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A Person-Centered Approach to Clinical Practice

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Abstract

Effective clinical practice depends on tools that facilitate nonstigmatizing personality assessment, rapid development of a therapeutic alliance, and the guided development of self-awareness so that people learn how to live well. As an expert in psychological medicine, the psychiatrist is uniquely qualified to develop a holistic treatment approach addressing the needs of the person's body, thoughts, and psyche for the promotion of health and well-being. Personality assessment can be integrated into psychiatric practice in a way that is practical and that has many benefits for the psychiatrist and his or her patients. Personal reflection on one's temperament and character profile promotes understanding without judging or blaming. The dialogue between psychiatrist and patient about personality promotes the rapid development of a therapeutic alliance based on mutual respect, positive regard, and shared goals. The expertise and empathy of the psychiatrist in knowing more about the person's strengths and vulnerabilities beyond even the person's own awareness builds respect, trust, and hope. In this way, the assessment of personality promotes recovery of well-being and reduces disease and stigma. Likewise, the psychiatrist is more effective and satisfied with practice, standing ready with expertise, patience, and compassion to assist patients to work and develop at their own chosen pace.

A person is more than his or her symptoms

What is at the core of the work psychiatrists do as mental health providers each day? What is the "work" of each exchange we have with another human being who comes to us for help? We encounter a patient as a person, another respected human being who has some problems for which help is sought. In short order (and at minimal expense) we are called to apply our professional acumen, our acquired clinical wisdom to discover "Who is the person before us?"

Sadly, when most trainees in psychiatry describe a clinical "case," the traditional summary may do little more than detail the symptoms that satisfy the criteria for one or more categorical diagnoses. After such checklist-oriented descriptions, most listeners would still have little indication of who the person is. If a diagnosis of personality disorder is not suggested, there is often little description of the person's temperament or personality

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development over the course of his or her life. As a result, treatments are recommended on the basis of symptoms, and the clinical outcomes often involve only partial and temporary improvement of symptoms, little or no reduction in vulnerability to future disorder, and no recovery of hope and well-being.

As long as psychiatrists reduce the person to a clinical case defined by symptom-based criteria, they fail to recognize the whole person and his or her unique biopsychosocial characteristics that are crucial for the development of health and well-being (1). The World Health Organization has long recognized that health is a state of physical, mental, and social well-being and not merely the absence of disease or infirmity (2). The evolution of the human brain clearly involved the development of five major adaptive systems that allow the conscious regulation of sexual, material, emotional, intellectual, and spiritual aspects of the life experience (3). To address the therapeutic needs of the whole person and optimize clinical outcomes, a psychiatrist needs to help the person learn to live well, which means more than assessing symptoms and prescribing pills. If we are to optimize our clinical results, we need to recognize how sexual activity, diet, exercise, work, recreation, social relationships, and spiritual practices all influence human functioning. In other words, we need to help the person become aware of his or her ability to make self-directed choices to do what provides lasting satisfaction, meaning, and well-being. Learning to live well is the consistent aim of all the various forms of psychotherapy (1, 4–8).

Personality assessment offers a useful bridge to establish a dialogue and therapeutic relationship between the patient and psychiatrist as two mutually respectful persons with the shared goal of well-being for the patient. In the process of describing and reflecting on a person's personality without judging or blaming, psychiatrists can build a rapport and a connection in which the patient knows that he or she is understood and appreciated (9, 10). When the psychiatrist is able to anticipate strengths and vulnerabilities that the patient has in various situations, then the patient can have confidence that he or she has been authentically understood.

Personality assessment can be used to help patients become more self-aware of their capacity and responsibility for making the life style choices that have a major impact on their overall health and well-being. Focusing on the well-being and functional capacities of the person, rather than taking a narrow view of deficits or psychopathology, empowers the person to make responsible choices about his or her life style, thereby building self-confidence. Thus, expertise in personality assessment and an interest in comprehensive health and well-being promote trust, credibility, and respect for the psychiatrist's professional skill and readiness to be helpful. This humanistic dialogue and therapeutic approach to assessment promotes a sense of hope that empowers the patient and enhances well-being (9). The patient can recognize that we are “decent enough folks” for him or her to want to continue working with us in a therapeutic alliance. In addition each patient is able to recognize that he or she has strengths to help himself or herself, particularly when assisted by a professional who is respectful, optimistic, and encouraging.

About 15% of the variance in treatment outcome is attributable to specific techniques of different therapeutic schools, whereas about 85% of the variance in psychotherapy outcomes

is explained by common factors shared by different approaches (11–13). What is attributed to the strong placebo effects observed in most drug or psychotherapy trials is substantially determined by common psychosocial factors, which can be as large or larger than putatively specific treatments (13). These common factors in all treatment include the patient's characteristics, the therapist's qualities of respect (i.e., prizing, unconditional positive regard, acceptance, and trust), empathic understanding, and genuineness (i.e., realness and authenticity), and the quality of the therapeutic alliance between them (shared goals and emotional engagement and exchange) (14, 15). These common factors are characteristic of all truly healthy interpersonal relationships (16) and are important for maintenance and recovery of all aspects of well-being, whether physical, mental, or spiritual (17–19). Claims of the evidence for the specificity of particular techniques for specific disorders are not well-justified because of inadequate assessment of these common factors (11). Nevertheless, there is a need to go beyond a simple common factor approach to assess and understand the mechanisms of personality change with professional expertise as a dynamic multistep process involving changes in awareness (1, 20, 21).

In other words, a psychiatrist's effectiveness in treatment depends substantially on his or her *attitude* toward—and *understanding* of—the patient. The interpersonal attitudes of respect, genuineness, and empathic understanding are crucial for the development of well-being (1, 22). Accordingly, effective clinical practice depends on tools that facilitate nonstigmatizing personality assessment, rapid facilitation of a therapeutic alliance, and guided development of self-awareness for people to learn how to live well.

SO, what is personality?

General definition of personality

If a person is more than his or her symptoms, then clinicians need a way to describe the person as a being that learns and adapts to situations in life. Personality is defined as the organization within the individual of the psychobiological systems by which a person shapes and adapts to ever-changing internal and external influences (23, 24). The Temperament and Character Inventory (TCI) is a tool for personality assessment that was developed to provide a comprehensive psychobiological model of personality as it develops within individuals (24). It deconstructs personality into seven dimensions that vary widely in the general population, rather than focusing only on pathology or abnormal traits (25). Nevertheless, it was designed to be equally applicable to clinical populations without being stigmatizing or pathologizing.

