting that their pause to evaluate the situation led to a sense of danger.

Some of the same researchers repeated the experiment by leaving toddlers for a half-hour with caregivers instructed to be either responsive or nonresponsive, and then introducing these children to the same highly stimulating laboratory play room. When nonsensitive children entered the playroom, their response was unaffected by the type of caregiver with whom they had waited. Sensitive children left with a responsive caregiver responded as had those with secure attachments (adrenaline but no cortisol); sensitive children left with a nonresponsive caregiver responded as did those with an insecure attachment style (adrenaline followed by cortisol). These studies suggest that how sensitive children assess their social support and security greatly affects their ability to adapt to new situations.

Consistent with our interpretations, Stansbury (1999) concluded from his own review of these studies that there are two pathways to adult hyper-reactivity of the adrenocortical system (signs of anxiety and depression)—temperament and less than optimal mothering early in life. But the majority of variance "would be captured by studies of the interactions between these two variables during early development" (p. 41).

Clinical Applications

Jungian Perspectives

Because of Jung's theory of typology, Jungians have been uniquely emphatic about the importance of individual differences in patients beyond their different psychopathologies. And as Knox (2002) expressed it, "The most urgent and vital task facing the whole depth psychology profession today is a reevaluation of our theoretical frameworks" and "the urgency arises partly from the explosion of scientific discoveries about the nature of the mind and the brain . . . whose sound empirical basis means they cannot be ignored" (p. 25). As genetic and neurophys-

iological substrates of individual differences are discovered, Jungians need to stay abreast of these—not to replace Volume 6 of the *Collected Works*, but to recognize different levels of explanation (behavior, character, neurophysiology, genes, etc.). It seems Jung was right about sensitiveness being an innate style that is an empirically and theoretically sound way to understand why some individuals become neurotic, without losing the basic sense of them by calling them "innately more disturbed" or even "genetically more vulnerable" or "easily traumatized." To understand them primarily in these ways would be as narrow, inaccurate, dreary, and unpoetic as making "skin cancer prone" our only term for those who are blonde, blue-eyed, and fair of skin.

Still, while the highly sensitive are much else besides vulnerable, they are that too, as the research amply demonstrates. They constitute about twenty percent of the population, but they could easily be fifty percent or more of those seeking our professional help. Further, because of their reflective nature and more vivid dreams (Aron & Aron, 1997), they are especially likely to choose a depth approach. So they are often in Jungians' consulting rooms, and they need a solid sense of how innate high-sensitivity interacts with environment—culture, family, and especially the quality of care giving in childhood—to produce the adults before us. And we need to explore the full range of the clinical implications of "sensitiveness," which is the goal of the rest of this paper, beginning with the ways in which the concept can contribute to our initial understanding of our patients' difficulties.

Recognizing High Sensitiveness

The first task, recognizing high sensitivity, is not simple in adults. Although it is not in keeping with the usual methods of depth psychology, one can administer the questionnaire in the Appendix. (This is the research version; scoring is simplified by rewording the questions as statements to be answered true-false. Such a version, with redundant items removed, can be found at www.hsp.person.com. There are no formal norms, as the full scale has not been given to a sample representative of the general public, but suggested cut-offs are given at the website for this shorter form. Men do tend to score lower.)

Otherwise, listen for self-descriptions of being aware of subtleties in the environment or in the behavior of others; sensitivity to pain, medications, caffeine, and temperature, as well as sensory sensitivity such as to noise or rough fabrics; and being easily overwhelmed, highly conscientious, and artistic or unusually appreciative of the arts. You will almost always uncover low self-esteem or at least a sense of feeling different. As for gender, there are as many males as females with this trait, but its effect is different and particularly difficult for men. I would also notice deep reflections or other signs of depth of processing, such as a quick understanding of interpretations, a rich inner life, vivid dreams, and high emotionality (although extreme overregulation and a preference for solitude are also common). I would listen for failures or decisions now regretted that are best explained by overarousal or the fear of it. (No one performs well or is comfortable when highly aroused due to overstimulation or fear of outcomes, and sensitive persons are more easily aroused in these ways than others). And I would listen for parents who were overprotective or else trying to overcome their child's "shyness" or "timidity."

Their typical presenting problems are related to low self-esteem (e.g., shame, shyness, being overworked or taken advantage of because they cannot maintain their boundaries); difficulty with emotional regulation (e.g., panic disorder, uncontrollable crying, or other affects that are under- or over-controlled); being easily overaroused (mentioned above); trying to live like a nonsensitive person (e.g., not enough "down time" for processing, frequenting overstimulating places they do not actually like); and extreme reactions to criticism (due to low self-esteem, but also their innate conscientiousness).

I would *not* expect to hear of risky behaviors, emotional outbursts in public, or a love of crowds and noisy places. The patient's voice would not be loud and communications would not be rude or blunt. Rather, needs would be more often communicated through hints and questions ("Would it be all right if …?"). I can think of exceptions to all of these, and realize that many disorders due to personal history could cause each of these characteristics. It is the pattern and the presence of these characteristics or their presence since birth that indicates the innate trait.

False Positives and False Negatives

In deciding on the presence of an attribute, one can fail to notice it when it exists, a false negative, or see it where it is not, a false positive. Either error can be made due to cultural bias. Living and working among relatively well-educated persons who will possess many of the attributes of sensitive persons, such as enjoying the arts and music or being conscientious, we can easily assume everyone is sensitive or else that the idea is meaningless and no one is particularly sensitive. In fact, there is a wide range in sensitivity: a random-digit-dialing phone survey (Aron & Aron, 1997, Study 4) found twenty percent of the population answered as if they were highly sensitive, and ten percent answered yes to every question asked, while at the other extreme, twenty-five percent of the general public answered no to most or all of the items.

A major source of false negatives is that, at least in more aggressive cultures, many aspects of the trait are seen as a flaw (for a discussion of cultural attitudes towards sensitivity, see Aron, 2004b). As a result, patients may hide their sensitivity or not even know about it, since parents often ignore or do not reinforce what is not admired culturally (Mead, 1935/1963). They may discuss one possible result of their sensitivity, such as shyness or easily losing control, hoping to have it and also the underlying trait eliminated. It is especially unacceptable in aggressive cultures for men to be sensitive (for example, to be sensitive to pain, easily overwhelmed, or aware of subtleties) so that many men have compensated or repressed such that they are unaware of it themselves. (Indeed, I have found that almost all men have a complex about sensitivity in men, whether they are sensitive themselves or not.) And although in the past sensitivity was considered a feminine trait, many determined women in today's cultural climate may be equally unwilling or unable to identify their trait as such. As one woman expressed it, "I don't want to know one more reason why I can't do what I want to do."

