EFFORTS TO CLASSIFY the psychotherapies have been in part prompted by the need for a more scientific approach to therapeutic assignment than is now the case. A. H. Maslow comments on this problem:

One way of summarising my impression of these therapeutic groups in relationship to individual psychotherapy is to come back to the old conclusion that many have come to that it's senseless arguing about group therapy versus individual therapy. For one thing, there are many kinds of each serving different purposes, different kinds of people, and so on. Secondly, they do have different functions in certain respects, and so our question then transforms itself into for what problems, under what kinds of circumstances, for what kind of people, for what kinds of goals, should we use what kind of group therapy or what kind of individual therapy, and in what combination or alternation (MASLOW 21, p. 178).

Clinical literature is indeed reflecting a growing sophistication with regard to group composition, modifications of specific therapies for specific diagnostic categories, and the problems of personality type as it relates to client-counsellor interaction. Yet, there is no systematic approach to therapeutic assignment that covers the issues summarised above by Maslow. The problem is one of more than academic interest as many failures in psychotherapy are directly related to inappropriate therapeutic assignment.

In my own clinical practice and research, it has become apparent to me that C. G. Jung's psychotypology offers a viable means by which the psychotherapies may be classified and given the perspective needed for their more effective application. Justifiable criticism may be made of Jung's and any other typology on the grounds that 'no pure type exists'. Jung himself decried the use of his typology for merely classifying individuals (ADLER 1, p. 550). He was concerned mainly with providing a means for communicating about the dynamics of ego orientation and what happens when an attitude or function is too rigidly held. It might be said that knowledge of the types as Jung describes them is one way to avoid becoming 'just a type', leaving the door open, so to speak, for enlarged personal growth and individuation (FORDHAM 9).

Jung was also concerned in his typology with problems of psychotherapy itself. One of his earliest efforts in this respect was the famous paper he delivered to the Fourth International Psychoanalytic Congress, Munich, 1913, in which he identified Freudian psychology with the extraverted attitude and Adlerian with introversion (JUNG 13, p. 499). Whether or not these assertions were the cause of his failure to receive the customary unanimous vote for re-election as president on that occasion is hard to say, yet nobody likes to be told that their world view of psychotherapy is only half the story. Meanwhile, many more than two theories of psychotherapy have appeared on the scene and Jung's own typology has been considerably expanded. It is the aim of this paper to point out the continued relationship of these many psychotherapies to the Jungian psychotypology in its final version. It is to be hoped that this effort will be perceived in terms of improved communication for and about psychotherapy rather than as a deadend exercise in categorisation.

Related Studies of Jung's Typology and Psychotherapy

Jung's typology is best known for the concepts of extraversion and introversion. This attitudinal dichotomy is not only a matter of common speech but is of popular interest with psychologists as well. There were 692 experimentally designed studies of extraversion-introversion reviewed in Psychological abstracts during the decade 1966 to 1975. Some of these investigations dealt with the differential effects of psychotherapy on these two basic personality types for reasons clearly expressed by Di Loreto:

We have a major dimension of personality which is relatively easy to assess, has high empirical validity, and is relatively independent of any one idiosyncratic operational definition ... and secondly ... introverts and extraverts have been found to differ on a number of qualities which may be predictive of differential treatment outcomes (Dr LORETO 5, p. 11).

In this instance, Di Loreto compared the group treatment approaches of systematic desensitisation, client-centred, and rational-emotive techniques with individuals identified as extraverted or introverted. It was found that in the
group setting, extraverts experienced greater anxiety reduction with the client-centred approach, while systematic desensitisation and rational-emotive techniques were more effective with introverts.

Differential responsiveness of extraverts and introverts within the group setting has been investigated by a number of other workers as well. Boller exposed both introverts and extraverts to sensory awareness and verbal cognitive T-group procedures. It was found that the sensory awareness mode was the more effective of the two approached, but that extraverts profited the most from both approaches within the group setting (BOLLER 2, p. 117).

In a four-week study, Jordan involved pre-service teachers in a training experiment with various group procedures. It was found that extraverts were significantly more involved in group experiences than introverts, but that introverts who were involved were as committed as the extraverts. It was also found that the introverts were significantly less committed to the use of specific techniques than either extraverts or ambiverts (JORDAN 18).

In another training situation, Toobert found greater initial interaction among the extraverts in a group procedure for staff education. However, there were no significant differences found for group interaction during the later training sessions with either the extraversive or introversive participants (TOOBERT 30).