Personality is a complex adaptive system

The TCI is based on a psychobiological model of complex interactions among genetic, psychological, and social variables, rather than an assumption that personality can be decomposed into independent dimensions using linear factor analysis (3, 26). Prospective studies of personality and the experience of clinicians consistently show that the same clinical disorder may have many different pathways that lead to it, a characteristic of nonlinear development called “equifinality” (27, 28). Likewise, experienced clinicians know that the same set of antecedent traits may develop in many different ways that lead to

divergent outcomes, another hallmark of nonlinear development called “multifinality” (29). Unfortunately, most modern inventories for measuring personality are linear models derived by factor analytic methods, which are actually invalid for nonlinear systems such as personality (26). Other personality models have been advocated, but no other is comprehensive and derived on a theory that integrates neurobiological and psychosocial influences on development as a nonlinear dynamic system. Without claiming that it is the only way to understand personality rigorously, we will rely on the TCI because it is a well-validated system for assessment, recognizes the nonlinear nature of personality development that is crucial for treatment planning, and has been shown to be useful and practical in clinical practice for treatment across the full range of personality and psychopathology (28, 30–32).

The TCI provides a quick, reliable, and clinically meaningful description of the person you are encountering in a respectful manner that describes without judging or blaming. We usually administer the TCI on the first or second visit, often while the patient is waiting to be seen. The test has 240 questions, either true-false or on a 5-point Likert scale and can be completed by the patient in 35–45 minutes. The patient is asked to complete his or her responses in one sitting, if possible. An office computer could be used in a quiet room, or the test can be taken and scored online from home or the office or scored in your office in 5 minutes. Information about administration is available online (http://psychobiology.wustl.edu or http://anthropedia.org). The automated scoring of the patient's self-reported profile is reviewed and discussed with the patient, as we will illustrate in an example later. The review and discussion of the patient's personality profile not only informs you as the psychiatrist but also allows the patient to reflect on how he or she has described himself or herself. This discussion gives you and your patient a shared language to understand who he or she is and what are his or her strengths and vulnerabilities. Such discussion allows the patient to see that you understand and can predict things about him or her even before these are revealed to you explicitly. For example, people who are easily bored and impulsive are more likely to have experimented with drugs than others. Discussion of the patient's needs and vulnerabilities in a mutually respectful dialogue rapidly builds respect, rapport, and a therapeutic alliance with shared treatment goals. The information about the individual's personality invites him or her to engage in further reflection, which sometimes activates rapid and spontaneous recovery. Hopeful dialogue also provides a greater awareness of his or her path of inner transformation as the two of you map out the ways in which he or she needs to develop to lessen the impact of what has been troubling. Discussion of the person's strengths as well as vulnerabilities assists in the recognition of the tools and resources available for achieving increased life satisfaction, happiness, and overall well-being. The resources available to patients may include medications you will prescribe as well as other exercises, activities, and meditations that will help them understand themselves and their situations more fully.

Distinguishing Temperament and Character

Temperament refers to individual differences in the strength of drives underlying basic emotions, such as fear, anger, disgust, and surprise, which are moderately stable throughout a person's life. In contrast, character refers to individual differences in a person's goals and

values that develop in a step-like manner as a person matures in insight through experience over his or her lifespan (33). The four dimensions of temperament and three dimensions of character measured by the TCI are summarized in Figure 1. Initially temperament was described in terms of three heritable dimensions—Harm Avoidance, Novelty Seeking, and Reward Dependence, as measured by the Tridimensional Personality Questionnaire (34, 35). Later work identified a fourth heritable temperament dimension called Persistence (36, 37). These four temperaments correspond to people with anxiety proneness (i.e., high Harm Avoidance, as in DSM cluster C), impulsivity and anger proneness (i.e., high Novelty Seeking, as in DSM cluster B), social detachment (i.e., low Reward Dependence as in DSM cluster A), and obsessionality (i.e., high Persistence, as in anankastic personalities) (38, 39). These four clusters have been called the “four A's”: asthenic, antisocial, asocial, and anankastic, respectively (40). Configurations of these dimensions provide a reliable way to subtype personality disorders (32, 41).

Groups of people with different configurations of temperament are depicted in Figure 2. Each of these temperament configurations differs on average as a group in their level of maturity (42). For example, individuals who are high in Harm Avoidance (H) and Novelty Seeking (N) but low in Reward Dependence (r) are described as having an explosive or borderline temperament profile (NHr). They are much more likely to be immature than those with most other configurations, but there are a substantial number of people with an explosive temperament who are nevertheless mature and responsible (that is, who do not have a personality disorder). Consequently, temperament alone is not adequate to determine whether an individual person does or does not have a personality disorder. Someone can be healthy and mature regardless of their temperament profile, even though groups of temperament profiles differ in maturity *on average*, as shown in Table 1. Therefore, the TCI character dimensions were developed to measure additional aspects of personality that allow people to regulate their emotional impulses and conflicts in such a way that they are mature and healthy regardless of the temperament.

What is a Personality Disorder?

In medical school, one of the oldest jokes is the “medical student disease,” the tendency of students to start imagining or overreacting to common phenomena so that they think they have whatever disease they read about. Psychiatry lectures about personality disorders are often especially troubling for medical students—as the identifying features are cataloged, often medical students begin to fear that most people they know have personality disorders, even though the prevalence in the general population is only about 10%. Nevertheless, many medical students overread indicators of immaturity, interpreting the imperfections that all people have in some situations as signs of personality disorder! The key, then as now, is the recognition of the extent and depth of disability, not just that, on occasion, one or another particular behavior or thought process was experienced. As noted in DSM-IV-TR, “A Personality Disorder is an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, leads to distress or impairment.”

To understand the person you are encountering, it is essential to assess both his or her temperament and character. The temperament traits are biases in emotional responses that are fully developed early in life and moderately stable thereafter. On the other hand, character involves higher cognitive processes that develop in a stepwise manner over the life course to enable a person to regulate emotions, achieve certain goals, and maintain particular values and virtues. Initially, it was thought that character was less heritable than temperament, but empirical studies have shown that both are moderately heritable (43). The key difference is the difference in the pattern of learning and memory: the procedural learning of habits and skills influences the conditioning of temperament, whereas propositional or semantic learning of goals and values influences the development of character. Both procedural and semantic learning interact with one another in self-aware consciousness so that a person can maintain a personal sense of continuity throughout many episodes of experience as his or her life history unfolds.

Describing Temperaments and Their Interactions

Temperament can be assessed in terms of the four TCI dimensions previously mentioned. The four TCI temperaments correspond roughly to the ancient Greek temperaments as described by Hippocrates and others: Harm Avoidance and melancholic humor, Novelty Seeking and choleric humor, Reward Dependence and sanguine humor, and Persistence and phlegmatic humor. However, the ancient Greeks thought of the humors as present or absent, whereas the TCI dimensions are quantitative with roughly bell-shaped distributions with most people near average and only the top third being noticeably “high” and the bottom third being noticeably “low.”

The TCI temperaments are described in Table 2, which shows that each trait is manifest in slightly different ways in different situations. Shyness in social situations and fearfulness in risky or dangerous situations both are indicators of anxiety-proneness or high TCI Harm Avoidance. A situation necessarily depends on both the person's outlook and the external circumstances themselves. For example, a person is described as high in Harm Avoidance if he or she is easily fatigued, fearful, shy, pessimistic, and inhibited. On the other hand, a person is described as low in Harm Avoidance if he or she is vigorous, risk-taking, beguiling, optimistic, and uninhibited.