False positives can occur by accepting a patient's self-diagnosis of sensitivity, since the idea can be a flattering or at least a non-pathologizing explanation for what is actually a character disorder or a chronic trauma-induced symptom (e.g., social withdrawal, somatization disorders, or extreme sensitivity to criticism).

Especially when there is a narcissistic defense, the greater an individual's distress, the greater the patient will feel the need for an explanation that does not induce shame. For some, being highly sensitive is a simple, satisfying, blame-free reason to enter treatment.

Still, the greatest danger with sensitive persons is not overlooking their pathology, but overlooking their sensitivity, or pathologizing certain normal and inevitable aspects to their personality, such as their need to avoid overstimulation, the greater preference for time spent alone, and their natural proclivity to deeply process all experiences, which can cause them to seem indecisive or "hypersensitive."

Relation to Disorders

This trait, found in twenty percent of humans and as an innate strategy in many or most other species, is hardly a disorder. Yet clinically it can be easily confused, especially with the autistic spectrum disorders, because sensitive boys in particular may hide away with their computers or sports memorabilia to avoid all the pain that comes with a social life, theirs in particular. In these disorders, too, there is a heightened sensitivity, but it is quite different and apparently due to unpruned neurons, so that instead of processing information deeply, it is hardly processed at all, and therefore has little social or emotional meaning. For example, those on the autistic spectrum have difficulty perceiving and interpreting social-emotional cues, while those with the trait I am describing are very aware of these cues. Further, even the most shy sensitive persons relate well once they are familiar with others.

Sensitivity might also be mistaken for the hypervigilance of Post-Traumatic Stress Disorder (PTSD), especially if there has been a reason for PTSD, to which sensitive persons certainly are more subject. In both cases there would be more vivid dreams and a faster startle response or other autonomic signs of easily triggered arousal. However, PTSD would be indicated instead of sensitivity or along with it only if there were intrusive thoughts about the trauma, avoidance of specific situations, more hypervigilance in some situations, and nightmares that are trauma-specific, all without signs of a generally thorough processing of stimuli and a lifelong sensitivity.

Sensitive persons can certainly have mood disorders, but should not be mistaken for being chronically depressed only because of a pessimistic view of the future of the world or of their own abilities (a pessimism which may well be accurate, as in the case of depressive realism, Taylor & Brown, 1988). Likewise they do not have an anxiety disorder merely because they worry more than the nonsensitive, and they do not have a personality disorder (avoidant, dependent, obsessive-compulsive, etc.) merely because their unusualness has been present throughout their lives as an impediment to the cheerful, resilient functioning expected of most people most of the time. Finally, an unrelatedness in the initial sessions can appear to be the result of dissociation, extreme shyness, or a very disturbed attachment style, when it may be simply due to overarousal in an inherently highly charged situation.

While the impulsivity and rages of a borderline are far from the behavior of most sensitive persons, they can be misdiagnosed as borderline because of the intense emotions of sensitive persons. Confusion has been added by the comments of Stone (1988, 1991) and Grotstein (1996) that "hyperirritability" is typical of bor-

derlines and can be *either* (my italics) inherent or traumatically induced. By analogy to physical systems, they argue that the borderline's sensitivity leads to a lowered threshold, exaggerated response, and chaotic oscillations. But this would seem to be the case only when affect regulation is lacking; in fact most sensitive persons do learn to regulate their affect. So if the overreactivity being described by these clinicians is inherited, it does not seem likely to be the same innate trait as is being described here, which predominately involves a preference for reflection or action.

Moreover, a lowered threshold in a living system can as easily lead to more accurate, orderly responses rather than to chaos. As van der Kolk (1996) observed, "Exquisitely sensitive children may interpret normative growth experiences as terrifying. However, our study suggested that shyness and biological vulnerability are not the predominant factors leading people to develop BPD; the superimposition of childhood terror upon adult situations is most likely to be the key" (p. 189).

There are of course sensitive patients with most of the classic borderline behaviors, including committing what amounts to interpersonal violence by evacuating their overwhelming negative feelings (Mizen, 2003). Indeed, it may be that many with borderline personality disorder are highly sensitive (but *not* all, and I certainly do not mean that many highly sensitive patients are borderline). Scattered findings suggest, for example, that those with borderline disorder have enhanced recognition of facial emotion (Lynch et al., 2006) and are more gifted (Park, Imboden, & Park, 1992), a trait often associated with sensitivity (Silverman, 1986). But when highly sensitive patients with borderline tendencies behave in "borderline" ways, in my experience they rarely go long before they reflect on what they have done. When they do express anger, they usually become depressed afterwards, concerned about the harm they have done to the relationship. Indeed, I cannot help but wonder if their innate sensitivity and conscientiousness makes it a little easier for them to achieve Klein's (1935/1984) depressive position. They quickly grasp the idea of having a complex—not that that reduces it immediately, but it does contain it somewhat, as does the tendency to develop a well-adapted persona. In Grotstein's (1988) terms, patients with personality disorders have two selves—one that functions well and one that does not. To work with them at all, we need them to be able to employ that better-functioning self when they are not with us, and in my experience sensitive persons are better able to do this.

Relation to Concept of the Puer

Before leaving the topic of diagnosis, we need to compare the sensitive with those who are overly identified with the archetypal child and youth. It is my observation that sensitive individuals reach most of the developmental milestones at a later age than others and are often in some sense immature compared to their age mates, although perhaps precocious in specific areas, such as mathematics, music, spirituality, creative writing, or general intuition. Jungians (e.g., von Franz, 1970) commonly suspect a puer or puella complex in patients who seem too young in appearance and outlook for their age; have been unusually attached to their mothers or possessed by a mother complex; are attracted to lofty, vague, ungrounded ideals or spiritual interests; have difficulty committing to a course in life or to a partner (lead a "provisional" life); hide a deep sense of inferiority with an air of superiority; and seem overly sensitive and, in the case of a man, too feminine.

