Indonesian Journal Of Psychology ISSN 3163-2556

Vol.1, No. 2, September 2026

# Understanding Guilt-Related Auditory Hallucinations and Persecutory Beliefs After Parental Loss: A Jungian Case Formulation

Laila Husna Nasution[1], Hapsari Nina Nabilah[2]

*Universitas Sumatera Utara*[1,2]

(Received: June 6, 2026; Revised: July 8, 2026; Accepted: September 5, 2026)

**Abstract**

This single-case study applies Carl Gustav Jung's analytical psychology to understand an adult man ("Mr. A") who developed guilt-laden auditory hallucinations and persecutory beliefs after the deaths of both parents within weeks of each other. Information was drawn from an autoanamnesis and an alloanamnesis with his elder brother, and the case was reported in line with the CARE guidelines. Mr. A, the second of three brothers, had long been compared unfavourably with a successful elder brother. In 2008 he quarrelled with his parents, withdrew from work and left home; his mother and father died in early 2009. He then heard voices saying that he had killed his parents, covered his ears, threw objects, avoided crowds for fear of being beaten, and was eventually restrained by his family and taken to a psychiatric hospital. The formulation proposes that an inferiority complex rooted in sibling comparison, a compliant persona that concealed a rejected shadow of anger and envy, and an unfinished individuation task in middle adulthood left the ego unable to contain guilt after the bereavement. Hallucinations and persecutory fears are interpreted as the autonomous, projected return of this complex. No formal diagnosis or psychological testing was available, so the formulation is hypothesis-generating. Implications for assessment, family work and culturally sensitive care are discussed.

**Keywords**: *analytical psychology; auditory hallucinations;shadow; persecutory beliefs*

## 1. Introduction

Hearing voices and holding fixed beliefs of being threatened are among the most distressing and disabling experiences encountered in clinical psychology. Contemporary services tend to understand them mainly through a biomedical lens built on diagnostic categories and pharmacological treatment (American Psychiatric Association [APA], 2022; Howe & Demjaha, 2022). Such an approach is indispensable, yet it can leave unanswered a question that patients and families often ask: why did these particular voices, with this particular content, appear at this particular moment in a life?

Jung began his career working with psychotic patients and argued that the content of symptoms is psychologically meaningful and linked to emotionally charged complexes in the unconscious (Jung, 1960). Recent work has revisited this position, suggesting that analytical psychology still offers a coherent account of how psychotic experiences develop and that analytic thinking can contribute to understanding and treating them alongside the medical model (Howe & Demjaha, 2022). It has also been argued that Jung's complex theory helps explain hallucinations across conditions, not only in psychosis (Howe et al., 2024).

Bereavement is a context in which such experiences are particularly intelligible. Perceiving a dead person is common among the bereaved (Rees, 1971), and whether it is regarded as normal, comforting or pathological depends heavily on the cultural frame in which it occurs (Sabucedo et al., 2023). The experience becomes far more distressing when the voice is not comforting but accusing, and when it is accompanied by a belief

*Corresponding author: Laila Husna Nasution (*lailanasution@gmail.com*)

that others will punish the bereaved person for the death. In collectivist family systems, where obedience, family honour and comparison among siblings carry great weight, unresolved guilt towards deceased parents may be especially difficult to carry. Families in Indonesia, moreover, sometimes respond to severe mental illness with restraint and confinement (Minas & Diatri, 2008), which may deepen fear and isolation.

The present article analyses the case of a man in Indonesia, referred to here as Mr. A, whose guilt-laden voices and fear of being attacked by crowds began after the deaths of both parents. The aim is to offer a Jungian psychogenesis of his difficulties by examining the structure of his personality (conscious, personal unconscious, collective unconscious, persona and shadow), his position on the path of individuation, and the way his symptoms may express an unintegrated complex. The case is presented as a theory-guided formulation rather than as a diagnostic or outcome study.

## 2. Literature Review

### *2.1 The Structure of Personality in Analytical Psychology*

In Jung's model the psyche is a totality that includes both conscious and unconscious contents. The conscious is what the ego experiences, whereas the ego is only a small part of the total personality; it must be complemented by the broader Self, the centre of a personality that is only partly conscious (Feist & Feist, 2008; Jung, 1966). The personal unconscious consists of experiences that were once conscious but have been forgotten or repressed. Its contents are organised into complexes, emotionally toned clusters of associated ideas that can behave with a degree of autonomy (Jung, 1960; Schultz & Schultz, 2017).