With individuals diagnosed as neurotic by means of the Eysenck Personality Scale, Schubert found that increasing the number of participants classified as introverted-neurotic has the effect of increasing group resistance in a sensitivity group procedure. On the other hand, extraverted-neurotic types moved to a higher level of interaction more quickly than the introverts in this group experience (SCHUBERT 28). He concludes that random selection for participation in sensitivity or T-groups is inadvisable, particularly with respect to the extravert-introvert attitude. The general principle of random or non-discriminating selection for encounter groups of all kinds is likewise discouraged by other authors in the field of group therapy (HARTLEY, ROEBACK & ABRAMOWITZ 12), (SPOTNITZ 29, p. 79).

Unfortunately, corollary studies with individual therapy are unknown to me at the time of writing. One can only conclude from the rather consistent findings of studies in group procedures that extraversive persons tend to respond more quickly in the group setting than introversives. There seems to be no evidence, on the other hand, that introverts do better than extraverts in individual therapy. My own clinical experience has shown that almost all clients prefer starting with the individual approach, but that introverts in particular resist the group modality. There are studies which suggest, however, that psychotherapists or counsellors themselves cluster towards group or individual therapies according to their own introversion or extraversion tendencies. There is also evidence which suggests that the greater the similarity in typology between client and counsellor (including function type), the deeper the therapeutic involvement.

In an early study of types among Jungian analysts, Bradway found that 82 per cent of them were introverts compared with 25 per cent of the general population being identified with this type. The same study showed that both male and female analysts were predominantly intuitive in orientation with thinking and feeling as auxiliary functions in that order (BRADWAY 3). The stability for Jungian analysts as regards preference for the introverted-intuitive outlook was demonstrated in a replication of the study 13 years later, using a larger sampled population (BRADWAY & DETLOFF 4). In this instance, 86 per cent were identified as introverts with intuition still the dominant function. The authors note that thinking remains the favourite auxiliary function, but that feeling is more representative than in the first study.

In another survey of Jungian analysts' typology, Plaut found by means of a self-reporting procedure a similar preponderance of introverts among the practitioners of this individual form of psychotherapy. Plaut's survey also indicate the greatest preference for intuition (51 per cent), with feeling (29 per cent), thinking (11 per cent) and sensation (8.5 per cent) having less favour as dominant functions (PLAUT 27). From the consistent findings of these three studies, one might justifiably conclude that Jungian psychotherapy is itself an introverted-intuitive modality.

In contrast, a study of the psychological type characteristics of secondary school counsellors showed that 73 per cent were extraverted. Within the same sample, counsellors judged as most effective were found by means of the Myers-Briggs Type Inventory (hereafter referred to as MBTI) to be significantly more oriented towards the intuitive feeling coordinate than were the less effective counsellors (LEvell 20).

The predominance of intuition among students of the helping professions was likewise determined in another study using the MBTI. In this instance, psychology students were predominantly intuitive-thinking, social work students mostly intuitive-feeling, and medical students primarily intuitive (DURFEE 6).

In my own research with the psychotypology of mental health workers, it was found by means of a questionnaire based upon discriminating items from the MBTI that 58 per cent of 102 professional staff of public mental health...
clinics in Oregon were of extraverted attitude. These same staff people indicated a 44 per cent preference for the intuitive orientation, 31 per cent for thinking, 17 per cent for feeling, and 8 per cent for sensation (WITZIG 31).

The similarity of distribution of function type among these mental health workers in Oregon clinics and Plaut's (27) findings with an international population of Jungian analysts is rather remarkable. The difference between the two groups is primarily in attitudinal type with extraversion dominating in the public clinic setting. These data seem to support the notion that Jung's typology is an effective tool for studying the relationships between therapeutic modality, place of practice and personality of both client and therapist. The collective setting found in both school and public mental health clinic seems to favour the extraverted counsellor. Extraverted clients respond in most respects better to group procedures than introverts. Therapy for the introvert seems best pursued on an individual basis, and there seems little doubt among Jungian analysts that theirs is a therapeutic approach founded by an introvert which continues to attract introverted therapists and clients alike. A pronounced preference for an intuitive orientation appears to be a common factor for all mental health workers regardless of their professional bias or work setting.