While many puers are not highly sensitive, the highly sensitive can have many of the puer's characteristics, with or without the usual etiology, so that the concept should be carefully employed. For example, sensitive patients' idealism and spiritual interests, even if ungrounded, are an understandable compensation given their deep concern about the state of the world and the meaning of suffering. And a preference for reflection before acting and a keen awareness of possible negative outcomes is reason enough to explain their slowness to commit to a career or family life (Caspi et al., 1989).

Of course many are also actually puers and puellas—that is, identified with the divine child that was originally projected onto them by their parents in the earliest stage of their development, before the disadvantages of their specialness was discovered (Stewart, 2001). They are very reluctant to grow up and accept the responsibilities of life, exactly as Jung described. But here, too, their sensitivity was often the original reason for the complex, even if that insight does little to alter the necessary treatment. For example, sensitive children are often less appealing to fathers, while mothers often make their most sensitive child a confidant and lifelong companion. I have seen many sensitive men, in particular, who were overly close to their mother in childhood because the father did not find his son adequately "masculine" and rejected him, relegating him to a "woman's world" (often the reason for the overbearing feminine in their dreams). Or sensitive men may be seen as immature or even homosexual because of their "feminine" interests, simply because they have the necessary sensitivity to appreciate flowers, opera, or cooking. This is especially the case if they happen to lack a mesomorph's body. (I have found little or no relation between body build and sensitivity, and gay men tell me there are no more sensitive men in that community than in any other.) An analyst once confided to me that in her opinion there were no "real men" among the analysts in a certain city, so I fear we are as prone to these misperceptions as anyone. Given the pain and prejudice that awaits them, it is understandable when sensitive men and women sometimes refuse to grow up.

On the other hand, I have seen patients with strong narcissistic defenses for whom their sensitivity played only a supporting role in their difficulties. Yet they, in particular, wanted me to validate their sensitivity as the sole reason for their lack of steady engagement in work and relationships. In their cases it seemed far more useful to look at them, at least at times, in terms of an identification with the puer aeternus.

Emotional Regulation and Complexes

As s Jung stated in the opening quote, a high degree of sensitiveness can be "an enrichment of the personality" until "difficult and unusual situations arise," when "calm consideration is then disturbed by untimely affects" (1913, para. 398). "Untimely" or what are now called unregulated affects, along with the larger topic of affect regulation, has become a useful clinical concept (see Schore, 1994; Siegel, 1999). Issues surrounding affect regulation are often the first sign that a patient could be highly sensitive. Recall the experiment described above (Aron et al., 2005, Study 4) in which sensitive persons were found to have a stronger emotional reaction than nonsensitive persons to the same emotionally-meaningful situation, as well as characteristics such as being more distressed under pressure,

more affected by others' moods, and crying easily—all found in the earlier studies (Aron & Aron, 1997). Or as Jung (1913) noted in the example of the two sisters, one troubled and one not, the sensitive one seemed to have "experienced things in a special way, perhaps more intensely and enduringly" (para. 397), leading to his conclusion that "a person who is sensitive . . . will receive a deep impression from an event which would leave a less sensitive person cold" (para. 401).

One might wonder why those who observe, reflect, and process situations more thoroughly would be more emotional, not less. The reason is suggested by the fundamental role that emotion-in-general (think "libido") has been given in the processing of information (see Ciompi, 1991; Fox, 1994; Schore, 1994; Siegel, 1999). Emotion causes attention to focus; it then gives value to the focus of attention as good or bad, interesting or threatening; and then according to this emotional appraisal, further processing is dampened or enhanced, creating additional meaning, still more affects, and finally some conclusion or behavior. That is, thought and emotion are inseparable aspects of all information processing. Thus, if a sensitive person processes experiences more deeply, it is because an emotional response has occurred and continues with each further step of processing.

The problem for the sensitive person is when and how this process of emotion-driven thinking will begin and end. For calm to be maintained or restored, sensitive persons need a variety of regulation skills. Central to these are the ability to use others, in memory or in person—recall the study by Nachmias et al. (1996) in which sensitive toddlers varied in their perception of threat in new situations depending on their attachment style. Most sensitive patients (as opposed to sensitive persons in general) probably have insecure attachment styles (Bowlby, 1980). They are either anxiously preoccupied, which means emotionally underregulated—overwhelmed by fears that they are not liked or will be abandoned—or they are avoidant and overregulated (in my experience the two styles can vacillate in the same patient, depending on other factors). There is a slight but significant tendency for sensitive persons who are insecure to be anxiously preoccupied (unpublished data), as one might expect and which fits with my impression that they are less able to regulate emotion through denial or repression. But overregulation of emotion also does occur in sensitive patients. Either way, they have and will continue to process more deeply every negative as well as positive event. In the case of the negative, their only choice is to reflect on the negative until they make meaning of it, which is why they to gain so much from a Jungian approach.

Another reason why the depth approach is important for sensitive patients is its unique appreciation of the powerful effect of chronic states of unsoothed, overwhelming overstimulation, which are now understood to be especially problematic during infancy (Schore, 1994; Stern, 1985/2000). Without an adult who is calmly attuned to the infant's needs, the brain can not develop an adequate flexibility of emotional regulation, especially during states of high distress. To protect against the spread of chaos within the brain, dissociation becomes quite literally the only defense. In 1913 Jung was already conceptualizing what we would call emotional regulation as a problem related to infancy and regression to infantile states through what he called a "a secondary fantastic dramatization" (para. 403). As Knox (2003) has suggested, we might think of these fantasies as mental representation of early, developmentally important attachments with caregivers. I

would argue that these fantasies are especially deeply processed and elaborated in sensitive infants. If the fantasy is of a hurting, neglecting, or intruding caregiver, future relationships are processed through a distorting, emotionally driven neural network, which social-cognitive psychologists call emotional schemas and Jung termed complexes (1921/1928), and beneath the personal complex lies the archetype, in this case the attachment system, with all of its rich symbolism and instinctual strength. (Indeed, Bowlby modeled his ideas on the concept of the archetype; see Stevens, 1983.)

As Jung (1921/1928) said, a complex is a set of "ideas and emotions which may be likened to a psychic wound," so that "one could easily represent the trauma as a complex with a high emotional charge" (para. 262). Hence a simple abreaction of this emotional charge does not alter the functioning of the complex, according to Jung, because "the essential factor is the dissociation of the psyche and not the existence of a highly charged affect" (para. 266). Since a complex is by definition at least somewhat beyond the reach of emotion-regulating processes, when the highly charged affect does exert itself during the processing of an experience related to the complex, "the explosion of affect is a complete invasion of the individual" (para. 267). What must be healed is the dissociation, which requires time and repeated revisiting of the cut-off emotions. All of this is uniquely appreciated by Jungians.

