Temperament and Psychiatric Illness

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The greatest mistake an analyst makes is to assume that his patient has a psychology similar to his own. *Carl Jung*

The purpose of this paper is to present a concept which can be used in Orthomolecular psychiatry to assist the patient in getting the best that the field has to offer. It is not a new Orthomolecular treatment; rather it is a discussion of a technique which enables patients and families to take full advantage of treatment. This method is also consistent with the field's interest in objective measurement, and an attempt is made to outline the importance for psychiatry of the measurement and understanding of temperament.

Psychiatric illness is assessed in terms of pathology, and the aim of treatment is a return of the patient to normality. It is necessary, therefore, to know what the patient is like in the absence of illness. We have excellent ways of mapping out pathology of illness using the Hoffer-Osmond Diagnostic Test (HOD) and the Experiential World Inventory (EWI), as well as numerous other measures. It has been uncommon until recently, however, to measure the temperament aspect of the patient's makeup, to know what he or she is normally like, to know how normal temperament changes with illness, and to understand interactions among patients and therapists of different temperaments.

There has been a lack of attention in psychiatry to the normal temperament of patients, perhaps because no good measuring device, and therefore no scientific standard for normality, has been available. Previous attempts to correlate illness and personality have concentrated on self-report variables and correlation of psychiatric illness with certain personality traits such as dependency, orality, and neuroticism (cf. Parker, 1980). Some studies have found other personality variables which are associated with psychiatric illness, especially depression. For example, Altman and Wittenborn (1980) found that 50 percent of items on a self-descriptive inventory discriminated between women who were

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depression prone and a group of controls. Neurotic and psychotic depression were differentiated by scores on a personality measure in a study by Pilowsky (1979). Mendelsohn and Kirk (1962) reported that client groups were more intuitive and somewhat more perceptive than non-client groups, and Dewinne and Johnson (1976) found that extroverts were significantly over-represented in a small sample of drug abusers. Studies of this kind are beset with difficulties, primarily those of defining illness, measuring personality, and making personality variables quantifiable so that they can be related to psychiatric illness. Thus it has been difficult to consider temperament as an important variable in the study of psychiatric illness.

The current edition of the Diagnostic and Statistical Manual for Mental Disorders (DSM-III) does attempt to allow for the diagnosis of both psychiatric conditions or mental illnesses as well as personality disorders, through the use of the multi-axial approach. This manual differentiates between personality and illness, thus allowing patients to have both a personality disorder and a psychiatric illness. DSM-III does, however, concentrate only on pathology and makes no attempt to measure normal temperament.

Fortunately, we now have a relatively simple measure of temperament, the Myers-Briggs Type Indicator (MBTI). Despite its flaws in some areas, the instrument is valuable because it has been the subject of enormous amounts of research and has very reliable norms for normal populations. For example, Isabel Briggs Myers studied 12,000 medical students and their specialties and related these findings to the personality types of the students (Myers, 1962, 1975). The Myers-Briggs instrument has not as yet been applied widely with psychiatric patients, but we have started to do so and can now investigate various patient groups with this inventory. Some research has been done with the MBTI to determine the types of persons seeking counseling (Mendelsohn and Kirk, 1962), and attempts have been made to correlate temperament with various scales on the MMPI (Carskadon, 1979). No clear-cut results have been found so far with this type of study and no work has been reported with actual psychiatric patients.

TYPE AS MEASURED BY THE MBTI

The Myers-Briggs Type Indicator was developed by Isabel Briggs Myers and Catherine Briggs, based on the theories of Carl Jung. The indicator is a multiple-choice instrument yielding results which compare individuals on four dimensions, three of which were outlined by Jung and the fourth added by Myers. These dimensions are as follows:

Introversion-Extroversion: This dimension indicates the extent to which the person turns his or her energy to the outside world toward people and things (extroversion) or to the inside to personal considerations, ideas, and concerns (introversion). For example, an introvert entering a room full of people will do his personal, internal work first, thinking or feeling how the situation is affecting him, and then will turn attention outward and be sociable. The extrovert will enter the room and do the external, social work first, greeting people and making conversation, and later retreat into her inner feelings and thoughts.

Sensing-Intuition: This dimension reflects the extent to which the person is concerned with facts, sensation, and tangible reality (sensing), or with possibilities and relationships (intuition). For example, the sensing person, when reading a book, will pay close attention to details presented in the book and have a good memory for the details, whereas the intuitive person will use the elements of the book for making ideas and associations. Intuitive persons sometimes do not finish a book, feeling in the early parts that they have "got the idea."