Not only does type preference seem to affect professional orientation, it likewise influences the relationship between counsellor and counsellee. Mendelsohn administered the MBTI to 201 clients seeking educational, vocational and personal counselling and to their counsellors as well. His results showed that the more similar in type client was to counsellor, the greater the number of sessions and duration of the counselling process (MENDELSOHN 23). In this instance, both attitudinal types and the four functions were under investigation. These experimental findings were anticipated by Jung in Psychological types (14):

As to the individual disposition, I have nothing to say except that there are obviously individuals who have a greater capacity, or to whom it is more congenial, to adapt in one way and not another. It may well be that physiological causes of which we have no knowledge play a part in this. I do not think it improbable, in view of one's experience, that a reversal of type often proves exceedingly harmful to the physiological well-being of the organism, usually causing acute exhaustion (p. 333).

...I have frequently observed how an analyst, confronted with a terrific thinking type, for instance, will do his utmost to develop the feeling function directly out of the unconscious. Such an attempt is foredoomed to failure, because it involves too great a violation of the conscious standpoint (p. 407).

Jung's insight and subsequent supportive experimental data certainly indicate a need for type-compatible approaches to psychotherapy. This need prompted the following investigation (WITZIG 31).

A Proposed Classification of Psychotherapeutic Modalities According to Jungian Typology

A two-page questionnaire was prepared for response by professionals in psychotherapy, heretofore mentioned as practising within Oregon mental health clinics. The first page dealt with attitudinal type and therapeutic assignment. Subjects were first instructed to assign two clients to either group or individual therapy. One client was described by extravert traits and the other by introvert traits, both sets of traits being derived from discriminating items in the MBTI for each type. Subjects were then asked to check which set of traits best described themselves. The results are shown in Tables 1 and 2.

As will be noted, group therapy was the treatment of choice for both

<table>
<thead>
<tr>
<th>TABLE 1 CLIENT TYPE AND ASSIGNMENT TO GROUP OR INDIVIDUAL THERAPY</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Introvert</strong></td>
</tr>
<tr>
<td>N = 102</td>
</tr>
<tr>
<td><strong>Grp. Rx</strong></td>
</tr>
<tr>
<td>65**</td>
</tr>
<tr>
<td>64%</td>
</tr>
<tr>
<td>37**</td>
</tr>
<tr>
<td>36%</td>
</tr>
</tbody>
</table>

* p < .05

** p < .01

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TABLE 2 THERAPIST TYPE AND PREFERENCE FOR GROUP OR INDIVIDUAL THERAPY

<table>
<thead>
<tr>
<th></th>
<th>Introvert</th>
<th>Extravert</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<tr>
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<td>57%</td>
<td>65%</td>
</tr>
<tr>
<td>Ind. Rx</td>
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<td>41</td>
</tr>
<tr>
<td></td>
<td>43%</td>
<td>35%</td>
</tr>
</tbody>
</table>

introverts and extraverts. Responding therapists seemed to take a compensatory attitude towards their introverted clients by assigning even more of them to group therapy than they did the extraverted clients. If group therapy may be regarded as an extraverted therapeutic modality in view of its emphasis on external interaction, then these hypothetical introverted clients are being violated in their attitudinal standpoint. It is small wonder that there is a high dropout rate in the formation of groups for therapy.

Table 2 shows an expected preference for group methods by extraverted therapists. What may be surprising is the token preference for group methods by introverted therapists. Considering that the survey was made among public mental health practitioners, this finding could be a reflection of demand in such settings for group procedures. However, responding subjects had free choice in the questionnaire itself. In contrast, a teacher referent sample responding to the same questionnaire assigned 56 per cent of the introverts to individual therapy and a significant 77 per cent of the extraverts to group methods. Teachers apparently have a more supportive approach to the problem than do clinicians.

The relationship of extraversion and introversion with group and individual psychotherapies can be seen even by laymen. The four functions offer more of a problem for classification of the psychotherapies and require some explanation. The following categories are proposed for classifying the psychotherapies within the context of the four functions of orientation, but are offered with more descriptive terminology than their original counterparts.

Thinking = Informational/cognitive; includes psychoanalytic, rational-emotive, educational, and transactional approaches to psychotherapy. The cognitive orientation of psychoanalysis and its various expressions is readily apparent from this statement by Reuben Fine:

"Psychoanalysis assumes that everything human is meaningful. Freud called this the principle of psychic determinism. Man is seen as an organism who is driven by unconscious, instinctually derived forces, which hitherto have been vastly superior to his alleged reason. These forces can be brought to consciousness and thereby brought under control. Freedom is knowledge; slavery is ignorance. It is paradoxical that psychoanalysis, which has studied irrational manifestations in the human being, comes to the conclusion that the human being is never irrational. What is called irrational is always rational at an unconscious level (FINE, 8, p. 7)."