The above processes are accentuated in sensitive patients in three ways that can be noticed early in working with them. First, because they process a given experience more deeply, a disturbing experience is more likely to rise to the level of being traumatic—that is, overwhelming. Thus there will be more disturbance for a given past event than would be found with a nonsensitive person, and they often describe their lives or their experiences as overwhelming. Second, since everything associated with an overwhelming emotional experience tends to be dissociated, creating a complex, they often also show more signs of dissociation, as said previously. They may report "not being in their bodies" or feeling things "for no reason" (the latter correlates significantly with the sensitivity measure; see Aron & Aron, 1997). Finally, as Jung described, when a complex is involved and situations similar to the originally disturbing ones arise, emotional regulation of the resulting affect is always almost impossible. But since the sensitive person's more active pause-to-check system will identify more stimuli as related to the trauma and therefore the complex, they will feel that they are more often out of control than others, perhaps even fearing they will go insane. Hence sensitive persons tend to feel particularly anxious, ashamed, or hopeless about controlling their emotional lives or their lives in general. That is, they not only have overwhelming affects but shame and hopelessness about having them, which needs to be addressed for the work to proceed.

The Persona

Paradoxically, many sensitive patients will seem at first to be relatively undistressed given their histories. To understand this, and accurately assess their affect regulation, requires discussion of the persona as a segment of the collective psyche (Jung, 1928b, para. 247-8). Often these patients have used their sensitivity to subtle cues about what others are feeling and expecting of them in order to develop an exquisite adaptation to the requirements of the collective. For many of

them, adopting the emotional responses of others, especially when these are calm or socially appropriate, is their most reliable method of affect regulation. However, because this is so destructive to their autonomy and often contrary to their personal interests, they frequently harbor a deep sense of powerlessness, anxiety about being discovered as empty masks, or, hopefully, anger at being dominated by others through having to imitate them.

The sensitive patient's use of the collective psyche as an emotional container is always tenuous. In an atmosphere of acceptance and emotional attunement, that chameleon-like persona will fall away, sometimes very quickly. However, it can initially confuse a clinician, since a sensitive individual can "present" as highly adapted and emotionally regulated. They are being exactly as reasonable and calm as yourself.

Clinical Illustrations

Persona, Extraversion, and Avoidant Attachment

I first realized this relation of the persona to sensitivity when I interviewed J. during my initial research (Aron & Aron, 1997, Study 1). She was quite conscious of having chosen a segment of the collective psyche, the tough extravert, to function as her persona and shield against overwhelming emotions. In fact, she remembered the day and hour when she adopted this persona. Because of a severely schizophrenic mother, she had largely raised herself, along with her younger sister, with whom she was very close. When social workers finally grasped the situation, her sister was placed in a foster home and she in a juvenile treatment facility. She bonded closely with one girl there, but they too were separated after a few months. Having been overwhelmed again by separation trauma, J. decided not to risk intimacy again. Instead she closely studied how others managed in the world, a task that she told me she found far easier, she was certain, because of her sensitivity. She had always been "a keen observer of human behavior" and of "what works."

J. used this loud, superficial persona for the first half of her life, and actually became a successful local political figure, which she again attributed to her ability to watch others, see how things are done, and imitate. But in her forties her borrowed mode of emotional regulation failed her, and she developed a completely disabling depression. In psychotherapy (not with me) she realized her sensitive, introverted nature and how much of her life had been a defense against separation and abandonment.

Persona Covering Unregulated Affect

A. came to her first session looking well dressed, slim, and efficient. She had a graduate degree, reported a stable relationship, and discussed with enthusiasm a responsible, meaningful position in a nonprofit organization. Her only complaint was her trouble limiting her ever-expanding workload, which is a common problem for successful sensitive persons. When asked, she also was happy to provide an insightful, relaxed discussion of a shocking life history. Her mother had made repeated suicide attempts, many of them in response to her children's acts of individuation or to being left by one of a series of boyfriends who supported

her until they realized money was all she wanted. This mother both merged with her daughter and degraded and abused her—sensitive children are often chosen as confidants and victims because they feel driven to meet a disturbed parent's needs. (Or in other terms, all sensitive children tend to be so attuned to others that their personal boundaries are innately too porous, and much of the work with them involves developing and role-modeling good boundaries.)

In treatment, all of the dissociation required to create her well-adapted persona soon broke down, as it was bound to do eventually, given her history. Within three months her job, always dependent on her overworking herself, and the relationship, kept alive through A's placating, had both evaporated. So, too, the slim figure, which was the result of amphetamines. What followed were years of difficult work, only made possible by her selling inherited assets, as she had never been able to support herself for long. Her complexes and the resulting unregulated affects would lead to chronic depression and a deep sense of being different, unlikable, and hungry for love, which in turn led to intense idealizations of those who were even politely kind, and anger when these feelings were not matched or were taken advantage of. Being very bright, she recognized all of this and was deeply ashamed, as well as distressed by her inability to put her quite extraordinary talents to use. In short, if a sensitive person reports major childhood trauma, its effects are there, however the persona may seem.

Distinguishing Trait from Trauma

In the briefly reported cases of J. and A., I have made their sensitivity a given. But one of the difficulties created by considering the role of temperament in the behavior of any adult—and perhaps the greatest difficulty if one is a skeptic—is the seeming impossibility of distinguishing inherited effects, which have to be viewed as normal and inevitable for that person, from the effects of trauma and the resulting unregulated, dissociated, sometimes emotionally overwhelming complexes that would have to arise, with or without high sensitiveness. Fortunately, Jungians are accustomed to considering temperament differences such as introversion and extraversion in this context. And I can add my own observation, that sensitive persons rarely seek therapy only to deal with their trait. Those with adequate parenting usually adapt well to being different from the majority. The exceptions are those who have faced a recent trauma, or sensitive children and youths, who may need help understanding why they are different and how to deal with their affects or the responses of their peers. With adults, if the history and symptoms do suggest serious damage to the ego structure, the task is only knowing whether an innate sensitiveness is an exacerbating factor. Perhaps this longer case will help in seeing how trait and trauma work together.