However, the level of Harm Avoidance varies moderately between situations. For example, some people who are shy are not easily fatigued and some people who are shy meeting strangers are risk-takers when driving an automobile. The components of Harm Avoidance that are manifest in different situations are moderately correlated, so it is useful for general discussions to consider all these as part of a higher order trait that is moderately heritable and moderately stable across time and situations. Likewise, Novelty Seeking, Reward Dependence, and Persistence are also moderately heritable and stable dimensions of temperament. Each extreme of temperament has both advantages and disadvantages, so there is no “good” or “bad” temperament, just different emotional styles of adaptation.

Describing Character Traits and Their Interactions

Assessment of the three TCI dimensions of character provides a description of a person's goals and values (Table 3). Each of the character traits comprises components that are expressed in different situations. The character dimensions also correspond to key functions of a person's mental self-government. As a result, high character development is socially desirable for each of the TCI dimensions, although the development of high Self-Transcendence may seem countercultural in materialistic Western societies. Despite the Western ambivalence about spirituality and Self-Transcendence, available data strongly indicate that, in fact, high Self-Transcendence is extremely important for well-being, especially when a person faces suffering or death (28, 44 – 46).

Self-Directedness provides a useful clinical measure of the executive branch of a person's system of mental self-government. A self-directed person is responsible, purposeful, and resourceful in dealing with life's challenges. As a result, a person's Self-Directedness is an important indicator of reality testing, maturity, and vulnerability to mood disturbance. Self-Directedness is high in people who are mature and happy, whereas it is low in people with personality disorders and those vulnerable to psychoses and mood disorders.

Cooperativeness provides a clinical measure of a person's ability to get along well with others. Cooperativeness represents the legislative branch of self-government, which makes the rules that allow us to get along with others. A cooperative person is tolerant, empathic, helpful, compassionate, and principled. In contrast, an uncooperative person is prejudiced, egocentric, hostile, revengeful, and unfair.

The third branch of mental self-government is the judicial branch. Self-Transcendence is the ability to know when rules apply to a particular situation. Self-transcendent people are described as intuitive, insightful, joyful, and spiritual or holistic in perspective, whereas those who are low in Self-Transcendence are conventional, unimaginative, joyless, and materialistic.

Each of the three branches of mental self-government is essential for well-being. Having one component excessively advanced, not held “with checks and balances” by the other two branches, can lead to particular pathological conditions. The interaction among the three branches of self-government is depicted in Figure 3. For example, excessive imagination associated with high Self-Transcendence often leads to perceptual aberrations and vulnerability to overvalued ideas or psychosis if there is not the solid reality testing associated with high Self-Directedness (47, 48).

How do we measure personality?

Listening to personal narratives

Personality can be well assessed by inviting the patient to tell his or her life story and conducting a standard mental status examination. When listening to the person's life narrative, however, it is essential to be actively tuned to recognize patterns of troubling or rewarding interactions when the person needs to adapt to particular types of situations. A checklist of signs and symptoms is neither necessary nor adequate for the assessment of

personality because only narratives provide an account of a person's continuity of self-awareness over their lifespan (49, 50). Within the life story, the key elements on which temperament ratings are made are the narrative account of emotional style, particularly in childhood, and general appearance and behavior on the mental status examination. The key elements on which character ratings are based are the range of a person's thoughts, the nature of his or her interpersonal relationships, and his or her insight and judgment. The clinician must not only consider the words of the patient, which may involve little or no cognitive insight or self-awareness, but also recognize the significance of nonverbal signs from body posture, facial expression, and gestures to understand that individual's particular way of perceiving and relating to others.

The level of a person's Self-Directedness reflects all of these other sources of information. Low Self-Directedness is the cardinal feature of severe personality disorder, and the combination of low Self-Directedness and low Cooperativeness are a reliable measure of mild and severe personality disorders (32, 38, 51). The DSM-5 Work Group on Personality Disorder has proposed that Self-Directedness and Cooperativeness define healthy personality functioning and that deficits in these features are consistent characteristics of all personality disorders. Their proposal is particularly noteworthy and valuable because it provides a clear description of healthy functioning, rather than merely distress or impairment. Other discriminating and variable features of personality disorders are summarized in Table 4.

Systematic observation and empathy

Temperament involves emotional biases that can be directly observed and felt by an experienced clinician. The tendency of a person to elicit strong emotions from others or “to get under the skin” of another is a sign of extreme temperament traits or personality disorder. For example, the person with extreme temperament may elicit an urge to be rescued or feelings of hostility in the examiner. Their general appearance and behavior may be ingratiating or negativistic. Specific features of temperament that distinguish subtypes of personality disorders are summarized in Table 5.

Character traits are assessed based partly on intuitive recognition and partly on history. Someone who frequently blames others or elicits strong emotional responses in the examiner should be suspected of having a personality disorder. The ratings of character are more precisely based on observations of key functions of self-awareness obtained in the life narrative and the mental status examination. The most informative finding concerns the level of integration or elevation of a person's thoughts in self-aware consciousness, as described in Table 6 (30). The presence of severe personality disorder means essentially that a person is usually not self-aware (level 0 in Table 6), which has also been described linguistically as nonpsychotic formal thought disorder (52). Most adults are in the first level of self-awareness most of the time: they are responsible, have initiative, and are able to delay gratification if they want, but are egocentric. Such individuals may have problems with jealousy or pride but are sufficiently self-aware so that they are not considered personality disordered. The Silence of the Mind meditation, a simple means to evaluate level of elevation of self-aware thought is described elsewhere (28, 30). Instruction in this

meditation is offered in the *Know Yourself* psychoeducational course (available from http://anthropedia.org, a nonprofit foundation). Even from the first experience of this calming exercise, most nonpsychotic people are able to begin to achieve metacognition or mindfulness. Meditations to quiet the mind and body can also be used to help a person improve their level of self-awareness, so it is useful for both assessment and treatment.

The ability to reach the second or third stages of self-awareness is an important key to improvement in psychotherapy, as described in detail elsewhere (30). Such growth in self-awareness and character development corresponds closely to the stages of cognitive and character development as described by Piaget, Freud, and Erikson. For example, the first stage of self-awareness corresponds to the presence of initiative in Erikson's terms. The second stage allows the development of generativity. The third stage is the basis for integrity and well-being (i.e., the resolution of despair and regrets). More fine-grained ways to quantify the range of a person's thoughts and human relationships are also described elsewhere (30). Such refined ratings can be particularly useful for treatment but are not essential for initial diagnosis.