Thinking-Feeling: The preference for making decisions and arriving at conclusions through logical, impersonal, rational thought processes is characterized as thinking. The process of making decisions through comparison to personal values and what is important to the person is thought of as feeling. When making a decision, the thinking person will outline and examine all alternatives, weighing the pros and cons and consequences of each alternative and make a decision based on the outcome. The feeling person will decide based on what will

make him and others feel a certain way, and what is consistent with his personal values.

Judging-Perceiving: This dimension reflects the extent to which the person likes a routine, planned, and orderly lifestyle and can make decisions with relative ease (judging) or likes a flexible, spontaneous lifestyle and prefers to leave decisions open as long as possible for new information to come in (perceiving). The judging person often has her Saturday morning planned, makes a list of things to do, and checks them off as they are accomplished. The perceiving person prefers to wait until Saturday morning and then see what comes along that he or someone else would like to do, a "roll with the flow" sort of outlook. These four dimensions, called preferences, combine to form sixteen types of four letters (preferences) each. For example, the designation ISTJ refers to a person who prefers introversion, sensing, thinking, and judging. These preferences are shown in Table 1.

Jung originally wanted to study differences between himself, Freud, and Adler, and to show that different types would develop different theories. He ended up, however, with a theory of intrapsychic conflict that does little to help people understand each other and appreciate people of other types. The theory is excellent for individual therapy, but has limited utility for the study of interaction. Persons working extensively with the MBTI have recently, however, begun to apply the indicator

Table 1
The Types

		STRUCTURALS Sensing-Thinking Thinking-Sensing	EXPERIALS Sensing-feeling Feeling-Sensing	OCEANICS Intuitive-Feeling Feeling-Intuitive	ETHEREALS Intuitive-Thinking Thinking-Intuitive
Introverts	Judging	ISTJ	ISFJ	INFJ	INTJ
	Perceptive	ISTP	ISFP	INFP	INTP
Extroverts	Perceptive	ESTP	ESFP	ENFP	ENTP
	Judging	ESTJ	ESFJ	ENFJ	ENTJ

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help people learn to understand people of other types, and this field shows great promise.

UMWELT THEORY

Dr. Humphry Osmond and colleagues did further work with Jung's theory, taking a slightly different tack from that taken by Myers and Briggs. They developed Umwelt or self-world theory, believing that each of the temperaments has a special world view or way of perceiving the world and consequently of behaving. This theory was inspired by Von Uexkull's notion of a time-space bubble, and umwelts or self-worlds which can be related to other self-worlds. Osmond, Seigler, and Smoke (1977) named the four main types as follows, with the other dimensions outlined by Jung and Myers used as "fine tuners" of the umwelt.

Structural (sensing-thinking): referring to this temperament's proclivity for building structures, including bridges, buildings, and theories and systems. The structural takes in factual information through the senses and organizes it into a structure, using thinking to assess and construct the system of data.

Experial (sensing-feeling): referring to this temperament's characteristic of experiencing everything, remaining in the "here and now" and basing decisions and learning on experience. The Experial also takes in information through the senses, but unlike the Structural, perceives the feeling climate, cultural mores, and customs and preserves these. These "feeling facts" are evaluated and stored, related to personal and social values.

Ethereal (intuitive-thinking): referring to the characteristic of this type to be concerned with possibilities and relationships in the realm of fact and to be always ethereally concerned with theory and the future. The Ethereal uses facts in a very different way from the sensing types, as springboards for ideas about what could be rather than what is, how different facts might be related, and what might be the implications of the facts for the future. Ideas are organized and evaluated rationally and with detachment.

Oceanic (intuitive-feeling): referring to this temperament's view of the world as a seamless whole, flowing and changing like the ocean. This temperament also concentrates on possibilities and relationships, but these are perceived and dealt with in the feeling realm, and great involvement and commitment are characteristic.