M. was a biology professor, mainly involved in research, and at thirty-eight still unmarried. He sought me out because a woman colleague he had briefly dated gave him my book, which he had glanced at before seeking and reading instead the research that backed it up. He liked my more neutral, biological explanations for his own rather negative view of himself as "ridiculously shy," and thought I might be an exception to his rule of "never psychotherapy."

His goal for us was to overcome his shyness enough to find a wife, so at first he found my desire to hear his personal history irrelevant. But once I was able to

give him a satisfying explanation, he complied. Still, I could sense his shame when he described a childhood with no happy memories whatsoever—indeed, few memories of any sort. His family seemed to be essentially a strange, loveless wasteland. For example, he recalled a parent-child school event at which he and his mother were the only pair not sitting together, as if neither had any inclination to be near the other. Another important memory was of his older sister pointing at him and asking their father, "*What* is wrong with him?" Father's theory was that M. was slightly retarded. In fact, M. tested as very bright, but his parents lacked higher education and saw no reason to pay for it for their children.

Fortunately his high school sciences teachers banded together and helped him apply to the state university, where he was able to work and borrow money to see his way through. Even while in graduate school he was doing research that took him to the top of his field. When his parents attacked his espousal of Darwinism, there was a violent fight in which he expressed all of his pent-up rage. After that there was no further contact with any of his family.

Although he saw himself as shy, he had a reputation for brilliant public demolitions of others' research. Naturally this had left him with few friends in his profession. Since this sort of cruelty was hardly typical of the highly sensitive, much less being an attractive behavior, I explored this with him. He admitted that it was a compulsion of his, and that he would later feel sorry for the person, but he insisted that he was at least as hard on his own work.

Eventually he confessed that his criticalness and general disgust and anger with people were also making personal relationships short lived. Soon after this he brought in his first dream, of an angry "Gestapo Man" on a murderous rampage. Privately relating this to Kalsched's (1996) theory of the archetypal defense of a protector/persecutor, I suggested that these attacks on himself and others might be a way to protect himself from closeness. When he could accept this, I also explained attachment theory to him, and he diagnosed himself immediately as an avoidant. At this point his sensitivity was no longer even being discussed.

Although he said my "expertise" was helping him, he interrupted me often and attacked every detail. But knowing about the child waiting in the wings, I was patient with the Gestapo Man, and it was not long before he began to admit to longstanding feelings of deep sadness. Then, without discussing it with me, he read the DSM description of major depression and began taking anti-depressants. When he finally told me, he admitted that it felt like a terrible defeat.

Soon after, he reported an embarrassing conviction since childhood that he was special, a belief he was now having to relinquish. Recurring childhood dreams had given him this view of himself: a female dream figure would appear, often in shining white, to give him various gifts of magic powers, such as the ability to hear what others thought or to see what he later recognized as molecular and DNA structures. Naturally I attributed his sense of being special to a narcissistic defense that was now less needed.

For five years our work focused on the horrors of his childhood and its impact—his depression, difficulties with intimacy, and poor self-care. (At the outset he was subsisting on ready-made sandwiches, candy bars, and coffee, and already had a serious heart arrhythmia and migraine headaches.) His sensitivity seemed to be breaking through everywhere, mostly as a problem. He began to feel

his bodily reactions to foods; the compassion that made it impossible for him to read a newspaper; and his overarousal in the face of too much stimulation, suggesting new explanations for old failures.

All of this provided opportunities to have with him the emotional attunement he had lacked, but his self-esteem still slid lower and lower. He had gradually accepted the importance of being less compulsive about his work and more diplomatic with colleagues, but I had not foreseen how much this would take him out of the professional spotlight and undermine his only sense of pride. I also realized that ours was his first and only close relationship with anyone, but also the first with a woman, and to him it was revealing "objectively real flaws" that he "might never fully correct" in time to marry and have a family.

For several years he did not bring in what he called his "meaningless nightmares," instead supplying me with various brain studies and theories that dreams were "nothing but." My consultant at the time suggested I view this as his effort to maintain some control and dignity, so I managed to resist arguing, even though he knew I placed dreams at the center of my work. I think now it was also part of his repudiation of the childhood fantasy of being special. Then, after a particularly important professional paper was rejected, he brought in a dream that so reminded him of those childhood dreams that he could not ignore it.

On a dark night he, a small child, opened the door to find two devious aliens in space suits. They instantly paralyzed him and began removing his brain, system by system, beginning with the hypothalamus. The procedure was deliberately painful, horrifying, and "anatomically accurate." Through a tremendous effort of will he managed to get up from the operating table and run, trying to hide himself various places, but no place was safe. Then a woman "of pure goodness" appeared who told him to stand behind her and not look while she dispatched the aliens.

He was certain the aliens represented his parents or else his two older siblings, and he thought the saving woman was me, and always had been, in that his early dreams were merely precognitions to comfort him through the worst until he would meet me. Close as this dream drew us (I did not reject the projection by insisting on her being an anima figure), his psyche had more to say on the subject. By our next session there was another dream, involving enormous snakes and spiders, and this time the saving figure was male. M. was trying to get away, but the man told him there was nothing to fear. The gender of this helpful figure suggested to me that it might not represent me after all, and a month later another dream made the figure a part of himself, which then emerged from him and showed him the delicate, subtly hidden machinery and microchips operating the spiders and snakes, and said again that there was nothing to fear. He continued to bring me his disturbing dreams, the painful side-effects of an unfreezing process. Sometimes no saving figure appeared, but when one did, it seemed too blatantly positive to be only the protective aspect of the archetypal defense as described by Kalsched (1996). Rather, these figures seemed to be dismantling the need for that defense. Thus I decided to consider whether they were a message to both of us about him having more inner resources than I was acknowledging, and whether his early statements that there was something special about him were being restated to me now. Perhaps I had discarded them too quickly as only a defense.

But how could a man with such a childhood and adulthood have this much inner strength appearing in his dreams? Perhaps he had given me the answer in our first session. He was special because of his sensitivity, a point on which I should have been the first to agree. He knew his sensitivity had caused him to be rejected by his family, but had come to me because of what I had written and he had read and trusted: This sensitivity was nothing to be ashamed of, but rather it was a special strength that had saved him from becoming as dull and loveless as the rest of his family. Indeed, perhaps his sensitivity was the innate core around which his individuation process was trying to form, while we were enacting the past by diminishing him to nothing but an avoidant attachment style, someone "retarded" in his development.