The informational/cognitive orientation of educational therapies is self-evident. The following statement by the founder of Rational-emotive therapy is quite concise about its relationship to the thinking function. Albert Ellis writes: "... man can live the most self-fulfilling, creative, and emotionally satisfying life by intelligently organising and disciplining his thinking" (ELLIS, 7, p. 13).

Intuition = Symbolic/intuitive; includes those approaches to psychotherapy which emphasise phantasy, meditation, brainstorming, or any other technique that attempts to transcend the rules of reason or sensory input. A typically intuitive attitude is expressed by Herbert A. Otto in his promotion of phantasy encounter group: ‘Life is a journey into phantasy and imagination. By nourishing and developing our capacity to fantasise, we enrich and expand life itself. Our horizons are limited only by our imagination’ (OTTO, 25, p. 3). Jungian psychotherapy is also included in this category. Jungian analysts may indeed seek resolution of psychological distress by way of all four functions, nevertheless the ultimate healing factor was perceived by Jung as an irrational, transcendent symbol. He describes this process as follows:

"It is as though, at the climax of the illness, the destructive powers were converted into healing forces. This is brought about by the archetypes awakening to independent life and taking over the guidance of the psychic personality, thus supplanting the ego with its futile willing and striving ... To the patient it is nothing less than a revelation when something altogether strange rises up to confront him from the hidden depths of the psyche—something that is not his ego and is therefore beyond the reach of his personal will. He has regained access to the sources of psychic life, and this marks the beginning of the cure (JUNG, 15, p. 345)."
Sensation = Sensory/experiential; includes most occupational, Gestalt, bio-energetic, and behaviour modification therapies. These approaches emphasise sensory response and association, and regard psychological health or growth as being dependent upon awareness of raw sense data. Fritz Perls, one of the founders of Gestalt psychotherapy, lays emphasis on the sensation function in the following statement:

*Experience occurs at the boundary between organism and its environment, primarily the skin surface and the other organs of sensory and motor response. Experience is the function of this boundary, and psychologically what is real are the ‘whole’ configurations of this functioning, some meaning being achieved, some action completed* (PERLS, HEFFERLINE, & GOODMAN 26, p. 227).

Feeling = Confrontation/conative; includes encounter and T-group modalities, classical supportive-ventilative procedures, and the client-centred approaches of Carl Rogers. As the term implies, the confrontational/conative therapies make a conscious effort to face the meaning of one's own affect or emotion as distinct from what one thinks ‘should’ be their response in these matters. Meador and Rogers emphasise the development of the feeling function in the following description of the seven stages of client-centred psychotherapy:

1. Feelings and personal meanings are neither recognised as such nor owned.
2. Feelings are sometimes described, but as unowned past objects external to self.
3. There is much description of feelings and personal meanings which are not now present. These distant feelings are often pictured as unacceptable or bad.
4. Feelings and personal meanings are freely described as present objects owned by the self. Feelings of an intense sort are still described as not now present.
5. Many feelings are freely expressed in the moment of their occurrence and are thus experienced in the immediate present. These feelings are owned or accepted. Feelings previously denied now tend to bubble through into awareness though there is fear of this occurrence.
6. Feelings previously denied are now experienced both with immediacy and acceptance. Such feelings are not something to be denied, feared, or struggled against.
7. The individual lives comfortably in the flowing process of his experiencing. New feelings are experienced with richness and immediacy, and this inner experiencing is a clear referent for behaviour (MEADOR & ROGERS, 22 p. 148).

The gut level, judgmental characteristics of feelings in the Jungian concept of this function are readily apparent in the above statement of psychological growth according to the client-centred school. Comparing its feeling approach with the emphasis upon sensual immediacy espoused by the Gestalt school clearly reveals Jung's intentions for differentiating the feeling and sensation functions. Confusion nonetheless arises, particularly with persons of English mother tongue, over the concepts of sensation and feeling function because of the synonymous relationship between ‘touching’ and feeling. It is intended by the use of the term confrontation/conative, for the feeling category of psychotherapies, that this confusion arising from terminology will be avoided, and that the dynamic differentiation between the functions of sensation and feeling can be clarified.