For purposes of this discussion, it is not important that the reader get a full grasp of the theory, but simply to realize that distinct differences in temperament do exist, and that they can be quantified and discussed in a common language. The temperaments have definite interactions with and application to Psychopathology. For a full discussion of these theories, the reader should consult the MBTI manual and papers, and the paper by Osmond, Seigler, and Smoke entitled **Typology Revisited.**

TEMPERAMENT AND PSYCHOPATHOLOGY

We have recently begun to apply the concept of temperament as it relates to psychiatric illness, and have conducted a series of research studies attempting to relate these two variables. The primary study involves 372 male and female psychiatric patients in two settings, a small private psychiatric hospital and the psychiatric wing of a community general hospital. Patients were given the MBTI as part of their initial battery of psychological tests upon entrance to the psychiatric treatment unit. We compared the MBTI results with the psychiatric diagnoses given by the attending psychiatrists. We measured the temperaments of the overall patient group, and subsamples of patients diagnosed with depression, schizophrenia, substance abuse, and bipolar manic disorder. We also compared these groups of patients to a normal population of 10,000 high school students.

Our research has shown that the temperaments are variously represented within groups of psychiatric patients and that some temperaments are more prevalent among the patient groups than among the normal population. The following are primary findings of this study:

(1) There is a prevalence of ISFJ, ISFP, and ISTJ types (Experials and Structurals)

in the overall patient sample and also in the depression and schizophrenia sub-sample groups, and these types are more highly represented among patients than among normals.

(2) Extroverts are more highly represented among the bipolar manic patients than among other patients. There is also a prevalence of intuitive-feeling and intuitive-thinking patients (Oceanics and Ethereals) in this sub-group as compared to other patients. There are two to three times as many intuitives as in the normal population.

(3) Compared to the overall patient population, substance abuse patients are more characterized by extroversion.

(4) Of the overall patient sample, sensing-feeling persons (Experials) accounted for 55 percent; sensing-thinking (Structurals) accounted for 30 percent; intuitive-feeling persons (Oceanics) accounted for 9 percent; and intuitive-thinking persons (Ethereals) accounted for 6 percent. Introverts and judging persons were generally more prevalent than were extroverts and perceiving persons.

In considering possible reasons for these findings, it may be that the characteristics or experiences of having mental illness and being hospitalized cause patients to answer the test so that they score in certain ways. For example, the introvert type is characterized by comtemplative turning inward, and perhaps hospitalization leads a person to answer the test in such a way as to score as an introvert. The sensing person is concerned with realities and sensory data and it is possible that having an illness and being hospitalized prevents the person from being concerned with anything other than reality. The patient may answer as a feeling person because of making decisions based on personal judgment, and this might be his only concern at the time of hospitalization.

On the other hand, perhaps persons of different temperaments are constitutionally more prone to develop certain kinds of illness and there may even be an organic basis for both temperament and illness. There is much well established and emerging information to indicate that there are brain and other body substrates for a variety of characteristics such as sex differences, aggressiveness, handedness, and many other traits. The biological basis and differentiation of both temperament and illness may be close to elucidation and on the way to being discovered through biological, psychological, and social research.

Questions such as these await further research for answers and whatever the findings, they will be important in their implications for treatment. We do know, however, that temperament is manifested in a number of ways, one of which is attention to sensory data such as time, another of which is attention to feeling data vs. factual data. Some temperaments attend to information for its own sake and others prefer information or data as "grist for the mental mill." Thinkers appear to be very good at developing delusions, especially Structurals, who like to build systems and are able to take sensory data provided by hallucinations and build very tight delusional systems. Sensing people may tend to be very disturbed by bodily perceptual changes, and intuitives can find ingenious ways to manifest their illness in hyperactivity and grandiosity.

IMPORTANCE OF TEMPERAMENT FOR PSYCHIATRIC PATIENTS

Temperament is an important consideration in illness for a number of reasons having to do with the patient, family, and treatment persons, as well as interactions among all these persons.

(1) Various illnesses may manifest themselves differently in persons of different temperaments. Some illnesses may appear as an extension of normal temperament, and some may depart widely from the person's normal experience and behavior. In the case of subclinical illness, biological anomalies may not show themselves as illness in persons well defended against these but may show up in others. Some illnesses may be ego-syntonic and others ego-dystonic. This concept is illustrated by the case of an Ethereal (intuitive-thinking) attorney with a diagnosis of bipolar manic disorder. In his normal state he often engaged in expansive and grandiose behavior to a certain degree, being rather active and flamboyant. When he became ill with a bipolar manic disorder it was a long

time before his family and friends were able to distinguish his illness from normal behavior. His illness appeared to be simply an extension of his normal extroverted, active, imaginative and expansive behavior. It is very possible that John Hinckley is an introverted Ethereal (intuitive-thinking) whose normal behavior includes rumination, quiet thought and planning, and that he has eluded treatment for so long because his illness did not show itself readily. In both of these cases, the illness is ego-syntonic, and therefore escapes notice until it is well established. In a person in whom the illness is ego-dystonic, however, it may come to immediate notice because it produces both experience and behavior radically different from that normally shown by the person.

