The MBTI instrument® – a psychotherapeutic template for "normal"?

by Sophia Dunn, MSc, Clin.Dip.Psych.

Most psychotherapeutic models avoid defining "normal", presumably because of the risk of pathologising unnecessarily, but also because of the overwhelming complexity of such a task. As a result of this avoidance, by 'default', many models of psychotherapeutic care appear to assume that a person is a blank slate upon which events and primary caregiving etch the shape of the personality. I call this the "invisible blank slate assumption" upon which some models of skilled psychological help rest. Seeking to avoid discussion around the notion that aspects of personality or temperament may be innate and associated thorny ethical issues, many models tend to infer by default that we are all (potentially) the same.

In discussing ideas with colleagues, I am puzzled that while they often see the MBTI® instrument as 'categorizing people into sixteen little boxes' (they seem very big to me!), such arguments fail to see the corollary of the criticism, namely, that everyone should end up in one big homogenous box.

Some models, notably the Jungian understanding (from which the MBTI® theory and instrument have been developed) together with many humanistic models, see the goal of therapy as 'individuation' or 'self-actualisation' - psychological growth - rather than the restoration of 'normal' from 'abnormal'. For me this is both more accurate, and more humane. Even so, avoiding the discussion of normal/abnormal doesn't make the issues go away.

There are few issues in the area of clinical mental health where the notions of normal/abnormal generate more controversy than around the diagnosis and treatment of personality disorder. Indeed, many clinicians deny the existence of personality disorder altogether, either because of the powerlessness it generates in the helper, or because of collusion with the patient's world view, or simply, as it's been explained to me by one psychiatrist, because the personality disorders represent a constellation of symptoms not amenable to treatment with drugs. Whatever the reason, the denial of the existence of the disorders is always framed as a kindness. For me, this is about as kind as denying the existence of epilepsy.

For well over a decade now, I have been involved in the treatment of people diagnosed with personality disorder, and have juggled the controversy. The business of diagnosis itself faces the normal/abnormal question head on. For want of a better way of doing it, various systematic descriptions of "abnormal", such as those offered by DSMIV(R)™[1] or the ICD-10©[2], are employed by psychiatrists to describe the features of psychological difficulty. There has been much criticism of these diagnostic systems, both from within and without the profession, most of it justified. The 'medicalisation' of psychopathology has created as many thorny problems as it has solved, and has created as much casualty as it has enabled healing. Both critics and proponents of diagnostic categorisation seem to conclude that it is a messy, sometimes ugly, but often necessary tool.

For the past three years, I have systematically used the MBTI® instrument as part of my interventions, both with the personality disordered population and those who present needing other sorts of help, from in-depth therapy to management coaching, and have over time, found it as or more useful than any other single tool in my kit.

Quite simply, the MBTI® allows me to approach the "abnormal/normal" question from the other direction. Over three years of full time clinical use with every patient save those who have shown symptoms of psychosis, on only two occasions have I noted any change in MBTI® questionnaire results from the beginning of therapy to those seen three months after the completion of therapy. In both cases where there was a change, the change was minor; in one case, a woman with a very unclear preference for Feeling showed a clear preference for Thinking three months after finishing, and in another instance, a man showing an unclear preference for Introversion at outset, showed a clear preference for Extraversion at completion. While these changes are within the range of change seen in the general non-clinical population, it seemed clear to me in both cases that the level of self-acceptance and self-awareness generated by the work of therapy allowed each person to see themselves in a slightly new, previously less than acceptable way.

Use of the MBTI® with the personality-disordered population would seem by its nature inadvisable. Surely if a person is troubled by a "disorder of the personality', a psychometric instrument designed to quantifiably describe the personality should be useless. Not so. In my practice I have discovered that a person diagnosed with borderline personality disorder who shows clear preference for INFJ (for instance) before therapy, almost inevitably shows clear preference for INFJ after therapy, despite considerable positive change in their level of disturbance as measured by well known instruments designed to measure depression, anxiety, and personality disturbance.

This may sound simple and straightforward but it may, in fact, offer something akin to a "template for normal" – a tool that psychotherapists have never really had. More importantly, I have found that it allows (me) the therapist to tailor interventions in a unique and individual way, guided by something more than experience and intuition.

This is no small gift. As a simple example – if a person presents and is described in referral as having "social phobia" , I will begin my exploration of this person's world in a very different way if I know that he prefers Introversion than if he indicates a clear preference for Extraversion. In the first instance, I would explore what a need for solitude and introspection mean for him, how this meaning has grown and developed, paying special attention to any negative constructions he may have learned from peers, teachers or family, or some fear that the person has developed on their own around the business of inner reflection. In some cases, people have felt they were "mad" when they entered their inner world, and that to do so was dangerous or "crazy". In other instances, I have discovered that people with a preference for introversion have been clearly taught that their preference is wrong, "weird", "abnormal", "spooky". In several cases like this, I've uncovered a childhood history in which the introverted child is positioned as "sick" and sent for psychological evaluation for a "failure to socialise", simply because the child enjoyed solitude. In such cases, therapeutic exploration and sharing around the healthy, normal, happy and satisfying expression of an introverted preference can and has had a sudden, breathtaking effect. I have watched it facilitate such powerfully positive change in the person's view of themselves, that I am always moved.

In the second instance, I would explore why the person with the preference for Extraversion was so reluctant to express it. Such a problem is equally moving, but from a different direction. Extraverts need tiny signals from the outer world all the time in order to know how to relate to it. I see the "chatting" introverts often find superfluous as a kind of "tuning fork", with which the Extravert defines her or his position relative to the outer world. An inability to orient him or herself in this way leaves the Extravert feeling "lost", often "wrong", depressed, anxious and socially displaced, without proper access to validation.

For an Extravert, social fear is an emotionally, psychically, spiritually and intellectually (as well as socially) crippling problem. Social phobia prevents the Extravert from forming an adequate understanding of "self-in-the-world" and I would need to find out how the

problem was structured, what it was protecting and how it arose. Is the person fearful? If so, of what? Is it an anxiously expressed preference for Extraverted Feeling? A fear of criticism or exposure of incompetence in a person with a preference for Thinking? Did the person grow up in a household where Extraversion was seen as "pushy"or "loud"? Or is it something developmental as is almost always true of those tortured by personality disorder – a learned terror of rejection, criticism, abandonment or abuse. This can often manifest in either a neurotic expression of preference (over-anxious Fe, or hyper-blaming Ti or Te) or a learned suppression of extraversion itself.

Even in this short and simple example, I hope I have managed to invite all those in a therapeutic role to consider how the use of the MBTI® might inform their care and intervention. While there is not a wealth of guidance on this in the MBTI® literature, certainly Judith Provost's Applications of the Myers-Briggs Type Indicator in Counselling: A Casebook (CAPT, 1993) and the Flex System© (especially FlexCare© and FlexTalk©) developed and produced by Judy Allen and Susan Brock (CAPT 2002) have provided me with valuable insight in the use of the MBTI® as a therapeutic tool.

I invite anyone who is interested in this or similar use of the MBTI® or has a story to tell in this regard to contact me – sophia@bridgepsych.com - I would be delighted to hear from you.

Notes:

1 DSM-IV®™ is a trademark of the American Psychiatric Association, and refers to the *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition (Revised). Washington, DC: American Psychiatric Association, 1994.

2 ICD-10© refers to the *International Statistical Classification of Diseases and Related Health Problems*, 10th Revision, as published by the World Health Organisation in conjunction with the German Institute of Medical Documentation and Information. 1994/2006.

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