Arguments are no doubt forthcoming that every psychotherapeutic method utilises more than one orienting function. Like the individual types upon which this classification of therapies is based, there is no ‘pure’ type. Most therapies make prominent use of one or two auxiliary functions, but close inspection reveals a characteristic dominance of one of the four functions as the primary path to psychological health. A case in point is behaviour therapy, which at first glance appears to be a thinking approach according to a statement by C. M. Franks:

*If behaviour is defined in terms of response, then behaviour therapy becomes a matter of response modification involving the application of some SR type of learning theory. More explicitly, behaviour therapy may be defined as the beneficial modification in accordance with experimentally validated principles based on SR concepts of learning and the biological properties of the organism* (FRANKS 11, p. 2).

The emphasis here upon theory and a rational ordering of reinforcement schedules according to experimental evidence is using the thinking function at its best. Yet this logical ordering of behaviour change according to abstract principles is not practical in the view of other behaviour modifiers. Kanfer and Saslow argue for practical considerations which sound very much like feelings in the following statement:

*Clinical strategy seems to be closer to the social process of policy formation, in which constant consideration of the interests of different parties is required and a solution can only be achieved by
'negotiation' or compromise between the rationally most desirable and operationally most feasible alternatives, than to a rational process aimed towards restoring a patient to a predefined state of psychological health (KANFER & SASLOW 19, p. 442).

Both of the foregoing statements emphasise the judgmental qualities attributed by Jung to the rational functions. Yet when all is said and done about the rational approaches to behaviour modification therapy, the goal of healing occurs only by a reconditioning of the physical organism in terms of stimulus-response connections. ‘Behaviour changes behaviour’ is a major axiom of this therapeutic modality, and conditioning therapy is a frequently used synonym. This emphasis on experience and the biological properties of the organism clearly identifies behaviour modification as a sensation-oriented psychotherapy.

Another way for perceiving the differentiating qualities of these function-classified psychotherapies is to make note of which attitude and orientation is most lacking within the therapeutic system itself as well as proving most disagreeable to its practitioners. This negative approach to psychological typing is often employed in a Jungian analysis to help identify the dominant function via the inferior one. Try to imagine, therefore, a Jungian analyst practising behaviour modification in a group setting, or a behaviour modifier paying any attention to the symbolic content of dreams. The informational/cognitive therapist may well use the functions of sensation and intuition to reinforce their thinking approach, but regard feelings as unnecessary if not deceptive distractions to rationally ordered lifestyles. Confrontational/conative therapists, on the other hand, dismiss the logic of abstract principles and moral arguments as the pathogenic equivalents of spirochetes in the psychological life of the individual.

Another argument against classifying psychotherapies into any system is that they are all dependent upon the clinical fact that none of them work unless the patients want them to, as Kanfer and Saslow (19) so clearly observe. Accordingly, therapeutic effectiveness for any psychotherapeutic modality seemingly depends more upon the motivational state of the client than it does on specific techniques used for effecting change. Unfortunately, clinical experience demonstrates over and over again that highly motivated clients are often not helped even though they have the best of intentions and have the services of well-qualified psychotherapists. What has gone wrong? It is the contention of this paper that considerable part of this therapeutic failure is due to the mismatch of the patient's dominant function with the orientation emphasised in the psychotherapy used in each case. It is also contended that the development of these various approaches to psychotherapy has occurred in order to give expression to the very functions and attitudes Jung describes in his typology, although this goal was hardly conscious in the minds of the innovators.

The emergence of these various psychotherapies out of the original introverted-thinking approach of Freud and early Jung gives strong empirical support for Jung's typological theories and the principles of compensations and complementarity contained therein. Had the informational/cognitive approach of early 20th-century psychotherapy proved adequate for treating all cases, psychoanalysis need never have faced alternative treatment modalities. Alfred Adler was the first major innovator to the informational/cognitive approach. He retained the basic ingredient of making rational a seemingly irrational symptom. His substitution of power for sex as primary motivation hardly affects the issue of re-education involved in this class of therapies. However, his shift of treatment setting from the couch to the family home and eventually to the forum of the Vienna public schools readily demonstrates the extravertive quality of his therapy as well as his theoretical bias. The power drive is common to introvert and extravert alike, as is the sexual instinct. It is how the therapist perceives these drives and treats disturbances in their expression that determines the typological classification of the therapeutic system. With his emphasis on birth order, family constellation, and the development of social interest, Adler's system seems much more extraverted than orthodox psychoanalysis which focuses on intrapsychic sexual conflicts and retains the couch as the treatment method least intruded upon by outside influences. Jung's interpretation of the Freudian approach as extraversive and Adlerian psychotherapy as introersive (13) seems to me to be a reflection of transitional developments in the theories of this psychological trinity without having the advantages of seeing their final theoretical constructs and approaches to psychotherapy.