(2) Persons of different temperaments will respond differently to the experience of illness and to hospitalization, and will require different kinds of support. For example, a feeling person is very likely to be most appreciative of a good bedside manner, whereas the thinker is likely to value technical competence above all else. The feeling person may respond well to peer pressure and the pressure of authority and become a responsible patient through adherence to cultural mores and the influence of rules. The thinker may require logical convincing about the advantages of fulfilling the rights and duties of the sick role, and the disadvantages of its neglect. A sensing person may be extremely disturbed about perceptual changes in the body, brought on by a schizophrenic illness, whereas the intuitive might either not notice the sensory changes, or find them interesting and not very disturbing.

(3) People of different temperaments will respond in divergent ways to therapeutic moves of various types. Temperament can be a good clue as to the ability of the patient to tell the therapist about feelings or sensory changes, and may suggest the extent of the patient's ability to learn and maintain roles. The sick role, for example, requires learning and following a set of rules and principles, which are more or less easily learned and adhered to depending upon temperament. It is even possible that various pharmacologic agents may affect patients of different temperaments in different ways, especially if we later discover that temperament and Psychopathology both have a common organic basis. Temperament may well turn out to be as good a measure as anything of the things to which a patient will respond best. A good example is the response of different patients in patient education. Some types of patients want a great deal of technical information and explanations, whereas others will want primarily emotional support and feel little need for information in great detail. There is some research to indicate that some types of patients respond better than other types to such therapeutic approaches as rational behavior therapy. Some patients are temperamentally more suited to group approaches, while others much prefer individual work. Knowledge of temperament is therefore very important in making a choice of treatment.

(4) Research has shown that professions of various kinds attract widely varying concentrations of the temperaments, including medicine, nursing, psychology, and psychiatry. It is important, therefore, for the treaters to know where they stand temperamentally as compared to their patients. Therapists and patients who are similar in temperament interact very differently from those who are temperamentally divergent. Treatment persons of different types will also possess therapeutic abilities to varying degrees, and will prefer different techniques.

For example, the thinking person is more likely to use technology in treatment and to take a scientific approach, whereas the feeling person will be more able and likely to use empathy and emotional support. It is extremely important to recognize these issues when interacting with various patients. Lack of knowledge of the patient's typology not only makes misdiagnosis more likely, but it makes it probable that mis judgements will be made on the basis of those typological errors. We have growing evidence that many patients form a much better relationship with those who pay attention to their temperaments.

(5) Finally, families are made up of persons with very different temperaments, and the patient and other family members may be either very similar or totally unalike. Interactions of family members can be very important in treatment and in the beginning

in recognizing illness. This can be an important consideration in understanding family dynamics and in enlisting the aid of the family in monitoring and managing the illness. Knowledge of typology of family members can account for many of the differences that two parents, for example, may have in their ideas about how to handle the ill person in the home. One parent may be supportive and resist any attempts to apply strict controls to the patient, while another may be very good at setting limits and enforcing family rules, but have little ability to provide emotional support. Knowledge of temperament of patient and family can give clues to possible difficulties the family is likely to have, and to suggest which members of the family may be better at carrying out the various parts of the treatment program.

USING TEMPERAMENT IN PSYCHIATRIC TREATMENT

This research is only a beginning of the investigation of the interactions of illness and temperament. Much remains to be discovered about these interactions so that we can begin to take both normal temperament and illness into account. In an ideal state one would have a Myers-Briggs test and an EWI of a patient when ill, followed by similar tests in various stages of illness. The results of both tests would then be related to behavior. Our goal would be to have a series of studies relating illness to typology so that we could gauge just how normal temperament is distorted by a particular illness. We would then choose a treatment that is most effective for the person's temperament, within the choices available for each illness, including an assessment of patient education needs. The therapist would be cognizant of his or her own temperament and how it interacts with that of the patient, and the temperaments of family members would be assessed and the varying abilities of each utilized in the management of the patient's illness. While we are some distance from the ideal state in which illness, temperament, and their interactions are used in all phases of treatment from assessment through therapy, treatment monitoring, and follow-up care, we have made some progress in these areas, and work is continuing to make these considerations everyday events.

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Readers who are interested in using the MBTI may obtain further information from the Center for Application of Psychological Type, 414 Southwest 7th Terrace, Gainsville, FL 32601.