Recognition of the situational specificity

Personality traits are never independent of situations; they are intrinsically functions by which a person adapts to situations, even when broad traits are derived by averaging over a variety of situations (53). Consequently, people do not change broad personality traits such as Self-Directedness as a whole by simply deciding to do so. Rather, character develops incrementally by one's learning to deal more effectively with specific situations (29, 30). Cultivation of growth in character can be gained from several situations. Character may develop as a result of loving and secure childhood attachments, from a secure psychotherapeutic alliance, from a secure relationship with a confidant (that is, a “best” friend or committed partnership), or from “corrective reparenting.” An example of this last process could be a person recollecting a difficult event or interaction sometime earlier in life and transforming his or her initial perception and understanding of those previously traumatic events. By recollection in self-awareness, the individual is able to add a mature understanding or positive response and thereby radically transform previously negative or traumatic feelings. For example, one of our patients was burdened by the weight of chronic anger toward her mother who had “abandoned” her as a teenager. In treatment, she felt safe to recall and reexperience the events with a different perception of the context of those life events in childhood. She recognized and accepted that her mother had been in an untenable relationship and that a younger sister had needed disproportionate support because she was extremely vulnerable and dependent. In this new outlook, the anger lifted, and the woman was liberated from the negative emotion and its burdens on her. She accepted and forgave her mother, experiencing a spontaneous release from her own sadness and anger.

Such vignettes illustrate the importance of understanding a person's life narrative from multiple points of view. The person's history about his or her family of rearing, education, marriage, and work history provides key information for evaluating character. Further, it is important to inquire about a person's goals and hobbies or recreational activities. Whether someone has had secure friends (particularly anyone who has been fully trusted or served as

confidant now or in the past) is important to know as a measure of the capacity for intimacy and as a predictor of the capacity for forming a therapeutic alliance. Relationships with prior counselors, as well as a history of disability claims and lawsuits, provide additional key information about personality.

Assessing change over the lifespan

Remember that it is often crucial to assess the personality of psychiatric patients when they were children or adolescents. In other words, it is important to evaluate their personality retrospectively as much as possible, particularly at an age before the onset of other psychopathology, such as substance abuse or depression. Current anxiety or depression is expected to inflate Harm Avoidance ratings. Stress or intoxication tends to release temperaments from higher cortical control by character. Likewise, chronic substance abuse, depression, or psychosis arrests character development while active, so early onset of mental disorders is often associated with character deficits. Patients with early onset of mental disorders usually fail to learn to adapt in mature ways. Fortunately, it is usually easy for a patient to provide meaningful information about his or her childhood personality if the clinician simply asks about the child's early relationships to parents, siblings, schoolmates, and other childhood friends.

Remember also that the single most important dimension of personality to assess in rating a person's level of maturity is his or her degree of self-directedness. Is the person responsible, or does he or she tend to blame problems on other people and unfortunate circumstances? Is the person purposeful, or does he or she fail to establish clear goals in life? Is the individual resourceful, or does he or she feel inadequate and look toward others to solve his or her own problems? Assessment of Self-Directedness alone is sufficient to determine whether a person has a personality disorder of at least moderate severity (24, 38). In contrast, the finding of high neuroticism is not the same as a finding of low Self-Directedness, even though the two factors are strongly correlated: a person with anxiety or mood disorder and no personality disorder may be high in neuroticism but not low in Self-Directedness.

Some mild personality disorders also require consideration of the person's capacity to get along with others, as measured by the Cooperativeness score. In addition, high-functioning individuals who do not merit a diagnosis of personality disorder may nevertheless have specific blind spots in insight and judgment, which may lead to severe problems. For example, a competent physician may usually be self-aware but lacks a capacity for intimacy or a sense of fairness or prudence in business. Such specific deficits may have severe consequences, even if a person is self-aware in other situations (54). As a result, it is important to consider the overall profile of a person's life in a wide variety of situations including sexual, material, emotional, intellectual, and spiritual issues (30). Simply deciding whether or not a person has a personality disorder is insufficient for an assessment of his or her personality and risk for psychopathology. An adequate initial assessment of a person's personality should allow ratings of all four dimensions of temperament and three dimensions of character, which in turn provide a basis for understanding a person's capacity for well-being and vulnerability to psychopathology (28).

Clinical value of psychometric testing

Most experienced clinicians should be able to make valid personality assessments without psychometric testing. However, psychometric testing is usually still useful for at least four reasons. First, it helps the clinician to refine his or her clinical assessments by asking more questions with comparisons to normative data than is usually practical during a clinical session. Second, it provides the patient written feedback, which does not depend on the clinicians' subjective biases, that can be studied and reflected on—it reflects back to the patient what he or she said without distortion and provides a language that can be used for accurate communication between patient and doctor. Third, it provides a standard for comparison to later assessments as a means of measuring growth. Fourth, the reflection and dialogue involved in obtaining and discussing the results facilitate a therapeutic alliance (49, 55). As a result, it is usually helpful to supplement clinical impression with documentation that allows the patient to describe himself or herself without reliance on the judgment of anyone else. The patient's effort to describe himself or herself often has the therapeutic value of stimulating the patient to begin to understand the motives underlying the patterns of his or her behavior. In addition, comparison of psychometric test scores with clinical impression is a helpful way for clinicians to train themselves in the art of personality assessment.

Establishing a common language for dialogue

To learn how to communicate in a simple but powerful way about temperament and character, many physicians might seek to observe someone else presenting the information and then practicing it themselves. As a substitute for observation, we provide here an example of what we might say to a patient in reviewing his or her TCI results for the first time. This is merely an example, and different language and emphases may be more useful with different issues. Only the clinician's part of the conversation is presented here, but, in practice, there should be a dialogue about each dimension of personality and its clinical and therapeutic implications.

> Now I'd like to talk to you about your results on the Temperament and Character Inventory. I'm sure you're familiar with lots of personality tests. I like this one particularly because I feel it offers a comprehensive and well-grounded system to understand how a personality is put together. It can provide us with a common language for discussing how your personality is related to your current problems. By better understanding who you are, you can set the stage for future changes to develop in a way that you can choose for yourself. The system divides personality into two components: temperament and character. Temperament describes your emotional style, which is partly unconscious or automatic reactions to things, like what makes you nervous or angry or excited. Temperament is moderately heritable. I think of it as your grandparents' personalities shining through you. Temperament is also fairly consistent over one's lifetime. Imagine someone who knew you in high school meeting you today. Something about you *is* still the same, something about how you function in the world or conduct yourself.
>
> In the TCI scoring, we are looking at percentile rankings: scores based on the distribution in a large population. Most people score close to the median or 50th percentile. People notice traits as prominent when they are in the top one-third

(67% or higher) or bottom one-third (0%–33%). So if your scores are far from the 50th percentile, two things can be said about your personality: 1) that trait may be more prominent, for example, “she's the one who always is” (fearful, bored, seeking approval, etc.) and 2) that prominent factor may be more problematic for you in your interactions. That same trait might be advantageous to you in some other circumstances. Extreme scores can have both advantages and disadvantages, depending on the situation and your goals, so they are not necessarily “good” or “bad.” We will review the role all these traits play in your life in different situations. We'll explore ways to help modify whatever is causing you trouble in your day-today life. The encouraging news is that by understanding your personality you can shape how you develop and live your life in the future. No matter how our parents reared us or what childhood experiences we have had, we always have the opportunity to cultivate our own growth, by ourselves or in therapy as you are now.