Beneath this layer lies the collective unconscious, the universal and inherited substrate of the psyche that is composed of archetypes, which are inherited predispositions to form images and ideas that recur across generations (Jung, 1969). Several archetypes have been described in detail, among them the persona, the shadow, the anima and animus, and the Self. The persona is the face that a person presents to the world and the social role that he or she is expected to play. The shadow represents the dark, repressed and unacknowledged qualities that a person does not wish to see in himself or herself and does not want others to see; at the personal level it holds experiences rejected on moral or aesthetic grounds (Feist & Feist, 2008; Jung, 1969). In Jung's schematic representation the conscious ego forms the outer layer, the personal unconscious lies inside it, the collective unconscious lies at the centre, and the whole symbolises the Self. For most people the persona is more accessible to awareness than the shadow, and the shadow is in turn more accessible than the anima or animus (Feist & Feist, 2008).

### *2.2 Individuation and the Developmental Task of Middle Life*

Psychological health in analytical psychology is achieved through individuation, the lifelong process by which a person integrates conscious and unconscious components into a more complete personality, realises his or her capacities, and is neither dominated by the unconscious nor identified solely with the conscious (Jung, 1966; Schultz & Schultz, 2017). Individuation presupposes that the contents of the unconscious are assimilated into the total personality.

Jung described middle life as the period beginning at about 35 to 40 years of age, when the task shifts from establishing oneself in the world to turning inward. Men in this phase are expected to loosen the ego's dominance over personality and to give priority to the Self (Feist & Feist, 2008). A person who has moved beyond both childish dependence and excessive adult over-adaptation is better prepared to enter and live this

phase fully. Difficulties in earlier phases, such as incomplete separation from the parents, therefore tend to surface as an imbalance among conscious, personal-unconscious and collective-unconscious components, which Jung regarded as a basis of psychopathology.

### *2.3 Hallucinations and Psychosis from an Analytical Psychological Perspective*

Jung worked with psychotic patients at the Burghölzli hospital in Zurich, and his early research proposed that unconscious complexes underlie hallucinations and delusions (Jung, 1960). Howe and Demjaha (2022) outline Jung's psychological account of how psychosis develops, compare it with current understanding of its causes, and argue for analytic thinking in understanding and treating the disorder. In a related brief report, Howe et al. (2024) describe Jung's view that complexes underlie hallucinations, and argue that this framework remains useful for explaining how hallucinations occur in a range of conditions beyond psychosis.

Jung's own anomalous experiences have also been re-examined. Incekara and Blom (2024) argue that his hypnagogic experiences, hallucinations and sensed presences did not indicate a psychotic disorder but reflected very vivid mental imagery. A relevant implication is that what distinguishes a person who falls ill from one who does not may be less the presence of such experiences than the capacity to contain them, place them in context, give them meaning and share them with others.

A cognitive perspective offers a complementary account of persecutory beliefs. Freeman (2016) describes persecutory delusions as threat beliefs that arise from genetic and environmental risk factors and are maintained by processes such as excessive worry, low self-confidence, intolerance of anxiety, reasoning biases and safety-seeking behaviours. The two perspectives address different levels of explanation: the cognitive model emphasises maintaining mechanisms, whereas the analytical model emphasises the personal meaning and biographical origin of the content.

### *2.4 Bereavement, Guilt and Cultural Interpretation*

Hallucinations of the deceased are reported by a considerable proportion of bereaved people and are not necessarily a sign of mental disorder (Rees, 1971). Their interpretation differs across cultures, ranging from normal and even desirable to dangerous and pathological, and these frames change over time (Sabucedo et al., 2023). Because psychotic disorders are diagnosed on the basis of specific symptom patterns, their duration, and the exclusion of other explanations (APA, 2022), formulation of a single case without a full diagnostic assessment must remain tentative.

## 3. Methodology

### *3.1 Research Design*

This study used a qualitative single-case design. A case study allows an in-depth exploration of a complex phenomenon in its real-life context (Crowe et al., 2011) and is suited to examining how a theoretical framework fits an individual life. The case is reported in line with the CARE guidelines for clinical case reporting (Gagnier et al., 2013), covering the presenting complaints, history, formulation and limitations.