Taking a new look at his assets, I found it easy to agree that he was special. He was a brilliant biologist, thanks in large part to his sensitivity. His tastes in literature and music often led me privately to try what he had raved about, almost always with pleasing results. He possessed an uncanny ability to grasp others' thoughts and motives, and all the other nuances of the social situations in which he moved—even if he could not usually take advantage of these insights. He also was simply surviving exceptionally well, in spite of having no family or real friends.

As we increasingly understood these recurring dreams since childhood as the "nature" that rescued him from his "nurture," his self-esteem and relationships improved—I would like to say significantly, but that was not quite the case. Indeed, he grew increasingly convinced that he would never marry, but rather, developed a few close friends and a greater love of solitude. So the difficult work of reworking his internal representations continued in ways unique to him, and once again his sensitivity was rarely the central topic. But after that I commented on it when I saw it. For example, he was often the only one to notice some subtle change in me or the office, and his pride in these moments became additional proof of the worthiness of his core self.

Thus, in spite of my interest in adult temperament, I had made the mistake Jung had struggled to describe and also perhaps to prevent through the more neutral concept of introversion—the error of assuming that sensitivity in combination with a troubled childhood leads *only* to neuroticism.

Adapting Treatment

Affect Regulation

The third major topic of this paper is the adaptation of treatment to sensitive patients. Again I find it helpful to center some of these thoughts around the concept of affect regulation, although treatment need not involve a self-conscious concern with it. It is simply another way to consider the well-established importance of the therapeutic relationship, which Jung (1921/1928) emphasized in just these ways. He said that the "curative effect" results from reexperiencing traumatic emotions "in the presence of the doctor," who provides "moral support against the unmanageable affect of his [the patient's] traumatic complex" (para. 270). Affect regulation is especially implied by Jung's stating that all of this is accomplished through the doctor's "human interest and personal devotion," or in more recent terms, affect attunement and affect regulation through containing and

role modeling: "The rehearsal of the traumatic moment is able to reintegrate the neurotic dissociation only when the conscious personality of the patient is so far reinforced by his relationship to the doctor that he can consciously bring the autonomous complex under the control of his will" (para. 271). These are much like Siegel's (1999) words:

> Unresolved trauma or loss leaves the individual with a deep sense of incoherence in autonoetic consciousness, which tries to make sense of the past, organize the present, and chart the future. . . . Making the connection within psychotherapy between these aspects of memory and past experiences allows patients to understand the origins of their disturbances. Such reflections must take place within the therapeutic attachment setting, which allows the mind to experience intensely dysregulated states and learn—dyadically at first—how to tolerate them, then to reflect on their nature, and eventually to regulate them in a more adaptive manner. Much of this emotional processing is in its essence nonverbal and is probably mediated via right-hemisphere processes (both those within the patient and between patient and therapist). (p. 297)

Or in the words of Schore (1994), the task is the transformation of "maladaptive internal working models coding insecure attachment patterns" into "adaptive models based on more secure attachment programs of affect regulation" through the "exploration of the patient's affective states." This is "a dyadic venture in which the therapist serves an affect-regulating selfobject function" (p. 449).

Jung (1928b) provides an important warning about this process, however, which applies to sensitive persons in particular. Patients can be overwhelmed by the "collapse of the conscious attitude," so that they are "delivered up, disoriented, like a rudderless ship that is abandoned to the moods of the elements." As a result, the patient may escape into a "regressive restoration of the persona" (para. 254). Since sensitive persons are prone to use identification with the persona as a means of affect regulation, the risk is probably much greater that a sensitive patient will "restore the shattered persona" and "become smaller, more limited, more rationalistic than he was before" (para. 257). As Jung notes, the "critical experience . . . is the transference," in that "a violent rupture of the transference may bring on a complete relapse, or worse" (para. 255).

Again, Jung's concerns are entirely in keeping with the increasing emphasis on affect regulation as the central role of the analyst and the general healing environment (Horton, Gewertz & Kruetter, 1998; Schore, 1994; Siegel, 1999; Spezzano, 1993). Sensitive persons are prone to find all aspects of psychotherapy highly stimulating, but especially as traumatic memories are reconnected with their dissociated affect. With the sensitive patient, there is undoubtedly greater traumatic generalization (Perry, 1999), but there also should be a greater possibility for affect attunement in that they are more sensitive to its presence as well as its absence.

Avoiding Overarousal

In order to create and maintain the subtle attunement and affect regulation that sensitive persons often lacked as children and to avoid the work becoming an aversive, deregulating experience, the analyst must strive to maintain reasonably comfortable levels of arousal during sessions and in between them—another way to think of Winnicott's (1965) concept of the holding environment and the extensive work by Horton (1982; Horton et al., 1998) on what he calls the "solace paradigm."

How to provide the necessary containment, however, differs in each case. A casual opening may relax one person and overexcite or even terrify another (because of the implication of greater closeness). One must watch for overarousal carefully, as patients may try to hide it out of shame or to spare the analyst having to deal with something that seems so out of place. Averting the eyes, trembling, paleness, coming very early or late, and overattentiveness to the time are possible signs.

Crying can also create as well as signal overarousal. The sensitive, compared to the nonsensitive, tend to report crying more easily (Aron & Aron, 1997). While some, and especially sensitive men, have made a great effort to overcome this propensity, most of them admit they do cry when alone, and a few find their own tears frightening. The return of their tears to an intersubjective realm is an important sign of increased trust, but can be overarousing in itself for many sessions and must be handled with great gentleness. And while tears are an excellent indicator that a vein of affect has been touched, some cry so readily that it is difficult to sense how much attention to give it. Give too little and an opportunity is lost, but too much attention only adds to their overstimulation as well as distracting both of you. A better approach could be merely to acknowledge together that this is how you both know that something important is happening and then continue with whatever that is.

It is important that patients not find themselves too often leaving sessions overaroused, although of course sometimes this cannot be avoided. The beginnings of sessions are also delicate, as these patients may underestimate the impact of taking up the work again. Even if the sensitive patient conscientiously plunges into difficult material at the start of the hour or after a vacation break, or pursues painful feelings until the last minute or hours before separating, one needs to see that these transitions are not so abrupt or emotional that the painful affect is uncontained between sessions. Of course moments of overarousal and lack of attunement as well as uncontained emotions are certain to occur, and are important opportunities in many ways, including a chance for the patient to see that calm can be restored and how that is done.

