Difference in the Therapeutic Mirror

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

As a clinician and executive coach, I am delighted to be asked to represent those with an interest in using the MBTI® clinically for TypeFace. I hope that this new Special Interest area will provide a forum for comment and discussion amongst clinicians of all sorts – counsellors, psychotherapists, psychologists, and other health professionals -- who find the MBTI®'s offer of psychological understanding of difference useful to their practice.

I was first introduced to the MBTI® about fifteen years ago. I was then a marketing executive and completed the inventory at a professional conference. I remember being both fascinated and horrified by the process, finding it both insightful and unexpectedly invasive. In the first instance, the convenor failed to explain the attitude of Introversion properly. (I now understand that he also failed to explain the whole notion of 'preference' properly, as well as other important things.) I remember, that for a moment, all I could hear was the word, 'Introvert' and suddenly felt as if I had been 'exposed' for the withdrawn, isolated, 'nerdy' girl I once had been. At that time I felt myself to be a competent, successful 35-year-old professional, thoroughly enjoying both my work and my place in the world. For me, being told that I was an 'Introvert' meant quite simply that I had failed at my significant efforts of building social skill and facility; that all my work with groups of people – training, managing, team building --- were a farce. Without a more clear, MBTI® or Jungian-based understanding of the word 'introvert' I simply took its social, vernacular meaning to heart. I was unprepared for this 'eruption of my inferior function' in a work context. I remember taking my book and my profile down to the pool area of the sumptuous resort, putting my sunglasses on and struggling with tears.

At the time, it was fairly devastating. When I look back on it now, I see it as very helpful. Every time I introduce the MBTI®, I momentarily cast my mind back to that first experience. It reminds me of the care I must take to safeguard the subjective experience of personality and provides a clear reminder of the dangers of imposing the MBTI®.

But the experience also fascinated me. I recall as I recovered from my emotional reaction, my dominant function (Ti) seemed to 'right' itself and take charge. I wondered, 'How can a questionnaire, however sophisticated, uncover and quantify so easily those things about my nature which I have spent twenty years trying to change, modify, and failing this, hide?'

I took my sunglasses off and looked at my profile again. Actually, the way it described me was quite nifty. It was true enough to be spooky, but looking at myself the way the profile described me, I began to warm to those characteristics I had always disallowed in myself. Having missed one conference seminar, I decided to go to the evening cocktail party and see if I could unearth another INTP. I did. He was the company Chairman. Meeting each other that evening through the lens of Type was a delightful and validating experience.

The seed had been sown. Now, fifteen years later, I see myself as halfway through a second successful career as a psychotherapist, supervisor and trainer. For the first years of my therapeutic career, I did not use the MBTI®, although I was fortunate enough to have a supervisor during my training who was interested in its use. In the last two years, I have begun a program of giving the inventory to every patient, every student, every supervisee. I have encouraged the other therapists in my clinic to qualify, and wonderfully, several of them have.

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The MBTI® has much to offer the clinician and the patient. First, it offers a benign and positive 'starting point', a glimpse of the way things might look for a person if all was going well. It also offers an initial opportunity to look away from the problem that has brought the client to therapy, and toward the areas of a person's being in which they experience themselves enjoyably and with confidence. The patient stops being a problem, and becomes, more realistically and less damningly, a person with a successful personality – who also has a problem. This is a very different place to begin. Vitally, the MBTI® provides a non-pathological, growth-oriented starting point. If kindly and carefully administered, it can offer even the most distraught and self-destructive person a place where they can begin to give themselves permission to be as they prefer. This was the self-to-self process that started for me that afternoon by the pool. At the time, I had not had nor felt I needed therapy. But as I look back, I realise that that moment was the very first time in which I experienced self-to-self relationship that was non-adversarial.

Many people fight themselves much of their lives. Many of the qualities of self they battle against are not at all harmful or 'bad' in themselves, but are experienced by the person as undesirable, invalid, in conflict with family, culture, work, spiritual or peer group expectations. We learn early on to be self-critical, to seek out and compare ourselves with societal norms, and often when we find ourselves different, we begin to see ourselves as 'abnormal', and this in itself can create a problem. The yardstick we measure ourselves by does not accommodate normal personality difference.

So the MBTI® provides the mental health clinician with much more than a starting point. For while there are therapeutic models (many of the humanistic models, for instance) which do not address psychological suffering in terms of what is wrong with a person – neuroses, psychopathology, complexes –– neither do they frame or name what is right with a person. From my point of view, regardless of how a therapist approaches providing clarity or solutions to a problem, to be able to speak to a person about how they prefer to be enables a kind of respectful accommodation that no other therapeutic tool I have used has ever done quite so well.

As a therapist, it allows me to begin with something much less threatening (and potentially self-damning) than the problem. It allows me to take a look and see how the organisation of a person's life suits their type-necessitated needs. Are the needs associated with their preferred attitudes and functions being adequately met? If extravert, does the person's work and social life provide enough opportunity for satisfying extravert validation? If intuitively preferenced, does the person's work require a lot of attention to undifferentiated detail? Is the work too concrete, not providing enough opportunity for the exercise of imagination? If the person is perceiving preferenced, is their life too structured, too routine? And so on. Often this first look at how the life suits the person's preferences reveals directly a great deal about how the presenting problem arose.

For those of us who use an analytically based model, the MBTI® provides a non-blaming way of looking at developmental difficulties. What events and environmental factors in the person's life encouraged and supported the development of their preferred attitudes and functions, and what prevented their optimum growth and development? Answering these questions near the outset of therapy allows us to identify developmental deficits, and points the way forward toward an understanding of how certain preferences came to be constricted or undifferentiated. Such developmental obstacles and the resulting rigidity in the expression of the preferred attitude or function can sometimes point directly to why a certain difficulty arose, and can also illuminate the negative self beliefs that can arise when a person is actively prevented from expressing a preference. Non-acceptance and critical disapproval of a preferred way of being can result in internalised non-acceptance, which in turn allows for the 'splitting off' of 'parts' of the personality that

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are disallowed. This can in turn surface in symptoms as diverse as dissociation, eating disorder, somatic difficulties, obsessive or compulsive problems, addictive behaviours and so on – in which the person self-destructively 'acts out' the preference in a dysfunctional way.

I was trained in the use of existential, Rogerian, cognitive and analytic tools. For me, the MBTI® has offered a fresh, intelligent and respectful way to structure and use my familiar therapeutic tools. Importantly, it provides me with a new way to lean kindly and intelligently 'forward' to meet my patients where they are.

I encourage all of you who use the MBTI® in a clinical context to contact me and share your experiences. I am especially interested to hear from those who would like to contribute something to this space --- an article, an insight, a case history. I can be contacted by email at Sophia@bridgepsych.com.

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Sophia Dunn is a clinical psychotherapist based in London. Along with her husband, Mark Dunn (INTJ), Sophia heads a small private psychotherapy clinic, The Bridge, and its executive coaching arm, iPsych. Having trained, worked and taught for the past ten years in the area of personality disorder within NHS, Sophia is currently involved in the development of an MBTI® based model of clinical psychotherapeutic treatment. Email: sophia@bridgepsych.com.