### *3.2 Participant*

The participant, referred to as Mr. A, is an adult man of Padang ethnic background (Minangkabau cultural context), whose highest education was senior high school and whose occupation was food trader in the family business. He is Muslim and the second of three brothers. At the time of the assessment he was an in-patient

in a psychiatric hospital. Name, birth date, places and other identifying details have been removed or generalised.

### *3.3 Data Sources*

Two sources of information were used. The autoanamnesis consisted of Mr. A's own account of his complaints, family relationships, work history and the course of his symptoms. The alloanamnesis was obtained from his elder brother, referred to here as Mr. B, a trader who is his biological brother. No psychological tests or standardised diagnostic instruments were administered, and the case material available for this article does not include a formal mental state examination report or a medical diagnosis.

### *3.4 Analytic Procedure*

The case history was first organised chronologically. The material was then read through Jung's structural model (conscious, personal unconscious, collective unconscious, persona and shadow) and through the concept of individuation and the developmental tasks of middle life (Feist & Feist, 2008; Jung, 1966, 1969; Schultz & Schultz, 2017). Each theoretical concept was matched to behavioural and verbal evidence in the history, and the resulting formulation was used to explain the psychopathology. Statements that were not directly supported by data were labelled as hypotheses requiring further assessment.

### *3.5 Ethical Considerations*

The participant was given the pseudonym Mr. A and the family members and institutions were not named. [Authors to confirm before submission: informed consent for publication from the patient or legal guardian and, where required, institutional ethical approval.]

## 4. Results and Discussion

### *4.1 Case Presentation*

*Presenting complaints.* Mr. A was frightened by voices stating that he was guilty of his parents' deaths. He could not control the voices and, when they came, he became angry and threw whatever objects were around him towards their perceived source. He believed that the voices were constantly pursuing him, which made him increasingly fearful, restless and withdrawn. He also withdrew whenever he believed that a group of people gathered together was about to attack and beat him.

*History of the complaints.* After his parents died in 2009, Mr. A began to hear voices saying “you killed your parents.” He did not know where they came from and they grew louder, so that he tried to cover his ears. From then on he shut himself in his room for fear of the voices, and he refused his brother's repeated efforts to coax him out. When the voices came he shouted “it wasn't me… it wasn't me,” covered his ears and threw objects such as glasses and chairs. On one occasion his brother took him for a walk, but on seeing a crowd Mr. A froze, refused to go on, cried out “help… they are going to beat me up,” and ran back into the house. For about two years he continued to live with his brother and sister-in-law in his late parents' house. His family became exhausted by caring for him, particularly because he suspected people who had no connection with them. One night, while he was asleep, the family tied him and took him to a psychiatric hospital.

*Autoanamnesis.* Mr. A is the second of three brothers and had continued his parents' business of selling food in the market. He described himself as very obedient to his parents and inclined to be shy. He started helping his parents after finishing senior high school and never wished to attend university, because he wanted to be

close to his parents and enjoyed working beside them, which also increased his knowledge and experience of trading. He always followed what his parents said and never opposed them. He apologised for every mistake, even for events that were not his fault. His elder brother, also a successful trader, scolded him when he erred and was constantly held up by their parents as a model for Mr. A to follow. As the second son he gave way to his brother.

Mr. A did not dare to start his own business. He knew that he burdened his parents but lacked confidence and worried that he would fail and never become as successful as his brother. His parents repeatedly urged him to be confident and to copy his brother, advice that made him jealous and uncomfortable and that eventually made him angry; he told them that he no longer wanted to work. He stopped working in 2008 and spent his time at home doing nothing. He quarrelled with his parents, who told him that he could not live as well as his brother and that he merely burdened them, unlike his clever and hard-working elder brother. In anger he said, "I will never be as good as Uda; only he can make you happy." (*Uda* is the Minangkabau term for an elder brother.) Soon afterwards his mother became seriously ill; according to his brother, from heart disease. Mr. A was deeply sad and stayed with her in hospital, and then agreed to follow all her wishes, but he still did not dare to open his own business. When the comparisons with his brother resumed, he again became uncomfortable and angry and left to stay with his maternal aunt (*etek*), where he only ate and slept, stayed indoors and had no contact with neighbours. He refused his parents' repeated calls to come home because he did not want to be treated differently from a brother whom he believed he could never match.