Jung's analytical method of psychology and therapy retained the introverted approach of one-to-one treatment but moved away from the informational/cognitive orientation of psychoanalysis. With his 1912 publication of Wandlungen und Symbole der Libido, Jung introduced the importance of intuited goals and the irrational transcendent symbol as the really crucial elements for effective psychotherapy. This move threatened not only Freud's authority but his rational informational/cognitive fixation as well. Jung also saw fit to introduce an extravertive element into his psychotherapeutic approach by facing his patient, and augmented it by founding the Psychological Club of Zurich, where social interaction could be experienced (JUNG 17 p. 469). Trigant Burrow, an American student of Jung's, carried this extraverted approach even further and introduced sensation as the dominant
function for achieving psychological awareness. He used a group camping experience to emphasise here-and-now rôle relationships.

The feeling-dominant confrontational/conative therapies made their appearance in their extraverted version by way of Moreno’s psychodrama groups and their introverted approach with the client-centred therapy of Carl Rogers. Both methods were prescribed as rational antidotes for a presumably narrow moralistic and technological thinking. Thus, by the 1930s the full complement of Jung’s psychological types had found its expression in the various psychotherapeutic modalities. It took nearly 30 more years of excited controversy and experimentation before clinicians came to the realisation that each of these therapeutic methods might have value.

By the late 1960s, psychotherapists began to regard all these therapeutic procedures more as an armamentarium for selectively attacking mental distress than as ‘cure-alls’ of mental illness. One could find in the larger clinics several approaches or modalities of psychotherapy being used, unfortunately however, generally on an intuitive or even ‘happenstance’ basis. It often came about that a particular procedure was used because that was the one an available therapist knew or wanted to practice. Nonetheless, there was often an ‘intuition’ that one patient might work better with a particular therapist or method than another. In other cases, there might be a ‘feeling’ that a procedure was inappropriate, so another was tried. Then there was often the concern for what the client ‘needed’ versus their current clinical status. These discriminating reactions to the problems of therapeutic assignment were most obvious in the matter of treating introverts and extraverts with individual or group therapy. However, it seemed to me there were other typological characteristics in the whole problem of therapeutic assignment; so I set about to research the professional literature on the subject and to devise an experiment to test the hypothesis (WITZIG 31).

Mention has already been made of the introvert-extravert: individual-group aspect of the experiment (Tables 1 and 2). The second page of the questionnaire used in this study presented four hypothetical cases to be assigned by responding clinicians to any one of the four categories of therapy described thereon as informational/cognitive; symbolic/intuitive; sensory/experiential; and confrontational/conative. Each category was listed with examples of the therapies I considered belonging within that particular function-oriented classification. No stipulations were made to use all four categories for assignment purposes. The four cases were each described in terms of eight items of two-point scoring value selected from the standard MBTI for each psychological type. The items were paraphrased for readability, lumped together according to type, and presented in single paragraph form for each case. No mention of Jung or psychological types was made in any part of the questionnaire.

Upon completion of matching client with therapeutic modality, subjects were asked to rank-order the four case descriptions according to the one most to least like themselves (Table 4). It was assumed that the rank-ordering procedure would give some indication of type orientation for each of the respondents even though the ‘case’ descriptions were somewhat limited in the number of traits involved in each instance. The results of this approach to self-typing showed a similar distribution of type among Oregon mental health workers with regard the four functions as has been found in the other studies of typology in mental health workers already quoted (44 per cent intuitive, 31 per cent thinking, 17 per cent feeling, and 8 per cent sensation for the Oregon study).