Soothing and Limit-Setting

Above all, moments of overwhelming affect within the session are opportunities for soothing abilities to be internalized. I find Horton's discussion of transitional relatedness to be helpful here. In an edited book based on Horton's thinking, Grotstein (1988) describes solacing objects in the usual terms of allowing a diminution of excitement in the absence of the mother, but Horton expands the meaning of these objects to include "the person's unique experience of an object, whether animate or inanimate, tangible or intangible, in a reliably soothing manner based on the object's associative or symbolic connection with an abiding,

mainly maternal primary process presence" (p. 35). Exploring a patient's history with such objects can provide new perspectives on their childhood. (For example, in the case of A., above, her dearest companion in childhood was a dog that A's mother told her had run away when in fact her mother had given it away.)

Soothing is not the only possible response to a patient's feeling overstimulated. Sometimes limit-setting is also required, given the strength of the transference. But usually this needs to be very gentle, with the exact meaning of the limit made clear. Generally, sensitive persons are distressed by even the mildest correction in the boundaries or frame. (Indeed, as children, levels of punishment that work with their peers will be counterproductive with them [Kochanska, 1998]—another way in which sensitive individuals are more easily traumatized in childhood.) Merely being asked to come at another hour can seem to imply that all along you were unhappy with the hour the two of you were meeting; and the gentlest hypothetical interpretation that implies criticism—the type of comment that might be quite ineffective with others—can be taken as an unappealable judgment by these patients. For example, a sensitive patient was paying a reduced fee because she was a student, so when she graduated and became employed, I waited a few months and then discussed an increase in her fee. She was extremely upset that I had asked her before she had thought to do it herself. That night she dreamed of coming to a session sixty (her first fee) minutes late. I'm angry and using big words; she hangs her head, ashamed, saying "I don't understand you." I say something about prostitution and that she is basically stupid. Discussing this dream, she realized that my asserting the frame in this way not only left her feeling stupid, but like someone who must pay for another's love.

The Therapeutic Relationship

If you do not wish to see sensitive persons, an excellent screening device might be to have a somewhat unkempt waiting room with fluorescent lighting, a disordered and visually stimulating consulting room, and a lack of care about details of the frame.

Otherwise, they will come, and usually soon develop an intensely positive transference, especially if their sensitivity is being accepted and understood for the first time. If you are perceived as being highly sensitive as well, this can be an even more exciting, hopeful experience for the patient. At the same time, as Hultberg (1989) describes, overstimulation can "evolve around an extreme sensitivity to the closeness of the analytical situation. . . .The highest goal of the analysand . . . is to be as intimate with the analyst as he possibly can, and the feeling that this wish could be fulfilled may again be too overwhelming [so that] the analysand has to defend himself against this dangerous situation" (p. 56). That is, fear and resistance will also be high, resulting in intense, highly arousing internal conflict—unless the pair colludes to keep the tension low out of a conscious or unconscious fear of the patient's "hyper" sensitivity and seeming fragility. In fact, as uncovering and regression proceed, sensitive patients often can be consulted as to the depth of work they can handle at the moment.

Another reason for an idealizing transference, beyond the regressive pull created by analytical psychotherapy itself, is the sensitive person's deeper awareness and fear of separation, loss, and annihilation. When the Self is projected onto

the analyst, it may make a merging transference seem like the only solution to these fears. As Grotstein (1996) describes, certain individuals have an innate tendency to directly experience "reality"—death, loss, existential nonbeing—as if they are able to make less use of the buffer provided by humankind's long history of creating comforting mediating symbols and fantasies about these terrors. Your presence may seem absolutely indispensable simply because with you these symbols and fantasies are being developed and encouraged. You, and symbols of you, may be providing the most viable buffer that the sensitive person has ever known against the cruelties of this "reality."

Other sensitive patients will have had or begin to have spontaneous spiritual or numinous experiences or dreams, causing them to feel that their inner work, and you specifically, are essential to their opening to this realm, or that you are all that stands between them and madness or a terrifying inflation.

I realize that all of the above can be true of nonsensitive patients as well, but again, these experiences will occur more readily with sensitive than nonsensitive patients given the same history of distressing childhood experiences.

In spite of the high possibility of an intense, idealizing regressive transference, I have found that most sensitive individuals are extremely cautious about transgressing the boundaries of the frame, even though their need for more of you may be very great. When a transgression by a patient does occur, again, it should be handled very gently, since errors here can be difficult to undo. Sensitive patients may be very slow to reveal their transference feelings and fantasies out of shame. Shame is always present in the therapeutic dyad (Sidoli, 1988)—patients expose themselves, therapists are looked to for their judgment whatever they do or do not say, and even if the patient is always judged as acceptable, the risk is relived over and over that someday the patient's hidden, horrible flaw will be uncovered. And for the highly sensitive, that "flaw" is already very real. They have always felt different, devalued for behaviors such as crying easily or failing when under pressure, responses that only became more common as the sense of being flawed deepened. As we saw, Jung himself would praise them in one paragraph, condemn them in the next. At the same time, their differentness is not visible, potentially increasing the sense of carrying a secret and being an imposter while others think they are "normal" due to their persona skills, already described.

Further, the essence of shame is misattunement. One feels elated, appreciated, liberated, and then finds this was all a misperception and the other has been disgusted rather than sharing in one's feelings. Sensitive persons with a complex about shame will process such moments fully, as they do everything else, and see this as implying a profound and permanent disconnection with you, and by implication, the entire human race. Therefore for the sensitive person even more than others, the analytic relationship is a potent and dangerous medicine. Every word and glance can heal as little else can, or bring psychological death by attacking the tenuous and all important sense of connection. As one told me, "I dread hearing even the briefest phone message from you, because I am afraid you will say something very subtle that I will know indicates that you in fact really do not like me."

This fear of doing or being unacceptable of course leads back to the problem of the regressive restoration of the persona (Jung, 1928b), or the false self (Winnicott, 1965), and a high degree of compliance. Therefore it may be necessary

actively to request and encourage expressions of disappointment, dissatisfaction, or anger towards you, although these may take years to be admitted and often appear as only vague or passing hints.