When he was told that his mother had fallen ill again he returned home. In early 2009 his mother died and, less than a month later, his father also became seriously ill and died in hospital in February. Mr. A felt deeply sad and guilty for having left home and for having been angry with his parents. He became more silent, refused to talk to anyone and often locked himself in his room. Soon afterwards he began to hear voices saying that he had caused his parents' deaths. The more he covered his ears, the more clearly he heard the voices, which seemed to chase and haunt him. He was afraid to go out because he did not want others to hear the voices and feared they would think he had caused the deaths and would beat or kill him. The voices came every time he remembered his parents' death. Nobody believed him when he said that voices disturbed him, which made him more afraid and more reluctant to leave the house. He shouted and threw things in an attempt to make the voices disappear.

In hospital he was assigned routine activities, such as bathing, cleaning the floor and taking medication, which he did without difficulty. The voices that blamed and pursued him were still present at first, and he was suspicious of the nurses who gave him medication; he believed that nurses sitting together at a table were planning to attack him, and he regarded other patients as people who might attack him if they learned that he was blamed for his parents' deaths. Gradually the voices stopped. However, whenever his brother visited he was reminded that his parents had always been proud of his brother and that he was the child who only caused them trouble until they died, and the voices returned. He withdrew and sat alone on his bed, convinced that staff on the ward would attack him. At the time of this report he still sat alone, stared intently at people around him and occasionally shouted "it wasn't me… it wasn't me."

*Alloanamnesis.* According to his brother, Mr. A was a good child who always obeyed his parents, but he never ranked in the top ten at school and was therefore constantly advised and compared with his brother. He was not sociable, lacked confidence at family parties, and tended to be closed and shy. His brother confirmed

that Mr. A had quarrelled with their parents about remarks that hurt his feelings. The parents had urged him to start his own business, which he refused because he felt unready; when pressed, he said, “I can never do it, because I will never be as good as Uda.” This shocked their mother, and his departure to the aunt's house followed. He returned home only when his mother fell ill.

Mr. B added that when the parents were discussed Mr. A's behaviour changed visibly: he covered his ears, stared into the distance, ran to his room and threw things. For that reason the family never spoke about the parents in front of him, and he was not involved in family discussions about the division of the inheritance, remaining shut in his room. At the end of 2010, when Mr. B brought a signed agreement on the inheritance that needed Mr. A's signature and explained its subject, Mr. A shouted “it wasn't me… it wasn't me,” tore the paper, covered his ears and sat in a corner. His condition worsened; he rarely bathed, ate irregularly and slept poorly, and his shouts of “it wasn't me” were heard almost every day. In early 2013, when the hospital reported that Mr. A had improved, Mr. B visited him. Mr. A looked at him with a sinister expression, then suddenly became frightened, covered his ears and shouted “it wasn't me.” The hospital ended the meeting. Mr. B went home sad, hoping that his brother would one day be as healthy as when their parents were alive.

**Table 1.** *Chronology of Key Events in the Case of Mr. A*

| Period | Event |
|---|---|
| Childhood to school years | Never ranked in the top ten; described as shy, obedient and uncomfortable at family gatherings; advised to follow his elder brother's example. |
| After senior high school | Chose not to attend university and began working with his parents in the family food business. |
| Until 2008 | Declined to start his own business for fear of failing; parental advice made him jealous, uncomfortable and angry; said he no longer wanted to work. |
| 2008 | Stopped working and quarrelled with his parents; mother fell seriously ill; he cared for her, then left for his maternal aunt's home when comparisons resumed. |
| Early 2009 | Mother died; father also became seriously ill and died in February, less than a month later. |
| After 2009 | Began hearing voices accusing him of killing his parents; shut himself in his room, covered his ears, threw objects and feared crowds. |
| Late 2010 | Refused to sign the inheritance agreement and tore the paper, shouting “it wasn't me.” |
| After about two years at home | Tied by his family and taken to a psychiatric hospital. |
| Early 2013 | Reported to have improved, but became frightened and shouted “it wasn't me” when his brother visited; the visit was stopped. |
| At time of report | Sits alone, stares intently at others and occasionally shouts “it wasn't me.” |

### *4.2 Psychogenesis According to Jung's Analytical Psychology*

The case is explained with Jung's analytical psychology, with individuation as the central concept. The personality structure of Mr. A is presented below, and Table 2 summarises the correspondence between each concept and the evidence in the history.