**TABLE 3 CLIENT FUNCTION TYPE AND ASSIGNMENT TO GROUP MODALITY**

<table>
<thead>
<tr>
<th>Group</th>
<th>Thinking</th>
<th>Sensation</th>
<th>Feeling</th>
<th>Intuition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mode</td>
<td>N = 102</td>
<td>N = 102</td>
<td>N = 102</td>
<td>N = 102</td>
</tr>
<tr>
<td>Info./Cog.</td>
<td>44**</td>
<td>36**</td>
<td>31</td>
<td>18</td>
</tr>
<tr>
<td>Sym./Int.</td>
<td>11**</td>
<td>20</td>
<td>10**</td>
<td>43**</td>
</tr>
<tr>
<td>Sens./Exp.</td>
<td>26</td>
<td>23</td>
<td>33</td>
<td>25</td>
</tr>
<tr>
<td>Con./Con.</td>
<td>21</td>
<td>23</td>
<td>28</td>
<td>16*</td>
</tr>
</tbody>
</table>

**TABLE 4 THERAPIST FUNCTION TYPE AND GROUP MODE PREFERENCE**

<table>
<thead>
<tr>
<th>Group</th>
<th>Thinking</th>
<th>Sensation</th>
<th>Feeling</th>
<th>Intuition</th>
</tr>
</thead>
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<tr>
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<td>N = 32</td>
<td>N = 8</td>
<td>N = 17</td>
<td>N = 45</td>
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<tr>
<td>Info./Cog.</td>
<td>45**</td>
<td>7</td>
<td>26*</td>
<td>51</td>
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<tr>
<td>Sym./Int.</td>
<td>20*</td>
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<td>36</td>
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</tr>
<tr>
<td>Con./Con.</td>
<td>27</td>
<td>7</td>
<td>10*</td>
<td>44</td>
</tr>
</tbody>
</table>

intuitive, 31 per cent thinking, 17 per cent feeling, and 8 per cent sensation for the Oregon study).
As can be seen from Table 3, responding clinicians indicated a significant preference for the principle of differential assignment of psychotherapy in general. Of the 102 subjects, only 4 per cent assigned all four types of clients to just one approach, just 8 per cent selected only two modes, while 44 per cent elected to use three approaches, and a final 44 per cent selectively assigned all four of the proposed modalities of psychotherapy. This finding not only implies different treatment for different personality types, but also gives recognition on the part of responding subjects that the four cases as described and the four categories of psychotherapy are indeed different in qualitative content.

In the actual assignment of clients, subjects assigned significant numbers of thinking types to the informational/cognitive mode (43 per cent) and intuitive types to the symbolic/intuitive mode (42 per cent), both in the hypothesised directions. Neither sensation nor feeling type clients were assigned in significant numbers to their respective hypothesised modalities (Table 3). One can see here that sensation type clients are more often assigned the informational/cognitive approach than any of the other three modalities. It is more likely that this finding reflects clinical practice and training than a reaction on the part of intuitive clinicians against sensation dominated modalities inasmuch as they selected sensory/experiential mode at chance level of probability. These same clinicians seemed to agree that the symbolic/intuitive approach was the least appropriate for treating feeling type clients, but gave no clear direction in their use of the other three modalities for treating this type. Despite their own predominantly intuitive orientation, Table 4 indicates that subjects favour the informational/cognitive mode (32 per cent at .01 level), and least like the symbolic/intuitive approach (20 per cent at .05 level). Both the sensory/experiential and the confrontational/conative modalities were preferred at chance levels of probability, near 25 per cent. Thinking type subjects were the only ones indicating preference for a modality in the hypothesised direction. It is concluded from these data that preference for therapeutic approach has more to do with training and treatment setting than with the personality of the therapists insofar as Jungian type is concerned for this population. This investigation in general suggests that responding subjects were supportive of clients in terms of function type, compensatory with regards attitudinal type, yet not particularly dominating of therapy with their personal typological bias.

Discussion

Criticism of the above investigation may be made on the basis of a too small and undiversified sample. Subjects were drawn from a fairly consistent population as regards work setting, and the number of workers of sensation type was much too small to draw any conclusions from their choices for therapeutic assignment. Also, the questionnaire itself may be regarded as a rather blunt instrument for assessing typological type. It could not, for instance, determine auxiliary or secondary functions nor the degree to which the primary function dominated. Nevertheless, the questionnaire proved an effective device for preliminary experimental research on the issues involved. The full Myers-Briggs Type Indicator is recommended for clinical application on the basis of its more accurate typing of both attitudinal and functional types than any other known method. The MBTI provides scale readings whereby the degree to which a patient holds an attitude of function may be determined. This is clinically important for the assignment of therapies because persons with weakly differentiated attitudes or functions may not be as affected by type dominated therapies as others having a more highly differentiated typology. There is also the possibility for relatively non-threatening approaches to therapy via a known auxiliary function if dominant function psychotherapy is unavailable.