Dream Material

Sensitive persons are especially likely to report vivid, unusual dreams (Aron & Aron, 1997). Their psyche speaks early and often through this conduit. In the difficult case of A. above, she reported dreams so detailed, vivid, and useful that one consultant insisted these were fabricated. But they were in fact typical of sensitive patients. While these dreams can prove quite useful therapeutically, one must be careful about plunging into interpreting these too soon, flooding patients or causing them to feel intruded upon and shamed before the relationship feels safe to them. In some cases I have found sensitive persons simply have no memory of dreams for years, until that inner safety is present.

As for a patient's symbolization of sensitivity itself, this will of course always be unique. Some illustrative examples are images of small or fragile plants, animals, ecologies, structures, or environments, or the condition of the feet, where the body must come in contact with "hard reality." Being barefoot over various surfaces, or the type of buffering shoes or socks available or lost, can all suggest the degree of protection. Sensitive men may dream of little girls who cry or need rescue and are, or are not, responded to. States of overstimulation may be expressed in dreams of destructive fires (the inflamed nervous system) or storms, tornadoes, hurricanes, lightning, and blizzards. Positive images of sensitivity may appear as personifications of great spiritual or magical power or wisdom, such as Merlin, or of a type of man or woman having great insight into nature (for example, an Australian Aborigine or a Native American, especially when these are shamans).

Sensitive patients can also have unusually violent dreams, or ones they find utterly revolting. One patient had an image of herself upended while someone stirred with a stick the content of her rectum. I suspected this dream was a representation of me from the perspective of the protector/persecutor (Kalsched, 1996). The archetypal defenses of the ego by the Self are a way to understand the dreams of anyone who has suffered early loss, abuse, neglect, or chronic hostility in childhood, but again will be more applicable to sensitive persons because of their greater vulnerability from birth (Kalsched, 1996).

Conclusion

In sum, what do sensitive patients need from us, in addition to the usual analytic work? The individuation process is always unique, but in general their foremost need is simply gentle, calm, kindly attunement to their emotional states. With that, they will almost inevitably become less ashamed and more able to calm themselves by internalizing the analyst as a transitional object in Horton's (1982) sense. The reason for this need, again, is that sensitive patients have a greater fear of and real potential for being overwhelmed from within and without. They cannot shut out the world's achingly subtle, fleeting beauty or its inexplicable cruelty and suffering. They must find their own meaning in it. And they were born with everything they need to do that, if we patiently hold them in our kind awareness.

A large proportion of those committed to a depth approach are probably highly sensitive, as was Jung himself perhaps. Indeed, the development of analytical psychology is tightly intertwined with them, and like them, our approach has been criticized for processing so deeply every human experience. We can readily sympathize when sensitive patients tell us tales of being pathologized for this deep processing. It helps to remember Jung's (1913) request that we not "yield too much to the ridiculous fear that at bottom we are quite impossible beings" (para. 442). Rather, our work "should be only a means for giving the individual trends breathing-space" (para. 441). The world often seems controlled by those who are impulsive and rarely stopped by unpleasant feelings. Perhaps we collectively stand to benefit by giving breathing space for those with a trend, indeed an imperative, to wait for their thoughts to descend to the deepest levels of the psyche before acting.

Notes

1). At one time I had thought Jung replaced his concept of sensitiveness with introversion after developing his typology. However, he did use the term again as a description of temperament in *CW 8* (1933b), in a passage about neurotic conflicts in the young that can arise when a "feeling of inferiority . . . springs from an unbearable sensitivity" (para. 762). He used it in *CW 16* (1933a): "The explanatory method always presupposes sensitive natures capable of drawing independent moral conclusions from insights" (para. 150) and in 1928, "When still a sensitive youth" and "A less passionate nature can put up with this for a time, but a highly-strung, sensitive nature in need of affection will be broken" (1928a, para. 502). These uses suggest that he still found the concept of a presumably innate sensitivity to be necessary descriptor in its own right. These later uses of the term were not referenced in the General Index, so there are no doubt other places where he used the term that I have not yet found.

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Appendix

QUESTIONNAIRE (HSP Scale)

INSTRUCTIONS: This questionnaire is completely anonymous and confidential. Answer each question according to the way you personally feel, using the following scale:

1 2 3 4 5 6 7
Not at All Moderately Extremely

____ 1. Are you easily overwhelmed by strong sensory input?
____ 2. Do you seem to be aware of subtleties in your environment?
____ 3. Do other people's moods affect you?
____ 4. Do you tend to be more sensitive to pain?
____ 5. Do you find yourself needing to withdraw during busy days, into bed or into a darkened room or any place where you can have some privacy and relief from stimulation?
____ 6. Are you particularly sensitive to the effects of caffeine?
____ 7. Are you easily overwhelmed by things like bright lights, strong smells, coarse fabrics, or sirens close by?
____ 8. Do you have a rich, complex inner life?
____ 9. Are you made uncomfortable by loud noises?
___ 10. Are you deeply moved by the arts or music?
___ 11. Does your nervous system sometimes feel so frazzled that you just have to get off by yourself?
___ 12. Are you conscientious?
___ 13. Do you startle easily?
___ 14. Do you get rattled when you have a lot to do in a short amount of time?
___ 15. When people are uncomfortable in a physical environment do you tend to know what needs to be done to make it more comfortable (like changing the lighting or the seating)?
___ 16. Are you annoyed when people try to get you to do too many things at once?
___ 17. Do you try hard to avoid making mistakes or forgetting things?
___ 18. Do you make a point to avoid violent movies and TV shows?
___ 19. Do you become unpleasantly aroused when a lot is going on around you?
___ 20. Does being very hungry create a strong reaction in you, disrupting your concentration or mood?
___ 21. Do changes in your life shake you up?
___ 22. Do you notice and enjoy delicate or fine scents, tastes, sounds, works of art?
___ 23. Do you find it unpleasant to have a lot going on at once?

___ 24. Do you make it a high priority to arrange your life to avoid upsetting or overwhelming situations?
___ 25. Are you bothered by intense stimuli, like loud noises or chaotic scenes?
___ 26. When you must compete or be observed while performing a task, do you become so nervous or shaky that you do much worse than you would otherwise?
___ 27. When you were a child, did parents or teachers seem to see you as sensitive or shy?

HSP Scale (8/97 Version), from: Aron, E., and Aron, A., (1997), "Sensory-Processing Sensitivity and Its Relation to Introversion and Emotionality," *Journal of Personality and Social Psychology, 73*(2), 345-368.