If we can't nurture our personality development, then we will have the “depressive” outlook of low Self-Directedness, low Cooperativeness, and low Self-Transcendence. People low in Self-Directedness blame their problems on other people or circumstances, lack clear goals in life, and feel powerless; their life seems hard to them. People who are low in Cooperativeness are prejudiced, hostile, and revengeful; they feel that people are mean and unfair. People who are low in Self-Transcendence feel little connection to anything beyond their own immediate experience; they may have difficulty appreciating and enjoying the beauty of nature or of a spiritual connection to others or even God. The depressive character configuration is evident in a person who grumbles: “Life is hard, people are mean, and then you die—so what's the value of living?” [The patient's scores on each character dimension should be discussed with give-and-take about whether the self-reported description corresponds to the patient's understanding of himself or herself, with give-and-take about its meaning and implication.]

On the other hand, if we are able to promote our character development, then, we'll have a more creative or “enlightened” outlook of high Self-Directedness, high Cooperativeness, and high Self-Transcendence. Self-directed people are responsible, purposeful, and resourceful. Cooperative people are tolerant, helpful, and forgiving. Self-transcendent people are intuitive, joyful, and spiritual. The creative character configuration is expressed by feelings of acceptance, generativity, and integrity. When people are dying with integrity, even if it's “too young,” they are able to say that “I've done what I could, loved and been loved, and now I'm ready for whatever's next.”

As a human being with intelligence and freedom of will, you are both free and responsible to make the choices that allow you to experience satisfaction and meaning in your life. The fact is that you are actively making choices all the time, so you might as well begin to understand what choices you really want to make—what you really value and find gives lasting satisfaction. Then we can explore together how to create congruence between what choices you make today and what you want to have happen in the next chapter of your life. You are always writing

that next chapter in your life journey. You can cultivate goals and values in your character that will allow you to better regulate your emotional drives (that is, what is measured by the temperament traits in this test) and thereby bring more satisfaction and well-being into your life. Once you understand yourself better, you'll find that it is really possible to become healthier and happier, even if that seems impossible to you now.

Temperament measures your emotional drives. The first dimension of temperament is called Harm Avoidance, a measure of anxiety proneness. [Discuss the patient's Harm Avoidance score.] It is higher in people who are prone to depression and anxiety and higher when they are in the throes of anxiety or depression. You can see here the related factors of anticipatory worry, fear of uncertainty, shyness, and fatigability. I can give you some tools to help you move away from being so susceptible to anxiety [here I might tell them of some cognitive behavior tools/ paradigms to address the anxious mind], but we need to recognize that, if you are high in Harm Avoidance now, were we to meet 10 years from now, it is likely you'll be worrying about something!

The second factor is Novelty Seeking. This is a measure of incentive activation, the appeal of the novel and the new, and also an indicator of anger proneness. [Discuss the patient's Novelty Seeking score.] The lower it is, the more structured and regimented you are and the more you prefer the usual routine. The higher it is, the more you demonstrate exploratory excitability, impulsiveness, extravagance, and disorderliness. The higher your Novelty Seeking, the more open you may be to taking a new route home from work today. Imagine I've given you plane tickets to an exotic location. If you have low Novelty Seeking, you'll prefer everything to be more structured and planned; maybe you'd want me to have provided tickets to the museum for Thursday, reservations at the best restaurant in town for Friday, seats for the ballgame Saturday…. If your Novelty Seeking is high, you might tell me “It will be fun to explore the city on my own and be surprised by all that's new or unexpected.” [People often laugh in agreement and begin to relax when they recognize how well they've been described, accepted, and understood by an ally!]

The third factor is Reward Dependence. I think of this as social currency. It is a measure of sentimentality, attachment, and dependence (although I need to let you know that these words have been given a meaning different from our conventional definitions). [Discuss the patient's Reward Dependence.] Imagine a dinner party that you've hosted. You're in the kitchen with the dessert, which you've made. The person with Low Reward dependence knows that he's used an excellent recipe, superb ingredients. It's a great dessert—he could sit and admire it—in the kitchen, all night long. The person with higher Reward Dependence needs to go out and serve a portion, or even seconds, to everyone, and have someone ask for the recipe. “Did you see? Mrs. Jones, she never likes sweets! And she's asked me for my recipe!” The value of the experience is really the same in both instances, except in the first case the value is derived from the individual himself and in the second, the value comes from the social interactions. In other words, highly reward-dependent

people need approval from others. As a result, they often have a hard time saying no when asked for favors.

The fourth temperament is Persistence. This is a measure of how we deal in a situation that offers only intermittent success. It measures determination, ambition, and perfectionism. [Discuss the patient's Persistence score.] Think of the laboratory animal in the cage: Press the Lever. Get a Treat. Press the Lever. Get a Treat. Press the Lever. – – – No Treat (?!) Now the animal needs to decide how to apply its efforts. High Persistence would have the animal persevere in pressing the lever to obtain treats, even though there is no guarantee of any additional treats. An animal with lower Persistence might decide to put energy into playing on the exercise wheel, which offers more immediate and ensured feedback for the effort invested. Persistence might be considered an indicator of prudence, how one chooses to apply the resources one has. Consider the “Hold 'Em” and “Fold 'Em” scenarios at a poker table. Only that particular individual knows what cards she has in hand; only that particular individual can read how the other players seem to be viewing their cards. Only that particular individual can vote to put her resources in (Hold 'Em) or pull out of the hand (Fold 'Em). Persistence is a measure of the impact of obstacles in a path. Let's say you are planning to meet a friend in the afternoon for coffee. Stepping outside, you realize your vehicle has a flat tire. The person with low Persistence loses heart, is dismayed that his day is ruined, his week is ruined, and his friendship will be irreparably damaged. The person with high Persistence recognizes that he would very much like to visit with the friend, only the meeting will be later than originally planned. You can see how Persistence is a measure of ambition, because we will enjoy few successes if we don't stick with anything to see it to fruition. One can also appreciate how plain old tenacity is no assurance of success either and may be an unwise application of valuable resources. The example that comes to mind is an unrequited dating relationship: one person is very much invested in pursuit… but no amount of attention, messages, or small or large gestures will win a disinterested heart.

This is merely one conversation of many thousands that could unfold, depending on the person, his or her background and interests, and the situation being faced. In actual practice, there is much dialogue between patient and clinician that is tailored to the patient's particular profile and situation, incorporating many elements that have already been revealed in the history-taking process. In one straightforward exercise, you have been able to begin to communicate and discuss meaningful information about your patient's experience of life, you have validated that unique experience, and you have established in both you and the patient a basis for genuine respect and empathy.