Numerous comments by responding clinicians pointed out that the questionnaire made no mention of the degree of distress involved in the six hypothetical cases. This point is well taken as it suggests that therapeutic assignment might be more supportive for the seriously disturbed client than for the individual seeking a growth or educational experience. This is an old issue in the field of psychotherapy, but is perhaps best demonstrated in R. E. Mogar's application of Jungian typology to the field of education. He contends that present educational practices emphasise thinking-sensation and are so consistent he refers to it as a uniformity approach, e.g. all students subjected to the same
education process resulting in a high degree of specialisation and compliance. This is obviously not effective for students of differing type orientation; so Mogar suggests the congruity approach as a more supportive alternative insofar as it goes along with and maximises the student's own dominant function. Once the dominant function becomes well-established, Mogar suggests that a third strategy be available, the complementary approach for persons ready and desirous of personal growth through development of their inferior function (MOGAR 24).

It would seem that Mogar's strategies for education could as well be applied to the practice of psychotherapy. Therapeutic effectiveness might be enhanced by a more congruent assignment of therapeutic modality with a patient's typological preferences. Complementary approaches to counselling should be limited to individuals seeking psychological education rather than therapy, in situations where a uniform approach to psychotherapy is unavoidable, an understanding of the Jungian typology of patient and therapy alike can permit greater sensitivity on the part of the therapists than would otherwise be possible.

Unfortunately, we continue to see too much of the uniformity approach to psychotherapy being practised throughout the profession. This is not surprising inasmuch as universities and training institutes continue to emphasise one or two therapeutic modalities which are often reinforced with an accompanying bias otherwise found in old-time religion. Such an unscientific approach to the teaching and application of psychotherapy may have been excusable before 1970 while new formations of psychotherapy were still being tested. Although new approaches to psychotherapy may be forthcoming, there are now sufficient numbers of therapeutic strategies available to make comparative studies not only possible but imperative if the profession of psychotherapy is to retain any scientific objectivity. The question of which method does what to whom has to be answered, and brings us back to the statement of Maslow quoted at the beginning of this paper. The point is reiterated by Jerome Frank:

... Ideally, a therapist should master as many rationales and procedures as possible and try to select those which are most appropriate for different patients ... If we determine that a person would be specially accessible to a method not in our repertoire, good practice would seem to require that we refer him to someone who has mastered this approach (FRANK 10).

and anticipated by Jung:

... Every psychotherapist who knows his job will, consciously or unconsciously, theory notwithstanding, ring all the changes that do not figure in his own theory. He will occasionally use suggestion, to which he is opposed on principle. There is no getting around Freud's or Adler's or anybody else's point of view ... Very many theories are needed before we can get even a rough picture of the psyche's complexity. It is therefore quite wrong when people accuse psychotherapists of being unable to reach agreement even on their own theories ... Theories are not articles of faith, they are either instruments of knowledge and of therapy, or they are no good at all (JUNG 16, p. 88).

There are many ways to test therapeutic effectiveness and differentiate theoretical fancy from usable fact. Some evidence has been presented in this paper to show a relationship between Jung's psychological types and therapeutic modality. Should such a relationship be supported by additional clinical evidence, it is argued that the foregoing classification not only makes possible the study of a theoretical system but has the potential for therapeutic instrumentation.

Summary

Classification of the psychotherapies is seen as a desirable goal for research purposes as well as a vehicle for improving therapeutic effectiveness. C. G. Jung's psychotypology is presented as a meaningful format for such a classification. The individual approach is regarded as introversive and the group modality as extraversive. Psychotherapies are additionally classified according to function type: Thinking = Informational/cognitive—including educational, psychoanalytic, transactional and rational-emotive therapies; Intuition = Symbolic/intuitive—including Jungian analysis, transcendental meditation and phantasy dominated procedures; Sensation = Sensory/experiential—including Gestalt, bio-energetic, behaviour modification, and most occupational therapies; Feeling = Confrontational/conative—including psychodrama, client-centred and encounter methods. The hypothesis for this classification is supported by relevant literature and was tested by means of a task-oriented questionnaire administered to 102 public mental health workers. Subjects were instructed to assign six hypothetical cases described in type differentiating traits to six modes of therapy proposed as reflecting extravert,
introvert, sensation, thinking, intuition and feeling dominance. The sampled population responded in support of the proposed classification and of the principle of differential assignment as well. In addition, subjects spontaneously raised the important issues of uniform, congruent and complementary approaches to therapy thereby reiterating the need for a systematic classification of the psychotherapies.

References


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