*Conscious (ego).* Mr. A's conscious wishes can be seen in his desire to stay close to his parents, which he realised by working with them. He was willing to keep trading with them because it made him happy and increased his knowledge and experience of trading. In this respect the ego was organised around closeness to, and the approval of, the parents.

*Personal unconscious.* Mr. A felt inferior because his parents constantly compared him with his brother. He remained unconfident about running his own business even though he knew that he burdened his parents, because he feared failing and not becoming as successful as his brother. Repeated comparison, with its associated feelings of inadequacy, envy and anger, can be understood as a complex: an emotionally charged cluster of ideas in the personal unconscious (Jung, 1960; Schultz & Schultz, 2017). Parental advice to "be like your brother" repeatedly touched this complex and produced discomfort, jealousy and anger.

*Collective unconscious.* On the basis of what has been passed down by his parents and his ethnic group, Mr. A was inclined and expected to become a trader with his own business and to be obedient to his parents. The authors read this expectation as a collective, archetypal pattern handed down across generations. It should be noted that such role expectations are also readily explained as cultural and social learning within the family, which is a limitation of attributing them to the collective unconscious.

*Persona.* Mr. A played the part of a child who always obeyed his parents whatever happened, although he wished to be like his brother, who was supported and not blamed. This is visible in the way he followed his parents' words and never opposed them from the time he started accompanying them to trade; he apologised for every mistake and accepted blame even for events that were not his fault. Whether this obedience was genuine or a persona needs to be explored further and supported with additional data such as psychological test results.

*Shadow.* The shadow represents qualities that people do not want to express and try to hide from themselves and others. For Mr. A the shadow contains the impulse to oppose his parents when he felt cornered and offended. When his parents advised him to be confident and to imitate his brother, he became uncomfortable and angry, said that he no longer wanted to work, and felt envious of his brother. In Jung's terms, such unacknowledged hostility and envy were incompatible with the image of the obedient son and therefore remained in the shadow (Feist & Feist, 2008; Jung, 1969).

**Table 2.** *Correspondence Between Jungian Concepts and Evidence in the Case of Mr. A*

| Jungian concept | Evidence in the history | Interpretation |
|---|---|---|
| Conscious (ego) | Wanted to stay near his parents and worked beside them willingly. | Ego organised around closeness to and approval of the parents. |
| Personal unconscious (complex) | Constant comparison with his elder brother; inferiority, fear of failure and jealousy. | A comparison–inferiority complex that parental advice and later the brother's visits repeatedly activated. |
| Collective unconscious | Expected to be an obedient son and an independent trader. | Inherited family and ethnic role expectations (to be interpreted with caution). |
| Persona | Always obedient; apologised even when not at fault. | Compliant persona, to be confirmed with further assessment. |
| Shadow | Anger, opposition to his parents, refusal to work and envy of his brother. | Rejected hostility and envy that conflicted with the obedient-son image. |
| Individuation | Continued dependence on his parents in his middle adulthood; no integration of the psychological components. | Developmental task of middle life unmet; imbalance among components of personality. |

### *4.3 Individuation and the Developmental Task of Middle Life*

Psychological health is achieved when the conscious and unconscious components are integrated into the personality, so that the individual is neither ruled by the unconscious nor by the conscious but is balanced in all aspects (Jung, 1966; Schultz & Schultz, 2017). Mr. A is in the middle-life stage, the period that begins at about 35 or 40 years of age, in which men are expected to release the ego as the main influence on personality and replace it with the Self (Feist & Feist, 2008). Individuation can in principle be achieved at this time.

Mr. A, however, has difficulty at this developmental stage. He has not become free, physically and psychologically, from his parents or found a place for himself in the world, as shown by his continued wish to depend on them. Nor has he balanced all his psychological components so that they can work as a unity. This imbalance among the conscious, the personal unconscious and the collective unconscious is regarded as the cause of psychopathology. The accusation voiced by the hallucinations (“you killed your parents”) came after a period in which the only identity available to Mr. A was that of a dutiful but inferior second son, and after the parents, whose approval organised his ego, were suddenly gone.