Implications for treatment

The person-centered treatment process

Personality assessment helps to identify and refine treatment targets based on biological, psychological, social, and spiritual considerations (19, 30, 56, 57). A radical assertion is suggested: once you, as provider, are familiar with the system and structure of personality as

outlined by the TCI and your patient's particular profile, the therapeutic tools that you have already used with success in your practice will become more effective as you refine the approaches to the specific countenance revealed by your patient. Thus, a pharmacological approach will be augmented by using a biologically relevant model of personality to conceptualize the complex interactions among different brain systems and aspects of learning. A psychodynamic approach will more pointedly appreciate the impact of particular factors in the person's experience and suggest a way to transcend the otherwise interminable struggle between drives and ego (30). A cognitive behavior therapy approach can focus more specifically on anxiety and Self-Directedness; reduction of dropout and relapse rates can be gained by facilitating the development of other strengths and well-being (1). A dialectical behavioral therapy approach will more emphatically underscore the need to cultivate mindfulness skills (and thus Self-Transcendence, a character component) as a starting point for other gains but can be made more understandable by recognizing the universal structure of personality within which behavioral conditioning processes develop. Behavioral interventions could focus on simple, specific tasks that are in opposition to an extreme bias in temperament (e.g., for low Persistence, suggest that the person make his bed daily; for high Persistence, urge her to walk away with sheets disheveled in the morning). Sometimes the exercise a person most needs will appear obtusely related to his or her complaint—such as a suggestion to increase self-forgetfulness (an early step in developing Self-Transcendence) by dedicating 21 minutes to an artistic exercise using sheets of copier paper and a fistful of crayons. If your proposal is viewed with frightened eyes or a brusque bewilderment, then it is all the more urgent for the person to try it, being observant and curious as the exercise is undertaken.

Try to invite reflective curiosity in your patient and in yourself about who the person is; be aware of responses elicited in you. For example, is a display of anger evidence that people feel their resources or options are exhausted? Reflect further: is anger a response to conflicting emotional drives in someone who never feels satisfied because of opposing needs for both safety and novelty (i.e., if he or she is high in both Harm Avoidance and Novelty Seeking) or intimacy and caution (i.e., if he or she is high in both Reward Dependence and Harm Avoidance). Dialogue and reflection on this by the patient and by the therapist help develop empathy and self-understanding, as well as an appreciation of outlook bias. Both need to recognize that perceptions are often colored by a subjective valence that may or may not be appropriate for the actual situation.

Modulation and avoidance of excess are important therapeutic goals because extreme biases in temperament or conflicts among incompatible drives often lead to personal distress. For example, a person who is very low in Novelty Seeking might be too invested in order, routine, rules, regulations, familiarity, and predictability. As a result, *change* in their world, however it unfolds, would be perceived as a source of distress, irritability, depression, anxiety, or dismay, rather than as an opportunity for new experiences and learning. On the other hand, a person who is high in both Novelty Seeking and Harm Avoidance may have approach-avoidance conflicts, as is often seen in bulimic individuals, until they learn to regulate these conflicts by increasing Self-Directedness (58). Conflicts about intimacy and security may be unresolvable until a person develops a greater capacity for tolerance,

empathy, and forgiveness as expressions of greater Cooperativeness. The methods for developing character and self-awareness will be described shortly; a patient who is moderately or severely ill may need to be stabilized with medication before anything further is offered. People profit little from psychotherapy when their distress overwhelms their capacity to think reasonably.

Use of personality in medication management

Medication management is an important component of a biopsychosocial approach. Both temperament and character have important biological components. Nevertheless, more tools for pharmacological treatment of temperament have been described than for character because character development depends on intentional problem-solving by the person learning to adapt to specific situations (30, 49). Understanding the patient's temperament and character structure facilitates medication management by recognition of the underlying emotional and adaptive processes. The use of psychotropic medications can be guided by both symptoms and knowledge of the neurobiology of personality dimensions as each contributes to the phenotype of the patient's experience and symptoms (26, 57). At first, stabilization is the aim, with specific attention to the issues of mood dys-regulation, aggression, emotional detachment, or even psychoses. Character structure has little influence on medication choice; pharmacotherapy and psychotherapy can be integrated by planning both on the basis of temperament structure. The less mature a person's character is, the more important will be the combination and integration of multiple treatment modalities, including pharmacological and psychotherapeutic management (8, 59). As a concise rule of thumb, the most useful classes of medications are antidepressants for high Harm Avoidance, stimulants or mood stabilizers for high Novelty Seeking, neuroleptics for low Reward Dependence, and mood stabilizers for low Persistence. A more detailed consideration of particular drug choices is described elsewhere (57).

In our experience, exclusive reliance on pharmacotherapy often leads to many “refractory” patients who can be more effectively helped by integrating psychotherapy with pharmacotherapy. Integrative treatment strives for more than simply having parallel medication management and psychotherapy offered by different professionals who (unfortunately) seldom communicate. Encouraging a patient to consider a different perspective or to use some of their strengths to adapt to a distressing situation will serve the individual more than always defaulting to an adjustment or change in the medication regimen. Exclusive reliance on medication neglects the opportunity to explore how suffering and distress are often a signal for a person to transform his or her outlook on the situation he or she is facing. As long as we ignore the meaning of our symptoms and their underlying causes, we cannot hope to have optimally helpful treatments. Medications can be very important, even life-saving; however, alone they are often not sufficient to relieve symptoms. Medications themselves offer substantially little to help a person to grow in self-awareness or to cultivate the perspectives essential for well-being. One of our patients, an articulate professional who had tried many medications with partial and inconsistent benefit, observed that

> One can read about an illness, and know something of it, but to live it is to truly know it. The highly individual nature of depression is fascinating. It can be caused,

> complicated, and evidenced by an astounding number of diverse factors. Antidepressants only treat the symptoms, and not the causes. I believe, like denial, they serve a short-term purpose.

Nevertheless, we recognize that the use of pharmacotherapy can be crucial to stabilize patients so that they are amenable to therapy, just as psychotherapy can help the patient to flourish instead of merely enduring. The less mature the character, the more crucial it is to integrate psychotherapy and pharmacotherapy.

Awakening a perspective of well-being

Recovery from mental illness is achieved through transformation of a person's perception of his or her life and relationships. Psychiatric care needs to aim beyond reduction of symptom lists and to cultivate a new direction for the patient's basic outlook on life. Psychiatry, which literally means “healing of the spirit,” can provide a means for the blossoming of a person's spirit. Otherwise, as we have all often seen, the individual is trapped in patterns that ensure the chronicity of complaints and suffering, despite contextual changes (new job, divorce, financial windfall, new dating partner, abstinence from drugs of abuse, and so on). Outlooks of separateness result in persistent vulnerability to fear, excessive desire, and feelings of pride or inadequacy until a person's outlook changes, thereby allowing character development (19, 30). The few (or desperately many) medications we have prescribed afford some small comfort, but do not change a person's character.

The basis for self-transformation is focusing on what a person values at the core of his or her being. Every individual must recognize what gives truly lasting satisfaction and then learn how to do that wholeheartedly. Therapy then is an invitation to understand and adapt one's outlook on life. The outlook is the prism through which all experience is perceived (e.g., think of the “rose-colored glasses” cliché). A person's outlook colors all of his or her perceptions and generates either a positive or negative tone (think constructive or destructive), which builds us up or breaks us down. Only by recognizing and changing our perceptions can we transform the way we experience life, which is summarized by the description of our personality (28).

Transformation from the situation that generates a person's presenting complaints into a position of health, satisfaction, and well-being involves cultivating growth in self-awareness. A person needs to gain a calm and accurate reflection of himself or herself first to transcend the conflicts within him or her. Each individual is unique, and no tidy procedural guide mandates the ideal script. Coherence therapy is described in *Feeling Good: The Science of Well-Being* (30). The rationale and content of coherence therapy is further described elsewhere in this issue (28).

Gains can be obtained from two complementary approaches. First, people are guided to understand themselves and how they are carving out the world by their perceptual outlook. Second, people are invited to appreciate the consequences of their outlook to understand why particular situations are difficult or troubling for them. Increments in insight can happen as a person honestly views himself or herself; these changes can be quantified by periodic retesting using the TCI (28).

So far we have primarily outlined the process of describing a person's temperament and character structure as a way of understanding the strengths and weaknesses that particular individual has in adapting. The attitude we have in this process, however, is from the beginning to prepare a person for a change to develop well-being through increased self-awareness (29, 30, 49). To develop greater self-awareness, we have found that the most rapid transformations occur when a person recognizes strengths already owned that have not been applied in situations in which problems have been experienced (58). Once the person begins to understand himself or herself and to recognize what he or she truly values and finds most satisfying, then he or she can quickly use existing strengths in new ways. A patient who feels hopeless because of chronic shame may begin to flourish if he or she accepts life's trials with courage and a sense of purpose. A narcissistic patient may realize by doing acts of kindness that he or she has denied or repressed strong needs for intimacy and approval (perhaps due to the remoteness or rejection of his or her parents during childhood). Previously unexpressed or undeveloped potentials are activated by new experiences and well-being practices. For example, once the awareness of the need for intimacy and the satisfactions of service to others are experienced directly, then transformation of a person's outlook is often rapid and radical (29, 30).

Ways of treating different personality configurations are described elsewhere in detail (8, 57). Much more could be said about the way people with different personality configurations use psychotherapy. For example, people high in Harm Avoidance may have trouble opening up emotionally to the therapist, people high in Novelty Seeking may be erratic in adherence to medication or appointment schedules, and people high in Reward Dependence may easily become dependent if a therapist is directive in giving advice or conditional signs of approval. These issues are discussed in detail elsewhere (8), but here we have sought to provide an overview of how busy practicing psychiatrists can organize their way of practicing to promote the development of healthy personality functioning in all their patients regularly.

The fundamental practices leading to the development of well-being are more fully described in other parts of this issue and elsewhere (30). To teach coherence therapy clearly and make it widely available, a series of psychoeducational and psychotherapeutic modules have been developed to provide a fully standardized and accessible approach. We realize that the demands on psychiatrists' time are extreme and so have developed the *Know Yourself* DVD series to assist clinicians with busy practices and limited time for psychotherapy. Regardless of prior background, any clinician can first explore the materials himself or herself and subsequently offer the resources for patients to consider as an adjunct to therapy. The modules can be used to supplement individual or group therapy, saving time for busy clinicians and providing the opportunity for well-organized homework by patients and their friends and family. Each of us is aware of our capacity for continued personal growth.

Questions and controversy

The challenge and adventure of adopting a new paradigm with new terminology is acknowledged. The proposal of the DSM-5 Work Group on Personality recognizes the need

to assess healthy personality in terms of character traits corresponding to TCI measures of Self-Directedness and Cooperativeness. It allows clinicians to describe personality traits in terms of familiar traits such as “compulsive” or “schizotypal,” even though such traits are causally complex. Hence the proposal for DSM-5 recognizes the need for clinicians to learn to think in terms of multidimensional profiles, rather than only in terms of categories. It also begins to address the fact that traditional psychiatric terminology has been overly focused on psychopathology, leading to unnecessary stigma and diminishing hope for recovery. The person-centered approach we have described should help clinicians to adapt to the emerging scientific consensus about the complex multidimensional nature of temperament and personality.

The TCI provides a gentle and encouraging language by which patient and psychiatrist can communicate respectfully and hopefully. Therefore, we invite you to learn the language and how to use it to enhance your assessment and treatment. Why should you bother learning a new system, even one corresponding to the proposed DSM-5 description of a healthy personality? We think the person-centered approach will improve your effectiveness and satisfaction with your practice, thereby improving the quality of your life, as well as the quality your patients lives.

The TCI is dependent in part on patient's truthfulness and self-understanding in a self-report. However, we have confidence in your clinical capacity to formulate an impression of personality structure and expect that this capability will be further developed as you directly rate personality configurations by observation and routine history taking (as we have described earlier). The TCI self-reports can be distorted by a person's poor insight; an individual might describe someone he wishes he was or someone she thinks she ought to be. Often, these people do not appreciate how this wish does not match who they are. Comparison of your own observation of the patient with his or her self-report provides a reliable way to detect such cognitive distortion. Discussion of such discrepancies opens a rich avenue of dialogue that can greatly help patients improve their self-awareness and subsequently modify their goals and values. In addition, patients with limited intellectual capacities may have a difficult time answering questions accurately. A clinician must always weigh the advantages of psychometric testing against the alternative of taking the time to develop a portrait of the patient's personality in discussion. Fortunately, various versions of the TCI are available for children and those with lower reading levels (http://psychobiology.wustl.edu). As TCI results are reviewed with a patient, be aware of how particular innate pathologies become manifest; for example, an individual with anxiety (high Harm Avoidance) might fret about “worrisome” values. We have heard of one person who was discouraged that she scored “high on all the bad stuff and low on all the good stuff.” This situation actually provides an opportunity to encourage the patient by pointing out that we are capable of radical transformation in personality once we accept who we are and wholeheartedly decide upon satisfying goals and values. In this way, people can learn how to live well, rather than thinking that they can only learn how to manage their deficits.

Summary

The Temperament and Character Inventory and the person-centered approach to assessment and therapy offer a new and powerful resource to the mental health provider in each individual interaction that comprises a workday. Patients are understood and validated in new terms, with a new set of aims of treatment and new guidance for both pharmacotherapy and psychotherapy. A respectful dialogue and personal connection is established using these methods. A person-centered therapeutic relationship serves as an effective fulcrum for the success of other interventions.

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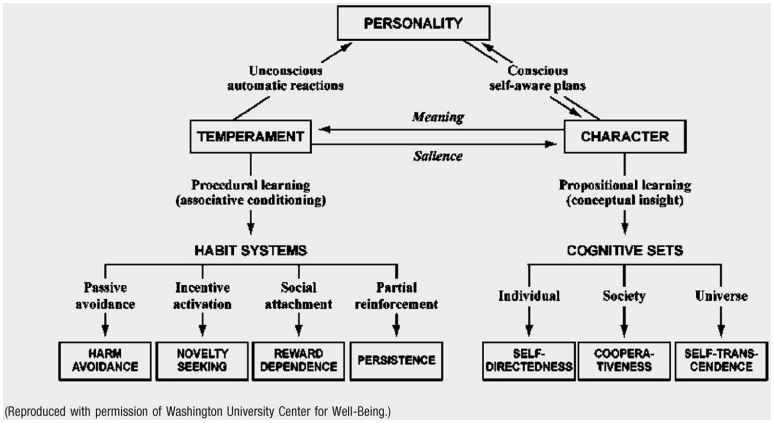

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Figure 1.
Psychobiological Model of Temperament and Character.