### *4.4 Psychopathology: Hallucinations and Persecutory Beliefs*

On the basis of his complaints, Mr. A's psychopathology is marked by delusions and hallucinations and may point towards a psychotic disorder. In psychotic disorders the individual cannot distinguish reality from fantasy, producing a new reality of his or her own, and ego functioning is almost extinguished, so that the person loses contact with reality and develops delusions and hallucinations. These symptoms are, however, consistent with several conditions, and a diagnosis would require a full clinical evaluation, including duration of symptoms, exclusion of other causes and psychological assessment (APA, 2022).

Within the analytical framework, the pattern of the symptoms can be read as the return of an unintegrated complex. First, the content of the voices is not random: “you killed your parents” condenses the guilt that Mr. A felt for having quarrelled with his parents and left home shortly before each of them died. The voices appeared whenever he remembered his parents' death, in the way Jung attributed hallucinations to complexes that are autonomous and charged with affect (Howe et al., 2024; Jung, 1960). Second, the persecutory belief that crowds, nurses and other patients would beat him if they learned that he was to blame can be read as the projection outward of a guilt that the ego could not contain. Third, his defensive repertoire of covering his ears, shouting, throwing objects, hiding in his room and fleeing crowds corresponds closely to what Freeman (2016) calls safety-seeking behaviours; in Mr. A's case the more he covered his ears the clearer the voices became, which suggests that avoidance maintained rather than relieved the experience.

The relapse of the voices during his brother's visit, and his reaction of fear and the cry “it wasn't me” towards the brother and towards the inheritance document, point to specific triggers. Both the brother and the inheritance are tied to the original complex: the brother embodies the comparison from which Mr. A suffered, and the inheritance is bound up with the parents' death. When these cues are met, the complex is activated and the ego, whose function is already weakened, is overwhelmed. In this reading, a distinction emphasised by Incekara and Blom (2024) becomes relevant: the difficulty may lie less in having an anomalous experience than in being unable to contain, understand and share it. Nobody believed Mr. A when he said that he heard voices, and the family avoided talking about the parents in front of him. This silence may have left him without any means of mourning or of giving the experience a meaning, and so reinforced his isolation. In the

cultural frame of his family, the voices were also not read as a form of contact with the deceased of the kind some communities accept (Sabucedo et al., 2023) but as an accusation that confirmed the wrongdoing.

The decision of the family to tie Mr. A and take him to hospital should be understood against a wider background in which physical restraint of people with severe mental illness is a recognised problem in Indonesian communities (Minas & Diatri, 2008). Whatever the pressures that led to it, being tied while asleep is likely to have been frightening for a man already convinced that others wished to harm him.

### *4.5 Clinical Implications*

Several practical implications follow from this formulation, although they remain tentative. First, comprehensive assessment is needed before any conclusion is drawn: psychological tests, a mental state examination, a developmental and family history, and a medical diagnosis would clarify whether the obedient behaviour is a persona and whether symptoms meet criteria for a psychotic disorder (APA, 2022). Second, the Jungian formulation is not an alternative to medical care, and it can be combined with pharmacological treatment and with cognitive approaches that target the maintaining factors identified by Freeman (2016), such as avoidance and low self-confidence. Third, psychoeducation and family work could help relatives talk about the parents safely, reduce comparison between siblings, and replace restraint with supportive care. Fourth, therapy could help Mr. A to name and mourn his parents, to recognise his anger and envy as part of himself, and to take the first steps towards an identity that does not depend on his brother's success or his parents' approval, which corresponds to the task of individuation.

### *4.6 Limitations*

This study has several limitations. It is a single case and does not allow generalisation. The information came only from the patient and from his brother, who was himself part of the comparison that is central to the formulation, and the data do not include psychological test results, a mental state examination report or a formal diagnosis. The analysis is theory-driven and interpretive, and Jungian constructs such as the collective unconscious and the shadow are difficult to test empirically; alternative explanations, including cultural, cognitive and biological ones, cannot be excluded. The treatment course and outcome were not followed. Future work should combine the analytical formulation with standardised assessment and a longitudinal follow-up.