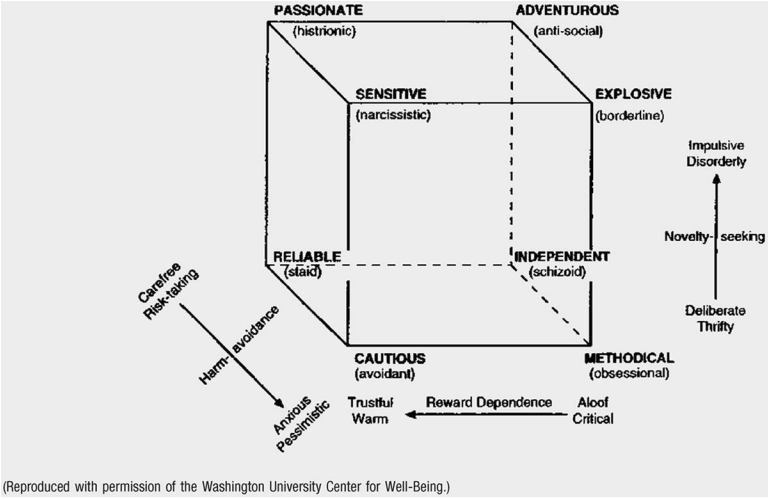

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Figure 2.

The TCI Temperament Cube: Descriptors of Different Configurations of TCI Harm Avoidance, Novelty Seeking, and Reward Dependence.

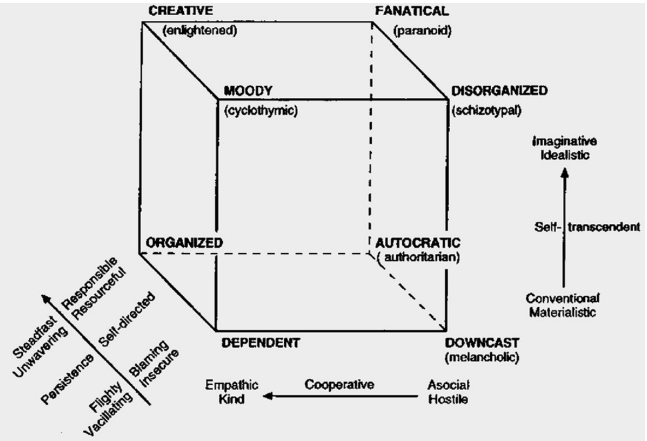

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Figure 3.
The Character Cube.

Table 1

Probability of Being Immature in Character As a Function of the Configuration of TCI Temperament Traits

Temperament Type	Configuration Code*	Number of Subjects	% Immature†
Explosive	NHr	39	72
Methodical	nHr	44	59
Adventurous	Nhr	25	48
Sensitive	NHR	30	40
Average	—	15	33
Avoidant	nHR	30	17
Independent	Nhr	31	16
Passionate	NhR	50	12
Staid	nhR	36	6
(Total)		(300)	(33)

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*Code indicates Novelty Seeking is high (N) or low (n), Harm Avoidance is high (H) or low (h), and Reward Dependence is high (R) or low (r).

†Immaturity is based on being in the bottom one-third of the general population in sum of Self-Directedness and Cooperativeness, a strong measure of personality disorder or immaturity.

Table 2

Description of People Who Are High and Low on the Four TCI Temperament Dimensions

Temperament Dimension	Descriptors of High Variant	Descriptors of Low Variant
Harm Avoidance	Pessimistic	Optimistic
	Fearful	Daring
	Shy	Outgoing
	Fatigable	Energetic
Novelty Seeking	Exploratory	Reserved
	Impulsive	Rigid
	Extravagant	Frugal
	Irritable	Stoical
Reward Dependence	Sentimental	Practical
	Sociable	Aloof
	Warm	Detached
	Approval-seeking	Self-sufficient
Persistence	Industrious	Lazy
	Determined	Spoiled
	Ambitious	Underachieving
	Perfectionistic	Irresolute

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* Each descriptor is measured by a specific TCI subscale.

Table 3

Description of People Who Are High or Low on the Three TCI Character Dimensions*

Character Dimension	Descriptor of High Variant	Descriptor of Low Variant
Self-Directedness	Responsible	Blaming
	Purposeful	Aimless
	Resourceful	Inept
	Self-accepting	Pretentious
	Self-disciplined	Self-defeating
Cooperativeness	Tolerant	Prejudiced
	Empathic	Insensitive
	Helpful	Hostile
	Compassionate	Revengeful
	Principled	Opportunistic
Self-Transcendence	Creative	Conventional
	Intuitive	Analytical
	Spiritual	Empirical

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*Each descriptor is measured by a specific TCI subscale.

Table 4

Qualitative Description of Personality Disorders

Feature Type	Qualitative Description
Discriminating	Maladaptive pattern of responses to personal and social stress that are
	Stable and enduring since teens
	Inflexible and pervasive
	Causing subjective distress and/or impaired work or social relations
Consistent	Low Self-Directedness
	Efforts to blame and change others, rather than oneself
	Poor self-acceptance
	Poor integration of goals & values
	Low Cooperativeness
	Strong emotional reactions elicited from others (such as anger or the urge to rescue)
	Hostility and impaired empathy
	Detachment and impaired intimacy
Variable	Odd, eccentric
	Erratic, impulsive
	Anxious, fearful
	Perfectionistic, obstinate

Table 5

Qualitative Clusters and Subtypes of Personality Disorders according to DSM

Cluster Label	Subtype Label	Discriminating Feature
A—Odd/Eccentric		(Low Reward Dependence)
	Schizoid	Socially indifferent
	Paranoid	Suspicious
	Schizotypal	Eccentric
B—Erratic/Impulsive		(High Novelty Seeking)
	Antisocial	Disagreeable
	Borderline	Unstable
	Histrionic	Attention-seeking
	Narcissistic	Self-centered
C—Anxious/Fearful		(High Harm Avoidance)
	Avoidant	Inhibited
	Dependent	Submissive
	Obsessive	Perfectionistic
Not Otherwise Specified		
	Passive-aggressive	Negativistic
	Depressive	Pessimistic

Adapted with permission from American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, 4th ed. Washington, DC, American Psychiatric Association, 1994.

Table 6

Clinically Observable Levels of the Integration or Elevation of Thought in Self-Aware Consciousness

Level of Integration of Thought	Description	Characteristic Features
0—Automatic	Reactive	Pleasure-seeking, reactive, behaviorally conditioned, without delay or planning
1—Self-centered	Judgmental	Able to delay gratification, show initiative, but egocentric, judging and blaming
2—Metacognitive	Mindful	Able to observe flow of own thoughts to understand without judging or blaming
3—Metaperceptive	Contemplative	Able to observe shifts in outlook that precede initial perceptions (i.e., the schemas that organize perceptions)

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