## 5. Conclusion

From the perspective of Jung's analytical psychology, the difficulties of Mr. A can be understood as the outcome of a comparison–inferiority complex formed in a family that constantly held up his elder brother as a model, a compliant persona that hid a shadow of anger and envy, and an unfinished process of individuation. The deaths of both parents, shortly after he had quarrelled with them and left home, confronted an ego that was unable to bear the resulting guilt, which then returned in the form of accusing voices and the projected fear of being beaten by others. The formulation gives a meaningful account of the content and the triggers of the symptoms, but it is based on limited data and must be tested against a full assessment.

Clinicians working with similar cases are encouraged to explore the personal meaning of symptoms and the family context in addition to establishing a diagnosis, to involve the family in grief work and psychoeducation, and to avoid restraint wherever possible. Future research should examine the integration of

analytical formulations with standardised assessment and with cognitive and pharmacological approaches in culturally diverse settings.

**References**

American Psychiatric Association. (2022). *Diagnostic and statistical manual of mental disorders* (5th ed., text rev.). https://doi.org/10.1176/appi.books.9780890425787

Crowe, S., Cresswell, K., Robertson, A., Huby, G., Avery, A., & Sheikh, A. (2011). The case study approach. *BMC Medical Research Methodology, 11*, Article 100. https://doi.org/10.1186/1471-2288-11-100

Feist, J., & Feist, G. J. (2008). *Theories of personality* (7th ed.). McGraw-Hill.

Freeman, D. (2016). Persecutory delusions: A cognitive perspective on understanding and treatment. *The Lancet Psychiatry, 3*(7), 685–692. https://doi.org/10.1016/S2215-0366(16)00066-3

Gagnier, J. J., Kienle, G., Altman, D. G., Moher, D., Sox, H., Riley, D., & the CARE Group. (2013). The CARE guidelines: Consensus-based clinical case reporting guideline development. *Global Advances in Health and Medicine, 2*(5), 38–43. https://doi.org/10.7453/gahmj.2013.008

Howe, A. J., & Demjaha, A. (2022). An analytical psychology conceptualisation of psychosis in modern psychiatry. *International Journal of Jungian Studies, 15*(2), 187–206. https://doi.org/10.1163/19409060-bja10027

Howe, A. J., Demjaha, A., & Lu, K. (2024). Auditory hallucinations in non-psychotic disorders: An analytical psychological perspective. *Psychoanalytic Psychotherapy, 38*(3), 209–215. https://doi.org/10.1080/02668734.2024.2367432

Incekara, F., & Blom, J. D. (2024). Carl Jung: A life on the edge of reality with hypnagogia, hyperphantasia, and hallucinations. *Frontiers in Psychology, 15*, Article 1358329. https://doi.org/10.3389/fpsyg.2024.1358329

Jung, C. G. (1960). *The psychogenesis of mental disease* (R. F. C. Hull, Trans.; Collected Works of C. G. Jung, Vol. 3). Princeton University Press.

Jung, C. G. (1966). *Two essays on analytical psychology* (2nd ed.; R. F. C. Hull, Trans.; Collected Works of C. G. Jung, Vol. 7). Princeton University Press.

Jung, C. G. (1969). *The archetypes and the collective unconscious* (2nd ed.; R. F. C. Hull, Trans.; Collected Works of C. G. Jung, Vol. 9, Part 1). Princeton University Press.

Minas, H., & Diatri, H. (2008). Pasung: Physical restraint and confinement of the mentally ill in the community. *International Journal of Mental Health Systems, 2*, Article 8. https://doi.org/10.1186/1752-4458-2-8

Rees, W. D. (1971). The hallucinations of widowhood. *British Medical Journal, 4*(5778), 37–41. https://doi.org/10.1136/bmj.4.5778.37

Sabucedo, P., Evans, C., & Hayes, J. (2023). Perceiving those who are gone: Cultural research on post-bereavement perception or hallucination of the deceased. *Transcultural Psychiatry, 60*(6), 879–890. https://doi.org/10.1177/1363461520962887

Schultz, D. P., & Schultz, S. E. (2017). *Theories of personality* (11th ed.). Cengage Learning.